REACHING OUT TO AFRICA FOR OUR CHILDREN

our response to child trauma

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PREFACE

Edith Kriel
Marita Rademeyer
Dr Joan van Niekerk

The plan to develop a publication containing papers from the African Child Trauma Conference 2019 predated the COVID19 virus pandemic, and the original plan was to make this book available to delegates who attended the 2019 conference and to launch the book at the 2020 African Child Trauma Conference, originally planned for May 2020, but put on hold due to the pandemic and the resulting lockdown. There has also been an enormous amount of work resulting from the pandemic, which although it has affected the lives of all of us and challenged us to work within the new normal, has had a profound impact on the lives of children.

Child protection services, inadequate as they have been in the past, have become even more stretched – lockdown and its resultant economic disaster and loss of employment has meant that services have had to extend to ensuring that the most basic needs of children are met such as the need for food, shelter and clothing, along with protection from all forms of abuse and services that promote healing when abuse does occur.

This book of collected papers, some looking at primary prevention of abuse, some at early intervention and some at how we respond to abuse after it has occurred, thus remains as relevant as when the papers were originally presented at the conference in august 2019.

The editors of this e-book wish to thank all contributors to this small volume of papers for giving so generously of their research, thinking and ideas about how to ensure that our responses to all African children are the best that we can offer.

The papers are not organised in the order in which they were presented at the conference but rather have been divided into prevention, early intervention and response. Some papers particularly those presented by government role-players represent a mix of all three areas of intervention. These are presented in the last section of the paper.

WELCOME SPEECH FROM THE CONFERENCE CHAIRPERSON

Dr Maria Mabetoa

Programme Director/ Mama of ceremonies: Ms Thozama Ngcongolo
Minister of Social Development in the Western Cape Province: Hon, Ms. Sharma Fernadez
Minister of Education in the Western Cape Province: Ms Debbie Schafer
Mayoral Committee Member for Health and Community Service: Councillor: Hon. Zahid Badroodien
The Chairperson of Jelly Beanz Child Protection and Family Organisation: Ms Marita Rademeyer and the Executive Director Ms Edith Kriel
Professor Benyam Dawit Mezmur
Professor of Psychiatry at the University of Stellenbosch: Prof. Soraya Seedat

Ladies and Gentlemen,

It is an honour as a chair of the conference to have this opportunity to address you at this crucial conference. My main role this morning is to welcome you on behalf of Jelly Beans Child Protection Organization and its partners and to express our appreciation to you for responding to the clarion call to come together during these four days to put our heads together not only to have a good understanding of the nature and scale of child trauma in the region, but most importantly to share and propose strategies, programmes and policies to address the escalated trauma subjected to our children. This trauma emanates from cruelty, violence, physical and sexual abuse, child exploitation in the form of child trafficking, sexual slavery neglect and even murder.

According to the World Health Organisation (2016) child abuse is a global problem and has serious consequences for the victims and society. International studies reveal that a quarter of all adults in various countries report having been physically abused as children and 1 in 5 women and 1 in 13 men report having been sexually abused as children. The incidence of child homicide is also increasing., In South Africa's child homicide rates are reported to be 5.5 per 100 000 children under 18 years, which is higher than the WHO's estimated global average of 2.4 per 100 000 children under 18 years (Mathews, Govender, Lamb, Boonzaier. Dawes, Ward, Duma, Baraecke, Warton, Artz, Meer, Jameson & Röhrs (2015).

The effects of violence on children, if not addressed through therapy, are known to be long-lasting as most children carry them into adulthood. Mental health problems, anti-social behaviour, substance abuse, bullying, are some of the common manifestations of the effects on people who have been abused during childhood as compared to those who did not suffer abuse as children.

It is also a well-known fact that perpetrators of child abuse and neglect are mostly primary caregivers, parents, other relatives, family friends and teachers. These are people that the child depends on for

his/her basic needs. In the case of sexual abuse, it is mainly people who are well known to the child and trusted by him/her.

The first question that everyone asks is what is causing or contributing to this attack on children? Literature points to domestic violence, violence and crime, the migratory labour system (that has had an impact on the role of men in families and communities), poverty and poor socio- economic conditions, absence of programmes that prepare young people for parenthood, HIV and AIDS and inaccessibility of services, etc.

In order to address the proper care and protection of children, many countries including South Africa have ratified the UN Convention on the Rights of the Child, the African Charter on the Rights and Welfare of Children. Laws have been passed, policies and programmes are in place in line with these conventions. For example, in South Africa we have section 28 of the Bill of Rights in our Constitution which clearly spells out the Rights of Children; in addition, the Children's Act of 2005 has been passed to protect the Constitutional rights of children. Despite these provisions the abuse of children is continuing and this has become an intergenerational vicious cycle as abused children often tend to become abusers in their adult lives.

Most of these issues will certainly be discussed during the conference. As a result, in order to ensure that the conference will have good outcomes we have invited professionals, practitioners and policy makers from different sectors because child protection requires collaborative efforts across disciplines and sectors. "It takes a whole village to raise a child".

We hope that you will find the conference informative and you will also get the opportunity of sharing your experiences in working directly or in directly with children, communities and families and the whole nation to eradicate child trauma. We also hope that this will in return embolden us to continue with the eradication of child maltreatment and provision of appropriate and effective interventions to affected children and their families in our different countries.

Looking forward to seeing and learning from you at the plenaries and breakaway sessions.

Thank you

References

Mathews S, Govender R, Lamb G, Boonzaier F, Dawes A, Ward C, Duma S, Baraecke L, Warton G, Artz L, Meer T, Jameson L. and Röhrs S. 2015. *Towards a more comprehensive understanding of the direct and indirect determinants of violence against women and children in South Africa with a view to enhancing violence prevention.* University of Cape Town.

World Health Organization. 2016. *Child Maltreatment*, Fact Sheet.

KEYNOTE ADDRESS: INTERGENERATIONAL TRAUMA: LEGACY OF THE PAST, IMPLICATIONS FOR THE FUTURE OF AFRICA

Professor Shanaaz Mathews -Director, Children's Institute, University of Cape Town

Africa's historical context

Africa is an expansive, diverse and "complex" continent and violence has characterised much of Africa's documented history. Much of this tends to focus on an account of collective violence and fails to highlight the various forms of interpersonal violence that is pervasive across the region. Types of interpersonal violence, such as intimate partner violence and child abuse and neglect, are endemic across the continent. Intersecting forms of violence - interpersonal violence and collective violence co-occur in conflict setting with immediate and long-term trauma effects

Mental health and Children in Sub-Saharan Africa

Child maltreatment in the African context is driven by extreme poverty, high levels of HIV, and sociocultural variations in family structures and socio-cultural norms and values. Child and adolescent mental health challenges in sub-Saharan Africa are prevalent in 14.5% children under 16 years. In the Western Cape, prevalence stands at 17%, post trauma stress disorder at 8% and generalised anxiety disorder at 11%.[1]

The most significant risk factors include maternal mental health, disruption of the family, marital status, exposure to stressful events, maternal age, and poverty-related factors (such as insufficient food, low socioeconomic status, and illness).

Understanding intergenerational vs transgenerational trauma

Transgenerational: The impact of violence being **passed through generations** with the effects being evident **without exposure to violence**

[1] Cortina M, Fazel M, Hlungwani T, Kahn K, Tollman S, Cortina-Borja N & Stein A (2013) Childhood psychological problems in school settings in rural Southern Africa. *PLOSone*. 8(6) e65041 DOI: 10.1371/journal.pone.0065041.

Intergenerational: Reports of the **experience or exposure violence has occurred across generations** of a family with intergenerational effects

Intergenerational transmission of the effects of trauma – epigenetics

Epigenetics explains how early experiences can have a lifelong effect. Experiences during a child's development can rearrange the epigenetic marks that govern gene expression. Epigenomes are affected by both positive and negative experiences. Early experiences cause epigenetic adaptations that influence how genes influence future health and resilience. Environmental influences can also affect how genes are expressed

Transgenerational Effect of Trauma and PTSD

Research examined the impact of the Tutsi genocide on the children of the women who were pregnant while genocide was ongoing in Rwanda. In 2011, more than 20% of the Rwandan population met criteria for PTSD – 16 years after the genocide. The study explored the risk for PTSD and its association with epigenetics in the children of women who were pregnant at the time of the genocide. Twenty-five widows and their children were included in the study, as well as 25 Rwandan control women who were pregnant at the time, but who were living abroad. Mothers exposed to the genocide and their children had significantly higher levels of PTSD and depression than the control group. Mothers and children exposed to trauma had a lower cortisol level than non-exposed mothers and their children (lower cortisol levels were found to be related to PTSD)[2]

Toxic Stress in the young child

Prolonged exposure to adversity such as neglect and abuse result in biological responses and

- Can damage the architecture of the developing brain
- Increase the likelihood of significant mental health problems that may emerge during childhood or years later.
- Impair school readiness, academic achievement, and both physical and mental health
- Poverty, violent neighbourhoods, and very poor child care conditions (environmental conditions) affect children's exposure and outcomes. Young children who experience recurrent abuse or chronic neglect, domestic violence, or parental mental health or substance abuse problems are particularly vulnerable to toxic stress.

[2] Perroud, et al The Tutsi genocide and transgenerational transmission of maternal stress: Epigenetics and biology of the HPA axis. World J. Biol. Psychiatry **2014**, 15, 334–345.

Violence across the life course of children[3]

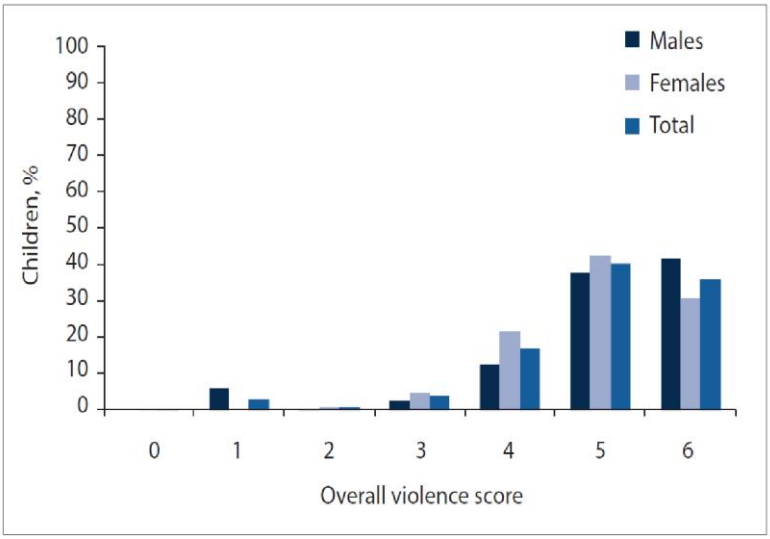


Fig. 1. Percentage of children who experienced violence according to the overall violence score (1 - 6 across all time points) by gender.

6 Categories:

Exposure/witness

1. home,
2. school,
3. community or
4. peer violence
5. Experience of violence
6. Experience of sexual violence

1% no violence 36% of children experienced violence in all 6 categories before 18y of age

Intergenerational effects of violence

For girls – this increases the risk of revictimisation as adults and increases the risk for internalising experiences – depression, suicidality, anxiety disorders.
For boys – this increases their chance of being violent in adolescence and adulthood and reduces their ability form emotional attachments.

[3] Richter L, Mathews S, Kagura J & Nonterah E (2018) A longitudinal perspective on violence in the lives of South African children from the Birth to Twenty Plus cohort study in Johannesburg-Soweto. *South African Medical Journal*.

Child abuse history, mental health and IPV[4]

	Measurement	Women	Men
Child abuse (physical, sexual or emotional)	Childhood trauma scale	86% any	80% physically abused 55% neglected 63%emotionally abused 20% sexually abused
Current PTSD symptoms	Harvard trauma questionnaire	11.6%	24%
Current mild depression symptoms	CESD Scale	23%	24%
Binge drinking	AUDIT Scale	14%	36%
IPV	WHO Domestic Violence module	○ 50% of women experienced IPV in their lifetime ○ 18.3% experienced IPV in the 12 months before the survey.	○ 56 % of men physically abused and 31% sexually abused partners at least once in their lifetime. ○ 22 %of men had one episode and 40 % had repeat episodes of physical or sexual IPV perpetration

The data showed the high prevalence of child abuse history (80+) using the CTQ that has been validated in SA and measures 4 domains of child abuse: physical, sexual, emotional and neglect. Men reported higher symptoms of PTSD symptoms- which are associated with exposure to traumatic events such as witnessing or experiencing violent crime, being near death, etc. Almost similar proportions of men and women i.e. about 1 in 4 reported mild depressive symptoms. Twice the proportion of men vs women reported binge drinking in the year before the survey. There is a high prevalence of IPV reported by women (experiences) and men (perpetrators).

Already we begin to confirm from the data that these issues are co-occurring in our society.

[4] Machisa MT, Christofides N, Jewkes R (2016) Structural Pathways between Child Abuse, Poor Mental Health Outcomes and Male-Perpetrated Intimate Partner Violence (IPV). PLoS ONE 11(3): e0150986. doi:10.1371/journal.pone.0150986

The Intergenerational cycle of violence

"Eish it is hard…. (pause) sometimes I think of killing my children because of what happened to me, now it is happening to XXXXX (crying). I did not plan to have her. I lost both my parents and I was then abused. Now they (her children) are abused as well what did I do to the Lord (silence crying) I even think about killing myself …….. (13-year-old)

This Mom and daughter had difficulties with communication and she blamed the child for the abuse. Mom disclosed her own sexual abuse as a child which resulted in being blamed and beaten by her own mother. She has been in a violent intimate relationship with an older man but remained due to the financial support. Mom displays feelings of self-hatred, and abuse of alcohol and drugs as a means of numbing her pain

The impact of violence in the home on boys:
A man explained he tried to intervene while his father was abusing his mother, as a consequence he was also beaten by his father, he said: *"What stands out for me was the time he smacked me I was a child and was very depressed I went and cried in the bushes*." (45 yr old male).

Violence impacts on feelings of safety and feeling scared and exacerbates feelings of powerlessness. Repeated painful experiences become internalised and affect later interpersonal relationships.

Childhood adversities in men who killed an intimate partner

Childhoods were *"rough"* and *"hard"*. There was **limited positive attention** by mothers, bordering on abuse and neglect. **Absent fathers** or fathers who were **emotionally uninvolved** had a profound impact on identity. Seeking affirmation outside the family **led to involvement in gangs or criminal activities.** Pathways to violent masculinities have a **complex interplay of social and emotional factors.**

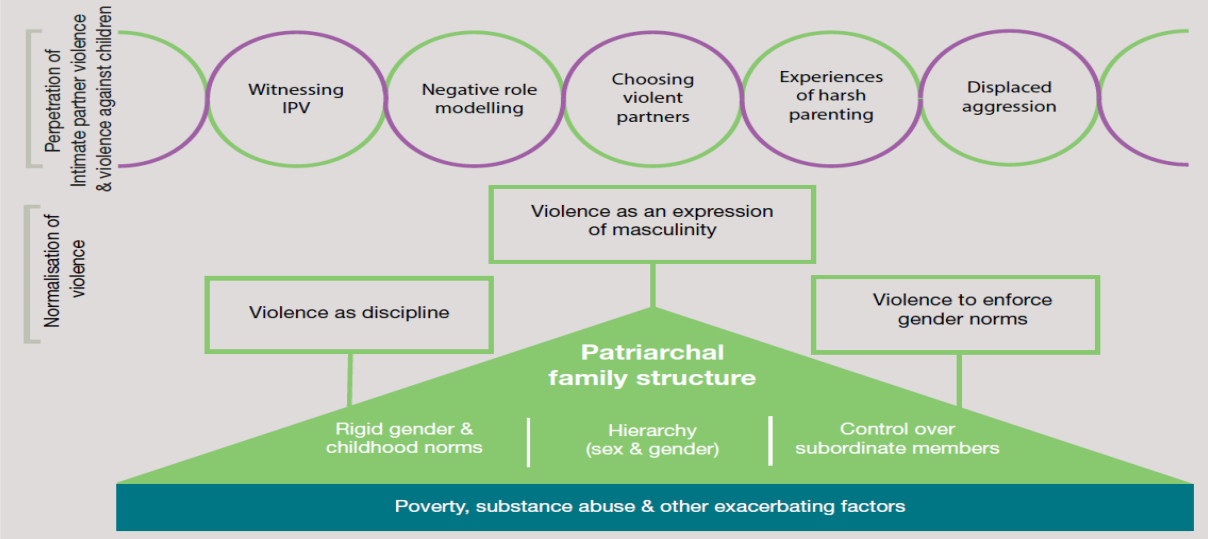
Some men spoke about the anger and resentment they felt towards their mothers when she remarried or entered a new relationship. One man speaking about his mother said: *I was mad at my mother when she married my stepfather ... I never went to live with my mother when she married again, I stayed with my grandparents*.

Although she was not an overtly poor mother, being raised by his grandmother resulted in an insecure attachment with her, which influenced his feelings of being abandoned once again by her when she remarried. Mothers' emotional availability, affecting the parent–child relationship and the nature of their attachment. Disorganized attachment is linked to the development of externalizing problem behaviours, such as criminal behaviour and the use of violence.

Psychological recovery post sexual assault [5]

	Interview One 4 wks post: (N=31)	Interview Two 4 mths post: (N=30)	Interview Three 8-10 mths post: (N=30)
PTSD Mean Symptom Scores:			
- Re-experiencing (5)	3	2.6	1.7
- Avoidance (7)	3.7	3.7	3.1
- Hyper-arousal (5)	2.7	2.2	1.6
PTSD Diagnosis			
Full –symptom	21 (67.7%)	14 (46.7%)	13 (43.3%)
Partial Symptom	9 (29.3%)	13 (43.3%)	9 (30.0%)

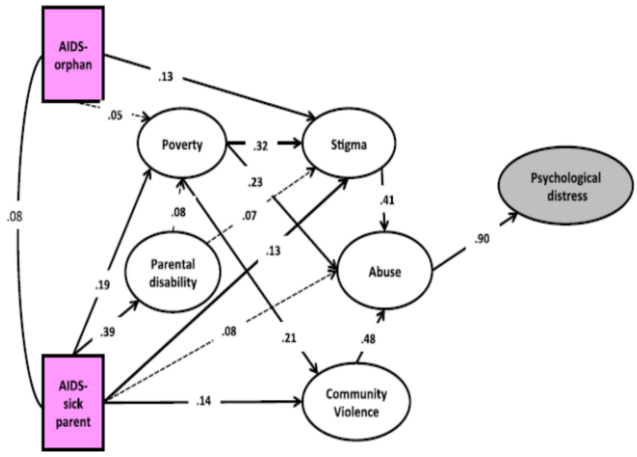
Intersecting forms of violence in the family[6]



[5] Mathews S, Jewkes R, Abrahams N. 2013. Exploring mental health adjustment of children post sexual assault in South Africa. *Child Sexual Abuse.* 22:6, 639-657

[6] Jamieson L, Mathews S, Rohrs S (2018). *Stopping family violence: Integrated approaches to address violence against women and children.* The South African Child Gauge 2018. Children's Institute. UCT.

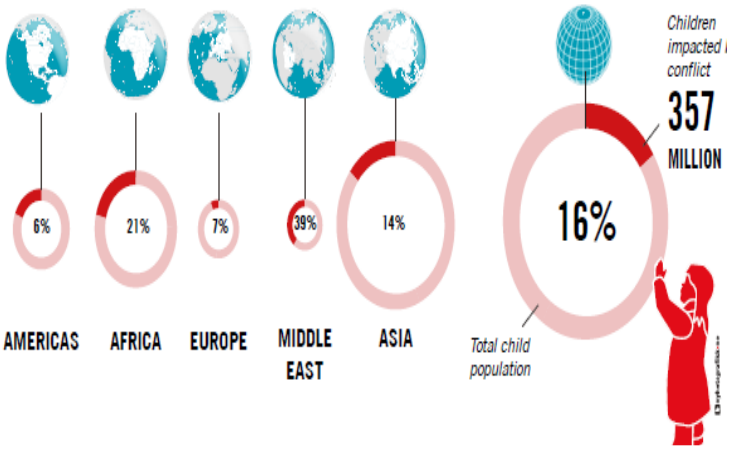
Pathway to psychological distress in AIDS orphans[7]



AIDS-affected children are more likely to be stigmatised outside the home, and maltreated

These 'interlinking factors' cause psychological distress i.e. depression, anxiety and suicidal behaviour.

Violent conflict destroys young lives



1 in 6 children were living in conflict areas in 2016

Children caught in conflict face violence, loss of or separation from family and friends, deteriorated living conditions and lack of access to basic services. Research shows high levels of toxic stress in children who have lived in or fled from conflict settings. Children get recruited or "taken" for forced conscription into armed forces or groups as child soldiers. Rape is systematically used as a weapon of war and young girls are often abducted and kept captive with long-term physical and mental health consequences.

The complex nature of trauma

Children's exposure to multiple traumatic events result in long-term impact of the exposure. Events are severe and pervasive, such as abuse or profound neglect. This may begin early in life and can disrupt many aspects of the child's development and interfere with the child's ability to form a secure attachment bond. Trauma is linked to a wide range of problems, including addiction, chronic physical conditions, depression and anxiety, self-harming behaviours, and other psychiatric disorders.

[7] Cluver, L, Orkin, M, Boyes, M, Sherr, L, Makhasi, D, Nikelo, J. (2013). Pathways from parental AIDS to child psychological, educational and sexual risk: developing an empirically-based theoretical model

It is important to intervene early to prevent injury and premature death or lasting neurological and psychological damage. Trauma during childhood and/or *"toxic stress"*

- affects brain development enhancing anti-social behaviour (Seedat et al 2009)
- Witnessing violence in the home associated with increased violence outcomes (Abrahams and Jewkes 2005)
- Children not living with parents or orphaned are more vulnerable to abuse (Mathews et al 2016)
- This impacts on adult relationships and ability to parent (Mathews et al 2015)
- Threatens well-being of the next generation (Mathews & Gould et al 2017)
- And results in economic costs to society (Hsiao et al 2018)

Challenges delivering mental health services in Lower-middle income countries

- Most children and adolescents with mental health problems do not receive treatment from health professionals (Patton et al, 2016).
- There is a shortage of mental health professionals and low capacity and of non-specialist health workers to provide quality mental health services (Patel, 2007).
- There are only 0.28 psychiatrists and 0.32 psychologists per 100,000 population working in the public health sector in South Africa (Lund et al, 2010).
  Task-shifting or task-sharing has been proposed as a strategy to manage this shortfall (Patel et al, 2011; Becker & Kleinman, 2013). Evidence shows that lay counsellors are able to provide skillful and effective task-sharing interventions (Murray et al 2013, Petersen et al, 2014). However, they require robust training, consistent supervision and support structures to ensure high-quality services and retention of human resources (Schneider et al, 2016)

Conclusions

There is an urgent need to address trauma in childhood to reduce its intergenerational effect. Intergenerational trauma needs to be taken into account in our therapeutic responses. The caregiver's own trauma need to be recognised and managed in order for the child to obtain the necessary support. Supporting families and caregivers to understand the child's trauma is critical for the child to benefit from this support system. Complex forms of trauma need to recognised and therapeutic approaches tailored to address the intergenerational complex nature of trauma in South Africa and other parts of Africa

INTERVENTIONS FOR YOUTH WITH POSTTRAUMATIC STRESS DISORDER (PTSD): *CONSIDERING THE AFRICAN CONTEXT*

Professor Soraya Seedat
Department of Psychiatry, Stellenbosch University, Cape Town, South Africa

Introduction

Trauma happens to people of all ages. If diagnosed with PTSD, the symptoms in children and teens can look different from those in adults. Children may be more likely to show signs of PTSD in their play while teenagers may be more impulsive. It has been known for nearly 40 years that children and adolescents may develop posttraumatic stress disorder following exposure to traumatic events.

Our knowledge and understanding of the epidemiology of trauma exposure and associated mental health problems, of risk factors for the development and maintenance of PTSD, and effective treatments for PTSD have all advanced considerably in recent years.

Objectives of this paper

- To look at the scope of the problem of PTSD, including prevalence, incidence and course, risk factors
- To discuss treatments for PTSD and different mode of delivery including whether psychological treatments work and how they work and how interventions can be disseminated more widely.

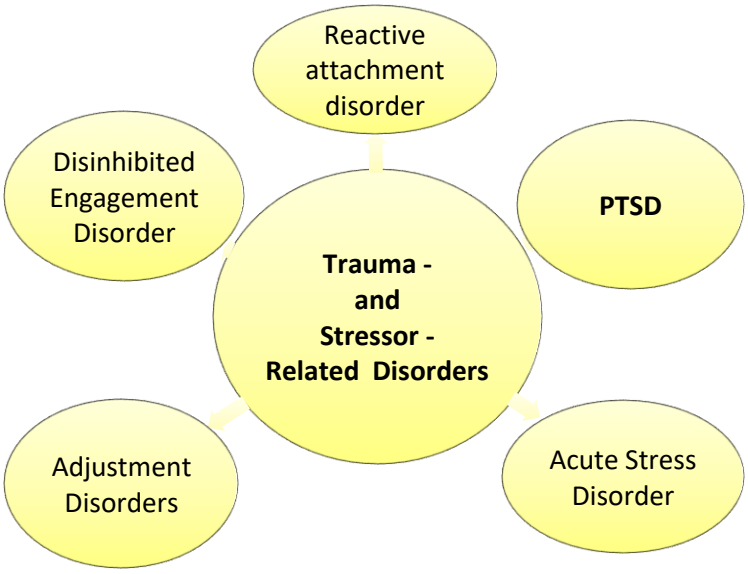
Burden of PTSD[8]

PTSD and other stress related disorders are the 6th leading cause of years lost to disability in LMIC countries and account for more disability than other severe and persistent mental disorders (e.g., schizophrenia) and other medical conditions. There are currently no disease-specific, tractable and clinically-actionable biomarkers. Genes together with environments and interaction with the brain milieu and its neurocircuitry, likely jointly shape the risk of PTSD.

[8] *Baxter et al., Psychol Med, 2014: Yehuda et al., Psychoneuroendocrinology , 2013; Zoladz et al., Neuoscience & Biobehavioral Reviews, 2013*

Trauma- and Stressor-Related Disorders[9]

Substantial changes were made to the diagnosis of PTSD in the DSM-5- these include the removal of the disorder from the category of anxiety disorders; changes to the traumatic stressor criterion, the inclusion of an additional symptom cluster to form 4 for the diagnosis and the inclusion of a preschool diagnostic subtype of PTSD specifically for children 6 years or younger.



Traumatic Events in Young People include

- Rape and other sexual assault
- Physical assault
- Domestic violence
- Community and gang violence
- Abuse and neglect (physical, sexual, emotional)
- Witnessing interpersonal violence
- Motor vehicle accidents
- Natural disasters (*e.g., fire, flood*)
- War and conflict

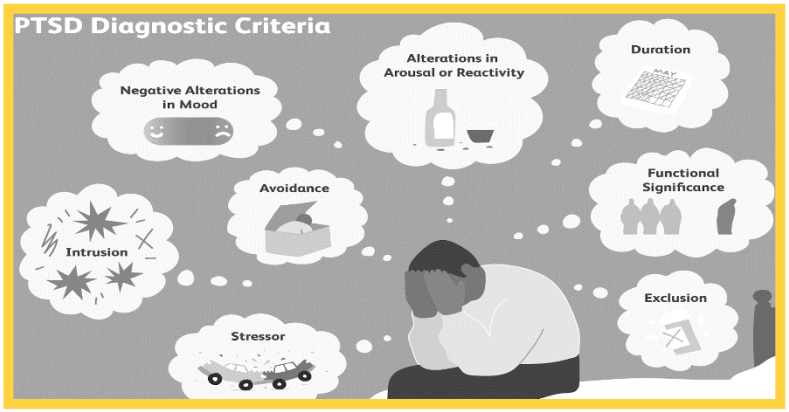
Key Findings [10]

Criterion A (one required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):
Direct exposure
Witnessing the trauma
Learning that a relative or close friend was exposed to a trauma
Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

[9] *APA, DSM-5, 2013*

[10] *APA, DSM-5, 2013*

Criterion B (one required): The traumatic event is persistently re-experienced, in the following way(s):



- Unwanted upsetting memories
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C (one required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related reminders

Criterion D (two required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E (two required): Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

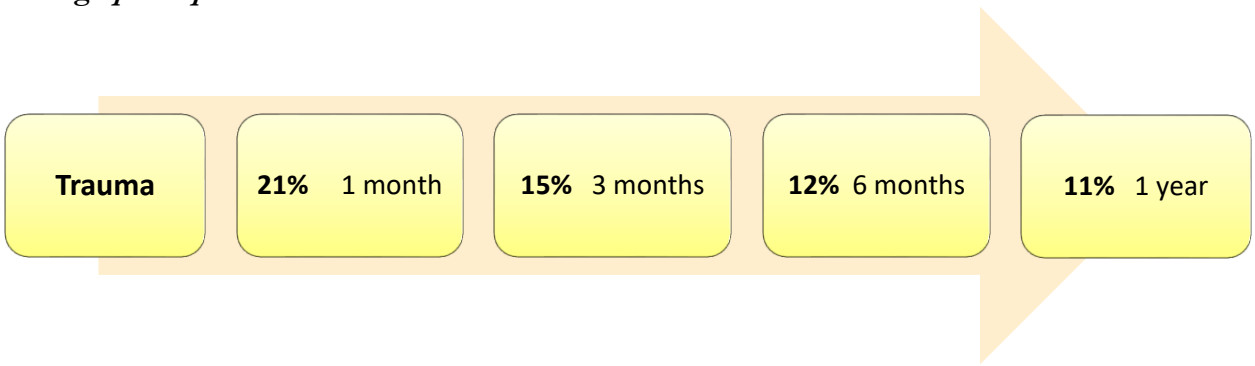
- Irritability or aggression
- Risky or destructive behaviour
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Criterion F (required): Symptoms last for more than 1 month.

Criterion G (required): Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion H (required): Symptoms are not due to medication, substance use, or other illness.

Average *point prevalence* of PTSD = 16%[11]



A recent meta-analysis of cross-sectional studies of child PTSD prevalence suggested an average prevalence of approximately 16% when collapsing across time points (Alisic et al., 2014). There is little evidence of further change in prevalence or symptom severity after 6 months, suggesting that it is unlikely a child would lose a PTSD diagnosis without intervention beyond this point.

Key findings[12]

- Trauma exposure is common among young people- By the end of adolescence, more than half of young people will have been exposed to at least one potentially traumatic event
- Most trauma-exposed youth do not develop PTSD, many recover spontaneously
- 1 in 6 trauma-exposed youth (1 in 5 in South Africa) are likely to develop persistent PTSD
- Spontaneous recovery after 6 months is unlikely.

Community-based studies in South African youth indicate that:

- Trauma 40%-100%
- PTSD 6%-22% - 1 in 5, and an additional 1 in 5 youth will have symptoms of PTSD that do not reach the threshold for diagnosis but have significant distress and impairment in functioning
- 40% of trauma-exposed, treatment-seeking youth have a PTSD diagnosis. 19% partial PTSD, and there is no difference in impairment or functioning between full & partial PTSD.

Gender differences: Girls experience more severe early childhood abuse, greater functional impairment and associated morbidity. Polyvictimization rates are high across both genders,

[11] *Hiller et al., J Child Psychology Psychiatry, 2016 (meta-analysis of 28 studies)*

[12] *Schwartz et al., J Interpers Violence 2019; Nöthling et al., Compr Psychiatry 2017; Oshodi et al., J Interpers Violence 2016; van der Walt et al., J Child Adolesc Ment Health.2014; Seedat et al., Mind & Brain J 2012; Seedat et al., Br J Psychiatry 2004*

polyvictimization poses differential risks for boys and girls. For girls, but not boys, higher levels of polyvictimization predict both PTSD and depression severity.

Sexual abuse is a significant predictor of PTSD in females. Being a victim of a violent crime was a predictor of PTSD in boys.

In a small sample of adolescent rape survivors that were assessed within 2 weeks of rape, a definitive diagnosis of major depressive episode was endorsed in 22.6%, stress-related disorders in 12.9%, and 16.1% had anxiety disorders. The survivors were followed up at 1,3,6,9 & 12 months. There was - persistent psychopathology over a 1-year period despite repeated clinical assessments and supportive counseling.

Exposure to witnessing violence, physical assault by a family and sexual assault:

Rates of current full-symptom post-traumatic stress disorder (PTSD) (22.2% v. 5%) and current partial-symptom PTSD (12% v. 8%). In the acute aftermath of rape at 6 weeks, adolescent PTSD rate (40%) was double that in adults (20%) Spontaneous recovery after 6 months is unlikely as most seek treatment late.

Why do only a minority of trauma-exposed young people develop PTSD?[13]

<u>Pre-trauma factors</u>:
Gender
Pre-existing psychopathology
Parental mental health

Peri-trauma factors:

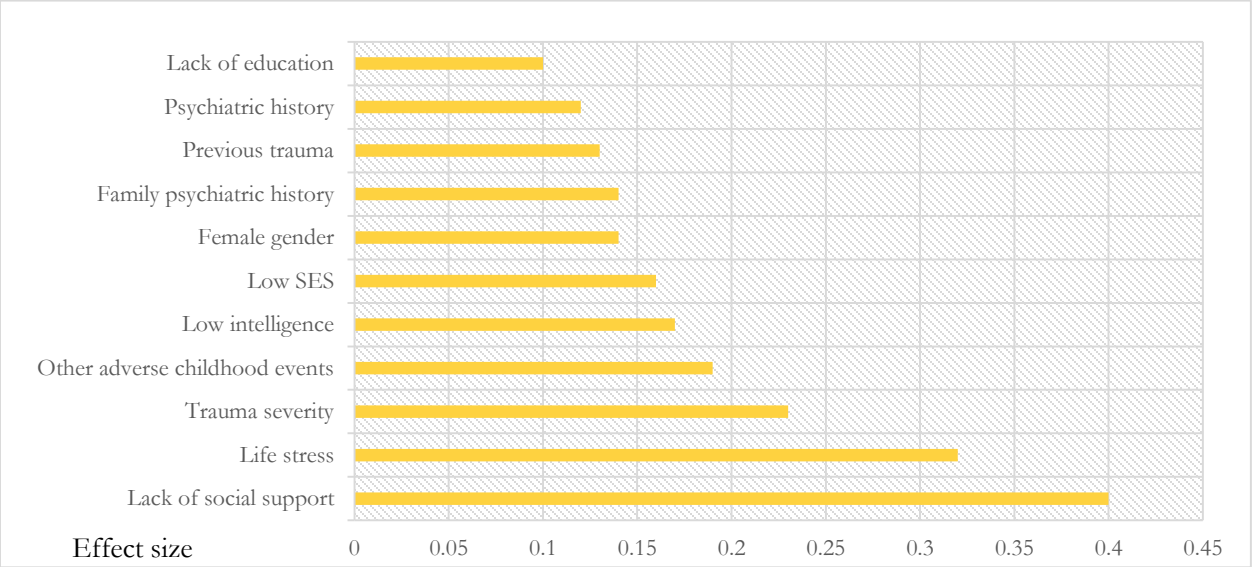
Perceived threat to life
Peri-traumatic fear

Post trauma factors:

Low social support
Social withdrawal

[13] *Trickey et al., 2012; Alisic et al., 2014*

Risk Factors for PTSD[14]



Effect size is a quantitative measure of the magnitude of the effect of a phenomenon.

Cohen suggested that d=0.2 be considered a 'small' effect size, 0.5 represents a 'medium' effect size and 0.8 a 'large' effect size. Of all of the identifiable risk factors for PTSD, the lack of social support has been found to be the most potent risk for the development of PTSD in youth.

Do psychological treatments work for PTSD in children and young people?
Well-established that **trauma-focused interventions** for PTSD in children and young people are highly efficacious. Trauma-focused interventions (therapies) that show medium to large effects on reducing PTSD symptoms are:

- Trauma-Focused Cognitive Behaviour Therapy (CBT) Interventions
  - **Trauma-Focused CBT** [TF-CBT]
  - **Prolonged Exposure** [PE]
  - **Cognitive Therapy for PTSD** [CT-PTSD]
- Eye Movement Desensitization and Reprocessing (EMDR)

Trauma-focused CBT interventions have common components[15]

- They are treatments for children and young people that are designed specifically to address the consequences of trauma and to facilitate healing

[14] *Brewin et al., 2000*

[15] *Cohen et al., 2004; Foa et al., 2013; Smith et al., 2007; Dalgleish et al., 2015; Meiser-Stedman et al., 2017*

- Psychoeducation – child and parent, what are normal responses to trauma, cataloguing child's symptoms and the triggers for those symptoms
- Skills-building –relaxation training, thought stopping techniques for dealing with recurrent trauma memories
- Trauma narrative - basically a revisiting of the trauma, telling the story, and also the cognitions and the thoughts that go along with it, imaginal exposure to the trauma memory
- Sharing with the caregiver - important process, these are not experiences and thoughts that are alone in the child's head, parent and child have a way of talking and communicating about these things

How do these psychological treatments work?
The course of TF-CBT treatment lasts 10-20 weekly sessions, usually delivered individually to a young person, and almost always involves parents or carers

The Mechanism of action of psychological treatments[16]

- Modifying negative appraisals of the trauma during trauma-focused therapy leads to a reduction in PTSD symptoms
- Reducing safety-seeking behavior (avoidance)
- Addressing the risk and maintaining factors in therapy

Do treatments work for very young people?[17]
Participants in most studies have been 8 years of age or older and considering the persistence of PTSD for several years if left untreated and age-appropriate interventions for this age group are needed. Adaptations to standard trauma-focused CBT protocols are needed when treating PTSD in very young children. These could include

- Greater involvement of carers in sessions
- Behaviour management training for carers
- Skills teaching in arousal reduction
- Using developmentally engaging ways to construct trauma narratives

M**edications (pharmacotherapy) for PTSD in children and young people**
There is a lack of strong evidence for medications and need to be used cautiously. Practice Guidelines from the UK (NICE, 2005, 2018), the US (AACAP, 2010) and the ISTSS (2019) all recommend trauma-focused talking as the first-line treatment for PTSD. In the UK, NICE 2018 states '*do not offer drug treatments for the prevention or treatment of PTSD in children and young people aged 18 years*'. In the USA, the American Academy of Child and Adolescent Psychiatry recommends that '*SSRIs (selective serotonin reuptake inhibitors) can be considered for the treatment of children and adolescents with PTSD'*

[16] *Smith et al., 2007; Meiser-Stedman et al., 2017; Jensen et al., 2018*

[17] *Dalgeish et al., 2015; Scheeringa, 2016 Meiser-Stedman et al., 2017; Smith et al., 2019*

Can early interventions prevent PTSD?[18]
Individual Psychological Debriefing is NOT RECOMMENDED for adolescents within the first 3 months of a traumatic event.
Self-Directed Online Psychoeducation for *caregivers and children* and Self-Directed Online Psychoeducation for *children* within the first 3 months have *emerging evidence* to prevent PTSD symptoms in children and adolescents

Intervention
There is insufficient Evidence to recommend TF-CBT in the first 3 months or the treatment of PTSD symptoms

Can treatment be effectively disseminated without losing effectiveness?[19]
Key question for practitioners:
Can the positive findings from research be translated into regular, busy, front-line clinical practice? **Yes**
TF-CBT can be delivered face-to-face at community clinics with strong effects by therapists with a variety of professional backgrounds (psychologists, psychiatrists, social workers, educational therapists) and levels of experience

New approaches to delivering treatment for PTSD
Barriers to accessing treatment include too few specially trained practitioners to deliver trauma-focused interventions, stigma prevents families from accessing treatment and practical barriers e.g. time commitment, cost.
Alternative Treatment Providers: **Task Shifting** defined as a "Task normally performed by a clinician is transferred to a health professional with a different or lower level of education and training or to a person specifically trained to perform a limited task only, without having formal health education".[20]

Task-Shifting dates back to the 1970s-1980s in the DRC, auxiliary nurses provided healthcare owing to the shortage of physicians. It was taken on in LMICs in Africa and South East Asia (HIV/AIDS, TB, immunisation). There are recent trials in depression, perinatal depression, anxiety disorders, autism spectrum disorders it is ***Feasible, Acceptable, Effective, Cost-Effective, Cost-Saving.***

Levels of task-shifting: Enabled by Supervision, Delegation, Substitution, Enhancement, Mentoring, Innovation

- Lay community health worker
- Registered non-mental health specialists in primary care
- Doctor
- Social Worker

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[18] *ISTSS, 2019*

[19] *Jensen et al., 2014; Jensen et al., 2017*

[20] *WHO, 2008*

- Occupational Therapist
- Registered Counselor
- Psychiatric Nurse
- Mental health specialists
- Psychiatrist
- Psychologist

Study that was conducted at Stellenbosch University
Inclusion Criteria

- Adolescents aged 13 to 18
- Experienced or witnessed an interpersonal trauma
- Chronic (≥3-months) full PTSD or sub-threshold PTSD**
- Comorbid mood disorders, anxiety disorders, substance use disorders and ADHD were eligible

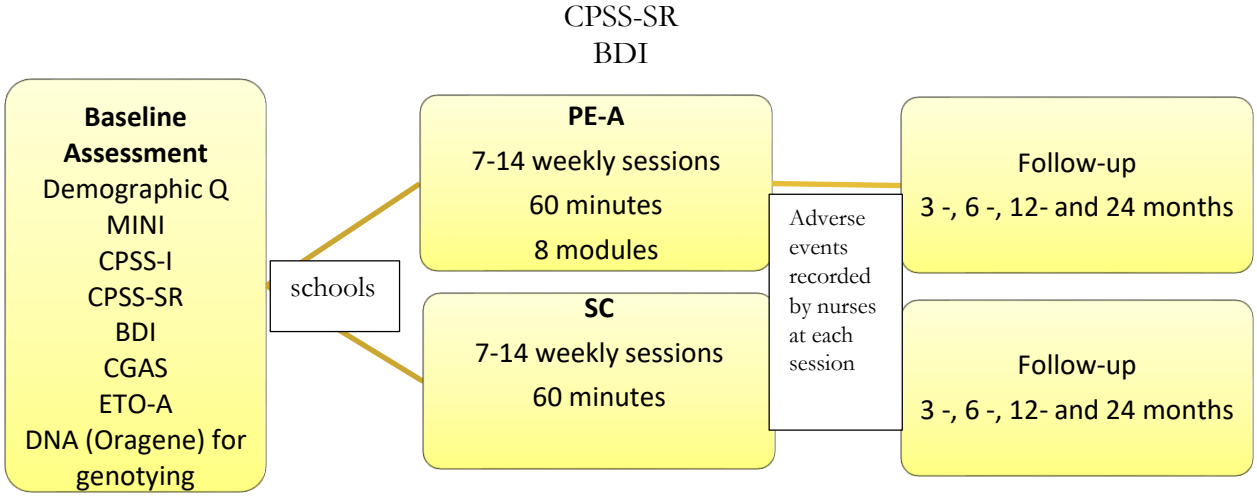
Exclusion Criteria

- Conduct disorder, primary substance use disorder, or psychotic disorder

Participants were recruited from 11 schools (low SES), from grades 8 through 12, were screened

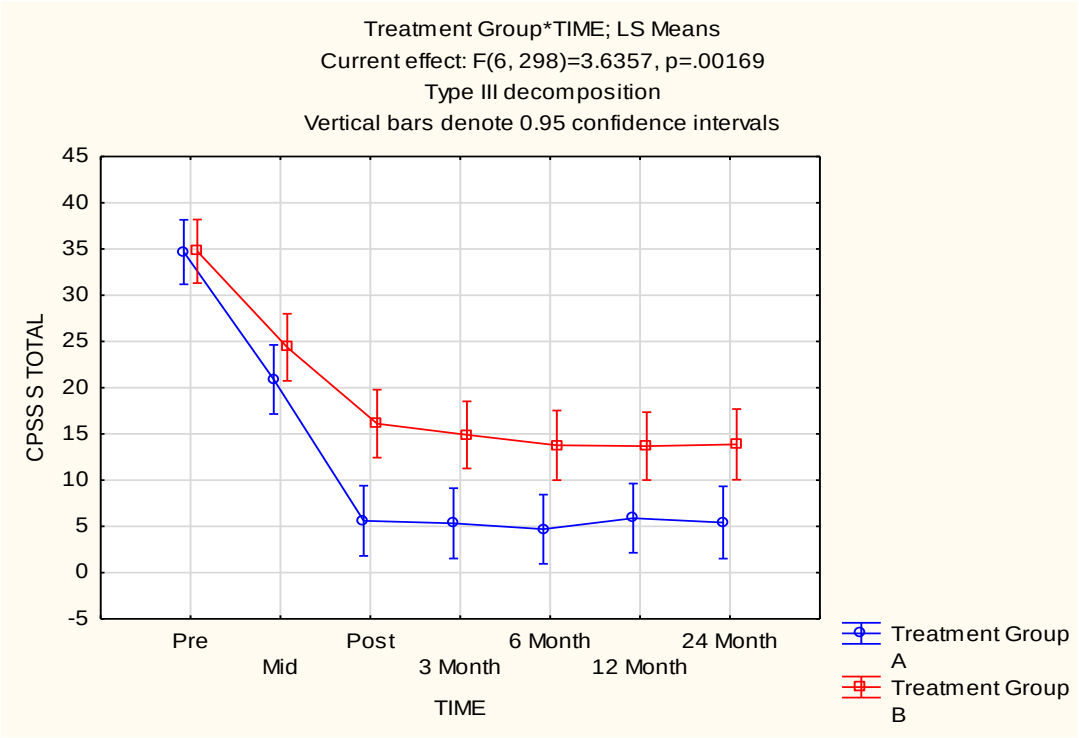
- If potentially eligible, pre-assessment scheduled with adolescent and parent or guardian
- Eligible adolescents were randomised to receive either PE-A or SC using a parallel, permuted block design with six randomizations per block (1:1 ratio)
- Pre - and post- intervention assessments conducted by two independent evaluators (IE) blind to treatment condition

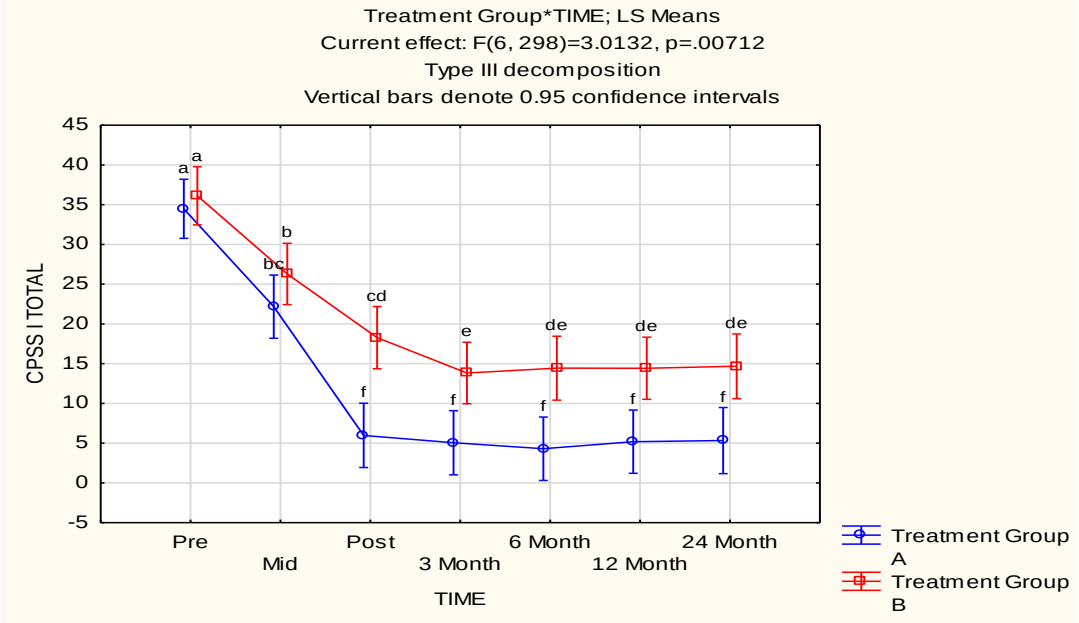
Study Flow: At each intervention session and assessment point



CPSS-I , CGAS, MINI PTSD module – Independent Evaluator
CPSS-SR, BDI - Adolescent Self-Report

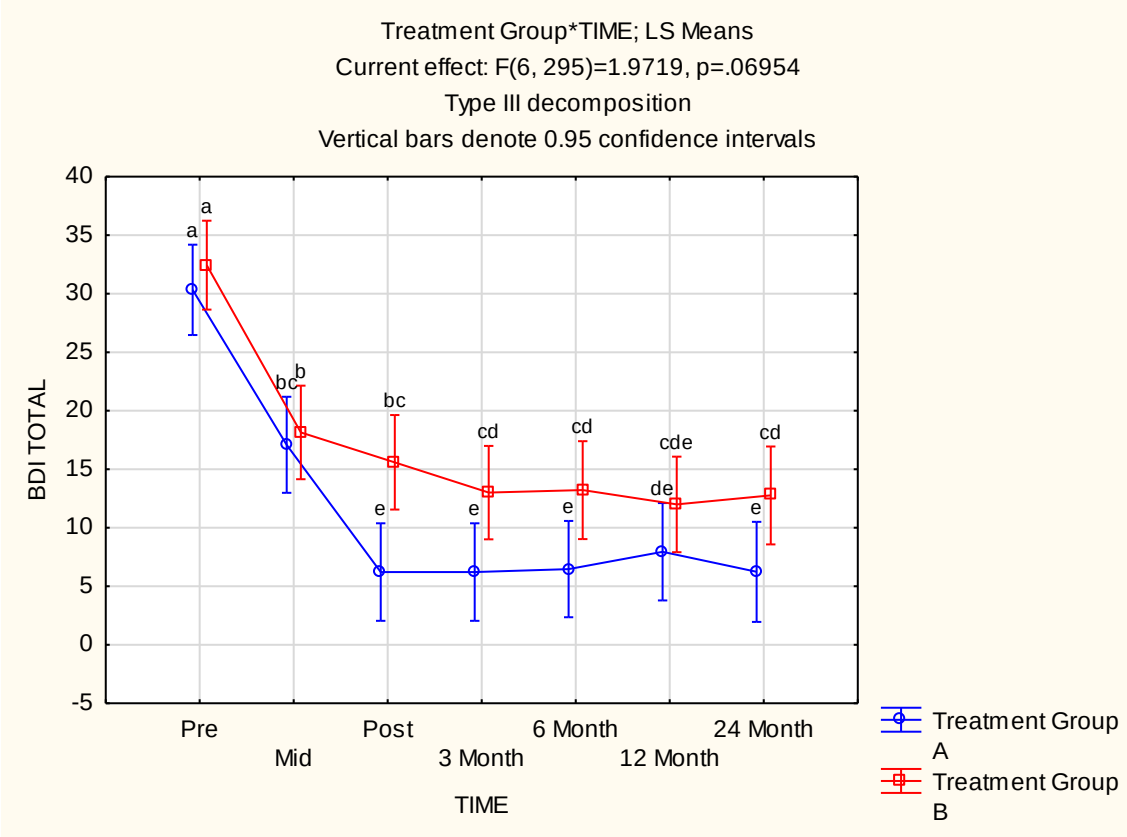
Adolescents with PTSD treated with either a trauma-focused intervention (Prolonged Exposure) or a non-trauma intervention (Supportive Counselling)[21]





[21] *Van de Water…..Seedat et al., 2018; Rossouw….Seedat et al., 2018*

Course of Depression treated with either a trauma-focused intervention (Prolonged Exposure) or a non-trauma intervention (Supportive Counselling)



Treatment providers were qualified nurses undertaking a one year diploma in psychiatric nursing, were trained by 2 clinical psychologists over 4 days (didactic training, role play). Weekly group supervision of treatment providers with case review of recorded weekly treatment sessions and individual supervision as required were provided. Treatment sessions were video- and audio-recorded and reviewed during supervision to monitor treatment protocol adherence and to assist the treatment providers in treatment management. Adherence to treatment protocols was assessed by reviewing recordings during weekly supervision sessions; in addition, 10% of treatment sessions were randomly selected for protocol adherence ratings by an independent trained rater. Audio-recordings were also listened to by adolescents as homework assignments.

Findings

- Adherence to the treatment protocols was high
- *Both treatments were effectively task-shifted* to previously psychotherapy-naïve non-specialist health workers in the management of adolescent PTSD.
- Adolescents who received SC reported ongoing distressing reliving their experiences.
- Adolescents described the therapeutic relationship with the nurse counsellors as warm with the counsellors *accepting, maternal, and trustworthy*
- Nurses stated that they would require institutional support to ensure delivery of these
- interventions in a scalable and sustainable manner.

Summary:

- 1 in 5 youth in communities, 2 in 5 traumatized youth seeking care, in SA have PTSD - mental health burden is substantial, treatment needs are high but services are inadequate.[22]
- Debate is ongoing on whether TS evidence-based treatments in LMICs are effective, transportable, scalable, culturally sensitive, and financially sustainable
- Additional African studies on adapting and evaluating treatments.
- Given our limited service capacity, task-shifting methods of delivering effective treatments are needed.
- It is important that the perspectives of those utilizing as well as providing the services are heard and taken into consideration when planning and implementing mental health interventions within communities.

[22] *Smith et al., 2019*

BUILDING CAPACITY FOR RELATIONAL COMPETENCY IN THE 1ST 1000 DAYS IN THE WESTERN CAPE

E Malek

*with acknowledgment to the contributions of Dr Hilary Goeiman, Ms Maureen McCrae, Edna Arends, Prof Astrid Berg, Dr David Harrison, Dr Anusha Lachman, Elizabeth Pegram, Lucy Jamieson, Lizette Berry, Rachel Rozenthal Thresher.

Why is the 1st 1000 Days so critical?

Conception to age 2 years is recognized as the time during which adverse exposures exert the greatest harm and effective interventions offer the greatest benefit. Ensuring that the brain achieves its optimum development and nurturing is therefore vitally important, and this enables babies to achieve the best start in life.

Important considerations in the 1st 1000 Days include the effects which prenatal (and postnatal) nutrition and maternal mental health (including prenatal stress) have on infant brain development. For infants and children under 2years of age, the consequences of undernutrition are particularly severe, often irreversible, and reach far into the future.

In addition, food insecurity is a factor in maternal depression and stress, beginning during pregnancy. Exposure to chronic maternal depression in the pre- and postnatal period has been associated with reduced weight gain in the first two years of life and a greater risk for failure to thrive. Infants of depressed mothers have been shown to have statistically significant poorer growth than infants of non-depressed mothers at the 3rd month.

In a Khayelitsha study (Berg. SAMJ. 2012), the majority of infants with faltering weight had a diagnosis of 'feeding disorder of caregiver-infant reciprocity' and depressive mood was particularly prevalent among mothers of these infants.

The impact of maternal stimuli due to prenatal stress on the developing brain is associated with changes in development through maternal substance use e.g. alcohol, tobacco, illicit drugs, maternal depression & anxiety and maltreatment or trauma. Studies show that maternal stressful events during pregnancy predict poorer cognitive outcome, and are positively associated with fearfulness in infancy. These early experiences can change the structure of the brain through epigenetic changes which alter the expression and regulation of genes and hormones, and ultimately affect how the infant sees the world (facial affect recognition).

The same stress can shift between toxic and tolerable, with tolerable stress being short-lived and toxic stress resulting in prolonged and unrelenting activation of the stress hormone regulation system.

The effects of adverse childhood events has also been well described and it is important to remember that every pregnant woman was once a child (Robert Block, ACES Study).

Trauma during childhood affects brain development enhancing anti-social, psychopathic behaviour and inhibiting children's ability to empathise. The impact of violence occurs at multiple levels with subtle, life-long intergenerational consequences, hampering a child's development, learning ability, self-esteem and emotional security, and can lead to risk-taking and violent outcomes. The impact of violence in childhood goes beyond the physical scars and has a lasting impact on the child's self-esteem, psychological development, learning ability, employment prospects and life expectancy. It also leads to risk-taking and violent behaviour, which compromises the wellbeing and life chances of future generations.

However, much of the above can be buffered by a caring environment, relationships and support, through primary attachment figures (parents and adult caregivers) who are attuned to the infant. Attunement is described as a "reciprocal connectedness" or "dance", requiring

maternal (caregiver) sensitivity, in which the infant's verbal and non-verbal cues and needs are noticed and are met to the mother's best ability. It is "mindful parenting", offering unconditional acceptance of the infant's emotion (anger or happiness), through methods such as touching (visceral connections), facial mirroring (matching) and interactive play.

This attunement and reciprocity is what determines early relational health, and is portrayed in the stated aims of the Department of Basic Education's National Curriculum Framework for children 0-4 years of age as Early Learning Development Activities (ELDA's), e.g. ELDA 1: to "Promote a Sense of Wellbeing", ELDA 2: to "Promote Identity and Belonging", and ELDA 3: to "Promote Communication" for babies and toddlers.

The Western Cape Provincial 1st 1000 Days Program: brief overview and context

The program was launched in the Western Cape in February 2016 within a provincial transversal communications campaign. The 1st 1000 days program is aligned to the Provincial Strategic Plan (2014-19) under Strategic Goal 3 Increase Wellness, Safety & Tackle Social Ills.

A unique identifier was developed reflecting 3 core scientific principles (*www.developingchild.harvard.edu*) with the logo "Right Start, Bright Future", and 3 icons depicting what children need to Survive and Thrive: (i) GROW: Nutrition and Health, (ii) LOVE: Nurture, Care & Support, and (iii) PLAY: Safety, Protection & Stimulation.

Within the 1st 1000 Days mandate given to Health services through the National Integrated Early Childhood Development Policy, recognition is given that many 1st 1000 Days activities are integral to existing health services but that gaps exist needing strengthening, in particular, to enhancing or redesigning existing maternal and child health services with respect to maternal mental health, psychosocial support for pregnant women and parental support for caregivers of infants in the first 2 years of life.

The systemic intervention framework of Survive, Thrive and Transform was adopted within health services to improve maternal, neonatal, child and nutrition outcomes as follows:

- **SURVIVE:** The ending of preventable deaths - maternal, stillbirths, neonates as well as babies in various stages of development.
- **THRIVE:** Children and mothers realising their full physical, cognitive/mental and social potential, as well as exercising their right to sexual and reproductive health.
- **TRANSFORM:** Policy and cultural transformation with strong intersectoral focus, addressing social determinants (education, violence, employment)

A Western Cape Provincial 1st 1000 Days intersectoral theory of change was developed indicating the transversal nature of the work which assisted in giving recognition to the social determinants of health in the 1st 1000 Days and emphasized the role of families and communities in making sure that caregivers and parents are supported to enable children to reach their full potential. It notes that investment in major transformation is required with a strong intersectoral focus and coordinated action amongst many stakeholders.

Arising from this, the Western Cape's 1st 1000 Days Manifesto, "*Relationships Matter Most"*, is based on science and framed by the ecological framework which illustrates that building babies' brains is everybody's responsibility and that support for mothers must start in pregnancy, acknowledging that while the pregnant woman is the environment of the developing foetus, the community is the environment of the mother.

The effect of the whole family on responsive care is clear in statements such as "The quality and disposition of the whole family plays a much greater role in the creation of the child's disposition than the individual disposition of the father or the mother." (Carl Jung Swiss psychiatrist); and "It takes a whole village to raise a child" – a well-known African proverb.

The role of parents, caregivers, family members as the best providers of nurturing care has been further enhanced with the launch of the Global Nurturing Care Framework at the World Health Assembly in May 2018 (www.nurturing-care.org), to which the W Cape 1st 1000 days Program has been further aligned. The 5 components of this Framework articulate the needs of children as being: adequate nutrition, good health, opportunities for early learning, safety and security, and – most importantly - responsive caregiving.

The Western Cape Dept of Health's 1st 1000 Days Support Package for Parents, Caregivers & Families: progress to date

Adopting the mandate of the NIECD policy for Health as the lead department responsible for the provision of comprehensive services for pregnant women, new parents and children younger than 2 years, health and nutrition programmes are being expanded to provide the following:

In the antenatal period:

- To screen, support + make referrals for maternal mental health, substance abuse and exposure to domestic violence
- To provide preparation for parenting

In the period from birth to 6 years:

- To provide parent support and skills building to promote children's healthy development and safety
- To promote secure attachments
- To provide parent support to prevent child abuse and neglect
- To identify children exposed to child abuse & neglect; provide support and referral.

Giving priority to providing support for pregnant women, new parents and children younger than 2 years:

- To counsel women on self-care, infant health, growth and learning during antenatal and postnatal care visits;
- To provide supportive home visits by CHWs to vulnerable parents/caregivers and their infants, during pregnancy and infancy for up to 2 years;
- To provide clinic-and community based support groups for pregnant women and caregivers and their babies that address self-care, infant health, nutrition, growth and early learning.

To this end, the Western Cape DOH 1st 1000 Days Parent/Caregiver/Family Support package is being developed and implemented in four geographic learning sites using the Whole of Society Approach (WoSA), in partnership with NGO's, other sectors and local government. Ongoing iterative processes are followed through adaptation, learning and reflection as experienced in the sites, alignment of interventions in services through service redesign initiatives and the incorporation of new evidence.

Partners include members of the *South African Parenting Program Implementers Network (SAPPIN)* such as The Parent Centre (Cape Town), Sonke Gender Justice – State of SA Fathers

Seven Passes Initiative (Touwsranten). Dhlalanathi (KZN)– Ilifa: Ibhaye Lengane, Grow Great campaign (DGMT): Zero Stunting, Philane Mentor Mother Project (Khayelitsha), Perinatal Mental Health Project (Cape Town) and others e.g. FARR (Family program for FAS), Mikhulu Trust, Bookdash.

The Western Cape DOH 1st 1000 Days Parent/Caregiver/Family Support package comprises of several key elements, including the following:

1. Communication and resources for parent support – see website for detail *(www.westerncape.gov.za/first-1000-days/)*
2. Implementation of the National Under 5 Side by Side Campaign and new National Road To Health Book *(www.sidebyside.co.za)*

The 5 themes of the new Road to Health Book are what children need to develop:

a. **NUTRITION:** Good nutrition is important for you and your child to grow and be healthy. It starts with breastfeeding.
b. **LOVE**: Your child learns from looking at you when you hold them close to you and love, play and talk to them.
c. **PROTECTION:** Your child can be protected from disease and injury by getting immunised and by playing in safe places.
d. **HEALTHCARE**: Your child needs help from you or a health worker when they are sick or injured.
e. **EXTRA CARE:** Your child may need special care or support and knowing what to do and where to go will help both of you.

This is embedded within the National Side-by-Side campaign which has a unique identifier logo. Side-by-Side describes the supportive relationship between a child and their caregiver, as well as relationship between all those who help and advise the caregiver.

Side-by-Side conveys partnership and togetherness, reminding us that it takes a village to raise a child. Side-by-Side speaks to the child-rearing journey that caregivers embark on with their children, and all those who help them. The journey on the Road to Health is shared. Health workers have a bigger role to play to ensure that children not only survive, but also thrive. Caregivers and health workers are equal partners in the early childhood developmental journey.

1. Health service entry point redesign to enhance psychosocial risk assessment and response, starting in antenatal care services and beyond, and through home visits. Examples include screening for maternal mental health at the first Antenatal clinic visit, and identifying babies at risk (e.g. not growing well, missed immunisations) using the Road to Health Book.

2. Parent and caregiver relational support resources (such as book sharing) aligned to antenatal and postnatal and well-child service touch points offering prenatal parent preparedness and support for caregivers of 0-2-year old's (including care for child development).

3. Home and Community Relationship Support: Recognising that supporting a child starts with supporting a mother, the *First 1000 days Relationship Support Tool "Ibhayi Lengane"* is an add-on package to existing home visiting programmes with the purpose of enhancing the mother- child relationship during the first 1000 days, by means of 12 structured home visits, starting in pregnancy.

Relationship support for responsive care by home visitors is a powerful opportunity for intergenerational trauma-informed counseling (TIC) intervention through
(i) using trauma informed interactions with caregivers and children to promote healing, (ii) alleviating toxic stress for the child and caregiver, and (iii) responding sensitively to the situation before responding to the responsive caring of the baby.

This is offered through trauma informed counseling guided by values (Barnes et al) including: Understanding the impact & prevalence of trauma, communicating with compassion, promoting safety, earning trust, embracing diversity, providing holistic care, respecting human rights, Pursuing the person's strengths, choice, and autonomy, and Sharing power.

The community health worker (CHW) home visitors also assess risk according to their district criteria, e.g. young mothers, HIV positive mothers, immigrants, mothers with a disabled child, depressed mothers, domestic violence, substance abuse, mothers with low birth weight babies.

Responsive Care is defined (for CHW's) as "the process of watching and tuning into your child's cues and thinking about what her behavior might mean and responding in a sensitive way". The focus of this definition is on watching, tuning in, thinking about, and responding to mental health problems (depression, anxiety) that disrupt responsive care. Providing responsive care in high risk settings can be difficult even without mental health problems, as different things may have the same disruptive result (mom feels overwhelmed, inadequate, fearful, ashamed, guilty), and there is recognition that the problem we need to address is disruption of psychological space to watch, tune in, think, and make meaning'.

The key messages in the program are: (i) The mother or caregiver is central to responsive care, (ii) Interventions for responsive care are mother (and baby) focused, (iii) Talking and telling responsive care is different to demonstrating and supporting responsive care, which requires the CHW to be and model the relationship they want to see.

The 3 core components of the program are:
(i) Mother focus – recognizing her significant stressors - often centered on her in a stigmatizing way (unplanned pregnancy, HIV, refugee/immigrant status) – and that she needs support through connection with a supportive helper, before she can connect with and support her baby
(ii) Relationship based - although relationship based care in infancy is well established, going beyond that – recognizing that everything is relationship (mother, family, helper, baby)
(iii) Activity based - Learning through doing resonates for the mother, invites her to do rather than to be told to do. Learning how to support in a way that is not rescuing, but inviting in, through finding tiny scaffolds to start with have later exponential power.

Holding difficult truth is a skill learnt using materials PLUS activities (play) PLUS responsive relationship, through partnering with the client in an authentic process that is non-threatening and non-judgmental and that is able to hold difficult truth, and remembering that it's about connecting,

holding and supporting. In this process, CHW's are guided to help clients start where they can, it may be difficult, it may be traumatic, but they choose the starting point in walking through their difficult truth.

In conclusion it is essential to recognize that: "*Traumatised parents can't access messages until they move out of their own trauma cycles. We need to build trust and safety in all our contact with community, while at the same time raising our own levels of maturity and ability to be present." (Shaun Nortje, Trauma Advocacy Network).*

Early relational health is about advancing a model in which is not about teaching parenting, but about developing health relationships, of intentionally strengthening the relationships of the 1st 1000 Days, which expands the social capital in a community to support all families, is strength-based and builds resilience and recovery in the face of trauma, and a mind shift to a relational focus. Relationships are healing. Safe, responsive and nurturing relationships can root and re-route.

Recommendations to strengthen relational capacity include:

INVEST in BUILDING RELATIONAL COMPETENCIES for responsive caregiving

Prioritise the EARLY IDENTIFICATION of AT RISK pregnant mothers, children and parents/caregivers at facility and household level and provide support.

Provide every vulnerable household with RELATIONAL SUPPORT for pregnant mothers, caregivers and children through integrating a structured 1st 1000 Days package for CHW's starting with identification of pregnancy through antenatal and postnatal care

Commit to strengthening COUNSELING, MENTORING AND MENTAL HEALTH SERVICE capacity for vulnerable clients AND for the frontline staff (Nurses, CHW's and Social services) working with vulnerable pregnant women, children and parents/caregivers.

INTERSECTORAL REDESIGN around perinatal and child services around the MOTHER-FATHER-INFANT TRIAD through the delivery of an integrated multidisciplinary comprehensive package of care (fully integrating mental health with maternal and child health) and redress administrative infrastructural and attitudinal barriers to supporting families in providing holistic nurturing care.

SEXUALITY EDUCATION: ENGAGING YOUNG PEOPLE IN MEANINGFUL CONVERSATIONS ABOUT SEX AND SEXUALITY

Edith Kriel
Jelly Beanz, Social Worker

Sexuality education is so much more than talking about sex and reproduction. In fact, educating children about the biological aspects of sex is only one part of this complex process. Sexuality education should include information and discussion on relationships and friendships, respect, romantic love, sexual orientation, rights and responsibilities, puberty, conflict resolution, anatomical names for genitals, biological functions of body parts, masturbation, contraception and family planning, sexually transmitted infections, termination of pregnancy, social media and pornography, sexual abuse and the laws of South Africa regarding consent to sexual interaction. The content that is shared with a child, would depend on the age of the child as well as the level of the child's development.

One aspect of sexuality education that is difficult for most caregivers to deal with, is the range of sexual behaviours children may engage in. Sexual behaviours in children are best managed when viewed on a continuum rather than categorized. Some sexual behaviours may be relatively simple and the age appropriateness readily established while others may be complex, especially if sexual interactions between children take place. Some basic guidelines follow to assist in decision making and management of sexual behaviours of children.

Sexual development is a sensitive process that begins pre-birth and continues throughout into adulthood. It is influenced by many factors including societal and community factors such as legislation, the value placed on positive development of children, culture and custom, religion, family values and norms, appropriate knowledge of caregivers regarding development as well as individual factors such as exposure to pornography or experiences of sexual abuse.

Caregivers of children play a significant role in the sexual messaging that children will receive from infancy. An everyday task of nappy changing may include negative or positive behaviours and verbalizations. A mother who does not react much to her toddler touching his genitals, compared to a mother who smacks him for doing so, impart very different messages around bodies and touching.

Caregivers may over- or underreact to children's sexualised behaviours, which may mean that age appropriate activities may be harshly and punitively dealt with, and inappropriate behaviours be overlooked or considered normal.

As sexual development and sexuality are often a taboo or seldom spoken about topic, many misconceptions and myths arise in this regard. This may result in children to continue to be vulnerable to sexual abuse and exploitation and for the cycle of transgenerational abuse to be perpetuated. It is extremely important that children need to be better educated regarding positive sexuality by their caregivers. This is often very difficult for caregivers as many of them never experienced appropriate sexuality education themselves as children. However, it is the responsibility and privilege of the caregiver to engage in such conversations with their children: firstly to ensure that children are less at risk when they have appropriate knowledge and secondly that children know that they can speak to their caregivers about anything, including sexual issues. By the time children enter formal schooling they should have a basic idea about all aspects of sexuality – both positive and negative.

Our own experiences and backgrounds will influence our understanding of sexual behaviours in children as well as our responses to the behaviours. One example would be the concept of masturbation. Adults ask questions including: Do children masturbate? At what point does touching of the genitals become masturbation? Is masturbation inappropriate? Do boys and girls masturbate? How do we respond to children when they masturbate?

At birth, a child's body is the same as that of an adult anatomically, although various physical and hormonal changes take place during puberty. We therefore need to keep in mind that just as it may feel pleasant for an adult to have the genitals gently touched or stroked, so it is for children. The physical response of a gentle touch is generally positive.

Children are born curious. Children will also be curious of various aspects of bodies and sexuality. At a young age the child's curiosity may be more overt and due to their lack of understanding of social norms and boundaries may be easier to notice. As children grow, their questions may be different and they may become more adept at knowing who, what and where to access information as may become more discreet when engaging in sexualised behaviours.

As sexuality development is a process, many of the aspects present in the younger child continue throughout development (touching of genitals, curiosity about sexuality), however may become more sophisticated and complex e.g. touching of their own and other's genitals.

All children will touch their genitals. Girls and boys, young and older children, children from different cultures and religions touch their genitals. What may be different, is the sexual messaging that the child receives when touching their own or others' genitals. This will in turn influence the child's physical and emotional responses to sexuality issues. Even with our society becoming more aware of gender equality, sexuality is an area where the boundaries for girls and boys are still very different.

Professionals may differ as to their opinion as to whether it is correct to teach children the anatomically correct words for their genitals which may include vagina, penis, and testicles. It is the opinion of the author that it is important for children and their caregivers to speak about bodies and sexuality openly and without embarrassment. Should the use of adult words negatively influence the sexual messaging

for the child, the use of family names such as 'cookie' or 'winky' is completely acceptable, as long as it facilitates conversations about sexuality.

Children do not automatically know the rules and boundaries regarding bodies and touching. Caregivers need to take the ages and developmental level of children into consideration during discussions. Keep in mind that behaviours that are appropriate or not, may not be always be easily discernible and may require collateral information or further investigation.

Many caregivers and parents fear that giving children information regarding sexuality, means that in some way they are giving them the message that engaging in sexual conduct is acceptable. This is in fact not the case. We know that when children have factually correct information, they are much better able to make informed decisions and tend to delay their sexual debut. Parents and educators need support in terms of understanding how information is power and that being able to share information regarding sexuality education, is not only not only a good parenting practice, but a privilege. Parents who are the first to discuss sexuality with children, have the opportunity to impart their value systems and are establishing communication channels for future engagement. Discussing sexuality issues also creates an opportunity for bonding to take place and creates a safe space for children to ask questions and ask parents for help.

Sexuality education plays an important role in preventing sexual abuse when children know that they can approach an adult with sensitive information without fear of being shamed or rejected. Preventing sexual abuse is not merely saying to a child "don't let anyone do this", "if someone touches that place come and tell your parents", or "run away and yell, and scream". Talking to children the negative or potentially bad consequences or aspects of sexuality is important but needs to be balanced by positive messaging about the boundaries of appropriate and healthy sexuality. It is also imperative to understand that children may not be able to run and tell and that the onus of preventing sexual abuse always rests on adults.

Parents have diverse religious or cultural beliefs around sexuality and it is important for helping professionals to listen to and engage with these beliefs to help parents make decisions in terms of what is good for them. When parents are able to do sexuality education with their children, it provides them an opportunity to impart their belief systems and values. If a child receives sexuality education at school or from peers, values, traditions and culture are not passed on to children.

By the time children go to formal schooling, they need to have a basic understanding of their bodies, the parts of their bodies, and also how bodies work in terms of sexual acts. For a pre-schooler, this may involve a basic explanation such as "a daddy and mommy come together in a very special kind of hug. Daddy shares a little baby making seed with mommy. When daddy's baby making seed and mommy's baby making egg join together, a baby starts to grow".

Young children generally find the part of the conversation about how the baby grows very intriguing, whereas parents often think that the sexual act would be of most interest to young children.
For many parents having conversations with their children regarding sexuality is really unchartered territory. Most of us have not grown up in families where there were open conversation around this,

and some of us may have had no conversations at all with our own parents in this regard. This makes it really tricky when considering how to approach this conversation or conversations with our own children because we have no experience to draw on. It may be useful for the parent to say to the child "we are going to be talking about something very important, mommy has not done this before so I may get a bit nervous or shy".

What is helpful for parents to consider, is that if we start off by giving children basic information that is truthful and honest, it builds a basic foundation for when they require more information and guidance. If we start off by saying "the stork brought you it becomes very difficult to then try and figure out how to tell the truth.

Most parents find it useful to have a book, concrete tool or pictures to help them facilitate those first conversations with children. There are many lovely books and online resources available which we can be using to engage children in the discussion and to be sharing information that is age appropriate with children. Children of course also enjoy the visual aspects of such books, and books are really helpful because we can keep on referring back to them, it's not just a once off conversation. We know that children learn by repetition, so being able to refer back to the book when and if needed is really helpful for children.

It is important for us as parents and educators to share information with children to prepare them for changes in their bodies. For example, a girl who is going to have her period needs to be prepared in advance to prevent confusion, fear and shame. It is so much more helpful for children to know that this is a natural process of growing up and how to deal with it than to be left to their own devices to cope.

It is also important for us to consider that children have access to many forms of information. They may ask peers or access the internet for information, and we know that this information is often inaccurate or distorted, does not impart healthy messaging around sexuality and does not impart values and boundaries.

It is useful for parents to reflect on what their hopes are for their children's sexual development as adults. Most parents wish for their children to happy in a loving caring relationship which would include sex. Messaging around sexuality should start early, should not make children feel ashamed, guilty or humiliated and should emphasise that sex is a very natural and normal part of development and relationships.

It is important for children to know that it is okay to have questions and who they can turn to when they have these questions. Adults need to know that if they battle to answer certain questions, that is also okay. A parent can say "I am not quite sure, let me find out and we will talk again tomorrow".

Children are exposed to extensive sexual content and messaging in today's society. Online pornography is a huge industry to which the majority of children will be exposed either accidentally or intentionally. Pornography does not impart healthy sexual messaging to children about how relationships work. It objectifies people and normalizes violence as well as deviant sexual acts, often

leaving children traumatized by what they have seen. Parents need to make sure that young children's devices are protected with appropriate software. Older children need guidance in navigating the online environment and how they should respond if their peers expose them to pornography.

Sexual messaging in mainstream media and the online environment makes it even more complicated to help children understand boundaries in terms of sexual behaviours. Respect, love and consent are all very important concepts to be talking to children about. They should understand that they should expect these as their rights and also respect the rights of others.

Warning young people of what can go wrong in consensual sexual relationships, does not necessarily change their behaviour. The possibility of pregnancy, STI's or punishment will not necessarily deter a young person, who may act according to impulses rather than cognitive understanding. Young people need ongoing guidance and supervision to help them make healthy and responsible decisions. It is critical for parents to understand the pressures that young people experience in relationships and from their peers to be sexually active. This needs to be continually managed.

Helping professionals need to keep in mind that when we are doing sexuality education with children in our community, we are working with many children who have already been sexually abused. We should never leave children who have had a traumatic experience feeling ashamed or responsible for their own abuse. We should be encouraging children to come forward and to speak out about what it is that has happened to them, knowing that if they speak out, we have to follow up and make sure that the child gets a helpful and protective response.

ENGAGING SOUTH AFRICAN FATHERS WITH PROGRAMME INTERVENTIONS AND POLICIES

Wessel van den Berg[23] and Gloria Khoza[24]

THIS PAPER IS AN EXTRACT FROM A PROGRAMME BRIEF THAT WAS PRESENTED AT THE 2019 AFRICAN CHILD TRAUMA CONFERENCE. THE ORIGINAL PROGRAMME BRIEF, PRODUCED BY SONKE GENDER JUSTICE AND UNICEF SA, IS AVAILABLE ONLINE[25] AND CONTAINS A MORE COMPREHENSIVE REVIEW OF PROGRAMMES.

Introduction

Families, parents and caregivers play a vital role in child well-being and development. The family, for example, plays the primary socialisation role in establishing a child's identity. It is the family that also provides children with love, care, provision and protection. Having said this, while families can be the greatest source of support for children; they may also be a source of harm. This holds particularly true for South Africa, where violence against children remains alarmingly high and children continue to experience corporal punishment and emotional abuse in their own homes by parents or other caregivers. Fathers are an often misunderstood element within this context of South African families, yet fatherhood is an important entry point towards improving children's lives.

To achieve social norms change, we need a supportive policy and legislative environment reciprocated by evidence-based programmes that reach parents directly. South Africa, like many other countries, has put in place policies and legislation that promote programmes targeted at developing parenting skills and strengthening families [1, 2]. With limited resources from government to embark on these parenting programmes, there is need for unity of purpose with civil society organisations, institutions, the private sector and communities to share responsibilities in delivering effective and sustainable parenting programmes to those who need them the most, and in particular to support positive and involved fatherhood. This paper refers to one such programme and matching recent amendments to law that represent steps towards better father involvement.

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[25] https://genderjustice.org.za/publication/engaging-south-african-fathers/

The importance of father involvement

Engaged, responsive fatherhood[26] and men's participation in the lives of children are generally positive for children, women and for men themselves. Fathers' positive involvement benefits child outcomes from the domains of physical development to socio-emotional to academic achievement. Mothers, who are supported by their children's fathers, experience greater satisfaction from their parenting roles, have lower levels of stress, and are less likely to suffer mental health problems [3, 4].

Supportive fathers not only contribute to mother's well-being, but also to children's well-being. [3]. Having said this, many fathers in South Africa live in different homes than their biological children [5] and active father involvement in children's lives is very low, with the most recent time use study showing that for every eight hours of care work a woman does in SA, a man only does one [6]. Furthermore, co-resident fathers are not always as engaged and involved as they could be, with mothers and other female caregivers usually doing most of the childcare, caregiving and house chores [7]. High rates of men's use of violence and matching public narratives of harmful masculinities reinforce each other and perpetuate harm [8].

Recent amendments to law that support gender equal parenting

Sonke Gender Justice was involved in advocacy towards a recent change to laws in South Africa that are relevant to gender equal parenting. The advocacy had begun in 2015, leading to a member of parliament from submitting a private members bill. The process to develop the bill, make submissions in parliament and support the Portfolio Committee of Labour was driven by a number of individuals and organizations including Mr Hendri Terblanche, Sonke Gender Justice, and COSATU. In January 2020, the implementation of the Labour Law Amendment Act 10 of 2018 was commenced.[27] The new parental leave provisions include an increase in the Unemployment Insurance Fund (UIF) benefits applicable to maternity and parental leave, the introduction of adoption leave, and the introduction of 10 days of parental leave for all parents who do not qualify for maternity leave. The largest group of parents that will utilise this leave are fathers. The MenCare Global Fatherhood campaign informed this advocacy, with the global campaign for equal, non-transferable, paid parental leave for all parents. Parental leave for fathers, or paternity leave, has been identified as a key policy intervention to catalyse men's involvement in care work. It allows men to take on child care work in the early days of their child's life and thereby relieve the mother of the same work, and simultaneously facilitates an opportunity for father and child to bond.

These legislative changes, along with the abolishment of the common law defence of reasonable chastisement, and more operational measures such as the new National Strategic Plan in GBV, provide a conducive environment for social changes that benefit children. Laws and policies alone are however

[26] In this paper fatherhood goes beyond biological fatherhood and includes other close social relationships between adult men and children who may not be biologically their own, but are regarded as father-figures.

[27] https://pmg.org.za/bill/615/

not enough and need to be complemented with programmes that work directly on shifting the applicable social norms.

Programming to engage fathers

The importance of caring fathers in the lives of children and families remains undisputed. In addition, many fathers and male caregivers are currently involved and playing positive roles in their children's lives, and others would like to be supported to be more involved. In sub-Saharan Africa, there are several examples where MenCare Global Fatherhood campaign partners are engaging men as caregivers and as fathers through high-impact programme development, and local- and national-level advocacy initiatives. The gender-transformative Bandebereho couples' intervention to promote male engagement in reproductive and maternal health and violence prevention in Rwanda showed within a rigorous evaluation that culturally adapted programmes can be effective at changing deeply entrenched gender inequalities and a range of health-related behavioural outcomes. The intervention was an adaptation of Program P, a couples focused intervention that supports gender equal and non-violent fatherhood. The intervention was implemented by the Rwanda Men's Resources Centre (RWAMREC) with support from Promundo. The results of a rigorous randomised control trial indicated several improved outcomes compared to the control group. Women in the intervention group reported less past-year physical and sexual intimate partner violence and greater attendance and male accompaniment at antenatal care. Women and men in the intervention group reported less child physical punishment for both women and men, greater modern contraceptive use for both women and men, higher levels of men's participation in childcare and household tasks, and less dominance of men in decision-making [9]. An interesting observation was that while men's participation in childcare and household tasks increased, women's time spent on the same tasks did not reduce. This may have been due to either a high volume of household work, or to the possibility that men and women were doing different kinds of household work.

MenCare Child Care and Protection Programme

The MenCare Child Care and Protection (CCP) programme has also been adapted from Program P. The programme in South Africa has gone through a process of uptake, implementation and adaptation to fit the South African context and its unique needs, in order to eventually be taken to scale as an evidence-based intervention. In determining what is considered 'evidence-based interventions', it was important to identify the elements of the MenCare CCP programme against a set of key criteria developed by Fixsen et.al [8] (see Table 1 below). As articulated in the table, the MenCare CCP programme has a clear philosophy in promoting the involvement of men in parenting as fathers and as caregivers to ensure gender transformative parenting. It is a structured programme that encourages social learning and includes referral protocols for participants. At an organisational level, the programme has well defined structures and systems in place facilitating consistent service delivery which is complemented by supervision and monitoring to ensure not only improvements in the delivery of the programme, but also collecting the evidence to see if the programme is beneficial to families and children.

Table 1: Implementation of Evidence Based Interventions

Common Elements Of Evidence Based Interventions	MenCare Child Care and Protection Programme Elements
Clear philosophy	Gender transformative parenting intervention
Specific treatment components	8 structure sessions, each with core messaging
Treatment decision making	Referral protocols
Structures service delivery components defined for programme delivery – organisational HR, data processing, management systems and processes	2 facilitators per group, logistical support, facilitator record keeping, participatory monitoring and evaluation
Continuous improvement components	Supervision and mentoring during training

The findings of the evaluation described below is a first step towards collecting sufficient evidence to support the programme to be taken to scale as an evidence-based intervention.

Overview of the MenCare South Africa Child Care and Protection programme: Working with Social Service Professionals

The MenCare South Africa Child Care and Protection (MenCare SA CCP) programme focused on improving the capacity of social services professionals to support involved fatherhood. This was done in order to pave the way for future implementation at scale by the Department of Social Development. In Phase 1, the programme worked with Provincial Departments of Social Development and conducted a 12-session intervention with state social services professionals focusing on the impact of fathers; pregnancy; birth; family planning; caregiving; gender, non-violence; the needs and rights of children and division of caregiving. In Phase 2, the programme worked with the National Association of Child and Youth Care Workers (NACCW) and conducted a five-session intervention with child and youth care workers, and male beneficiaries and their partners (where applicable) focusing on the legacy of the father, gender values clarification, violence prevention, and caregiving activities.

The MenCare SA CCP programme recognized diversity in caregiving and the right for all people to care for children. The programme further promoted father's presence during pregnancy and advocated for paid parental leave for both parents.

Key findings of the MenCare SA CCP programme evaluation

The programme was evaluated in 5 provinces: Western Cape, Eastern Cape, Northern Cape, Gauteng, and North West in partnership with the Department of Social Development and the University of the Western Cape. The evaluation used a mixed methods approach with quantitative analysis of survey questionnaires and qualitative analysis of focus group discussions.

Gendered norms of fathers and male involvement in parenting

Participants in the intervention shared perceptions of men as absent, strong, unfeeling, uninvolved, violent, disengaged, uncaring and 'macho' men, or 'ATM fathers'. Both men and women in the two phases of the evaluation also indicated that socialisation and community influences defined

responsibilities for men and women, with men being laughed at if involved in childcare, caregiving, or house chores. Men (and some women) indicated that it makes sense that women were responsible for most of the childcare, caregiving and house chores due to women's 'maternal instincts' and men being ridiculed if involved in caregiving.

However, many also acknowledged that a lot of fathers do have the desire to be involved in their children's and partners' lives, and some are prevented from doing so. Respondents spoke of the importance of focusing on the positive roles of fathers and men as members of their homes and communities in terms of ending violence against women and children, encouraging men to be present and actively involved in their children's lives, the importance of treating women with respect, and the importance of sharing responsibilities regardless of cultural, traditional or religious beliefs and marital, residential and financial status.

Increased father involvement in domestic and caregiving roles.

The MenCare SA CCP programme aimed at improving attitudes of participants about the sharing of domestic and caregiving work. In the post-intervention survey, both men and women showed improved attitudes and awareness of the importance of gender equality in caregiving. In some cases, these changes in perceptions led to action as some participants spoke of improved partner communication in terms of roles and responsibilities, fluidity in deciding who conducts house chores, fathers getting more involved with the family and school activities, and fathers spending more time bonding and being present as a parent.

High prevalence, and reduction of, violence against women and children

The MenCare SA CCP programme aimed at reducing gender-based violence. However, post-intervention results for female state social workers were disturbing in that there was an increased reporting about being exposed to current partner violence. While this is indeed worrying and was addressed as a matter of urgency, it was noted that the MenCare SA CCP intervention made it possible for survivors to be able to speak out. It was of equal concern that male state social workers reported use of violence, although it was encouraging in the post-intervention that this use of violence had decreased significantly.

Improved relationships between fathers, their partners, and children

The MenCare SA CCP programme assisted in building and improving relationships between fathers, children and mothers. The participants in the evaluation highlighted positive changes in family interactions by fathers such as increased communication, spending more time with their family '*weekends are family time*', increased involvement with children's school projects, and improved relationship building and bonding through being available and present in the lives of the children, for example non-resident fathers visiting regularly, ensuring the children's needs are met and showing interest in the children's health and well-being. One female participant noted: *'he has changed after the programme because he is expressive. He does not bottle things inside anymore'.*

Another female partner highlighted the benefits of taking part in the intervention with her partner when she stated *'At first, we had a strained relationship; it was only after the programme that he started to reach out to me and ever since I can say our relationship is getting better'.* These statements indicate the importance of

the MenCare SA CCP programme in building and improving relationships between fathers, children and mothers.

Conclusions

The MenCare South Africa CCP evaluation has shown the value of educating social service professionals like social workers and child and youth care workers on the importance of involved fatherhood, and the programme has the potential to be adapted and replicated elsewhere to achieve improved parenting outcomes through the involvement of men in parenting as fathers and as caregivers.

References

1. Department of Social Development, *White Paper on Families in South Africa*. 2013, Department of Social Development: Pretoria.
2. South African Government, *Children's Act 38 of 2005*. 2005.
5. Van den Berg, W. and Makusha, T. (2018). *State of South Africa's Fathers 2018*. Cape Town: Sonke Gender Justice & Human Sciences Research Council.
3. Richter, L., et al., *Fathers and other men in the lives of children and families.* 2012.
4. Martin, A., R.M. Ryan, and J. Brooks-Gunn, *When fathers' supportiveness matters most: Maternal and paternal parenting and children's school readiness.* Journal of Family Psychology, 2010. **24**(2): p. 145.
6. Statistics South Africa. (2013). A Survey of Time Use, 2010. Pretoria: Stats SA.
7. Bray, R. and R. Brandt, *Child care and poverty in South Africa: An ethnographic challenge to conventional interpretations.* Journal of Children and Poverty, 2007. **13**(1): p. 1-19.
8. Richter, L., et al., *Harnessing our manpower.* ChildrenFIRST, 2004. **8**: p. 16-20.
8. Fixsen, D., Naoom, S., Blase, K., Friedman, R., and Wallace, F. Implementation Research: A synthesis of the Literature, National Implementation Research
9. Doyle, K., et al., *Gender-transformative Bandebereho couples' intervention to promote male engagement in reproductive and maternal health and violence prevention in Rwanda: Findings from a randomized controlled trial.* PLoS One, 2018. **13**(4): p. e0192756.
10. Makusha, T., & Richter, L, *Fatherhood in the first 1000 days*, in *State of South Africa's Fathers 2018*, W. Van den Berg and T. Makusha, Editors. 2018, Sonke Gender Justice & Human Sciences Research Council: Cape Town. p. 49-63.

THE IMPORTANCE OF GOOD NUTRITION: GETTING TO THE ROOT OF VIOLENCE PREVENTION FOR CHILD PROTECTION

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Background

There is a growing body of research that suggests that malnutrition and violence are related, with early malnutrition predisposing to later violence (Ledger, 2016). This paper presents a systematic review of evidence that exposure to malnutrition prenatally and in early childhood results in neurological and physiological changes, which predispose a child to later cognitive and behavioural challenges that are linked to increased aggression and violence. It also argues that the long-term social and economic trajectory for these children is poor. Early exposure to malnutrition, within a South African context of widespread community violence, scarce resources and limited opportunities, increases the risk of poor school performance, subsequently reducing employability and increasing the risks of substance use and poverty, all of which are risk factors that are well-known to be positively correlated with high rates of violence against women and children (Hsiao et al., 2018).

South Africa's White Paper for Social Welfare (1997), as well as Chapter 7 of the Children's Act (No. 38 of 2005 as amended) recognise the need for a multi-sectoral approach to child protection. They make provisions for the implementation and resourcing of primary prevention and early intervention programmes that promote the well-being of families and children. However, despite these clear guidelines in the legislative framework, our child protection strategies not only lack sufficient inter-departmental collaboration to effectively address all of the risk factors linked to violence against women and children, but also remain primarily reactive. Key recommendations that require collaboration between the Department of Health, Social Development, Education and the non-profit sector are put forward in relation to the review findings. These provide a proactive approach to child protection that is in line with the intentions of our current child protection legislation.

Academic Literature Search Methodology

Using an academic search engine, this rapid review searched four major electronic databases, seeking all articles on violence and nutrition. This search strategy employed the following databases: Elsevier, JSTOR, Semantic Scholar and Springer. In addition, Google Scholar was used to identify any other publications, or grey literature. These databases were selected to encompass the range of subjects touching on this interdisciplinary topic, including: child development, psychology, physiology,

nutrition and health. The search strategy in each database targeted subject headings (where available) and free-text terminology representing the concepts of violence and nutrition.

The literature search was completed on July 19th 2019. The literature search was limited to articles published in English, and no limits were placed on date of publication. The final literature search was limited to the following terms: Violence, Child, Nutrition, Malnourished, Aggression, Health, Poverty and Africa. The following results were obtained:

- Elsevier – 590 search results
- JSTOR – 21 search results
- Semantic Scholar – 260 search results
- Springer – 62 search results
- Google Scholar – 16800 search results

The abstracts of potentially relevant research articles were read, and if the article met the inclusion criteria, it was forwarded for a full article review. Potential articles were transferred to a shared folder. This amounted to a total of 43 articles, which were further reduced to 30 articles upon review of the full articles.

The final set of articles reviewed included peer-reviewed journal articles, journal reviews and book chapters published between 1986 to 2018. The majority of the articles included research findings based on north American and European samples, with only one of the articles referring to research conducted in South Africa. This is one of the three primary limitations arising from this systematic review, which are discussed in more detail in the final sections of the paper.

Findings

Across the 30 articles reviewed, there were four primary themes regarding the association between malnutrition and violence:

1. Critical ages of exposure to malnutrition
2. Critical nutrients in brain development linked to aggressive behaviour
3. The interaction between malnutrition and other risk factors
4. Nutrition as an intervention

These themes are briefly presented followed by a discussion of the implications for considering nutrition as a preventative child protection strategy.

1. Critical ages of exposure to malnutrition

The first theme that was evident from the findings was that there are critical ages of exposure to malnutrition that are associated with a predisposition to later aggression. These are specifically prenatal exposure and exposure within the first 3 years of life.

Neugebauer et al., (1999) found that the male offspring of mothers severely malnourished during the first and second trimesters of pregnancy had 2.5 times the normal rate of antisocial personality disorder in adulthood. Postnatally, prospective findings indicate that children with certain micro and

macronutrient deficiencies at age 3 years exhibited greater antisocial, aggressive, and/or hyperactive behaviours at the later ages of 8, 11, and 17 years (Liu et al., 2004; Liu et al., 2003).

Linked to measures of food availability, accessibility, utilization and stability, the General Household Survey conducted in 2017 found that approximately 1.7 million households across South Africa are affected by food insecurity (Stats SA, 2017). An estimated half a million of these households include children under the age of 5 years old (Stats SA, 2017). The long-term physical, social and economic consequences resulting from malnutrition within those early stages of development, arguably contribute towards perpetuating the cycle of poverty.

2. Critical nutrients in brain development are linked to aggressive behaviour

The research presented in the articles reviewed suggests that not only does nutrition play an active role in brain development during pregnancy and early childhood, but that there are critical nutrients that play this particular role in relation to the development of aggressive tendencies. This is supported by both human and animal studies.

The findings from the studies suggest that a deficiency in macronutrients (like protein), micronutrients (like trace elements zinc and iron), and a component of omega-3 fatty acids (docosahexaenoic acid or DHA – a long-chain essential fatty acid) have a particularly negative impact on brain development. This is based on numerous findings showing a correlation between these nutrient deficiencies and behaviour disorders in children (Breakey, 1997; Fishbein, 2001; Lister et al., 2005; Liu & Raine, 2006; Werbach, 1992). Zinc deficiency, for example, has been specifically associated with greater violence and aggression (Liu et al., 2004; Watts, 1990), as well as hyperactivity (Brophy, 1986), low iron has also been linked to aggression, conduct disorder, and juvenile delinquency (Rosen et al., 1985; Werbach, 1995). In animal models, monkeys and rats deprived of the amino acid tryptophan show higher rates of aggression (Bjork et al., 1999), possibly due to the role of tryptophan in synthesizing serotonin, which has been shown to be lowered in individuals with impulsivity and violent behaviors (Virkkunmen et al., 1995; Werbach, 1995).

The exact nature of these relationships is still not clear, however, Coccaro et al. (1997), Ferris and Grisso (1996) and Liu and Raine (2006) speculate that the nutrients mentioned above may be involved in the regulation of neurotransmitters or hormones, or else exacerbate neurotoxins, and in so doing predispose to brain dysfunction, aggression, and hyperactivity.

3. The interaction between malnutrition and other risk factors

The third theme that was evident in the literature related to evidence highlighting other risk factors as potential mediators in the relationship between early malnutrition and later propensity to violence and aggression. This research suggests that early malnutrition alone does not predispose a child to later aggression, but rather that certain genetic and environmental risk factors influence the outcomes of this relationship.

Genetic predispositions were not documented in detail amongst the articles reviewed for this study, however, studies on the mediating effects of cognitive function, the early home environment, smoking during pregnancy, diet and poverty were. There is speculation that proteins and minerals play a role in either regulating neurotransmitters or hormones, or else exacerbate neurotoxins, and in doing so predispose to aggressive and violent behaviour (Coccaro, 1996).

Numerous studies have demonstrated that high levels of testosterone are related to aggression (Book et al., 2001; Chance et al., 2000; Harris, 1999). High levels of testosterone are associated with withdrawal and aggression among 9 to 11 year old boys (Chance et al., 2000). Female criminals have also been found to be much more likely to commit crimes around the menstrual phase of their cycle when progesterone is low, while aggression is reduced around the time of ovulation when oestrogens and progesterone levels are high (Carlson, 1998). More recently, however, others have argued that elevated testosterone alone does not account for aggressive behaviour (Bernhardt, 1997). Rather, it is suggested that aggressive behaviour may be influenced by high testosterone levels combined with low levels of brain chemical serotonin. In addition, environmental factors influence the level of testosterone. Other hormones such as cortisol have also been found as a correlate of severe and persistent aggression in male children and adolescents (McBurnett et al., 2000; Susman and Ponirakis 1997).

Cognitive function and the early home environment: A study on conduct problems in adolescence found that later vulnerability to conduct problems was mediated by the more proximal neurobehavioral effects of the malnutrition on cognitive function and by adverse conditions in the early home environment (Galler, Bryce, Waber, Hock, Harrison, Eaglesfield, and Fitzmaurice, 2013). Adverse conditions such as smoking, poverty and diet are factors for which there is increasing links to malnutrition.

Multiple studies focusing on nutritional supplementation as an intervention lead to the conclusion that daily diet has positive and negative influences on behaviour. Meyer et al. (2015) found that supplementing the diet of prison populations with Omega 3 and 6 fatty acids, reduced instances of violence. Golomb's (1998) research with offenders highlighted that low cholesterol was associated with higher rates of aggression. Wallner and Machatschke (2009) found that when children are hungry, they are more irritable, anxious and likely to engage in bullying. Further research by Moore, Carter and van Goozen (2009) demonstrated that children who consumed confectionary on a daily basis at aged 10 years, were more likely to have been convicted for a violence offence by age 34.

The interaction between smoking and malnutrition has been made evident by a number of studies which show that smoking during pregnancy impairs the transportation of zinc to the foetus, causing a deficiency of that particular nutrient during brain development (Raine, 2002).

Poverty is a root cause of malnutrition, and also a mediator in the relationship between early malnutrition and later aggression and violence. Studies focusing on the timing, depth and duration of poverty experienced by families, found that the greater the experience of poverty, the greater their exposure to malnutrition, which in turn influenced the predisposition to violence and aggression (Engle, Castle & Menon, 1996).

Despite reference to the potential mediating role of other risk factors in the literature, there is very limited research on the interactions between these risk factors and malnutrition, in terms of the extent to which they predispose to aggression and violence.

4. Nutrition as a form of intervention

The systematic review of the literature on the relationship between malnutrition and later aggression, unequivocally points to ensuring good nutrition as a primary intervention strategy to address violence.

More specifically, the recommendations are that violence prevention should be integrated with programs that promote and support good nutrition, particularly amongst:

1. Pregnant women (Seccombe, 2000).
2. Young children in early child development (WHO, 2014)
3. School-aged children (Jackson & Vaughn, 2018)
4. Populations with mental health diagnoses, or who are at risk of aggressive behavior (Sever et al., 1997)

Limitations

Despite the promising results, the findings presented in this systematic review of the literature on malnutrition and externalizing behaviors remain both limited and controversial (Liu et al., 2004), particularly in an African context, for three primary reasons:

1. Firstly, there are very few studies focusing on the hypothesized relationship between malnutrition and violence. The articles are predominantly reviews, which tend to include the same set of studies.
2. Secondly, 29 of the final 30 articles included in the review were based on North American, South American and European samples. Only one of the studies was conducted on a sample of farm workers in Cape Town. Furthermore, this study did not focus on the relationship between malnutrition and aggressive behaviour, but rather on malnutrition as a factor contributing to increasing inequality.
3. Finally, there is not enough research that tests for the interactions between malnutrition and other risk factors that are also known to contribute to aggressive behaviour and violence.

Recommendations

1. Ante-natal programs focussing on the importance of adequate nutrition
2. Where possible provide nutrition programs at school.
3. In cases where child support grants are provided it should be accompanied with education on nutrition
4. Making healthy foods affordable to all
5. Awareness raising from eco-systemic perspective (Public and private sector
6. Education, Health, Social Development, Faith based institutions, recreation facilities, media platforms and the corporate sector)

Conclusion

Children who suffer from malnutrition are more likely to endure its consequences over their life time, if there is no means to escape it. Being trapped in this lower hierarchy of needs does not only hinder children's growth and well-being, but also destroys their chances of developing into productive and contributing members of society.

The South African government has made a number of strides in addressing the scourge of poverty that continues to affect more than 60% of children in our country. The child support grant provides assistance to approximately 11 million of these children and has been found to be an effective tool in improving the well-being of children. However, a considerable number of children continue to be plagued with malnutrition. Despite mounting evidence for the links between malnutrition and an

increased capacity for aggressive behaviour, there is limited advocacy for the development of violence prevention programmes that target malnutrition in early childhood development as a root cause of the levels of violence in our society. Promoting adequate nutrition across 'at risk' groups in particular is a proactive approach to child protection that will lead to healthy children, a healthy economy and healthy generations free from violence.

References

Bernhardt, P. C. (1997). Influences of serotonin and testosterone in aggression and dominance: Convergence with social psychology. *Current Directions in Psychological Science, 6*(2), 44–48. https://doi.org/10.1111/1467-8721.ep11512620

Bjork J., Dougherty D., Moeller F., Cherek D., & Swann A. (1999). The effects of tryptophan depletion and loading on laboratory aggression in men: time course and a food-restricted control. *Psychopharmacology*;142(1):24–30. [PubMed: 10102779]

Book, A. S., Starzyk, K. B., & Quinsey, V. L. (2001). The relationship between testosterone and aggression: A meta-analysis. *Aggression and Violent Behavior, 6*(6), 579–599. https://doi.org/10.1016/S1359-1789(00)00032-X

Breakey J. (1997). The role of diet and behavior in childhood. *Journal of Pediatric Child Health*;33(3): 190–194.

Brophy, M.H. (1986). Zinc and childhood hyperactivity. *Biological Psychiatry*;21(7):704–705. [PubMed:3708042]

Carlson, N. (1998). *Physiology of behavior*. 6th ed. Allyn and Bacon; Needham Heights, MA.

Chance, S.E., Brown, R.T., Dabbs, J.Mm & Casey, R. (2000). *Testosterone, intelligence and Behaviour Disorders in Young Boys*. Personality and Individual Differences; 28:437-445.

Coccaro, E. F., Kavoussi, R. J., Sheline, Y. I., Lish, J. D., & Csernansky, J. G. (1996). Impulsive aggression in personality disorder correlates with tritiated paroxetine binding in the platelet. *Archives of General Psychiatry, 53*(6), 531–536. https://doi.org/10.1001/archpsyc.1996.01830060075010

Coccaro EF, Kavoussi RJ, & Hauger RL. (1997). Serotonin function and anti-aggressive response to fluoxetine: A pilot study. *Biological Psychiatry*; 42(7):546–552. [PubMed: 9376450]

Engle, P.L., Castle, S., Menon, P. (1996). Child Development: Vulnerability and Resilience. *International Food Policy Research Institute*: FCND Discussion Paper No. 12.

FAO, IFAD, UNICEF, WFP and WHO. (2017). *The State of Food Security and Nutrition in the World 2017. Building resilience for peace and food security*. Rome, FAO. Retrieved from http://www.fao.org/3/a-I7695e.pdf. Accessed September 5, 2018

Ferris, C.F. & Grisso, T. (1996). Understanding aggressive behavior in children. New York, NY: New York Academy of Sciences; 1996.

Fishbein, D. (2001). *Biobehavioral Perspectives in Criminology*. Belmont, CA: Wadsworth/Thomson Learning.

Galler, J.R., Bryce, C.P., Waber, D.P., Hock, R.S., Harrison, R., Eaglesfield, G.D., Fitzmaurice, G. (2013) Infant malnutrition predicts conduct problems in adolescence. *Nutritional Neuroscience*;16(5):239.

Golomb B. (1998). Cholesterol and violence: is there a connection? *Ann Intern Med*; 128:478–87

Harris, J. A. (1999). Review and methodological considerations in research on testosterone and aggression. *Aggression and Violent Behavior*, *4,* 273–291.

Hsiao C., Fry, D., Ward, C.L., *et al* (2018). Violence against children in South Africa: the cost of inaction to society and the economy. *BMJ Global Health*; **3:**e000573.

Jackson, D.B., Vaighn, M.G. (2018). The Bully-victim overlap and Nutrition among School-aged Youth in North America and Europe. *Children Youth Services review*; 90:158-165.

Lister, J.P., Blatt, G.J., Debassio, W.A., Kemper, T.L., Tonkiss, J., Galler, J.R., Rosene, D.L. (2005). Effect of prenatal protein malnutrition on numbers of neurons in the principal cell layers of the adult rat hippocampal formation. *Hippocampus*; 15(3):393–403. [PubMed: 15669101]

Liu, J., Raine, A., Venables, P., Mednick, S.A. (2003). Malnutrition at age 3 years and lower cognitive ability at age 11: A prospective longitudinal study. *Archives of Pediatrics & Adolescent Medicine*; 157:593–600. [PubMed: 12796242]

Liu, J. (2004). Childhood externalizing behavior-theory and implication. Journal of Child and Adolescent. *Psychiatric Nursing*; 17(3):93–103. [PubMed: 15535385]

Liu, J., Raine, A. (2006). The effect of childhood malnutrition on externalizing behavior. *Current Opinion in Pediatrics*; 18(5):565–570. [PubMed: 16969174]

Makoae, M. (2014). *Safeguarding South Africa's future: The need for integrated prevention programmes in child protection*. Human Sciences Research Council: Policy Brief.

McBurnett, K., Lahey, B. B., Rathouz, P. J., & Loeber, R. (2000). Low salivary cortisol and persistent aggression in boys referred for disruptive behavior. *Archives of General Psychiatry, 57*(1), 38–43. https://doi.org/10.1001/archpsyc.57.1.38

Meyer, B.J., Byrne, M.K., Collier, C., Parletta, N., Crawford, D., Winberg, P.C., et al. (2015). Baseline Omega-3 Index Correlates with Aggressive and Attention Deficit Disorder Behaviours in Adult Prisoners. PLoS ONE 10(3): e0120220. doi:10.1371/ journal.pone.0120220

Moore, S.C., Carter, L.M., van Goozen, S. (2009). Confectionary consumption in childhood and adult violence. *British Journal of Psychiatry*; 195:366-367. [DOI: 10.1192/bjp.bp.108.061820]

Neugebauer, R., Hoek, H.W., Susser, E. (1999). Prenatal exposure to wartime famine and development of antisocial personality disorder in early adulthood. *JAMA*; 282:455-462

Raine, A. (2002). Annotation: The role of prefrontal deficits, low autonomic arousal and early health factors in the development of antisocial and aggressive behavior in children. *Journal of Child Psychology & Psychiatry & Allied Disciplines*; 43(4):417–434.

Rosen, G.M., Deinard, A.S., Schwartz, S., Smith, C., Stephenson, B., Grabenstein, B. (1985). Iron deficiency among incarcerated juvenile delinquents. Journal of Adolescent Health Care; 6(6):419–423. [PubMed: 4055462]

Seccombe, K. (2000). Families in Poverty in the 1990s: Trends, Causes, Consequences, and lessons Learned. *Journal of Marriage and the Family;* 62: 1094–1113

Sever, Y., Ashkenazi, A., Tyano, S., & Weizman, A. (1997). Iron treatment in children with attention deficit hyperactivity disorder. A preliminary report. *Neuropsychobiology*;35(4):178–180.

Susman, E.J., & Ponirakis A. (1997) Hormones—Context Interactions and Antisocial Behavior In Youth. In: Raine A., Brennan P.A., Farrington D.P., Mednick S.A. (eds) *Biosocial Bases of Violence. Nato ASI Series* (Series A: Life Sciences), vol. 292. Springer, Boston, MA

Virkkunen, M., Goldman, D., Nielsen, D.A., & Linnoila, M. (1995). Low brain serotonin turnover rate (low CSF5-HIAA) and impulsive violence. *Journal of Psychiatry and Neuroscience*; 20(4):271–275. [PubMed: 7544158]

Wallner, B., Machatschke, I.H. (2009). Influence of Nutrition on Aggression. *CAB Reviews: Perspectives in Agriculture, Veterinary Science, Nutrition and Natural Resources*; 75:4

Watts, D.L. (1990). Trace elements and neuropsychological problems as reflected in tissue mineral analysis (TMA) patterns. *Journal of Orthomolecular Medicine*; 5(3):159–166

Werbach, M.R. (1992). Nutritional influences on aggressive behavior. *Journal of Orthomolecular Medicine*; 7(1):45–51

EARLY CHILDHOOD DEVELOPMENT PRACTICES FROM THE PERSPECTIVE OF CAREGIVERS IN GA-DIKGALE COMMUNITY

Michelle Walford

Introduction and Overview

Early childhood is a critical stage in life. The care, nutrition, nurturing and stimulation that a child receives in early childhood is proven to affect their quality of life into adulthood. (Heckman, 2000) Early Childhood Development (ECD) practices are structured around meeting the needs of children in all respects: intellectual, physical, emotional and social, to help them reach their full potential. (Africa, 2008) Girdwood suggests that high quality Early Childhood Development (ECD) practices can increase an individual's chances of breaking the inter-generational cycle of poverty. (Girdwood, 2012) Furthermore, attachment theory suggests that the relationship between child and primary caregiver, be it parental or otherwise, sets a precedent for the child's relationships in future and will affect their mental, emotional and behavioural development. (Vu et al., 2015, Bretherton, 1992) The quality of ECD care provided can shape an individual's socio-behavioural patterns into adulthood. (Vu et al., 2015)

The Children's Act (2005) defines a caregiver as: *a person who cares for a child with the implied or express consent of a parent or guardian of the child.* (Africa, 2006) (p11) Caregivers are crucial in ECD facilities in ensuring an environment where children are cared for, protected and stimulated. (Berry et al., 2013) They provide a sense of security for children, and their effect on children's lives can be immense. (Berry et al., 2013) The level of care they are able to provide may be impacted not only by their state of mind, but by their perceived self-efficacy: the belief that one holds in their own ability to succeed. Bandura suggested that in educational facilities, perceived efficacy on both personal and collective (in this case, facility) levels can directly affect the educational outcomes of the facilities as a whole. (Bandura, 1993) It is important to better understand how the caregivers in ECD facilities perceive themselves and the services they offer within the context of their environments, as this may affect the developmental outcomes of the children in their care.

Literature review

South Africa is facing a variety of issues surrounding the standards of care and safety provided to children attending ECD facilities, and particularly those attending rural ECD facilities. (Atmore et al., 2012) Only one in six South African children has access to site-based ECD services and, even then, rural facilities have historically been of poorer quality than their urban counterparts. (Porteus, 2004) While there has been an improvement in access to rural ECD facilities over the last two decades, there

is still an issue pertaining to quality; children in rural areas still struggle to access high quality ECD services. (Berry et al., 2013) Children who grow up in difficult circumstances and lack access to high quality ECD may be vulnerable to compromised outcomes later in life. (Berry et al., 2013) Girdwood demonstrates that children who come from poorer backgrounds tend not only to enter the system with a disadvantage due to lack of home stimulation, but as they enter formal schooling they tend to continue underperforming relative to their peers. (Girdwood, 2012). South African children whose performance falls below the benchmark in early schooling tend to stay below average for their entire school career, reflecting the long-lasting damage of poor early education. (Spaull et al., 2016) Furthermore, poorer school performance is linked to falling into a lower income quintile later in life. (Spaull et al., 2016)

Between the ages of three and five years old, a combination of effective parenting and receiving ECD support outside of a home environment significantly increases a child's likelihood of being open to formal learning when they enter the school environment. (Dodge, 2003, Berry et al., 2013) A set of goals and objectives have been developed for children coming into Grade R and the services at ECD facilities lay the foundation for formal education through active learning and play. (Africa, 2015)

Caregivers are responsible for child safety and wellbeing, as well as preparing the children in their care mentally, physically, socially and emotionally for formal school. (Berry et al., 2013) They are responsible for providing an environment that is safe, nurturing, healthy and stimulating. (Berry et al., 2013) The care that children experience – not only in terms of meeting their needs, but the affection and responsiveness of their caregivers – directly influences their development. (Berry and Malek, 2017) Caregivers are expected to show an interest in the children in their care and a passion for ECD in general. (DSD and UNICEF, 2007)

Caregiver training is mandated by law, and is shown to affect the quality of care provided, and therefore child development in the long term. (Africa, 2008, Atmore et al., 2013) For a child to have the best chance of meeting their developmental outcomes, it is imperative that caregivers are trained to provide a nurturing, safe and healthy environment for that child that meets their physical, mental and emotional needs. (WHO, 2004) Caregivers and parents who do not realise the importance of their interactions with children are less likely to provide nurturing and stimulating care. (WHO, 2004) Moreover, the emotional state of the caregiver affects the care provided and therefore can affect their relationship with children in their care. (WHO, 2004)

It has been shown that higher self-efficacy leads to better results, and in this case, children's outcomes improve under the care of teachers or carers with high self-efficacy. (Bandura, 1993) Increased perceptions of self-efficacy are linked to individuals' ability to cope with challenging situations. (Schwarzer, 2014) People who have a sense of self-efficacy will visualise their own success and are more likely to achieve it, while those with self-doubt tend to focus on barriers to success and are likely to stand in their own way. (Bandura, 1993) This effect is multiplied under stressful conditions. (Bandura, 1993)

Similarly, workers who are living in poverty may be at risk of poor productivity due to the effects of poverty on their own lives, and therefore poverty may in itself lead to poor outcomes, all else held constant. (Callander and Schofield, 2016) People living in poverty or a state of deprivation, report feeling worn down and find it difficult to adequately care for children. (WHO, 2004) In addition,

people caring for vulnerable or at-risk children report feeling overwhelmed and tend to have higher levels of emotional distress. (WHO, 2004) Caregivers in vulnerable communities may be living in poverty themselves. It can thus be suggested that caregivers living in poverty who have lower levels of self-efficacy, may indeed negatively affect the developmental outcomes of the children in their care.

Method and results

This was a cross sectional and exploratory study using qualitative and quantitative methods to understand Early Childhood Development (ECD) practices in the rural community of Ga-Dikgale from the perspective of ECD caregivers. This study considered ECD, a highly researched topic, from within the context of an under resourced South African community, lacking in access and financial means. It explored the care provided from the unique perspective of those providing it.

Ga-Dikgale is a rural community of 29 villages in Limpopo. There are approximately 4 800 children in the community – or 11% of the population – under the age of five years old. (StatsSA, 2011) The research focused on caregivers working at ECD facilities that cater to children from birth to age five, who are traditionally not yet attending school. (Biersteker and Kvalsvig, 2007, Berry et al., 2013) The study population were caregivers working at ECD facilities in Ga-Dikgale between August 2016 and March 2017. The study unit was the ECD caregiver, who was actively working in an ECD facility in Ga-Dikgale at the time of the discussion. The study used purposive sampling, tapping into the existing social structures within the community. The research was approved and supported by Makgosi (*wife of the chief*) Dikgale and the community's Indunas (*traditional leaders*). Six facilities were excluded as they had an existing working relationship with the researcher.

At the time of the study there were a total of 109 caregivers working at the 32 facilities, or an average of 3.4 members of staff per facility. 102 of these members of staff (94%) were female. The ages of the caregivers spanned a difference of 65 years (the youngest was 20 years old, while the oldest was 85 years old); they ranged in their experience from none at all, to over 40 years; their education ranged from Grade seven or lower, up to those with university degrees. There appears to be a loose relationship between the level of education and the position held by individuals, where those with relevant ECD education hold more of the managerial roles, while those with lower or less relevant education hold more of the support roles. Facility sizes range widely, from eight children at the smallest facility up to 142 children at the largest. The lowest ratio of caregivers to children is one adult to four children (1:4). The highest is 1:20.

Facility-level interviews took place at a total of 32 ECD facilities, and thereafter each facility was invited to send a representative to a Focus Group Discussion (FGD). There were a total of 33 people who took part in five FGDs, with one facility absent and two of the facilities sending two people each. 100% of the FGD participants were female. Their ages ranged from 25 to 62 years old, with an average age of 48 years. The majority of FGD participants were managers of their respective facilities and they were generally the most educated members of their facilities.

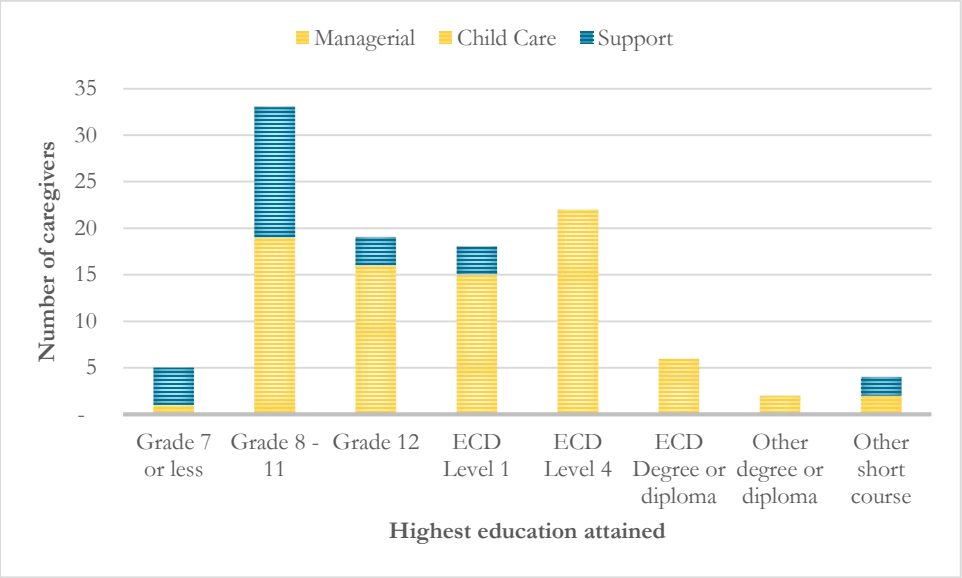

FIGURE 1: EDUCATION AND POSITION DISTRIBUTION OF CAREGIVERS ACROSS 32 FACILITIES IN GA-DIKGALE

FGDs were chosen as the format for data collection because of their ability to put people within the group at ease, as well as create an additional depth to the discussion introduced by a group dynamic. (Robinson, 1999) The FGD discussions centred on the participants' perceptions of ECD and their work, in terms of ECD in general as well as their own facilities.

An overarching theme in all of the FGDs was that of limitations felt by the participants. The participants struggled to articulate what they felt was going well. They would say something they were proud of, and then revert back to why they weren't doing what they would like to be doing. The caregivers expressed a feeling that they were ill-equipped to fully meet the needs of the children in their care. Although they felt proud of their contribution to the community, like being able to take kids from the streets and teach them, they felt that they could be doing more if they had the necessary resources and skills, saying: *"we lack a lot of things but we do work."* (E4)

The respondents recognised the importance of ECD and spoke about holistic development, school readiness and keeping children safe. They identified part of their role as preparing children for formal schooling, saying: *"When they get to school, they won't encounter a lot of problems."* (B5) One participant spoke about children getting "*good jobs in the end*". Their focus was primarily on immediate areas of impact rather than the longer-term potential impact of high quality ECD.

The World Health Organisation (WHO) suggests that in order to provide the best possible care that they can, caregivers or parents should be aware of just how impactful ECD care is. (WHO, 2004) While the respondents believed in the importance of their work, it is not clear whether they understood the potential long term impact their work could have.

During the focus groups, conversations would repeatedly lead back to the areas of lacking that the participants felt at their facilities. Shah et al suggest that a sense of not having enough of something causes people to focus with urgency on the areas where they perceive scarcity to be the greatest. (Shah et al., 2012) This theory lends itself to the finding that, regardless of how well or poorly a facility

appears to be functioning from an outsider perspective, the participants drew attention to what they don't have and who could get it for them, as opposed to what they did have or could achieve on their own. The respondents' perceptions of lacking may indicate poor self-efficacy in terms of the care they are providing to children in Ga-Dikgale. This may be due to the difficulties faced by caregivers in their own situations, such as living and working in resource-constrained environments. (WHO, 2004)

The participants spoke about the importance of being trained in order to meet the needs of the children. When discussing their priorities, one respondent noted that *"Without being trained, you might have all these things, but not know how to use them."* (E) One person felt that training was the most important of any need, saying: *"…Between water and training. You'll go for training without water. You'll go for training without eating. Let's think twice."* (B) This discussion linked with conversations about the legal implications of not being properly trained. The participants spoke about being worried that if some harm came to a child in their care, they would be held liable. According to South African law, caregivers are responsible for the care and protection of the children who attend their facilities and as such, not being sufficiently trained is considered illegal. (Africa, 2006) Therefore, it could indeed be the case if that caregiver is not qualified to provide ECD care they can be held liable by law.

Global literature demonstrates the importance of caregivers being qualified to provide ECD care. Vu (Vu et al., 2015), for example, links various ECD interventions and the training required for each, with improved long term personal and family outcomes. However, Atmore et al indicate that training alone is not a direct indicator of the quality of ECD care provided in South African ECD facilities. They suggest that a lack of practical training or on-site support may be the cause. (Atmore et al., 2012) Given that the level of education was generally high amongst the focus group participants, it may suggest that Bandura's theory of self-efficacy (Bandura, 1993) is at play and that despite being sufficiently trained, the participants' perceptions of inadequacy could be negatively impacting their work.

When discussing their relationships with the children in their care, the respondents spoke with warmth toward the children: *"We have love for the kids and they love us as well… When they go to Grade R they still talk about us."* (E2) The participants spoke about facilities being places where children could be kept safe, saying, *"We protect them as well as caring for them."* (C7) They mentioned that children who stay home may be neglected, get injured or abused: *"Working parents and school pupils… can't leave a child at home because some of them are abused."* (D5) Participant E4 mentioned that *"…maybe if they are left at home they could get burned or be raped or something else."* (E4) As Berry et al have suggested, the relationship between a child and the adult or adults in their life shapes their relationship patterns into adulthood and it is crucial for this reason that children have a stable, nurturing adult relationship in early childhood. (Berry and Malek, 2017) The findings suggest that while a loving relationship is present, the respondents may not have a formal understanding of its importance for the development of the children in their care.

The respondents consistently focused on their areas of lacking throughout the FGDs. They spoke about working hard but needing assistance that was not forthcoming. The WHO reflects on the difficulties that workers face who are themselves living in poverty, such as feeling worn down and feeling unable to meet the needs of the children in their care. (WHO, 2004) The results show that this may indeed be the case in Ga-Dikgale, where the respondents find themselves living in poverty while still trying to care for children in resource-constrained circumstances and perceive the quality of the care that they are providing as poor.

Conclusion

This qualitative study explored Early Childhood Development (ECD) practices in Ga-Dikgale, from the perspective of the ECD practitioners or caregivers themselves. It explored the characteristics of the caregivers, their perceptions of the care provided, and what they considered to be their highest priorities for providing high-quality ECD services.

The respondents have an understanding of what is required of them as ECD practitioners and from ECD facilities. They are focused on their shortcomings and gaps, and do not appear to fully understand the positive impact of the work that they are already doing. Since the perceived efficacy of care provided can affect the developmental or educational outcome of the children in their care, this perceived shortfall may be detrimental to the long-term developmental outcomes of the children attending facilities in Ga-Dikgale. These findings serve as a reminder of the risk of living in scarcity and how it affects the lens through which one views their own world. A sense of inadequacy – regardless of the level of training received by participants – may indicate poor self-efficacy (Bandura, 1993) which may adversely affect the learning outcomes of the children at the ECD facilities, thereby playing into the cycle of poverty that high-quality ECD services are designed to break. (Spaull et al., 2016) This is a concern that may have implications for policy and implementation of ECD.

Further research is required to fully explore caregivers' level of understanding with regard to the long-term benefits of ECD, including the long-term benefits of a healthy relationship between a child and a nurturing adult. In addition, further research is required into the implications of working at an ECD facility that does not meet the required standards.

The National Integrated ECD Policy speaks to the gaps in the system at present, specifically to those regarding the health of mothers and children. It mentions that focus and funding is skewed towards urban facilities, and that the quality of care is often insufficient. (Africa, 2015) Furthermore, the Policy suggests a need to measure programmes and their impact on child outcomes. (Africa, 2015) It is necessary to consider the effect that caregivers' self-efficacy will have on the outcomes of children in their care; and how policy – and thereby, funding – can be channelled to ensure that caregivers are not just trained, but believe in their own ability to provide care.

References

Africa, R. O. S. 2006. Children's act 38 of 2005. *In:* Justice, D. O. (ed.) *28944*. Cape Town: Government Gazette.

Africa, R. O. S. 2008. Children's Amendment Act 41 of 2007. Government Printer, Pretoria.

Africa, R. O. S. 2015. National integrated early childhood development policy. Government Printer, Pretoria.

Atmore, E., van Niekerk, L. & Ashley-Cooper, M. 2012. Challenges facing the early childhood development sector in South Africa. *SAJCE,* 2**,** 21.

Atmore, E., van Niekerk, L. & Ashley-Cooper, M. 2013. Early childhood education: the difference between policy and reality. *In:* Hofmeyr, J. (ed.) *2012 transformation audit.* South Africa: compress.

Bandura, A. 1993. Perceived self-efficacy in cognitive development and functioning. *Educ Psychol,* 28**,** 117-148.

Berry, L., Dawes, A. & Biersteker, L. 2013. Getting the basics right: an essential package of services and support for ECD. *South African Child Gauge 2013*. Cape town: Children's Institute, University of Cape Town.

Berry, L. & Malek, E. 2017. Caring for children: relationships matter. *South African Child Gauge 2017*. Cape town: Children's Institute, University of Cape Town.

Biersteker, L. & Kvalsvig, J. 2007. Early childhood development and the home-care environment in the preschool years. *Monitoring child rights and wellbeing: a South African approach*, 159-190.

Bretherton, I. 1992. The origins of attachment theory: John Bowlby and Mary Ainsworth. *Dev Psychol,* 28, 759.

Callander, E. J. & Schofield, D. J. 2016. The impact of poverty on self-efficacy: an Australian longitudinal study. *Occup Med (Lond),* 66, 320-5.

Dodge, D. 2003. Human capital, early childhood development and economic growth. *In:* Tremblay, R., Barr, R. & Peters, R. (eds.) *Encyclopedia on early childhood development [online]*. Montreal, Quebec: Centre of Excellence for Early Childhood Development.

DSD & UNICEF. 2007. Guidelines for early childhood development services. South Africa: UNICEF South Africa

Girdwood, E. 2012. A pre-r year: is it worth it, and what would it cost? *Strategies to overcome poverty & inequality: towards Carnegie iii.* Cape Town; .

Heckman, J. J. 2000. Invest in the very young.

Porteus, K. 2004. The state of play in early childhood development. *In:* Chisholm, L. (ed.) *Changing class: education and social change in post-apartheid South Africa.* Cape Town: Human Sciences Research Council press.

Robinson, N. 1999. The use of focus group methodology with selected examples from sexual health research. *J Adv Nurs,* 29, 905-913.

Schwarzer, R. 2014. *Self-efficacy: thought control of action*, Taylor & Francis.

Shah, A. K., Mullainathan, S. & Shafir, E. 2012. Some consequences of having too little. *Science,* 338, 682-685.

Spaull, V., van der Berg, S., Wills, G., Gustafsson, M. & Kotzé, J. 2016. Laying firm foundations: getting reading right.

Statssa 2011. Census 2011 release v1.1. *In:* Research, s.-t. (ed.).

Vu, J. A., Hustedt, J. T., Pander, W. M. & Han, M. 2015. Building early relationships: a review of caregiver–child interaction interventions for use in community-based early childhood programmes. *Early Child Dev Care,* 185, 138-154.

WHO 2004. The importance of caregiver-child interactions for the survival and healthy development of young children: a review.

THE SPECIALISED BEHAVIOUR MANAGEMENT PROGRAM

Nicolette Vigeland

Introduction

The Specialised Behaviour Management Program was designed in 2011 by a Clinical social worker with a background in family preservation. At the time a gap in service delivery was seen. There was an influx of behavioural issues being reported from child and youth care centres and schools in communities and referred to social work agencies and child and family psychiatric units. Leliebloem House was approached by the Department of Social Development to pilot the project. Children from Child and Youth Care Centres were recruited into the program and it ran successfully. A decision was later made to roll out the program into the community.

The Specialised Behaviour Management Program

The Specialised Behaviour Management Program is a Primary Early Intervention Program, therapeutic by nature and focusses on family preservation. Adolescents and families are given tools and skills to better manage these behaviours and improve family functioning. The program looks at providing solutions to the puzzle of adolescent behaviour. It is for adolescents who are thirteen to eighteen years old, reside in the Athlone/Wynberg Districts and show signs of Conduct or Oppositional Defiant Disorder. Signs of Conduct Disorder include aggression to people and animals, destruction of property, deceitfulness or theft and serious violations of rules. Signs of Oppositional Defiant Disorder include non-compliance, blaming others and vindictive behaviour. Diagnosis is not necessary but behaviours should be extreme and frequent enough to disrupt functioning in their social, family and school environments. There must be previous attempts to deal with the behaviours by the referring agency and the child and family must want intervention.

Aims and Ethos

The overall aims of the project are to provide specialised behaviour management support, therapeutic intervention and to prevent school drop out and family breakdown due to unmanageable or out of control behaviour experienced. The ethos when dealing with adolescents and families is that the behaviour being experienced is the problem and not the child. Therefore, the behaviour becomes the point of focus as opposed to the child being labelled as the problem. In this way, the behaviour being exhibited is seen as a plaster. This plaster is what is shown on the outside and we therefore need to find and heal the wound underneath so that the behaviour is no longer necessary.

Strengths Based Approach

The approach used is a strength based one which instils hope for the child, works in a positive way with what everyone else sees as unsolvable and gives the child the opportunity to work with a clean slate. No blame is put on the child or family as the process encourages them to take responsibility for their thoughts and actions enabling them to change negative patterns and implement them at home.

This empowers the family to take control and enables all members to be a part of this change. It also means that the change is monitored and guidance is given to all parties as the therapeutic process unfolds. Unconditional positive regard throughout the intervention is key. This means that the family can continue to try again and again without the fear of failure. It is important that the family understands this when negative behaviours reoccur and they then choose not to give up on themselves or the child. A relationship of genuine caring and concern toward the family provides the mechanism through which all this is possible as trust is vital as we build healthy ways of relating.

Referral Procedure

Referral is accepted from individuals, schools and Organisations. The referral form includes assessment forms for Oppositional Defiant Disorder and Conduct Disorder as indicators of the behaviour being experienced. The referral form is completed by the referring party and the assessment forms are completed by the family and school. Once the forms are received, the family is placed on the waiting list. Once recruitment commences, the forms are assessed and an appointment is made for an initial assessment or a referral is done to another agency if the referral to the program is deemed unsuitable. If the child is accepted into the program sessions with the relevant parties commence.

Intervention

Intervention is done in a few ways. It commences with a comprehensive assessment being done with the child and family. Here the full family history as well as the history of the child is completed. From the assessment intervention can commence based on the needs of the child and family. The family will however be referred for alternate services if the program cannot meet the needs of the family after the assessment.

Once accepted into the program, the family is given a comprehensive overview of what the program entails and the commitment that is required of them. It is important that they take ownership of the process that is about to unfold and buy into it. This commitment is what will ensure that they push through and keep going on in the months to come. Intervention is done in three ways: with the child, with the family and with the school. Intervention with the child is done through one on one counselling, behaviour management support, cognitive behavioural therapy and when needed, referrals. There is also a link with another program where the child has access to a camp. Here behaviour can be assessed as well as leadership development and holiday programs can be accessed.

As intervention is holistic, it is imperative that the family is involved. Family sessions are run where parenting skills and behaviour management education are taught and progress is monitored. Tools which include anger management, emotional expression and management as well as discipline techniques have been found to enhance the coping of the family when taught to both the child and the family member. Here these techniques can be tested at home, feedback given in sessions and progress is then seen as the family commits to using these techniques instead of previous unhealthy ones.

Home visits are conducted when needed and contact is maintained telephonically and via e-mails. If there are additional needs like food, school uniform etc., this is provided and the necessary assistance is given based on a needs analysis of the family. Parenting workshops are run and cover topics like punishment versus discipline and the adolescent brain. These often include the child and encourage

communication skills and strengthen relationships within the family. This means that intervention is holistic and tailored to meet the specific needs of the family.

School intervention includes sessions at school, disciplinary intervention and assistance with applications for placement at a new school or a school of skills. Monitoring of the child's behaviour at school, study skills as well as monitoring of school results is included. Behaviour management support at school is given and workshops can be held for educators and parents as well. This is much needed as it ensures that the parents and educators are on the same page and discipline is clear from all sides.

Aftercare

The program runs for a year depending on the progress made and the commitment of the family. On completion of the program a post assessment is done to track the changes in behaviour and the family is placed in Aftercare. Aftercare can run for up to 6 months and includes sessions only if needed. The family can attend workshops which are run during this time and access additional support or referral. This ensures that any additional or recurring problems are dealt with to make sure that the changes in behaviour are maintained and lasting.

Administration

Administration is key to ensure that all referrals are recorded both on file and electronically. Individual files are maintained and stored safely. This ensures that the confidentiality and anonymity of participants and families is maintained. Records of all intervention provided to the child, family and school is kept and reported on a monthly basis. Progress of participants can be tracked from entry to completion of program. This ensures transparency is maintained and results are not skewed. The pre-assessments and post-assessments ensure that behavioural changes can be tracked and explanations can be given as to why or why not progress was made on a given case. This has been see to directly correlate to the commitment of the family to the program, which is seen as interesting to the process.

Impact of the Program

The Program is in its ninth year. Thus far it has been successful in bringing about change in the lives of adolescents aged thirteen to eighteen, reducing the signs of Oppositional Defiant Disorder and Conduct Disorder and preventing the necessity of Statutory intervention. The treatment provide is individualised and the continuous evolution of the program ensures that it meets the needs of its beneficiaries.

We have noticed the changes that take place within family members. Children are less aggressive, stop stealing, attend school daily and do their school work. Parents understand the development of their child better, use the tools given to assist their child and better discipline is in place. This takes time, requires the involvement of all role players and means that underlying and contributing factors are dealt with successfully.

An increased commitment was seen of participants in the program, attendance increased at school and parents were more involved as well as changing their parenting style to better parent their child. There was also an improvement in results at school. Family relationships were improved and parents started using support mechanisms and attending parenting workshops they were also prepared to continue with their child where previously they had given up hope.

Statistics

2017-2018 we received 31 referrals. This increased in 2018-2019 as we received 50 referrals during that financial year. As we have the capacity to only deal with 10 adolescents and their families a year, we are overwhelmed by so many referrals. Some referrals were outside of our District and therefore we could not intervene. We ensured that they were referred to other Organisations for intervention.

In 2017-2018, 26% of our referrals were from Manenberg and 26% from Hanover Park. 36% were from the greater Athlone. In 2018-2019, 34% of our referrals were from the Manenberg area, 20% from Hanover Park and 18% from the greater Athlone area. In 2017-2018, 71% of the referrals were male and 29% were female. In 2018-2019, 76% of these referrals were male and 24% female.

In 2017-2018, 26% of those referred to the program were 13 years old, 20% were 11 years old and 14 percent were 12 years old. This indicates that in total, 60% of those referred were between the ages of 11-13 years old. This suggests that our referrals are in fact being received mainly from Primary Schools and this is where our intervention needs to occur. In 2017-2018 over 50% of referrals were 13-14 years of age indicating that the age of referral dropped in 2018-2019.

From these statistics it can be seen that during the 2017-2018 and 2018-2019 financial years, the bulk of referrals were received from the Manenberg and Hanover Park areas and then the greater Athlone area. Over 70% of referrals are for boys to be in the program and the age of referral in most cases is 14 years old and younger.

Conclusion

The Specialised Behaviour Management Program was developed in 2011 to address the need of unmanageable behaviour as seen at that time. It uses a strengths-based approach to instil hope and empower the family to change negative patterns of behaviour thereby preventing school dropout and statutory intervention. It continues to be successful in its methodology of intervening in a holistic, therapeutic manner to children and families. There is however a need for more to be done.
The overwhelming number of referrals being received indicates that this program needs to be researched, manualised and rolled out to sufficiently meet the needs as indicated. There is also an indication of the age of intervention being lower than fourteen years of age as well as intervention largely being needed with our boys. This indicates that the target age of 13-18 needs to be dropped to include those possibly 10 years old and older.

We cannot however meet the needs as expressed without training and the assistance of additional long-term funders. We hope that this will become a reality and that we can start to meet the needs as indicated by families and young people in both the Athlone and Wynberg District as well as the greater Cape Town District. Our young people and families are in clear need of assistance in a manner that addresses their needs in a holistic manner and is successful in doing so.

BOXING-4-AUTISM: PROMOTING *ALL* CHILDREN'S CAPACITY TO PARTICIPATE IN ACCESSIBLE MENTAL HEALTH PROMOTION PROGRAMMES

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Background

Mental health problems are an important issue worldwide due to their impact on the human rights and quality of life of those affected. Recently, mental health promotion has become seen as a cross-cutting health priority internationally, and has been included in the United Nation's (UN) Sustainable Development Goals (SDG) 3: "By 2030, reduce by one third premature mortality due to non-communicable diseases through prevention and treatment and promote mental health and well-being"

In South Africa almost 33% of the population suffers from some form of mental health illness, with increases of 500% in the diagnosis of Autism Spectrum Disorder (ASD). However, more than half of these individuals do not have access to any form of mental health intervention (Tromp, Dolley, Laganparsad, & Govender, 2014).

Fight with Insight was approached by the Occupational Therapy departments of Health (Tara H. Moross Psychiatric Hospital) and Education (Johannesburg School for Autism) to assist young people with physical education and through this consolidate the Occupational Therapy goals in a group setting. Fight with Insight has subsequently developed a physical and mental health intervention designed to achieve a broad developmental impact on the core deficits of ASD. This programme is called Boxing-4-Autism. A brief descriptive account of the programme is presented in this paper, along with insights obtained through an anthropological study of it.

Autism Spectrum Disorder

Autism spectrum disorder (ASD) refers to a complex neurodevelopmental disorder characterized by repetitive patterns of behavior and difficulties with social communication and interaction. The term 'spectrum' refers to the wide range of symptoms, skills, and levels of disability in functioning that can occur in people with ASD.

Although there is significant caution around labelling people with autism according to the characteristic symptoms they may have, being aware of the kinds of physical, emotional and social characteristics that are considered to be common is helpful for coaches to prepare, plan and manage

sessions. This also serves to protect the children from micro-traumas on the part of coaches. These micro-traumas occur predominantly when people with little understanding of the disabilities of a child with ASD interacts with them in ways that are not normal for them.

Intervention: Boxing-4-Autism

In partnership with the Johannesburg School for Autism, Fight with Insight delivers boxing classes to learners aged between 10 and 21 years old. 14 classes of 6 to 15 learners are run throughout the week and are grouped by age level and support needs. The majority of the children in these programmes are referred to either the Psychiatric Hospital, or School as a result of their diagnosis. Once in these settings, they have access to Fight with Insight. However, access is not limited through these programmes. Some children with psychiatric diagnoses participate in our open-access boxing sessions for everyone, which are fully-inclusive, and integrated with children from all backgrounds and with different abilities.

The classes run for 60 minutes each. The programme aims to assist learners with:

– Sensory modulation,
– Muscle tone, stamina and general fitness, as well as
– An appropriate outlet to express feelings such as anger and frustration.

Boxing-4-Autism is an 'open access' social impact programme that ascribes to the International Classification of Functioning. It is based on the premise that participation in society should be encouraged regardless of ability, because participation is believed to promote functioning. There is strong evidence to suggest that Boxing-4-Autism produces a wide range of benefits for young people with complex support needs, beyond the physical health benefits of exercise. The classes are divided up into five overarching elements: Warm-up, boxing on the bags, focus mits, conditioning and mindfulness. Each element has varying effects on the child.

Warm-up

To start, the warmup consists of a series of cardiovascular activities designed to warm up the different parts of the body involved in boxing fitness. In this process, the children become visibly more relaxed and present, in spite of their burning muscles, and the bright sights and loud sounds of the boxing gym. They successfully adapt to the new space, activities and instructions.

Boxing on the bags

This involves the practicing different combinations of punches on the boxing bags. During this part of the session, children begin to experience a more active versus passive engagement with the world. Children have the opportunity to explore their bodily boundaries in a very concrete way, in feeling where the bag ends and their body begins, as they throw punches. There is a noticeable sense of empowerment as children find their rhythm and experiment with power.

Focus mits

This requires turn-taking , as each child gets a chance show their skills on the focus mits. The focus mits are used to visually prompt different combinations of punches, and to throw punches back. The children learn to defend and to think, not only about what they are doing, but also about what the

coach is going to do. Eye contact is necessary and there is some fear of what is to come. However, this exercise results in brain activation and alertness, which is evident when the child's eyes light up and they become fully engaged in the activity.

It is in this activity that children experience boxing as a dance, and a form of communication. The coaches use multi-modal communication, which includes a combination of verbal, symbolic and graphic representations of the activity, which the child must follow. As the coach signals the boxing actions, and the child responds, the two are engaged in the dance.

Conditioning
The children are taught that boxing requires strong muscles, which are developed through conditioning. As in most cases, it is everyone's least favorite part of the session. It involves exercises for core and limb strengthening, that incorporate vestibular balance, bilateral coordination, midline crossing, postural control and motor planning. It is the final aerobic burnout that results in an increase in body temperature. Children attempt to push themselves beyond their limits, particularly in relation to the push-ups, and there is a healthy sense of competition amongst themselves and with the coach.

Mindfulness
The final component of the session is about mindfulness, which is achieved through a series of stretching and breathing postures. Many of the children struggle to be still but are visibly more relaxed and energized. By the end of the boxing session, we aim to have the children in the correct band of arousal for learning, as they head back to school.

The Benefits of Boxing in the context of ASD

For the child with a mental health disorder
For young people with a mental health disorder, a balanced lifestyle is a challenge and there are limited resources for adolescences and young adults in this regard. Fight with insight's programme blends a therapeutic activity with a physical activity, producing endorphins. Medically, these children are on medication that makes them prone to gaining weight, Boxing assists to fend off diabetes and pre-diabetes, specifically in children with Autism, and gives a calorie burning avenue, which reduces health risks.

For the family
The feedback we have received from parents and caregivers indicates that the family experience is improved through the child's participation in boxing. It is an enjoyable experience that can be shared with their family. It creates a common field for socialization with their peers. Giving them a peer group in the boxing circle is really useful and beneficial to the child's development, promoting improved self-esteem and decreasing the symptoms and risk of depression. Of most significance, is the change in the parent's perceptions of their child's capacity. Upon reflecting on the progress of their child in boxing, a parent made the following comment: "I have never seen my child do these things. It's not that I thought my son couldn't do this, it's just that I never thought he could."

For schools and mental health service providers

Feedback from the schools and hospital has indicated that the boxing sessions promote calmness and more appropriate levels of alertness over the course of the day. Over long periods, it promotes a more stable level of arousal. Teachers have indicated a marked difference between those children that participate in Boxing and those that don't.

For society

There is a level at which the relational element of the work that we do is key to demystifying long-standing beliefs and assumptions, in which we underestimate children with ASD's ability to communicate and make meaningful social connections. Challenging those assumptions in activities of daily living, like boxing, and seeing the positive results, teaches us that it is only our own inability to deal with people who are a-typical of our mind that we are trying to cope with when we place these limitations on them.

Conclusion

Through the creation of Boxing-4-Autism we aim to facilitate *all* children's capacity to participate in a mental health promotion programme, which recognizes their ability for agency. In this context, children do not need to be defined by the label that brought them to care. At the heart of this approach are the principles of the International Classification of Functioning, which says that despite the limitations that a disability poses on a person, it should never limit their participation.

We want life space interventions. We need to be thinking of what activities of daily living can be contributing therapeutically to promoting the child's functioning. There are limited interventions that can be deployed equally into advantaged and disadvantaged areas, that involve group participation, where children with Autism Spectrum Disorder (ASD) can come together and participate in activities that have a quantifiable social, cognitive, emotional and physical benefit.

References

Diagnostic and statistical manual of mental disorders: ***DSM-5***. Arlington, VA, American Psychiatric Association.

Tromp, B., Dolley, C., Laganparsad, M., & Govender, S. (2014) *SA's sick state of mental health. Sunday Times*, 6 July:4.

STRUCTURE FOR INPATIENT CHILD AND ADOLESCENT PSYCHIATRIC LIFE SKILLS BOXING PROGRAMME AS AN ADJUNCT TO OCCUPATIONAL THERAPY

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Background

There is substantial evidence reflecting high prevalence of mental illness in adolescents. In South Africa, approximately 20% of children and adolescents have been diagnosed with a psychiatric disorder (Paruk, 2016). Common psychiatric disorders in adolescents include anxiety, mood, eating and behaviour related disorders. (Allen and McKenzie, 2015). Clinical and psychiatric interventions are the normal course of intervention for these young people. Unfortunately, these interventions tend to reinforce the focus on the disorder and are only accessed when there is a crisis. Although many Mental Health Professionals are advising patients to participate in physical, outdoor and mindfulness activities, there are very few socially integrated programmes that offer an ongoing source of specialist intervention for young people in need of care (Peluso & Guerra de Andrade, 2005).

Fight with Insight (FWI) has developed an open-access programme that uses boxing to engage young people from different social and differently abled backgrounds in activities that promote physical and mental health promotion. These activities are: Fitness, Food, Feelings, Friends and Fun, which constitute the Five F's of Child Protection and Development. Furthermore, FWI ascribes to the International Classification of Functioning, which is based on the premise that participation in society should be encouraged regardless of ability, because participation is believed to promote functioning. As such, the boxing programme has been extended to include children with autism, children affected by HIV and children diagnosed with psychiatric disorders. These children participate in a mental health promotion programme, which recognizes the ability for agency in children, regardless of whether they are suffering from a mental health crisis, or not. Children do not need to be defined by the label that brought them to care.

In collaboration with the Occupational Therapists at Tara, Fight with Insight has developed a weekly boxing programme for children and adolescents who are in-patients at the Tara H. Moross Psychiatric Hospital. Through the programme, children are equipped with the resources required to optimize their development physically, emotionally and socially, ultimately improving their opportunities when they enter the world as adults.

This paper provides a brief descriptive account of the mechanisms of the programme from three different perspectives: (1) Occupational Therapy, which looks at functional feelings on the outside, (2) Psychiatry, which focusses on neuro-physiology on the inside, and (3) Child and Youth Care, which focusses on social aspects through life space intervention. The paper also presents some insights from research into the perceived benefits of the programme, from the perspectives of young people and Occupational Therapists who were a part of it.

Occupational Therapy: Matching sensory input with the expressed behaviour

> ***"It makes me feel relief. When punching the bag, I feel relieved" - Participant***

The theory underlying the use of boxing relates to the potential therapeutic benefit from non-traditional body-based therapies. Sport alone is a neutral stimuli, only when conducted by mindful and skilled adults can sport programmes become an intervention for mental health challenges (Lawerence, De Silva, & Henley, 2010). Child and Youth Care theory provides a framework for designing boxing-related activities that assist both intra and interpersonal functioning.

> ***"The boxing has given me a space to build onto myself by my own means and gave me a different effective release of energy which caused me to recognize things about myself." - Participant***

The beauty of the intervention is that boxing does not feel like 'therapy', and can be accessed outside of the in-patient context, making it accessible in broader society. The broader accessibility promotes uptake of the intervention once discharged, as a young person can "go to boxing", which has a social context, unlike therapy, which removes the social context.

> ***"During my stay in the hospital, boxing was the only activity, everybody looked forward to during the week." - Participant***

In addition, there are sensory integration, proprioceptive and vestibular movement outcomes from an Occupational Therapy perspective. Firstly, boxing provides a context in which all of the senses are occupied, encouraging the integration of senses like: the unforgiving smell of sweaty boxing gloves, the overpowering sounds of music and bags being hit and the overwhelming feeling of physical fatigue. Secondly, the basic movements required to train boxing, such as: slipping, rolling, ducking, pivoting and stepping are a source of proprioceptive and vestibular movements that have positive therapeutic outcomes.

The sensory inputs, and outcomes, are enhanced by the structure of the group, which begins with a check-in allowing the participants to reflect on what they bring into the room and be present. The same process is repeated with a check out after the group, allowing participants to reflect on what they take with them when leaving the room. Finally, there is an attempt to get the participants to apply this

beyond the session using the principles of Kolb's Experiential Learning Cycle model. The Kolb Facilitation Model relies on the facilitator generating an experience, discussing it and generalising what is taken from the programme to the young person's world. This, in turn, generates another experience to think about. The group aims to support work done in **individual psychotherapy** where Mindfulness is practiced, and children are assisted to "be still and present".

> ***"I like learning the skills it helps me to centre myself and focus my energy on one thing" - Participant***

Psychiatry: Understanding what is happening inside

> ***"It changes my mood. Afterwards I feel refreshed, centred and mindful" - Participants***

Prof. Wendy Suzuki, a neuroscientist studying the effects of exercise on the anatomy, physiology and functioning of the brain, argues that exercise is the single most transformative treatment for the brain, highlighting the immediate effects on mood and energy levels that result from the release of dopamine and serotonin (Basso & Suzuki, 2016/2017).

> ***"The shift in terms of motivation in the kids. A lot of them come in with the ambivalence and you can see the change in how motivated they are to engage in the techniques. There's no external thing that needs to push them, they come in and they are willing to work no matter how hard it is, how frustrated or dysregulated a person is, they come in and they do the work." – Occupational Therapist***

Noradrenaline (normally associated with Fight and Flight and specifically initiated by boxing in pairs) assists with priming the body and brain to be able to respond and focus (Xing, Li & Gao, 2016). These effects have been shown to last at least two hours after a minimum of 20 minutes aerobic exercise, and have lasting effects on brain function, neurogenesis and the prevention of cognitive decline, if the activity is extended to a minimum of 90 minutes a week (Basso & Suzuki, 2016/2017). As a result, we have extended our Saturday Group intervention to include child and adolescent psychiatric outpatients from both State (Tara H. Moross Psychiatric Hospital) and Private (Akeso Clinic) Psychiatric Hospitals. Here we introduce the importance of nutrition, based on evidence of the gut-brain connection. We teach children and adolescents to cook Real Food and use the kitchen as a Mindfulness exercise, as well as a group cohesion intervention, thereby creating a positive peer culture. We then promote fitness and support functional feelings with Psycho-social Support Life Coaching for developing intra and intra personal life skills, such as: conflict resolution, communication, gender relations and coping. The life skills interventions are underpinned by "in the moment therapeutic interventions" based on Child and Youth Care Theory.

Child and Youth Care: Life space intervention for the social context

> ***"It's given me both physical and mental stimulation and gives me a goal to work towards plus provides me with a safe social environment." - Participant***

Child and Youth Care Theory and Practice was developed for work with at risk children and adolescents in institutional care. The Boxing, Fitness and occupational therapy group uses this body of knowledge in the Tara institutional setting to run the groups. Daily life events are the focus of the intervention with the children and adolescents. The focus is on the context of the interaction, both between peers and the Child and Youth Care professionals. The interactions between participants are observed in the group by the multi-disciplinary team. Once observed and reflected, the individual experiences and group interactions are then processed (like the mother bird taking in the worm and giving it back to the children in a digestible way) within the moment in the group, by the multi-disciplinary team. The aim is to assist with emotional and behavioural regulation as it is occurring.

> ***"…When there is a fallout you can just see it in the way they're engaging within the session, but also they're able to mend within the session. Because of the nature of boxing and the rules, where yes we fight and hit each other, but then afterwards we shake hands. They may not necessarily emphasise that, but there is development in their social skills to be able to do that…" - Occupational Therapist***

An example that often occurs in the combat sport context draws from the theory of rupture and repair in psychoanalysis. Boxing training is aerobically taxing and everyone has different fitness levels and physical abilities, which often leads to frustration if the participants cannot successfully complete a task, and they may give up. That internal rupture (dysregulation) is reflected and managed through relational encouragement by the coaches who are trained in fitness techniques where everyone can participate (in line with the International Classification of Functioning objectives) to their best level. There is then a repair of this internal dysregulation, when the young person resumes the activity.

We contend that this promotes a concept we have coined as "resistance" as opposed to resilience. The change in terminology is an attempt to recognise the agency of these medicated young people with psychiatric diagnoses. The term resilience implies that we can 'drop' children and they will 'bounce back', whereas resistance implies that the child has agency and has resisted an undesired outcome. The adults in the room are facilitators assisting the children to find their regulation band, which is their window of tolerance and activation and resist giving up when the session is too hard; their low mood where they struggle to become activated; their sympathetic overdrive and their struggle to be focused and ordered.

> ***"The coaches are encouraging and kind. Everybody supports one another." - Participant***

The peer group also assist, verbally and non-verbally, to encourage and do 'with' each other. When there is dysregulation and the resultant disruptive behaviour, life space theory provides for interventions to restore balance.

Any dysregulated behaviour within the sessions is interpreted as resistance – a protest to something happening internally or externally. The multi-disciplinary team aim to "listen to behaviour" and respond with "carefrontations" that assist the child to re-regulate while trying to gain insight into the behaviour as well as its effects on others. Co-regulation is key and the multi-disciplinary team need to be trained in psychological first aid, and have knowledge of child and adolescent developmental theory on life stage (i.e. identity vs. role confusion) and life-long (Maslow's Hierarchy of Needs) development. This allows for a therapeutic response involving observation, reflection, management and support in the moment.

As the links between feelings (internal) and behaviour (external) are brought to the child's attention in a social context, the young person has the opportunity to practice alternatives with thoughtful and caring adults, which then result in a sensory/behavioural intervention that can be generalised into everyday life events. This, in turn, will improve the child's subjective experience of their space and place in the world and with others.

The proposed Holistic approach outlined above holds great promise for interventions with vulnerable and hard to reach children. Further research is underway to provide an evidence base that supports the expansion of the programme into other contexts. This is a novel approach to working, which requires courage from the young people that participate, courage from their parents/caregivers and courage from the professionals working with them. For those who have been the traditional professionals providing care to young people with medicated psychiatric diagnoses, this adjunct somatic therapy calls for flexibility and a holistic approach to child and adolescent mental health, because it is not something you do with children that makes a difference, it is everything. All of us need to be part of that difference.

References

Allen, K, A. & McKenzie, V, L. (2015). Adolescent mental health in an Australian context and future interventions. *International Journal of Mental Health, 44*(1/2), 80-93. doi: 10.1080/00207411.2015.1009780

Baixauli, E. (2017). Happiness: Role of Dopamine and Serotonin on Mood and Negative Emotions. Emergency Medicine (Los Angel) 7: 350. doi: 10.4172/2165-7548.1000350

Basso, J. & Suzuki, W. (2016/2017). The Effects of Acute Exercise on Mood, Cognition, Neurophysiology, and Neurochemical Pathways: A Review. Brain Plasticity, 2:127–152.

Lawrence, S; de Silva, M; Henley, R (2010) Sports and games for post-traumatic stress disorder (PTSD). Cochrane Database of Sys- tematic Reviews (1). ISSN 1469-493X

Paruk, S. (2016). Update on Adolescent Mental Health. South African Medical Journal 2016;106(6):548-550. DOI:10.7196/SAMJ.2016.v106i6.10943

Peluso, M.A. and Guerra de Andrade, L.H. (2005) Physical Activity and Mental Health: The Association between Exercise and Mood. Clinics (S?o Paulo), 60, 61-70. https://doi.org/10.1590/S1807-59322005000100012

Xing, B., Li, Y. C., & Gao, W. J. (2016). Norepinephrine versus dopamine and their interaction in modulating synaptic function in the prefrontal cortex. *Brain research*, *1641*(Pt B), 217–233. https://doi.org/10.1016/j.brainres.2016.01.005

LAWRENCE HOUSE: OVER TEN YEARS' EXPERIENCE OF WALKING ALONGSIDE MIGRANT CHILDREN AND YOUTH

Giulia Treves and Sindi Moyo

Introduction

Lawrence House is a registered child and youth care centre which specialises in the care and protection of unaccompanied migrant children and separated refugee minors. The purpose of this paper is to share our learning and experiences from working with migrant children and young people for more than ten years with others. This paper forms part of a wider conversation that is hoping to strengthen the practice of child and youth care centres working with migrant children and young people in South Africa. The paper will share and reflect on the reality of unaccompanied migrant children and separated refugee minors in Cape Town, and why we believe there is a need for specific support and intervention for these young people within residential settings. We will explore our understanding of the different care needs of migrant and refugee children and how this has informed our developmental care methodology.

Unaccompanied migrant children and separated refugee minors in South Africa

Among the migrants and refugees seeking protection and opportunities in South Africa, separated migrant and refugee children and unaccompanied minors are particularly vulnerable given the lack of clearly defined frameworks for their protection. The scarce knowledge of these children's rights by social, health and educational institutions, affects the realisation of their rights and best interests.

While it is difficult to correctly quantify the number of foreign children in South Africa, reports from international and national organizations as well as through the work of non-governmental organizations and child and youth care centers with migrant and refugee communities in Cape Town, it is clear that unaccompanied and separated minors are in need of support in South Africa. Furthermore, known data indicates that between 2005 and 2015, the number of child refugees worldwide, under UNHCR's mandate, more than doubled from 4 million to 9 million (UNHCR, 2017). In 2017, 59% of the refugee population in Africa were under 18 years old (UNHCR, 2018), and in the same year South Africa housed the largest number of child migrants in Africa (UNICEF analysis based on UNDESA, 2017). A survey conducted by the Scalabrini Centre in the Western Cape Province on migrant children placed in child and youth care centers across the province indicated that 4% of the children were not South African citizens (Sloth-Nielsen and Ackermann, 2015).

Understanding the need for a specialised facility as Lawrence House

Lawrence House was founded in 2005 to address the gap within the child protection system as far as social assistance towards migrant and refugee children was concerned. Lack of clarity in the interpretation of the legal frameworks protecting children resulted in the partial denial of their rights. In fact, the first children transferred to Lawrence House, were a group of abandoned migrant and refugee children who were living in a shelter at the outskirts of Cape Town. A restrictive interpretation and application of the law was ultimately excluding them from accessing services under then valid legislation, the Child Care Act 74 of 1983 exposing already vulnerable children to ulterior distress and risks.

Today, thanks to our collective advocacy work many of the challenges have been addressed, yet based on our daily experience a specialized care and protection program remains vital in addressing the particular needs of migrant children. In fact the milestone of accepting that *a child is a child is a child* which seemed initially the goal (children should not access different rights based on their nationality) is creating increasingly more blind spots to the particular needs of migrant and refugee children in care leaving them once more vulnerable.

Understanding the different care needs of migrant and refugee minors

For many young people with migration backgrounds, their sense of self, of relationships and of history have become fragmented as a result of both place-based and relational loss. Further, the complex realities of structural and social marginalisation that surround their lives mean that many have experienced intimate and societal exclusion and violence in both their past and present lives. Reflecting on this context, young people have shared that they feel 'in-between' and unsure of how to make sense of self. The implications of non-belonging for the mental health and wellbeing of young people on the move are significant. This is connected to a sense of powerlessness and instability in their lives, impacting their capacities to feel safe, accepted, and to build a future within a collective community.

Global research has found that the mental health difficulties (PTSD, depression, attachment and anxiety disorder, etc.) that migrant children face are at least partially linked to their experience of loss and non-belonging (Gonzales, Suárez-Orozco and Dedios-Sanguineti, 2013; Jacobs, 2018); this personal experience is amplified by the, at times, difficult integration process and the experience of rejection and exclusion reinforced within South African Society (Willie and Mfubu, 2016; Opfermann, 2019). These influences impact migrant and refugee children's' capacities to build a positive concept of self and to sustain supportive relationships. The construction of an empowered sense of self and feelings of belonging and connectedness can support foreign children to lead resilient lives now and in the future.

The Lawrence House intentional set up

Today Lawrence House is a specialized facility whose holistic approach has succeeded in creating a therapeutic milieu where developmental and therapeutic programs are used intentionally to guide children and youth through their individual journey of healing and connecting to their belonging. Since its inception over eighty young people from eleven different African countries have crossed paths in Lawrence House. Lawrence House is unique in that it combines care and protection services with a much needed advocacy agenda to bring about meaningful change for all displaced migrant children in

South Africa, and by being on the forefront of creating new programmatic responses to the growing complexity of needs migrant children and young people in institutionalized care display.

The safe and caring environment at Lawrence House supports children and young people displaying psychological, emotional and behavioral difficulties to become equipped with the necessary skills and competencies to manage themselves and to successfully manage their transition to adulthood including their return to their families, their home countries or their integration in local society. The psychological and emotional well-being of, and the enhancement of social inclusion for separated migrant and refugee children and unaccompanied foreign minors promotes better integration. A young person who is confident about themselves and their identity and who feels accepted is more likely to contribute positively in turn.

The weight of dislocation & loss: Understanding why refugee and migrant young people need a specific care and treatment support

In child care we speak about the importance of the continuum of care, yet the experience of minors with migratory backgrounds is usually rather one of a continuum of loss. To identify appropriate individual development plans for the impact of place-based loss and relational loss needs to be understood. The refugee/migrant journey includes the pre, during and post flight/journey experience which we can translated into a mostly abrupt separation of all that is known: places, language, culture, food, etc. This sense of loss is further aggravated as it is usually linked to relational-loss: the migration can be linked to the death of a family member or caregiver and include forced abandonment and separation, the reorganised into a different family unit.

Lived experiences of conflict, crises and violence travel with these young people across space and time and become embedded; there is a loss of who you are and how you see your place in the world. At Lawrence House we witness repeatedly how this experience of non-belonging produces a fragmented sense of self and with it more than often a mental health decline. There is a sense of falling apart (= fractured identity) and a sense of being overwhelmed, almost an incapacity of making sense (of emotions, events, etc.) and so one can observe young people (especially those in their teenage years) to be in a state of toxic stress. Linked to this emotional state is also an increased difficulty in trusting which means reinforcing the sense of isolation and abandonment. In our experience the young person's capacity to trust needs to be rebuilt by healing the fractured sense of self first. The final layer of complexity is added by the difficult road to documentation; under the current Immigration system it is very difficult for undocumented minors to legalise their stay; should children have refugee claims the Refugee system does offer protection yet there are obstacles in terms of access.

The challenge when working with migrant children and young people is to capture the impact of this sense of insecurity that stays with them – from the initial separation and loss experience to the uncertainty that their future holds. It is within this context that our interventions need to build a sense of self, increase resilience and self-reflecting capacity. A protracted sense of insecurity reinforces the feeling of being overwhelmed and increases stress and anxiety levels; there is for us an evident connection between the lack of documentation and the young people's mental wellbeing.

Lawrence House developmental care methodology - countering dislocation by building (new) belongings

"On my first day I looked at the other children and saw they had much nicer shoes than I…I felt ashamed and tried hiding my feet. Later I saw them play soccer in the yard and I heard some of them speak Swahili. By the time it was evening I was part of them" (Shared by Patrice reflecting back on his first day at Lawrence House at the age of 6)

How a child enters a facility and how he or she is received impacts tremendously on the journey to follow; and not just of the child or youth concerned, also family members who might be present at that moment. To us, to welcome is not just a verb, it is a methodology. Especially when working with migrant children and young people who have experienced exclusion or rejection, even institutional xenophobia. In the light of their lack of knowledge of the role of social services in South Africa, we have to be mindful how we present ourselves and how we position ourselves. We cannot be perceived as yet another institutional or statutory power that asks questions and demands answers. We have made it part of our very essence to intentionally acknowledge cultural and linguistic diverseness and create a sense of inclusion and understanding first. Often all is needed is as simple as a greeting in the child's mother tongue.

We have to be aware that the experience of the adult might not be very different from that of the child; we need to be mindful that people with migration backgrounds often seem to have internalised their sense of difference – a feeling reinforced by repeated experiences of exclusion and the assigning of labels (i.e. being labelled as *illegal*). In our approach of the young person we make intentional use of our accumulated knowledge in terms of having navigated migrant communities and understanding cultural and linguistic differences as an opportunity of growth in mutual understanding.

Once the child has settled at Lawrence House it is important to observe and capture signs of how or through what belonging is built. A refugee child cannot be defined only in terms of his or her refugee experience. There was a child who had relationships, hobbies, who was going to school…It is of utmost importance to connect to people, feelings and memories and only a truly child centred approach can challenge us to see young people in their wholeness. Within that knowledge of the individual we will discover something, a symbol, an object, a recollection of a moment that will provide a starting point to re-build a sense of self belonging; and it is important to understand the symbolic nature of belonging.

Lawrence House' Developmental care methodology

Our practice is based on an extensive analysis and reflection of the first quadrant of the circle of courage (National Association of Child Care Workers (NACCW), 2014); understanding whether the young person's sense of belonging is normal, absent or fractured is the starting point; we try to understand the impact on or the absence of the sense of belonging in the light of the child's life story and in particular his or her experience of being uprooted. Particular attention is also given to verify how the minor's survival skills, so essential during the migration and initial integration process, have transformed within a safe and normalised environment like Lawrence House.

Over the past three years we have been developing a participatory and creative approach to shift the circle of courage and strengthen belonging with young people. We have taken a layered approach, that allows for an overall reflective process to hold the space for and with the young person as we move from one intervention or activity to the next. Trust building and trusting relationships are essential to this journey and time is needed for trust to develop within this particular space. This insight is the result of "This is me" which was a multifaceted process which Lawrence House piloted in 2018 that aimed at fostering a (new) sense of self in migrant youth living at Lawrence House by guiding the young people on self-discovery journeys to revive their cultural roots, define new ways of belonging and discover and own their identity and life story.

The table below shows how we interconnected different activities which moved from a private reflection to a collective representation. Visualisation techniques first, followed by an embodiment process using dance (specifically the 5Rhythms approach), to creative writing and finally the theatre of the oppressed and forum theatre methodology. A journey from looking at myself and my past, to feeling myself here and now, to verbalise at individual and group level what is felt and understood, to finally act through the collective and discovering that *I am now* and that *I can do*.

Conclusion

We have learnt by walking alongside migrant children and young people that their and our journey as care workers and social service providers involves continuous learning. We know that we cannot simply run a programme, but need to embed lessons learnt in our daily practice, to make every moment count, to build belonging consistently. We have also learnt that belonging is a two-way process; it's a negotiation that will repeatedly challenge the trust relationship and the young person's trust capacity.

Within that developmental process, young people will share who they are, and their aspirations for the future over time. As trust grows stronger more can be known and understood about how to support young people in their journey. Young people need to be held in that process. Importantly the foundations of this work involve a commitment to recognising and hearing young people's voices.

The outlined process is not a programme to be imposed on young people and to be done for them. It is a participatory process that is developed with young people, only then can what unfolds truly shift the young person's sense of self and facilitate the building of belonging.

References

Gonzales, R. G., Suárez-Orozco, C. and Dedios-Sanguineti, M. C. (2013) 'No Place to Belong: Contextualizing Concepts of Mental Health Among Undocumented Immigrant Youth in the United States', *American Behavioral Scientist*, 57(8), pp. 1174–1199. doi: 10.1177/0002764213487349.

Jacobs, S. F. M. (2018) 'Collective narrative practice with unaccompanied refugee minors: "The Tree of Life" as a response to hardship', *Clinical Child Psychology and Psychiatry*, 23(2), pp. 279–293. doi: 10.1177/1359104517744246.

National Association of Child Care Workers (NACCW) (2014) *Hands-on Learning from our implementing partners: Learning Brief 53*.

Opfermann, L. S. (2019) '"If you can't beat them, be them!" – everyday experiences and "performative agency" among undocumented migrant youth in South Africa', *Children's Geographies*. Taylor & Francis, pp. 1–14. Available at: https://doi.org/10.1080/14733285.2019.1646890.

Sloth-Nielsen, J. and Ackermann, M. (2015) *Foreign children in care in the Western Cape Province*. Cape Town: Scalibrini Centre of Cape Town.

UNDESA (2017) *Trends in International Migrant Stock: The 2017 Revision*. New York.

UNHCR (2017) *Global Trends: Forced displacement in 2016*. Geneva, Switzerland.

UNHCR (2018) *Global Trends: Forced Displacement in 2017*. Geneva, Switzerland.

Willie, N. and Mfubu, P. (2016) 'No Future for Our Children: Challenges Faced by Foreign Minors Living in South Africa', *African Human Mobility Review*, 2, pp. 423–442.

DISCIPLINE 101 – FROM THE SILENT GENERATION TO THE MILLENNIALS. WHAT SHOULD PARENTAL AUTHORITY MEAN TO TODAY'S CHILD?

Adv. Veerash Srikison, Director of Fair Practice and Trustee of Matla A Bana[28]

Throughout my years of training and practicing as a mediator, I have realised that there is common ground in addressing adults on dispute resolution skills and addressing parents on methods of constructive discipline skills. Today the focus of my presentation is going to be on respectfully and consciously disciplining a child using basic dispute resolution skills that moves away from the age-old adage "spare the rod, spoil the child". The aim of my presentation is to highlight the need for a parenting style that positively impacts the emotional state of the child at a time when both parent and child are experiencing high states of angst and despair, via using the communication skills of a trained mediator. The purpose is to produce a generation of parents who respect the voice of the child, and not silence it[29], with the prospect of enhancing ongoing constructive relationships between parent and child.

As someone who trains professional adults in higher education institutes in the alternate dispute resolution skills of mediation and negotiation, I am often asked why do I focus on preferring divorce and family mediation and negotiation between parents at the outset over the litigious battle in resolving parenting disputes. My answer: one of the core features of mediation in parenting disputes is to preserve the ongoing relationship that these parents will have as they watch their children mature and develop over the years. Mediation moves disputing parents away from the high emotions that causes upheaval and tension between them when making decisions to a place of mutual respect and consideration. I have never negated the use of litigation or advocated that mediation is an alternate

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[29] Section 10 of the South Africa Children's Act 38 of 2005 gives children the right to be heard. In Du Toit, C. (2013). Legal Representation of Children. In Child Law in South Africa. Juta p 93 ,Du Toit submits that the child's right to participate is a central theme in The Children's Act 38 0f 2005.

to litigation, instead I believe that mediation should be an ancillary legal process to the conventional choice of litigation to minimise time and costs spent in attempts to reaching solutions.[30]

Mediation is key in enhancing the communication skills of the parents to actively listen, ask open ended questions and engage in problem-solving[31] so that in the event that unforeseeable difficulties arise along their path of raising their children, they are able to communicate directly with each other in an effective, reasonable and realistic way forward that does not perpetuate a destructive relationship.[32] Attending mediation sessions with a competent mediator will influence parents to respond with perspective and understanding before reacting to any dispute that arises between them. By listening to each other's needs, fears and concerns, parents co-operate and reach mutual agreement that is beneficial to their particular family. This leads to an eventual change in the dynamic in how they handle any frustrations that once may have driven them to lash out at each other and break down their relationship, to being one of collaboration and respect.

While conducting mediation and negotiation training programmes, I realised that a parallel method of teaching parents the communication skills of a mediator should be endorsed to assist parents in addressing misbehaviour with constructive discipline and not destructive punishment. The mediator is trained to facilitate discussions by *inter alia* asking open-ended questions, paraphrasing, rephrasing and summarising what has been said, to guide the parents towards agreement.[33] For parents, training on these communication skills will involve taking into account the child's right to be heard[34] with the parent having to take time out to fully understand and pay attention to what the child is saying, why the child has engaged in wrong doing, and the parent thereafter responding to the child in a manner that is age appropriate.

In his book "*How to Father*", Dr Fitzhugh Dodson's view was "Punishment is a very ineffective method of discipline… for punishment, strangely enough often has the effect of teaching the child to behave exactly the opposite way from the way we want him to behave! Many parents use punishment simply because no one has ever taught them better ways of disciplining their children".[35] Punishment as a deterrent however takes away a child's thought process to shift his or her focus of how to deal with the violation he has experienced instead of processing his or her own misbehavior.[36] By teaching children how to develop a thought process where they are able to express their current state of

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[30] Srikison. V. (2020). Mandatory Child-Inclusive Mediation – A Possibility in South Africa?. LLM Mini-Dissertation, University of Pretoria. I began my research in 2016 on why mediation is the appropriate forum to support child involvement in all matters related to them. So to I believe that when disciplining a child the consequences of what ensues between parent and child when addressing untoward behaviour must be beneficial to the child's development and I believe this is only possible by engaging with the child on the effects of their wrong doing to minimise such wrong doing from recurring.

[31] O'Leary J. (2014). Mediation in Family & Divorce Disputes. Siber Ink. p 26-27.

[32] De Jong M. (2017). Child-informed Mediation and Parenting Co-ordination. In Child Law in South Africa. Juta. p 134-135.

[33] O'Leary. (2014) p 28

[34] Sec 10 of the Children's Act 38 of 2005 of South Africa

[35] Faber, A & Mazlish E. (2001). How to Talk so Kids Will Listen & How to Listen so Kids Will Listen. Piccadilly Press Ltd. p 116

[36] Faber et al (2001) 93; Siegel et al. (2015) p 24.

emotion and challenges, parents will be able to engage with their children in a mature and reasonable manner creating a family standard of dispute resolution.[37] In the long run, this type of engagement between parent and child will protect the mental health of children and break any generational cycle of emotional abuse caused by physically and/or verbally abusive punishment disguised as discipline, from perpetuating.[38]

A parent's first lesson to disciplining consciously must understand the difference between punishing a child and disciplining a child. In their book "*No-Drama Discipline*", Siegal and Bryson submit that many parents throughout time have believed that "punishment is what discipline is meant to be", however the writers submit that the discipline has its roots from the word disciple meaning student or learner.[39] The writers add that , "a disciple is not similar to a prisoner or any recipient of punishment but rather one who is learning through instruction".[40] For discipline to be effective between parent and child, as with a teacher and student, mutual respect and trust must be present.[41] This requires a mind shift within parents nowadays to move away from the archaic view held by generations before that a child must obey the command of their parent at the cost of the child's integrity.

In this paper I will briefly demonstrate the parallel between mediator skills training in getting parents to co-operate in the midst of a dispute and parenting skills training related to disciplining their child in the midst of misbehaviour. Together we will go on a quick journey of understanding that split moment in time in a parent's mind, when a child misbehaves and the parent needs to decide whether to react with punishment or respond with discipline.

As in dispute resolution training, every trainee begins by introspectively understanding themselves, their prejudices, biases and perspectives. This is done by engaging in self-reflection activities. This involves a deeper understanding on they handle conflict and disputes within their own lives and how much effort they make in actually paying attention and listening to others while understanding another's perspective. The training includes understanding the difference between conflict and disputes. This is something I want you all to keep in mind as I take you through understanding the difference between a conflict and a dispute and its relevance to the difference between punishing a child and disciplining a child.

Conflict refers to a state of being in a long term disagreement.[42] Usually where there is an opposition in thought between individuals in their interests, ideas, principles, values, authority and power.[43] The

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[37] Siegel, DJ. & Bryson, TP. (2015). No-Drama Discipline. Scribe. p xiv.

[38] Ibid

[39] Siegel *et al*. (2015). p xiv.

[40] Siegel *et al*. (2015). p xiv.

[41] Ibid

[42] Available at: https://www.differencebetween.com/difference-between-conflict-and-vs-dispute/ (accessed May 2019)

[43] Available at: https://www.differencebetween.com/difference-between-conflict-and-vs-dispute/ (accessed May 2019)

possibility of resolving the conflict is slim to none with a continued state of disharmony between the individuals.[44]

A dispute on the other hand is a short-term disagreement that can be resolved.[45] This resolution comes about by evaluating and considering the interests of those concerned in the dispute and determining their rights through a reasonable solution.[46] It is important to note that disputes can stem from a larger conflict which is important to remember when understanding the consequences of punishing a child.

The next step to gaining inner perceptive is to understand how each trainee responds to conflict or a dispute. They individually subject themselves to a personality evaluation by taking the Thomas Killman test.[47] With the axis on each side of the Thomas-Killman graph being that of co-operation and the other assertiveness. The level of importance each individual places on assertiveness against co-operation by answering a series of question determines the trainees dominating personality type during a conflict or dispute from a choice of five possible options. These options are, to have either a competing, avoiding, accommodating, collaborating or compromising dominant side in the manner in which each person handles a dispute or conflict.

Competing type is very high on being assertive with very little co-operation. they give little to no attention on the relationship with the other person. Competitors are swift decision makers and are good to have around in instances of an emergency.[48] Avoiders are people who usually bury their heads in the sand and walk away from disputes.[49] Avoiders are low on assertiveness and low on co-operation.[50] Accommodating personality types are low on assertiveness and high on co-operation and maintaining relationships. Accommodators agree to everything at the expense of their own needs.[51] They will do anything to have a good relationship with someone.[52]

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[44] Ibid

[45] Available at https://www.differencebetween.com/difference-between-conflict-and-vs-dispute/ (accessed May 2019)

[46] Ibid

[47] Available at https://kilmanndiagnostics.com/assessments/thomas-kilmann-instrument-one-assessment-person/ (accessed May 2019)

[48] Available at: https://www.youtube.com/watch?v=PFIydyH2H8Y (accessed May 2019)

[49] Ibid

[50] Ibid

[51] Ibid

[52] Ibid[52] Available at https://kilmanndiagnostics.com/assessments/thomas-kilmann-instrument-one-assessment-person/ (accessed May 2019)

[52] Available at: https://www.youtube.com/watch?v=PFIydyH2H8Y (accessed May 2019)

[52] Ibid

[52] Ibid

Compromising in a dispute means there is a give and take but not necessarily an equal give and take.[53] Instead the give and take happens as an easy way out.[54] After a compromise, no one is usually left satisfied and the relationship becomes strained when the exchange is not deemed fair.[55] Collaborators on the other hand engage in problem solving.[56] They work through disputes to find a solution.[57] Collaboration takes time with back and forth honest discussions and in the end there is an understanding of what each person needs.[58] Both co-operation and assertiveness rank high in collaborative problem solving.[59]

Every single one of us in this room today can identify with a personality type on the Thomas Killman model. The same holds true for every parent. Coupled with having identifying a personality type in dispute resolution, each parent identifies with a parenting style that influences their parental authority. In their article for the Journal of Sociology and Social welfare (June 2018) Brittany Hearne and André Christie-Misell identify four commonly known parenting styles parents use when developing their relationship with their child; authoritarian uninvolved, permissive and authoritative.[60]

Authoritarian parents are neither warm nor responsive to their children[61]. They are instead strict, demanding and their communication is through rules and orders to their children. "The lack of negotiation and explanations of rationale for rule may lead children to fear their parents."[62] This harsh parenting style builds resentment and inhibits children from taking ownership of their actions.[63]

Uninvolved parenting also known as indulgent parenting is characterised by a lack of responsiveness to a child's needs and parents exhibit emotional distance from their child.[64] Unresponsive or uninvolved parents do not impose rules and expectations on their children.[65] As a result of a lack of

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[53] Ibid

[54] Ibid

[55] Available at: https://www.youtube.com/watch?v=PFIydyH2H8Y (accessed May 2019)

[56] Ibid

[57] Ibid

[58] Ibid

[59] Ibid

[60] Hearne, BN & Christie-Mizell, CA. (2018). Educational Attainment in Young Adulthood, Depressive Symptoms, and Race-Ethnicity: The Long-Reach of Parenting Styles in Adolescence. The Journal of Sociology and Social Welfare. Vol 25(2). p 94-96

[61] Hearne *et al* p 95

[62] Ibid

[63] Ibid

[64] Hearne *et al* p 95

[65] Ibid

supervision children respond to this lack of warmth and attention with defiance so at elicit parental attention.[66]

Permissive parents allow their children to be dominant in the parent-child relationship. Permissive parents also lack demands and expectations from their children while allowing their children to be the dominant communicators within the family social structure.[67] Although permissive parents provide emotional support allowing their children to have independent decision making skills they avoid discipline and confrontation with their children.[68] In this relationship there are no strict rules and children of permissive parents reject outside authority as well as that within the household.[69]

"Authoritative parenting includes setting clear limits, engaging children in reason and being responsive to their emotional needs"[70] Authoritative parents engage in conversations with their children regarding rules and expectations.[71]

By identifying your parenting style you will have insight into how your relationship with your child has developed over the years and your reactions or responses to your child's misbehaviour. Do you assert yourself onto your child with your punishments or do you have a more collaborative approach and engage with your child when they misbehave? Do you choose to use spanking or some form of physical punishment as a quick fix to stop bad behavior, after all do you believe that it is your house so it should be your rules that must be obeyed. By understanding that punishment and discipline are not one in the same, what is the most appropriate manner in which to effectively discipline your child?

Such question was posed by Chief Justice Moegeng in the Constitutional Court case of *Freedom of Religion South Africa v Minister of Justice and Constitutional Development and Others* heard in November 2018.[72] In this case the Constitutional Court heard arguments on whether the use of "moderate and reasonable chastisement" to discipline children forms part of a parent's responsibilities and rights or whether it is in the interest of the child for parents to refrain from corporal punishment altogether. This was after the lower court ordered that parents who 'smack' their children will no longer be able to plead the special defence of reasonable chastisement in court if criminally charged for assault against their child.[73]

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[66] Ibid

[67] Ibid

[68] Ibid

[69] ibid

[70] Hearne *et al* p 94

[71] Ibid

[72] *Freedom of Religion South Africa v Minister of Justice and Constitutional Development and Others* [2019] ZACC 34. At the time of delivering this presentation, no judgment had been given on the court's finding. However at the time of submission of this paper for publication, the Constitutional Court ruled in September 2019 against the defense of reasonable chastisement as a means of conducting corporal punishment in the home, declaring such defense unconstitutional.

[73] Available at: https://www.news24.com/SouthAfrica/Local/City-Vision/corporal-punishment-challenged-in-court-20181205 (accessed May 2019)

It was submitted by the representative for the Minster of Justice and Social Development, that the common law defense of reasonable chastisement allows parents to moderately and reasonably chastise their children to maintain discipline at home. It was argued that this defense encouraged conduct by the parent which would otherwise be considered as assault when applied to adults but is excused when it is applied to children.[74] Professor Ann Skelton, on behalf of the fifth, sixth and seventh respondents, submitted to the Constitutional Court that "adults have protection against any violence" whereas children are susceptive to private abuse without any protection leaving their right to dignity and protection from violence open for infringement through the common law defense of reasonable chastisement.[75]

The counter argument from the representative for the Freedom of Religion South Africa, was that there is a difference between violence, corporal punishment and "moderate and reasonable use of chastisement and should not be considered one in the same."[76]

Chief Justice Moegeng asked "what would be the pragmatic substitute for parents to instill discipline within the household?"[77] He asked further what options do parents have within their rights to discipline children, pointing out that most members of the bench experienced some form of physical punishment when they were badly behaved.[78] I believe that what the Chief Justice points out as generational forms of punishment at the hands of the parent as being true.

"Over the generations" there have been two schools of thought "spare the rod spoil the child", and the "free to be you and I" school of thought.[79] Those parents who were from the generations as far back as the 1920's until 1945 (known as the silent generation) upheld traditional values and were set in their ways to respect authority.[80] Their identity was more group focused, free from technology and loyal to their personal beliefs. They are now the grandparents to grandchildren raised by the Gen X and great grandparents to the millennials' child.

The current youngest generation of parents, known as millennials, born from approximately the early 1980's until 1996 are less influenced by traditional beliefs that physical punishment will get your children to obey you. With the parenting views of the millennials being influenced by social media and their focus on individual rights, one only has to follow the online parenting portals that millennials frequent for child raising advice and information to understand that those considered as "new age parents" are more open minded when it comes to controversial topics such as punishing children and prefer to engage with their children on a *quid pro quo* basis, you respect me and I will respect you.

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[74] Available at: https://www.dailymaverick.co.za/article/2018-11-30-what-is-the-best-way-to-discipline-children-asks-justice-mogoeng/ (accessed May 2019)

[75] Ibid

[76] Ibid

[77] Ibid

[78] Ibid

[79] Siegel *et al*. (2015) p xvi

[80] Faber *et al* (2001) p 9

In the past twenty years, during the generational gap between the silent generation and the millennials, scientists have been giving more attention to the brain's function and its response to discipline.[81] They have been looking closely at the developmental connections in the brain from negative destructive discipline methods and the developmental connections in the brain from effective discipline methods.[82]

It has been argued by Siegel and Bryson that when "discipline is called for" it is those "important moments of parenting" that parents have to shape their children in the most powerful way that uplifts their development not stunts it.[83] Therefore when faced with a child that has exhibited bad behavior parents need to ask themselves in that moment , what do I want to achieve from my actions if I were to punish my child? According to Siegel and Bryson " as a result of the words we use and the actions we take in front of children, children 's brains will actually change and be built as they undergo new experiences causing brain connections to be formed from repeated experiences".[84] In effect, as they develop, children are forming their ability to understand the parenting style of their parents when watching and experiencing their management of frustrations, disagreements, disputes and conflict.

In their book "*How to listen so kids will talk and talk so kids will listen*" Adel Faber and Elaine Mazlish submit that for parents to take make progress towards discipling their child with authority as opposed to punishing their child, such progress begins when the parent is able to hear themselves and are attentive to their own reactions at the time of the disagreement.[85] The ability to react and respond are triggered at the same time. However, a split moment will determine whether a person will react or respond to their child's misbehaviour. To break the pattern of negative reactions a parent needs to know that in that split moment they can activate their ability to respond if they choose to. When parents believe that they have no choice but to punish their child otherwise they will lose control over that child Siegel and Bryson submit that punishing a child creates a pattern of behavior that is "kids act, parents react, kids react" causing a cycle of reactions and ensuing drama.[86] Reactive behaviour stunts everyone's ability to listen and felt heard.[87]

Parents need to move away from thinking of their child as being a problem that needs to be corrected.[88] Once again I advocate that parents must exhibit an authoritative manner when disciplining their child. Authoritative parenting entails first gaining the perspective of the child in the circumstances they are faced with, by understanding the underlying cause of the misbehavior or wrongdoing. In mediation training we term this activity as going below "the iceberg" to understand each parent's fears, concerns, needs and interests of the parents (disputants).[89] This is done by using the

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[81] Siegel *et al*. (2015) p xvi

[82] Siegel *et al.* (2015) p xvii

[83] Siegel *et al* (2015) p 21

[84] Siegel *et al* (2015) p 24

[85] Faber *et al* (2001) p 3.

[86] Siegel *et al* (2015) p xix

[87] Faber *et al* (2001) p 109

[88] Siegel *et al* (2015) p 109

[89] Available at: http://ombudsfac.unm.edu/Article_Summaries/Search_Beneath_the_Surface.pdf (accessed May 2019)

communication skills of the mediator to get parents to open up the cause not reaching agreement. While asking questions about the fears, concerns and needs, and subsequently reality testing the options before the parents, the mediator is gathering information for both parents to engage in lateral thinking, overcome their obstacles and find mutual ground for agreement.[90] This activity eventually leads to the parents making informed decisions and understanding the context of such decisions.

So to in parental skills training, for a parent to truly understand the child's perspective, that parent would need to gather information in an age appropriate manner, from the child about what had caused the misbehaviour and explore the child's interests, concerns, fears, and needs to move away from reacting with punishment. Once the parent is properly educated as to what led the child to behave in the manner that he or she did, the parent will make an informed decision on the effective discipline that is required, consciously taking into account the age, stage of development and maturity of the child. To skip the phase of gathering information to gain an understanding, parents will maintain an egotistical attitude of always being right. This creates underlying tension between parent and child, which will lead to constant future misunderstandings and an eventual breakdown in the relationship causing conflict within the family.[91] From your understanding of what conflict looks like you know that sometimes these unresolved issues can lead to long-term disagreements and a break down of the parent -child relationship even when the children are adults. The aim of every parent faced with a disciplinary issue is to resolve the dispute before it is left to fester into an ongoing battle of wills. To do so, I submit that today's child must experience the discipline methods of an authoritative parent to truly benefit from parental authority.

While it is acknowledged that every child is different in their nature and mannerisms, the generic use of the authoritative style is to elicit co-operation from a child and to assist such child in behaving in an acceptable manner as the short term goal, with the long term goal being to equip the child with the skills and capacity to "handle challenging situations, frustrations, and emotional storms that might make them lose control" .[92] When using the authoritative parenting style. parents will break the cycle of reactions and move the child from the reactive side of their brain (flight, flee, freeze or faint) to the receptive part of their brain[93] thus causing the child to listen and to be heard. Once both parent and child have calmed down and are ready to engage in responding respectfully towards each other, they may brainstorm options on an appropriate consequence to the misbehaviour. During this phase of gathering of information and problem-solving, the parent appeals to the child's "more sophisticated upstairs brain" allowing the upstairs part of the brain to take control of the more reactive downstairs part of the brain. Siegel and Bryson submit that "by demonstrating respect for the child, nurturing the child with lots of empathy, and remaining open to collaborative and engaging in reflective discussions" the parent is communicating that there is "no threat" and the reactive part of the brain then relaxes.[94]

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[90] O'Leary J. (2014) p 33

[91] Faber *et al* (2001) p 109

[92] Siegel *et al* (2015) p xv - xvi

[93] Siegel *et al* (2015) p 47

[94] Siegel *et al* (2015) p 47

The prefrontal cortex takes control and the child engages in calm decision making- controlling their emotions and impulses.[95]

If I were to apply the Thomas Killman test to parenting styles, I would place the authoritative parenting style as being high in assertiveness at the same time high on co-operation. My reasoning would be that the authoritative parenting style is high on building the relationship between parent and child while keeping the drama low. I believe that to break the cycle of generational abuse of punishment disguised as discipline, we need to educate the current generation and future generations of parents into becoming authoritatively responsive parents to curb any misunderstanding on how to raise children responsibly.

Faber and Mazlish support authoritative parenting and provide that problem solving with a child means taking time out to really get to the heart of the child's misbehavior and the cause of it.[96] Using body language to calm the child must be included, the child is sensing the parent as a threat. Using non-threatening body language will assist in getting the child to be more receptive. The aim is to change the narrative in a parent's mind from being too punitive or being considered a doormat to being assertive using problem solving skills minus punishment.

When realising how much effort it takes to use the authoritative style of parenting, parents complain about not having the time to follow through on the connection and redirection it takes to problem solve and engage with their children. Siegel and Bryson argue that the time it takes to calm a child down, engage on an emotional level and obtain co-operation is far less than the time spent on the cycle of reactions and the display of high emotions.[97] Redirection happens while you calm your child by using a tone of voice that displays concern and start to direct the child towards problem solving.[98] Faber and Mazlish concur that once a child becomes accustomed to problem-solving, s/he will begin to subconsciously take responsibility in resolving conflicts as they grow older.[99]

Every activist endorsing positive discipline and promoting the authoritative style of patents admits that as a parent in the heat of the moment of misbehavior, it may be difficult to experience that mind shift from wanting to react harshly to responding authoritatively.[100] You may not always get it right however a step in the right direction would be to start practicing this parenting style now onwards.

To provide an answer to Chief Justice's Moegeng's question, *what would be the pragmatic substitute for parents to instill discipline within the household?*, I submit that parents need to engage in dispute resolution skills to demonstrate and teach their children that disputes and misunderstandings can be negotiated and resolved. What needs to be the overwhelming message and change in mindset that each person takes away today is that parental authority when disciplining today's child must be communicated verbally and physically under the umbrella of respect and patience.[101]

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[95] Ibid

[96] Faber *et al* (2001) p 102

[97] Siegel *et al* (2015) p xxii

[98] Faber *et al* (2001) p 102 - 111

[99] Faber *et al* (2001) p 132

[100] Faber *et al* (2001) p 108

[101] Siegel *et al* (2015) p 50-56

With discipline meaning education[102], it is "essentially programmed guidance that helps people to develop internal self-control, self direction and efficiency."[103] Effective discipline methods used over time will promote good behavior, and teach skills and nurture the "connections in a child's brain that will help them make better decisions and handle themselves well in the future"[104] The inevitable goal for each parent when discipling their child is not to win a battle declaring their child the loser at the expense of an ongoing respectful relationship with their child , but instead to give the child the tools to actively participate in problem solving which prepares them to deal with disputes in the world they will be let into.[105] When reflecting on how to interact with your child, a saying I once heard comes to mind, "you can be right or you can get along with your child". All parents have the ability to be empathetic, we were all children once. It is in your hands to create a meaningful respectful relationship with your child that is not at the expense of their bodily integrity and dignity.

References:

Children's Act 38 of 2005 of South Africa

De Jong M. (2017). Child-informed Mediation and Parenting Co-ordination. In Child Law in South Africa. Juta.

Du Toit, C. (2013). Legal Representation of Children. In Child Law in South Africa. Juta.

Faber, A & Mazlish E. (2001). How to Talk so Kids Will Listen & How to Listen so Kids Will Listen. Piccadilly Press Ltd.

Hearne, BN & Christie-Mizell, CA. (2018). Educational Attainment in Young Adulthood, Depressive Symptoms, and Race-Ethnicity: The Long-Reach of Parenting Styles in Adolescence. The Journal of Sociology and Social Welfare. Vol 25(2).

O'Leary J. (2014). Mediation in Family & Divorce Disputes. Siber Ink.

Siegel, DJ. & Bryson, TP. (2015). No-Drama Discipline. Scribe.

Srikison. V. (2020). Mandatory Child-Inclusive Mediation – A Possibility in South Africa?. LLM Mini-Dissertation, University of Pretoria.

Internet Sources

https://www.differencebetween.com/difference-between-conflict-and-vs-dispute/ (accessed May 2019)

https://kilmanndiagnostics.com/assessments/thomas-kilmann-instrument-one-assessment-person/ (accessed May 2019)

https://www.youtube.com/watch?v=PFIydyH2H8Y (accessed May 2019)

[102] Faber *et al* (2001). p 116

[103] Ibid

[104] Siegal *et al* (2015) p xvii

[105] Faber *et al* (2001) p 109

https://www.news24.com/SouthAfrica/Local/City-Vision/corporal-punishment-challenged-in-court-20181205 (accessed May 2019)

https://www.dailymaverick.co.za/article/2018-11-30-what-is-the-best-way-to-discipline-children-asks-justice-mogoeng/ (accessed May 2019)

http://ombudsfac.unm.edu/Article_Summaries/Search_Beneath_the_Surface.pdf (accessed May 2019)

Case law:

Freedom of Religion South Africa v Minister of Justice and Constitutional Development and Others [2019] ZACC 34.

THE ISIPHO SETHEMBA PILOT PROGRAMME: POST-TRAUMA PSYCHO-SOCIAL AFTERCARE FOR CHILDREN AND CAREGIVERS

Edith Kriel and Marita Rademeyer

Problem statement: The crisis of child sexual abuse in South Africa

Researchers, child protection workers and clinicians are in agreement that the sexual abuse of children in South Africa is an extreme threat to the well-being of children, families and society at large. The effects of sexual abuse include HIV infection, STI's, unwanted pregnancy, reproductive health problems, depression, substance abuse, developmental delays, school drop-out, acting out behaviours, relationship difficulties, dependence on welfare and the continuation of the intergenerational cycle of sexual abuse.

The Optimus foundation found that one in three South African children have experienced some form of sexual abuse before age 17.[1] Boys are abused at the same rate as girls, although experiences of abuse may differ. Most children who have been sexually abused suffer from chronic sexual abuse or exploitation as well as other forms of abuse and neglect.

Services for children who have experienced sexual abuse, are inequitably distributed in South Africa. The vast majority of children affected by sexual abuse have limited or no access to state mental health services and medico-legal services2 and support for caregivers of sexually abused children has been found to be mostly non-existent.3 This aspect is very concerning, as the support of parents and caregivers is critical in the long term mental health and physical outcomes for children who have been sexually abused.2

Objectives of the project

The core objectives of the project were to

- develop a South African post-trauma psycho-social intervention which is structured, replicable and time-limited so as to reach families who would not otherwise have access to services,
- implement a pilot programme in three geographical areas to assess the impact of the intervention on the caregivers and children involved.

In line with these objectives, the "Isipho seThemba" project (which is Zulu for "gift of hope") was designed, aimed at

- assisting parents and caregivers of children who have been sexually abused to experience personal relief of trauma as well as strengthening their coping skills to respond to the effects of trauma on the children,
- giving children an opportunity to take part in psycho-social strengths building activities and providing mechanisms for emotional integration,
- bringing caregivers and children together in attachment building activities,
- providing a platform for dialogue and peer support to develop between caregivers which may serve as a support mechanism post- intervention.

In implementing the pilot programme, further objectives included:

- building skills of helping professionals in rendering services to children and families affected by sexual abuse,
- creating income opportunities for small businesses in the targeted communities (catering for workshops, transport of delegates),
- creating income for skilled individuals who contribute to the boxes (e.g. embroidery of blanket, manufacturing of materials such as play dough and feeling stones).

The intervention

This project was funded by The Foundation for Professional Development and USAID. **The team is grateful for the support** in developing creative African solutions for children and families who have experienced trauma and abuse.

Format

The Isipho seThemba pilot programme consisted of two workshops of four hours each and took place two weeks apart. The programme was developed by Marita Rademeyer (clinical psychologist) and Edith Kriel (social worker). Dr Antoinette Basson (research psychologist) developed a research design to test the intervention. For the pilot programme, Jelly Beanz contracted facilitators employed by Childline as they were based in the communities identified for intervention.

The caregiver workshops were facilitated by one and the children's workshop by two helping professionals. The workshops ran concurrently. At the first workshop each child and each caregiver received a box with therapeutic aids and activities, some of which were facilitated during the workshop and some which were to be implemented at home. At the second session, supplementary tools and activities were handed out and facilitated.

Selection of participants

In the pilot project, children between the ages of six and twelve who had been sexually abused and their parents or caregivers were identified by Childline KZN and Childline Mpumalanga. The workshop facilitators contacted the caregivers and extended an invitation to attend the programme. All the identified participants lived in poverty-stricken communities and received a travel stipend. Adult participants were given a grocery voucher equal to one day's wage to attend workshops to compensate for any loss in earnings incurred by attending the workshops. Families had a snack on

arrival and a cooked meal at midday. All of the workshop materials were made available to participants free of charge.

Selection and training of facilitators

Childline KZN and Childline Mpumalanga recruited and selected facilitators who were trained by Jelly Beanz. The facilitators completed an online course accredited by the HPCSA and SAPSAC entitled "Understanding sexual abuse in South Africa: back to basics" and a two day experiential training course on using the therapeutic toolkit. Two training workshops were hosted in Mpumalanga and Durban. The training was facilitated by a registered counsellor and national training coordinator of Jelly Beanz).

Structure of the programme:

The socio-emotional effects of child sexual abuse are far reaching and complex. For the purposes of this time-limited programme, core socio-emotional themes in the experience of children and caregivers were identified and activities were designed to address these themes. Some activities were facilitated during the workshops and other therapeutic aids were sent home with the caregivers and children.

Socio-emotional themes for children

The model of traumagenic states, first developed by Finkelhor and Browne[4], is regarded as the best conceptualization of the effects of sexual abuse on children. This model was utilized in identifying core themes to be addressed in the children's activities during the workshops as well as aids to be sent home.

The following core themes for children were identified:

- Management of heightened anxiety and emotional dysregulation
- Reduction of stigmatization and self-blame
- Grounding activities aimed at reducing dissociation
- Restoring a sense of safety and mastery
- Reduction of acting out behaviours
- Correcting distortions about bodies and sexuality
- Enhancing safety seeking behaviours to prevent re-traumatization

Socio-emotional themes for parents and caregivers

South African research on caregiver experience of child sexual abuse was utilized to identify the core socio-emotional themes for the caregivers. [5-8]

The following themes were identified:

- Reduction of alienation, stigmatization and blame
- Addressing the caregivers' fears for the child's future, re-victimization, HIV infection, reprisals from perpetrators)

- Offering support in terms of experiences of grief and loss
- Creating space for caregivers to process feelings of guilt, anger and distress
- Offering caregivers information on dealing with children's behaviours resulting from sexual abuse
- Introducing the concept of positive discipline

Research design

A mixed methods approach was chosen for the research component of this programme, which included quantitative and qualitative research techniques. Pre- and post-test questionnaires were administered to adult as well as child participants. Focus group discussions were held before and after the intervention with identified adult participants. A purposive sampling technique was utilized. An animated three point scale was used for the adult questionnaire so as not to exclude illiterate or semi-literate participants. An animated three point scale was utilized for the children and facilitators were instructed to guide the children through the completion of the questionnaire. The focus group discussions with adult participants were semi-structured. Eight adults took part. The focus groups were facilitated by one person while another took notes of discussion points. Telephonic interviews with selected adult participants were also conducted four weeks after the intervention had been concluded to gather further information.

Selection of areas for service delivery

Three areas, namely Gert Sibanda (Mpumalanga), Harry Gwala (Kwa-Zulu Natal) and Umkhanyakude (Kwa-Zulu Natal) were selected for service delivery.

The Pilot Programme Implementation

Training: Professionals trained

The breakdown of professionals attending the training in the pilot programme is as follows:

District	Profession	Number of delegates
Ermelo	Social workers	3
Kokstad	Child and youth care workers	3
Umkhanyegude	Community development workers	3
Umkhanyegude	Youth development worker	1
Umkhanyegude	Trauma counsellors	2
	Total	**12**

Components of training

Facilitators were expected to complete the online course "Understanding sexual abuse in South Africa: back to basics" before attending the experiential training workshops. The online training covered the following topics:

- Different forms of child sexual abuse and exploitation

- Prevalence of child sexual abuse in South Africa
- Perpetrators of sexual abuse
- Factors that impact on children's reactions to sexual abuse (pre-abuse factors, the nature of the abuse, responses to disclosure, the criminal justice system, emotions, cognitions and behaviours of the child)
- Appropriate sexual development in children
- Inappropriate sexual behaviours in children
- Motivational continuum of sexual offenders
- Understanding child sexual abuse as a process
- Frameworks for understanding children's responses to sexual abuse
- Post Traumatic Stress Disorder (PTSD)
- Neurobiology of trauma and traumagenic dynamics
- South African legislation relevant to child sexual abuse
- Services available to sexually abused children as defined by SORMA

The onsite training was presented in an experiential format to ensure that the facilitators were familiar with all programme components and could facilitate all aspects of the programme.

Reflections on training

The training was well received by the delegates. Though some struggled with the experiential work, many of the facilitators commented that the training had enriched them as individuals.

> ***"I wish to express my gratitude to each of you, thank you so much my friends. how could i forget the confidence and support you gave me. Not only did it help the caregivers but it also changed my life in a meaningful way. thank you so much from the bottom of my heart."***

The following challenges were encountered by the training coordinator during the pilot programme:

1. A significant number of helping professionals selected to facilitate the training, had themselves been abused and/or traumatized as children and had unresolved difficulties in this regard.
2. Many facilitators had limited knowledge of the dynamics and complexity of sexual abuse. The online training that was provided by Jelly Beanz was regarded as a basic training that should have been covered in mental health tertiary education. It was evident, however that many of the facilitators has never been trained adequately in this regard.

To deal with the first challenge, the Jelly Beanz team provided ongoing supervision and debriefing for the facilitators before, during and after the workshops, to assist them in dealing with the emotional impact of working with traumatized families. Due to geographical challenges, supervision took place via Skype or cell phone.

To deal with the second challenge, it was decided to send senior staff from the Pretoria and Cape Town offices to assist facilitators and in some cases take over the facilitation from some of the identified Childline facilitators so as to ensure the success of the programme.

Lessons learnt

Lessons learnt from the training of the facilitators, which will be carried over into future implementation of the programme, include:

- Screening potential facilitators for primary trauma and abuse experiences, assessing the degree to which these experiences may affect the current functioning of the candidate and assessing the impact these experiences may have on the candidate's dealings with clients.
- Making provision for debriefing of facilitators during and after the intervention.
- Expanding the training component on understanding sexual abuse dynamics from an online course to direct training.

The Jelly Beanz team is also planning to engage with more stakeholders on tertiary education level to address the shortcomings in the training of mental health professionals in dealing with child sexual abuse.

The Intervention: Attendance

The workshops were attended as follows

District	Workshop 1 Caregivers	Workshop 1 Children	Workshop 2 Caregivers	Workshop 2 Children
Ermelo	16	18	15	18
Kokstad	13	19	13	20
Umkhanyegude	21	21	21	21
Umkhanyegude Destiny house	9	21	9	21
Total	**59**	**79**	**58**	**80**

There was only one caregiver drop-off in attendance between workshops 1 and 2. In Kokstad a mother brought one of her other children to the second workshop. This child had also been sexually abused but had not received any psycho-social services.

Number of facilitators

Each workshop was facilitated by three trained facilitators (one for the caregiver group and two for the children's group). In addition, two support staff members were deployed per site for the pilot project to help with the logistics (handing out Themba boxes, travel stipends, helping with snacks and meals, filling

Examples of activities during pilot project: Children's activities

- Fluffy the bunny is an activity aimed at safety seeking behaviours and enhancing the experience of mastery

- Children made symbolic bracelets aimed at strengths building and grounding.
- Clay, "feeling ones" and "feeling faces" were used to express wishes for the future against the backdrop of her current situation.
- Children blew bubbles as part of a deep breathing activity aimed at reducing anxiety

Examples of activities from caregiver workshops:

- Caregivers identified their emotional reactions as well as coping mechanisms.
- Caregivers explored self-care strategies
- Caregivers explored problem behaviours in their children as well as managements strategies

Some examples of attachment activities:

- Caregivers wrote positive messages to children, after which caregivers and children coloured in the picture together
- Caregivers and children wrote and drew positive messages on puzzle pieces and the puzzle pieces are joined to symbolize the value of support received and provided to each other.

Feedback received from children and caregivers

The intervention was very well received by caregivers as well as children. The post-intervention questionnaire tested the participants' opinions on aspects such as the usefulness of the information imparted, the quality of the facilitation and the value of the activities. Satisfaction ratings were as follows:

- Caregivers' ratings ranged between 90% and 98%
- Children's ratings ranged between 86% and 90%

During the post-intervention focus groups, caregivers had the following to say about the intervention:

"This has been mind releasing to me"

"I learnt that I am not alone in this experience"

"Themba has helped me release and calm down"

"This is the first time I talked about what happened to my child. It helped relieve a lot"

"Being here helped reduce my anger"

Caregivers from all of the sites expressed a wish for ongoing support from the facilitators in dealing with their children's behaviours and navigating the child protection system. One mother said "Please come back to our community, but next time book a community hall or stadium to reach more people".

The caregivers were encouraged to create a whatsapp group to keep in touch with each other post-intervention and invite the facilitator to be part of the group. This happened in one area, where the facilitator is still in touch with caregivers and able to offer support.

Challenges

The challenges experienced during the facilitation of the programme include the following:

1. The intergenerational cycle of sexual abuse. A significant number of caregivers had themselves been sexually abused as children, which made the facilitation of the workshops challenging in keeping caregivers contained. In one case, the mother who attended the workshop had been raped as a child over a period of time by her biological father, resulting in a pregnancy. The boy child she had accompanied her to the workshop and was the product of these rapes. The boy child had in turn been raped by his father/grandfather as well as an uncle. The mother's other child, a girl, had been raped by her uncle and a neighbour.
2. The secondary trauma caused by the child protection system failing the caregivers and children: in one area five of the caregivers reported that no investigation of their children's abuse had ever taken place. They all named one specific SAPS official who had, according to the families, taken bribes to make the dockets "disappear".
3. The ongoing struggle against poverty and deprivation which continues to make the families vulnerable to further abuse and exploitation.

Lessons learnt

The Themba team took many lessons from the implementation phase of the project, including:

- There were significant cultural differences between communities in terms of openness in speaking about sexual abuse and sexual matters in general, which necessitated skilled facilitation.
- More work needs to be done to involve male caregivers in the process, of all the caregivers who attended, only one was male.
- In future, more time will be spent in facilitating the creation of social network support platforms for caregivers which would include a trained facilitator.

In the bigger picture of working with families who have been affected by child sexual abuse, the team will persist in:

- Sensitizing and holding to account all role players in the child protection system.
- Working towards the prevention of child sexual abuse by developing and disseminating tools for parents and caregivers of children.
- Training professionals across sectors in dealing with child sexual abuse in a constructive way.

The way forward

- The Jelly Beanz team has made adjustments to the contents of the programme as per the feedback from the participants as well as the facilitators.
- A facilitator's manual has been developed to replicate the training of helping professionals.
- A presentation on the programme was delivered at the 10th Annual Child Trauma Conference hosted in Cape Town in May 2018 where local stakeholders in the NGO, government and private sectors were introduced to the programme.

- The abstract for an oral presentation was accepted for the international ISPCAN conference in Prague in September 2018. The team hopes to connect with organizations working in other developing countries to discuss this programme and future implementation.
- The programme has been replicated in three children's homes with caregivers and children from June to July 2018.
- Jelly Beanz is currently partnering with ARISE, a non-profit community based in the Cape flats to replicate the programme. The planned date for implementation is October 2018.
- The team is currently working on a monitoring and evaluation tool to ensure the quality of future training and interventions.

References:

[1]Artz, L., Burton, P., Ward, C.L., Leoschut, L., Phyfer, J., Lloyd, S., Kassanjee, R., Le Mottee, C.L., (2016). The Optimus Study: Sexual victimisation of children in South Africa. Zurich, Switzerland: UBS Optimus Foundation.

[2]Waheeda Bux, Duncan J Cartwright and Steven J Collings (2016) The experience of non-offending caregivers following the disclosure of child sexual abuse: understanding the aftermath South African Journal of Psychology 2016, Vol. 46(1) 88–100

[3] Gaboipolelwe, MM (2017) Guidelines for support to mothers of sexually abused children in North-West Province Doctor of Philosophy in Nursing.

[4] Finkelhor, D and Browne, A (1985) The Traumatic Impact of Child Sexual Abuse: A Conceptualization American Journal of Orthopsychiatry, 55(4), October 1985.

[5] Lakey, A and Roman, NV (2014) An explorative study of parental experiences after the disclosure of child sexual abuse Child and Family Studies Volume 9, No.2

[6]Meinck, F, Cluver, L. et al (2017): Disclosure of physical, emotional and sexual child abuse, help-seeking and access to abuse response services in two South African Provinces, Psychology, Health & Medicine

[7] Bux, w, Cartwright, DJ and Collings, SJ (2016) The experience of non-offending caregivers following the disclosure of child sexual abuse: understanding the aftermath South African Journal of Psychology .2016, Vol. 46(1) 88–100

[8]Gaboipolelwe, MM (2017) Guidelines for support to mothers of sexually abused children in North-West Province Doctor of Philosophy in Nursing.

COURT PREPARATION IS MORE ABOUT HELPING THE CHILD THAN WINNING THE CASE

Mrs Buyi Makhubela
Dr Shaheda Omar

Introduction:

This paper will cover and explanation of what court preparation consists, the procedure and processes to be followed, the aim of court preparation, aspects to be considered when doing court preparation, some pointers on do's and don'ts, the benefits of court preparation and recommendations.

Court preparation is process orientated in that it provides support for the children and their families from the moment they enter the programme till finalization of the court case (often lengthy process). It focuses on helping children cope in criminal courts. The motivations for providing this programme include:

- To educate the child and provide information.
- Children lack understanding of the trial procedure and what their role as a witness is and therefore they find court appearances very stressful.
- Children have different perceptions of role players court processes and procedures.

The procedure

- **Referral:** The clients are referred from the Police, Department of Justice, Department of Social Development, Department of Health, Department of Education and Child Welfare. A written referral form is completed.
- **Booking: after the referral form is received,** then the child's caregiver is made aware of the Saturday court preparation programme, the booking is made and the appointment recorded in the office diary.
- **First session: Contracting: The** parents/caregivers are briefed about court prep and sign the contract form. The court prep facilitator introduces the child to him/herself and the programme. The intake form is completed and a file is opened.
- **Sessions:** The court prep counsellor conducts 3 to 10 sessions depending on whether a child is ready to testify in court. During the court prep sessions the following material can be used: Puppets, Court pictures, Court uniforms, Worry Sheet and Worry strip. Process note forms are completed after every session.
- **Reporting:** On completion of the child's sessions, the report for readiness to testify will be sent to court or to the prosecutor who referred the case to TTBC
- **Accompany the child to court:** On the day of the court the court prep facilitator consults with the prosecutor handling the case to check the number and the time of appearance. The court prep facilitator briefs the parent(s) with the information from the prosecutor. The court prep facilitator does a court prep session with the child before the child goes in to testify. The parent of the child waits at court and the child remains at TTBC offices until the prosecutor

calls him/her. If that particular court does not have TTBC office then the child will waits in a room for victims.

- **Conclusion:** After the child has finished testifying the court prep facilitator debriefs the child and terminates the sessions and The child is issued a certificate. If the child shows signs of trauma, the child is referred to the Social Worker by using a referral form.
- **Follow-up:** Court prep facilitator must follow-up with the prosecutor, I/O or parent regarding the conviction, acquittal or withdrawal of changes and after the case outcome has been received close the file using the closing report form.

Court preparation processes include one on one sessions, classification of children into age groups, role play in the courtroom and parent support groups. There is a panel of experts who support the parents and provide information.

The aim of Court preparation is:

- To make children more confident and equipped to give evidence in court.
- To help them understand the legal processes and their role within it.
- To encourage them to reveal their fears and misapprehensions.
- To provide children with knowledge and skills.
- To enable parents to be supportive of their children.

Aspects to be considered when doing court preparation

1. Introduction to the programme:
   This includes an introduction to who the facilitators are, how important it is to attend and to be on time, do ice breakers, start building with trust. The facilitator must be aware of what the outcome of the programme is.
2. Who's who in the criminal justice process: Name the parties, explain who they are and what their role is. Explain their dress code.
3. What do courts look like: get the children and parents to walk around the court, to sit in the chairs of the court officers, desensitise them to the courtroom. Discuss with them the different courts structures.

Do's and Don'ts of Court Preparation

✓ **Do:**

- Listen to the child.
- Create an environment that is safe enough for the child to discuss his/her feelings.
- Adjust the discussion in terms of the child's needs and understanding.
- Support the child and parents/caregivers at court

✖ **Don't**

- Never discuss the evidence of the case directly with the child.
- Do not help him/her change testimony in any way.
- Never make promises that you cannot fulfill.
- Never judge the children.

The benefits of court preparation

- Helps reduce child's anxiety
- Alleviates any fears and misunderstandings of the child and parents about the court
- The child's confidence and ability to testify is improved
- The child and parents are well informed about the procedures and processes
- The children know their rights in court

Why is court prep essential?

It is essential to" educate", provide information, identify the role players and where they sit and what they do. Inform the child of court room etiquette e.g. everybody rises when the magistrate arrives etc. the rules applicable to witnesses, taking the oath, to practice question and answer skills. Court orientation tour is recommended for every child and if done repeatedly would be in the best interests of the child.

Does each and every child need a full course of court preparation?

It will vary from child to child some children may need 4 to 5 sessions and others may be competent to testify after 2 sessions. However, a proper orientation over a few sessions is likely to alleviate the anxiety of appearing in court. In addition, it would enhance the ability to become a competent witness and enable them to speak the truth.

Will the act of testifying traumatize a child?

Testifying or more specifically cross-examination is sometimes called secondary victimisation or secondary trauma. It is almost always difficult and stressful, but so far no research has confirmed that testifying is emotionally damaging at least for most children. In addition, a previously traumatized child may be more likely than another child to be triggered into a flight/fright/freeze reaction. Our clinical experience shows that testifying (and anticipating the act of testifying) typically elevates anxiety symptoms, but elevated anxiety will normalize in most children once the court case ends. Unwelcome case outcomes such as acquittal can retard this process. Some consequences of prosecution, many of which might be unwelcome e.g. parental divorce, changing schools, residential moves, incarceration of a loved one may also cause ongoing stress.

Could an acquittal put a child at risk / harm?

These are the cases where a prosecutor and court prep counsellor need to work hard to ensure the best interests and safety of the child where the child will not be at risk of secondary harm or further traumatisation. In some cases children continue to live in the same vicinity as the alleged perpetrator and feel further traumatised.

A mother at court prep shared her experience of her victimised daughter refusing to leave the house and stopped attending school because the perpetrator was living in the same yard. She was terrified and became quite ill manifesting, stomach aches, headaches, recurrent nightmares, fearful of all adult males and much more. The alleged perpetrator was acquitted because of lack of sufficient evidence.

Why child witnesses sometimes do not get pre-court preparation?

Lack of transport sometimes IO's do not have vehicles and cancel at the last minute, parents not aware of court date as they have not been informed, sometimes a parent moves to protect the child from secondary trauma to another area and the police are not informed of this and sometimes they are not informed of court prep. Some of the responses elicited from parents/caregivers is that they are too

afraid to contact the police to enquire or ask any questions because of their perceptions that the police are not helpful.

Should all children testify in court?
It is not realistic to expect that all children who made police statements can or should repeat that information in court, even with loads of support and accommodation. Age and stage of development has to be considered. Cognitively impaired children and very young children may struggle. Some children are simply too young to testify. The existence of unresolved trauma symptoms is also something to consider and excessive fear. The brains reaction to a trauma may affect how a memory is transferred from short term to long term memory. This process may cause unwelcome and involuntary thoughts of the event, a flood of emotions randomly / cued by triggers.
There are also some cases of domestic violence where children should not be placed in the position of testifying "against" a parent. Sometimes the potential benefits of a criminal conviction outweighs the costs to the victim.

In a study in the UK 84% felt more confident and had clearer expectations of the processes to follow. 95% felt better about going to court.

Recommendation(s)

- Court preparation does not equal therapy - Refer child and family for counselling
- Escalate cases where there are delays
- Work with all relevant role-players
- If the child is struggling rather take it off the court roll and refer for counselling and re-open at a later stage
- If any irregularities are noted pursue them.

THANK YOU, SIYABONGA, DANKIE, KEALEBOGA

"VICTORY IS THE CHILD OF PREPARATION AND DETERMINATION."

TRAUMATIC EXPERIENCES OF CHILDREN IN EMERGENCIES: THE CASE OF CHIMANIMANI AND SIPEPA, ZIMBABWE

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Introduction

Zimbabwe like many other countries in Southern Africa is prone to disasters (Betera, 2011). Disasters can be natural or human induced. The disasters to have hit Zimbabwe have not been Zimbabwe's first disasters. They followed in the wake of other physical and man-made disasters, an indication that Zimbabwe might be a 'slow learner' or 'reactor' to disasters preparedness and response. Disasters generally leave a trail of damage to the country. Such damage can take the form of destruction of houses, infrastructure destruction, death and disability of people. Traumatic events such as disasters, road accidents and injuries are a common feature of life including childhood. Many children and adolescents in Zimbabwe are exposed to traumatic life events. Zimbabwe has experienced disasters in the last few years related to flooding. Puttnam in Cornish (2011) acknowledges that climate change is one of the great, if not the greatest challenge of the 21st century, and children in developing countries are particularly vulnerable to the increase in severity and frequency of climate-related disasters. Simba (2018) maintains that the seriousness and urgency of climate change issues are now universally recognized and climate change poses serious global challenges that will become worse in the future. Floods recently hit Sipepa in Matabeleland North and Chimanimani in Manicaland, Zimbabwe resulting in expensive trauma to mostly children and women. Kousky (2016) acknowledges that children, particularly the poor and those in developing countries, are at risk.

Children generally comprise a significant population proportion in crises but are less visible. Their voices are hardly heard. The susceptibility and vulnerability of children during disasters and emergencies has been highlighted by other researchers. Mudavanhu et al (2015) and Martin (2010) have observed that in developing countries, children represent the largest segment of the population and are often the first victims of natural disasters. This research explored the traumatic experiences of children in emergencies with a special focus on natural climatic flooding events that affected the Sipepa community in Tsholotsho, Matabeleland North and the Chimanimani community in Mutare, Manicaland Province, Zimbabwe

Methodology

This research employed the narrative research design. This design was premised on the idea that listening to what children in crisis have to say is not only a moral and ethical responsibility for donor and humanitarian actors, but that it is also a humanitarian obligation (Save the Children, 2015). This research reached out to one hundred and forty five children purposefully chosen on the basis of their experiences in floods and comprised of those in school as well as those out of school. NVivo v.10 was employed to conduct thematic analysis on participant transcripts. Steps proposed by Braun and Clarke (reading, re-reading the data, generating initial codes, searching for and developing themes and classifying themes) were employed in data analysis

Results

Psychological Burden, Distress and Trauma

When children are direct witnesses to the impact of a disaster, the emotional consequences are more severe (Stafford, Schonfeld, Keselman, Ventevoge, Carmen & Stewart, 2006). Children highlighted that they experienced unprecedented fear, distress and anxiety owing to the rising floods.

> ***"The waters kept rising, our houses were submerged, others gave in to the forces of water and our animals were swept away. I was afraid that I was going to die in the waters" (Respondent 3).***

The fear of floods is still heavily entrenched in the minds of the children and key informants reported that children are still hounded by the experiences and some cry at the sight of dark clouds gathering in fear of a repeat of the deadly flooding.

Separation and Child Psychosocial wellbeing

Attachment to parents and care givers is one of the fundamental blocks of child development. Separation and loss of parents and caregivers was reported to have posed unanswered puzzles in children's lives.

> ***"We don't know if our parents and siblings are going to come back one day. Each passing day leaves us with little hope of reunion. We are just alone here. We can't erase the memories of the fateful night. To us flooding is a coward. Where did it take our parents to?" (Focus group discussion, Chimanimani 2).***

Kousky (2016) maintains that children who become separated from their parents or primary caregivers during or after a disaster represent another cause for concern, especially on the part of nongovernmental organizations as such children may be abused, exploited, and neglected.

Death, Pain and suffering

Loss of human life and livestock, escalation of prices, social insecurity and costs of rebuilding infrastructure are additional layers of constraints that affected regions (Dewan, 2015). Respondents highlighted that they still feel the pain and suffer from the fresh memories of witnessing death. One respondent had this to say:

"The memories of my young brother crying while being swept away are still very fresh. I can still hear the voice as it fades away. I don't understand why he had to die like that? Why, Why? He was only just but a baby" (respondent 8).

The pain in the above expression summarizes the anguish that respondents went through.

Sex and sexual abuse

The likelihood of children being sexually exploited or experiencing sexual violence is determined by an interconnected number of factors, some of which are in existence prior to the disaster and others which arise as a result of the emergency (Delaney, 2006). Respondents highlighted that during their stay in the camps they were exposed to free sex videos that are still imprinted in their minds to date.

"We saw our sisters being led away, through the cut perimeter fences and witnessed them being taken advantage of. They were violated in our eyes and we just can't forget this or wish it away. It still eats our happiness to date" (Respondent, 6 Sipepa).

Is This Life?

The status of the affected community impacts heavily on the vulnerability of children as refugee and internally displaced communities often have more restricted livelihood options and access to basic services (Delaney 2006). Children in Chimanimani and Sipepa reported an entrenched disruption of organized communal patterns of living that they have become accustomed.

"We are here but our thoughts and lives still miss the old beautiful communal life back in our villages. We can't do much here; the surviving elders and parents keep a big eye on us and make us feel that the worst is not over" (Respondent 1).

Respondents who highlighted that they had friends and neighbours who perished in the floods noted that they feel death is stalking them every day they cannot end a day without thinking about their friends and neighbours who departed from the face of the earth in a very cruel way.

Destroyed Education, destroyed social networks

Kousky (2016) has highlighted three primary ways in which natural disasters can harm schooling and these include destruction of schools themselves and interrupting children's education in the process; hurting the sick, resulting in them not attending school as frequently and/or may perform more poorly in school and also reducing household wealth or income which may lead parents to shift children out of school and into the labor market to help enhance family income. Education in emergencies ensures dignity and sustains life by offering safe spaces for learning, where children and youth who need other assistance can be identified and supported (INEE 2011). Children in this research bemoaned the destruction of their schools and some social networks. In Sipepa, children reported missing their old school, Malaba that had been closed. They highlighted that in the new school set up at Jimila, they felt like aliens with no entitlement and were treated with scorn.

Malaba school, Matabeleland North

In Tsholotsho, respondents also highlighted have to take their lessons in make shift and temporary tents (See picture overleaf). Respondents noted that these tents especially for Tsholotsho have been there for over four years and have given in to the vestiges of the weather and add to the ridicule that learners using these as classrooms face. In both Tsholotsho and Chimanimani, respondents highlighted that because of the floods some of the families out-migrated resulting in the destruction of their social networks. One respondent had this to say,

> "***Rita akaenda Mushure memvura zhinji. Akaenda nemhuri yake. Ndiye aiva shamwari yangu uye taitaura nokubatsirana pabasa redu rechikoro. Iko zvino akaenda. Handichina mumwe wakaita saye and handifungi kuti ndichamuwanazve akadaro. Munamato wangu ndewekuti dai tazoonenazve muupenyu. Rita aiva kunge hanzvadzi kwandiri uye mubatsiri akavimbika.***
>
> ***Rita (not her name) moved away from this place together with her family. She was my best friend here and we would share and reflect on our education together here every day. Now she is gone. I don't have a friend like her anymore and I doubt if I will have someone like her again. My prayer is that we reunite again in life because Rita is just more than a friend to me. She was a sister and a very dependable helper for me'.***

Such broken ties that have held families and individuals together over time have resulted in bouts of lack closure, stress as families and friends face the ignominy of being alone.

Temporary tent Structures that have been there for over three years now

Respondents expressed frustration and dissatisfaction at the tented education facilities from which they were learning compared to their original classrooms. To many of the respondents, they were now squashed and learnt in temporary shelters long after the disasters. They yearned to go back to their old places. Respondents reported that many of them and their accomplices had dropped out of school and also failed to access basic services such as health. Food rations were also reportedly insufficient. Witnessed attack, domestic violence and victimization in camps coupled with images of their destroyed homes and economic livelihood ruins experienced have left the children very shaken.

Destroyed Homes

Disasters often result in destruction of homes. The associated destructions according to the children impacted on them negatively. They highlighted that the destruction has bred fear and anxiety in them. Respondents noted that owing to the destructions of their homes, they have faced and experienced multiple life changes that include from staying in tents, with different people where there was no privacy and to a slow get back to life that causes them to feel emotional distress. Children highlighted that the several changes they have been undergoing have resulted in strained relationships between family members, friends, and communities. The children that reported having gone back to their original home areas report suffering hallucinations and nightmares, lack of sleep and sleep walk. Furthermore, children who lost their homes, animals and pets reported great stress and an inability to get over their loss because of attachments. SAMHSA (2018) and Koplewicz & Cloitre, (2006) also reported depression, anxiety and other mental disturbances among children who suffered the loss. Koplewicz & Cloitre (2006) notes that children who have lost their homes, belongings, or loved ones may go through lengthy periods of grief and pain.

Derogatory, Stigmatized Tags

Disaster risk and conflict tend to be mutually reinforcing (Walch, 2018). Respondents highlighted that in their new school set ups they were subjected to derogatory tags that humiliated them leaving them traumatised. Such tags include terms like ""yimkutulwa" meaning spilled by the water, "ingqondo zahamba lamanzi" (brains went with water) and "abe manzi" (those from the waters).

Prostitution and Extramarital affairs

Disasters often heap a lot of pressure on survivors resulting in negative coping mechanisms. Respondents in school highlighted that the dual nature of their homes affected them emotionally. They highlighted that the extra marital affairs that their mothers engaged in, in the absence of their fathers in the fields in their old homes drained their emotional stability and left them very disturbed.

> ***"What those builders do with our mothers in the absence of our fathers affected us. We are grown up and we see these things daily. Some of our siblings are not from our fathers. We see it every day, and we are sorry for our fathers. Why can't they beat them up or let them go" (girl, 16 years at Tshino Secondary School).***

Care (2019) found negative coping mechanisms including some women exchanging sex for relief items and girls engaging in prostitution in order to get money for exercise books, school fees and cloths were observed in a rapid gender analysis Malawi – Nsanje District Cyclone Idai Flooding study.

Conclusion and Recommendations

Children in emergencies face a myriad of challenges. Disasters can harm children's physical and emotional health, affecting their schooling as well. It is critical to mitigate the effects of disasters to protect the well-being of children. This research recommends that the treatment of child survivors in the acute aftermath of traumatic events is complex and certainly not a once off event as what happened in Zimbabwe. On the basis of the results, a call is made urgently identify secondary stressors that are still in operation as well as symptoms of re-experiencing trauma. Cognitive Behavior Therapy could be employed for children reporting heightened anxiety. The research recommends the strengthening of children's voices and visibility, paying attention to the voices of children in emergencies, building partner capacity in differentiated children emergency support services and the crafting of national multi sectoral response guidelines and referral case management.

References

Betera L (2011) Overview of Disaster Risk Management and Vulnerability Civil Protection Unit Harare.

Delaney, S (2006) Protecting Children from Sexual Exploitation and Sexual Violence in Disaster and Emergency Situations ECPAT Bangkok.

Dewan T.H (2015) Societal impacts and vulnerability to floods in Bangladesh and Nepal Weather and Climate Extremes 7 (2015) 36–42.

CARE Rapid Gender Analysis Malawi – Nsanje District Cyclone Idai Flooding 8 April 2019, CARE

INEE MINIMUM STANDARDS FOR EDUCATION: PREPAREDNESS, RESPONSE, RECOVERY New York, NY 10017.

Koplewicz, H. S, & Cloitre, M. (2006). Caring for kids after trauma, disaster and death: A guide for parents and professionals (2nd ed.). New York, NY: New York University Child Study Center and New York University School of Medicine. Retrieved from https://www.preventionweb.net/publications/view/1899 (on 12/10/2019).

Kousky, C (2016) Impacts of Natural Disasters on Children VOL. 26 / NO. 1 / SPRING 2016.

Martin, M. 2010. Child participation in disaster risk reduction: The case of flood affected children in Bangladesh. Third World Quarterly 31(8): 1357–1375.

Mudavanhu, C ; Manyena, S.B; Collins A.E ; Bongo, P; Mavhura, E & Manatsa D (2015) Taking Children's Voices in Disaster Risk Reduction a Step Forward Int J Disaster Risk Sci (2015) 6:267–281 www.ijdrs.com DOI 10.1007/s13753-015-0060-7.

SAMHSA (2018) Disaster Technical Assistance Center Supplemental Research Bulletin Behavioral Health Conditions in Children and Youth Exposed to Natural Disasters September 2018.

Simba, F.M (2018) Zimbabwe's Preparedness in Managing Meteorological Disasters: A Case of Applying Disaster Risk Management in Managing Impacts of Climate Change. Journal of Geography & Natural Disasters 2018, 8:3 DOI: 10.4172/2167-0587.1000231

Stafford, B; Schonfeld, D ; Keselman, L; Ventevogel, P ; Carmen López Stewart P (ND): "The Emotional Impact of Disaster on Children and Families". Module 9.

Walch, C. (2018) 'Disaster risk reduction amidst armed conflict: informal institutions, rebel groups, and wartime political orders' Disasters 42(S2): S239–S264.

THE ENNEAGRAM AS A THERAPEUTIC MODEL TO ASSIST WITH IDENTITY FORMATION IN AFRICAN ADOLESCENTS

Ena Theron

Problem statement

Knowledge and university curricula still reflect the dominance of Western knowledge forms (Naude, 2017). Psychology as a science were developed in an individualistic and rational framework of Western thought. Despite globalisation and the movement of decolonialisation, few models of psychotherapy have been developed or adjusted to cater for the needs of the African population.

The European vs African ethos:

- The European ethos focuses on individual survival which is based on the survival of the fittest. The African ethos focuses on the survival of the community and union with nature.
- The European ethos values such as competition, individual rights, autonomy, individuality, uniqueness, responsibility for oneself and individual differences. The African ethos values centre on co-operation, interdependence and collective responsibility.
- The European ethos favours personality theories these principles are expressed in concepts such as ego or I-identity, self-concept and self-realisation or self-actualisation.

Whereas the African ethos focuses on psychological modalities of behaviour that would fit these attributes are communality, group orientation and agreement.

The negation by Africans of a unique identity is shared by the Eastern Perspective and by post-modern views.

Adolescence is seen by Erickson (1968 as a stage of ego identity vs ego diffusion. The definition of identity formation is an active process of developing an understanding of who I was, who I am and who I will be. It involves an active exploration of possibilities and a decision to commit to certain values, goals and activities and how one sees oneself and who others confirm one to be. Identity building is grounded in social accounts and the experience of collective belonging. Research has demonstrated that religiosity and spirituality can have a positive impact on adolescent's identity formation.

In African culture identity formation is a stage of initiation that is often accompanied by rituals. Initiation has become a symbol of identity in two senses:

- people see themselves as belonging to an ethnic group by virtue of having been initiated by rites;
- initiation is a mark of African identity and that young adults who fail to undergo some kind of initiation ritual are not "real" Africans (Magubane,1998).

Themes of self-identity in Tswana culture

From his research Alverson (1978) noted the following statements from Tswana people regarding their identity:

- What a person essentially is (boene ba gagwe) is not changed by events (ditirafalo).
- The real inner self (botho ba motho) can never leave a person.
- The qualities of the self are largely innate, given by God or the ancestors or otherwise inborn.

There are 5 Themes of Tswana identity

- To be free of poverty
- To be doing agriculture or animal husbandry
- To build a family and a home
- To keep community and the law (self-imposed obligations)
- To be building one's name – using metaphors as a form of self-praise

The Enneagram Model

The Enneagram model considers the wellness of humanity beyond a dominant Eurocentric subset and is a post-modern concept of identity The Enneagram model considers the wellness of humanity beyond a dominant Eurocentric subset.

The description of spiritual gifts in the Enneagram will help with identity formation. This Corresponds with Tswana's concept of self-identity: qualities are innate/given by God or Ancestors. The description of the social instinct integrates the ubuntu principle and the value of collective living in African ethos.

Spiritual gifts of the Enneagram

The Enneagram describes 9 different spiritual gifts according to personality

- appreciates the spiritual gift in one self and in others.
- Focuses on strengths not weaknesses.
- Self-acceptance and acceptance of others.

It describes three centres of functioning:

- Body
- Heart
- Head

❖ The Body

- Has sensory intelligence
- Has anger and energy
- Is practical and grounded
- Wants control

❖ The Heart

- Has emotional intelligence
- Image/emotional energy
- Is sensitive and empathic
- Wants acceptance

❖ The Head

- Has rational intelligence
- Has fear energy
- Is questioning and level headed
- Wants knowledge

❖ There are three instincts

- Self-preservation
- Sexual/one-on-one
- Social

Self-preservation is based on dispersed energy, the idea that survival depends on me, warm and inclusive interactions and a focus on survival before energy is spent on relationships or society. The self-preservation Instinct focuses on finances and financial security, personal possessions, home, food, safety and security, comfort and daily rhythms.

The sexual/one-on-one instinct focuses on one- to- on energy, survival depends on the other/the relationship, intense, hot or cold in interactions, focus is on relationship before energy is spend on finances or society. The focus on the sexual instinct is relationships, unity in relationships, creativity, person charisma, sexuality and partnerships.

The social instinct is focused on inclusive circular energy, survival depending on the group, formality in interactions and community and the group before energy is spend on finances or relationships. There is focus on society, politics, friendship, social roles and obligations, participation in a group setting, playing a role and making a contribution in the community and standing and position in society.

There are 9 personality types

Type 1: The perfectionist, whose focus is error and has gifts of integrity and wholeness ethical action, responsibility and commitment.
Type 2: the helper whose focus is on needs and has gifts as a natural nurturer, a loving disposition, warm and generous, friendly and gracious.
Type 3: The helper whose focus is on goals and has gifts of an ability to sustain a goal or vision, hope, determination and purpose and efficiency.
Type 4: The individualist whose focus is on what is missing and has gifts of a creative disposition, compassion and empathy, passion and idealism.
Type 5: The observer whose focus is information and has gifts of vision and foresight, wisdom, confidentiality, dispassion and clear-headedness.
Type 6: The loyalist whose focus is danger and has gifts of loyalty, faithfulness, is dependable and dedication.
Type 7: The enthusiast whose focus is opportunity, plans and options and has gifts of bliss and delight, is inventive and resourceful, a love of life and is adventurous.
Type 8: The controller whose focus of attention is control and who has gifts of justice, an understanding of power, truth and honesty and is a defender and protector.
Type 9: The peacemaker whose focus of attention is the agenda of others and has gifts of acceptance, being, harmony and is supportive.

Conclusion

It is time for psychology to join the critique of dominant Western models of knowledge and thinking. In a time of modern globalisation, a model like the Enneagram can be used as a tool to work towards a more universal psychology. The Enneagram is rooted in Eastern philosophy and allows for the integration of spirituality and transcendence of ego that affirm a spiritual identity. Research has proven the Enneagram an effective model for the advancement of ego development (Daniels, 2018). The Enneagram allows for a group therapy approach that is not just cost effective, but also addresses the collective way of being of the African person. The Enneagram is not a well-known therapeutic model in South-African Psychology. However, the model is widely used in American Psychology and a lot is written in the form of books and journal articles.

"THEY SHOULD NOT HAVE TO LIVE LIKE THAT", AN UBUBELE CASE OF PARENT-INFANT PSYCHOTHERAPY IN A CONTEXT OF INTERNAL AND EXTERNAL POVERTY.

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Introduction

South Africa presents a complex milieu of socio-political and socio-economic dilemmas. These systemic challenges are characterised by increasing levels of crime, violence and poverty. South Africa is professed to be one of the most violent countries in the world (Crime Stats SA, 2015). Women and children are particularly vulnerable to acts associated with crime and violence (Hanson & Patel, 2010).

The lens on domestic violence has exposed that intimate partners are responsible for 50% of women murdered in South Africa (Joyner, Rees & Honikman, 2015). Moreover, women who have been subjected to domestic violence are likely to experience an increased prevalence of mental health complexities related to depression (including postpartum depression), substance abuse and suicidal ideation (Jewkes, 2013; Miura & Fujiwara, 2017). Despite the fact that infants and children were initially perceived to be 'witnesses' of domestic violence, it is increasingly recognised that children experience both direct and indirect harm. There is subsequently a growing recognition that exposure to domestic violence is a form of child maltreatment (Wathen & MacMillan, 2013).

Poverty, as a form of structural violence, further perpetuates the plight of women, infants and children. Poverty serves a dual function in that it is perceived to be a catalyst for domestic violence as well as a means of retaining women in the custody of violent relationships (Slabbert, 2016). Furthermore, research indicates that women are at an increased risk of gender based violence during pregnancy and early motherhood, thus placing both mother and infant at risk (Campo, 2015). Whilst the occurrence of gender based violence highlights risks of physical survival (Bhandari, 2018), the implications on the infant's cognitive development and mental health is gaining increased awareness (Ashley, Pagni & Choujaa, 2018; Bianchi, McFarlane, Cesario, Symes, & Maddoux, 2016). It is postulated that the mother's exposure to domestic violence negatively impacts her capacity to provide the infant with a secure attachment, because the mother does not experience a sense of safety or security in her own social world (Pires de Almeida, Cunha, & Pires, 2013).

The parent-infant relationship and attachment is at the core of the work promoted by the Ububele Educational and Psychotherapy trust - a non-governmental organisation situated in Kew,

Johannesburg. The organisation's efforts has centred on the promotion of infant and child mental health, by offering parents and caregivers with preventative, psycho-educational and therapeutic services. This paper aims to illustrate the parent-infant-psychotherapy intervention with a mother and baby. Clinical material further illustrates the implications of systemic trauma, domestic violence and poverty on the dyad and their relationship.

"They should not have to live like that" – an Ububele case

There are significant challenges to offering Parent-Infant Psychotherapy in a context such as ours. Many of the families we work with are chaotic and have suffered trauma of one type or another. Many if not most of the families we work with have in fact suffered multiple traumas: domestic violence and/or family dislocation, chronic, often dehumanising poverty and often (unfortunately) very poor sometimes terrible service in overburdened state facilities with burnt out indifferent health care staff. We are often left with terrible concern about the babies since they are very much our clients and we know (as we have learned from research into the first 1000 days) that babies simply can't wait. It is for these reasons that we have adapted our frame and offer our services in homes and in children's homes and other settings.

Let me (KF) introduce this dyad, mother and child, and provide a little background. Identifying details has been disguised.

Buyisiwe is a 22-year-old, very diminutive woman, that at first impression looks compromised in some way, perhaps intellectually? She is very dark, very short, very thin with a stooped posture. She has a pretty smile and long eyelashes and thick hair though these pretty parts take time to reveal themselves. Baby, Nathi now nearly a year old is a beautiful boy. His skin in even toned, he has dimples and is always clean-enough and just about well-enough dressed. They both smell overwhelmingly of poverty, of attempts at trying to be clean but not quite managing it.

Buyisiwe and Nathi lived in a room in Alex, with no electricity or water. She walks to fetch water every day and I think they cook using a fire, from the smell of it, in their room. She and baby smell of smoke, soap and formula milk. The room is one of several abodes and she shares the room with her 'husband' Jo – 38. Buyisiwe's mother reportedly died when Buyisiwe was 2 months old and she was taken to live with her elderly grandmother, returning to live with her father in her early teens that then precipitated a very turbulent time – dropping out of school, drugs and promiscuity.

Buyisiwe and Nathi were referred to our Parent Infant Psychotherapy Clinic by Zanele, one of our Ububele Early Childhood Community Practitioners, who had finished the 10 Home Visits and who remained really concerned about the quality of interactions between the mom and baby. She described Buyisiwe as being "2 moms in one". I was really curious about this description and it didn't take me long to see why she had been described this way.

Within the first 2 sessions, I observed a manner that Buyisiwe had of being with Nathi, and a way of telling me of the events in her life. Buyisiwe speaks about events in the recent past as if they are happening in the present so instead of using reported speech to explain an incident, she is transported to being back into the situation as if baby, Nathi and I become characters in the story.

When she is narrating a violent interaction that may have happened in the past week, month or in her history, she looks at her little son as if in that moment he is his violent father and Buyisiwe's face contorts and she spits out words telling him this or that using explosive language and gestures. She

has spat out words directed to both me or Nathi referring to an incident with her partner like "you are dead to me" and "you can go to hell" caught in the affective storm that the memory of the event brings. Both Nathi and I are viscerally transported to an atmosphere that he must regularly experience of unpredictability, frighteningly harsh words and terrifying acts.

At other times, Buyisiwe looks at Nathi and is almost overwhelmed with love and affection for him, gently touching his legs or playfully stroking his hair, seemingly in awe of this little person that she has brought into the world.

So I was alerted to these '2 moms in one' and endeavoured to challenge and soften the brutal, abusing one that I knew was so detrimental to Nathi's growing self.

It has been one task of the therapy to listen to and support this young mother though it is another altogether to help her think about her way of being with her son and the impact of this aggressive unpredictable parenting style on his growing sense of himself, his sense of safety or unsafety and of how to protect himself in the context of it all. It is a further and unique task of parent-infant psychotherapy to process some of these experiences for Nathi and to provide him with an experience of a different kind of presence, with me, his therapist.

Buyisiwe's and Nathi's lives are characterized by violence. The first session was a vivid description of a vicious strangling attack inflicted on Buyisiwe by her sister-in-law. Buyisiwe, to her credit, walked to the local police station and got a restraining order. And I recognized that it is this part of her, that I have to ally with in thinking about protection and safety for Nathi. Though it is the presence of this little boy, witness to and sometimes recipient of violent attacks that concerns me. I have tried to keep him and his experience in mind as Buyisiwe tells of things at home. Sometimes all that means is touching his hand and saying directly to him, that his mom is talking of such very frightening things.

Nathi has, I think, given us little opportunities to challenge and talk about these interactions. He is a lovely smiley boy and is I think what Daniel Stern describes as a 'Mr sparkle plenty', a defensive strategy of using false positive affective responses such as defensive smiling to elicit warmth in contexts of unpredictability. I am certainly drawn to him and I make authentic contact with him and often hold his hand as his mom veers in her affective states from the telling of one traumatic incident to another.

Toward the end of a later session, Buyisiwe takes the bottle from Nathi and roughly again puts him onto his tummy and tells him to 'give up your wind' and strokes his back. He eventually does bring up the wind. She anxiously looked to see if any posset had come onto the mat, it hadn't at this point… and then as he struggled, he did posset and she crossly and roughly wiped his face and the blanket as I attempted to reassure them both that I was used to babies and ordinary baby things and that it was alright. She then gave him a hard smack on his backside (without any reflectiveness and hesitation in my presence) and I felt horrified at what I had seen and was, briefly, speechless. Nathi didn't react and this lack of response worried me as I wondered about how accustomed he was to this.

I left this session terribly worried about this dyad and about both of their safety, hers in relation to her abusive husband and sister-in-law and his at being witness to these bruising encounters but also in the day to day ordinary mothering received from his mother.

And so ends the case material

I have been very preoccupied with this case, not just for the reasons suggested at the beginning of this presentation but also because it brings a core goal of PIP to the fore namely interrupting negative patterns of interacting. It is also such a privileged pertinent case in the context of all of the violence that we hear about every day because here we are Buyiswe, Nathi and me when these seeds are being sown. And I have also been struck at how hard this actually is, how intractable ways of being are. There remains much work to be done.

But it is not just for Buyiswe that these interventions are focused. Of course, the goal is to interrupt and hopefully stop these disregulating ways of being, ultimately for Nathi and his future But these interpretations are also vital in processing some of the trauma that has already taken place and continues to take place for him. He looks very hard and long at me when I am speaking to him about scary feelings and frightening events. I have felt that he sometimes turns to me, when things are overwhelming.

There are many complex feelings in the room and I experience an array of responses from feeling powerless, impotent, colluding and desperate particularly when witness to something distressing. This response is common in families where there is domestic, interpersonal violence, even more so when there are small children involved. This oscillation in emotional responses gives me some insight into the affective environment of both Nathi and Buyisiwe where 'cool and calm' states of mind, that are conducive for thinking and reflection are fleeting. I have had to work hard to carry on thinking.

It has also been fascinating and concerning to observe Nathi's defensive structure in relation to this way of receiving care. The 'Mr Sparkle Plenty', false positive strategy that I mentioned earlier is augmented by what I think may be the beginnings of what where the body and musculature is reinforced as a physical and psychical defence in environments of toxic-stress – he needs to grow up fast and he needs to grow up tough. He is also becoming busier and more active and I worry about him evoking and provoking more and more physical ways of disciplining him as his diminutive compromised mom struggles to follow, contain and control him. Another area of work…

In conclusion, from a therapeutic perspective, there remains a lot of work to be done. Buyisiwe's thoughts about committing to a place of safety were short-lived as she oscillated in her abusive relationship. A difficult decision was eventually made to remove Nathi (hopefully briefly) to a place of safety. Her family has been activated to claim their baby. And hopefully, this will provide me with further opportunity to continue with this critical case

We remain humbled at the struggle of the work, by the conditions in which people have to live and babies have to grow and we are inspired to keep on going. It is simply too important not to.

We hope that the clinical material described in detail in this paper illustrates the implications of systemic trauma, domestic violence and poverty on this dyad and their relationship and also on the many families that find themselves in such complex situations. We also hope that the paper suggests that there are means of intervening but that a therapeutic intervention without structural change is like climbing an insurmountable mountain.

References:

Ashley, R., Pagni, E., & Choujaa, A. (2018). Intimate Partner Violence and Its Impact on Pregnant Women and Their Infants: A Systematic Review.

Bhandari, B. (2018). Domestic Violence during Pregnancy and Its Effects on Birth Weight: Perspective from Nepal. In *Handbook of Nutrition and Pregnancy* (pp. 423-433). Humana Press, Cham.

Bianchi, A. L., McFarlane, J., Cesario, S., Symes, L., & Maddoux, J. (2016). Continued intimate partner violence during pregnancy and after birth and its effect on child functioning. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *45*(4), 601-609.

Campo, M. (2015). Domestic and family violence in pregnancy and early parenthood. Canberra: Australian Government. Retrieved from https://aifs.gov.au/cfca/publications/domestic-and-family-violence-pregnancy-and-early-parenthood

Crime Stats SA. (2015). Crime Stats South Africa. Retrieved from http://www.crimestatssa.com/national.php

Hanson, S., & Patel, L. (2010). Linking the circles of violence: Woman and child abuse in the same family system in South Africa, *Practice, 22*, 33-44.

Jewkes, R. (2013). Intimate Partner Violence as a Risk Factor for Mental Health Problems in South Africa. *Violence against Women and Mental Health, 178*. DOI:10.1159/000342013

Joyner, K., Rees, K., & Honikman, S. (2015). Intimate Partner Violence (IPV) in South Africa: How to break the vicious cycle. Policy Brief, Retrieved from http://www.sun.ac.za/english/faculty/healthsciences/Documents/News/2016/IPV_policybrief%2012%2001%2015%20final.pdf

Miura, A., & Fujiwara, T. (2017). Intimate partner violence during pregnancy and postpartum depression in Japan: a cross-sectional study. *Frontiers in Public Health,* 5 (81) 1-7.

Pires de Almeida, C., Sá, E., Cunha, F., & Pires, E. P. (2013). Violence during pregnancy and its effects on mother–baby relationship during pregnancy. *Journal of Reproductive and Infant Psychology*, 31(4), 370-380.

Slabbert, I. (2017). Domestic violence and poverty: Some women's experiences. *Research on Social Work Practice*, 27(2), 223-230.

Wathen, C. N., & MacMillan, H. L. (2013). Children's exposure to intimate partner violence: impacts and interventions. *Paediatrics & Child Health,* 18(8), 419-422.

SITUATION ANALYSIS OF THE SEXUAL EXPLOITATION OF CHILDREN IN SOUTH AFRICA

Willy Buloso

Introduction

South Africa has, along with many other countries, obligated itself towards the protection of children from sexual abuse and exploitation by ratifying international legal instruments that seek to protect the rights of children, such as the Convention on the Rights of the Child and its Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography. South Africa has also strongly articulated its commitments to protecting children with specific inclusions in national legislation. Foremost amongst these is the strong focus on children's rights within the 1996 National Constitution which has also given rise to the development of various legislative instruments such as the Children's Act of 2005 and the Prevention and Combating of Trafficking in Person's Act of 2013.

Yet the violation of children's rights through sexual abuse and exploitation continues to be a widespread concern in South Africa today. A major study indicating prevalence showed that of the 4086 young people interviewed by a researcher, 16.8% reported experiencing some form of sexual abuse though this rose to 26.3% when using a private, self-administered survey[106].

Effective and efficient protection of South Africa's children requires an evidence-based understanding of the contexts and manifestations of sexual exploitation of children (SEC) and the degree to which children are vulnerable. An understanding of the systems designed to protect children, and how well they are responding to the threat of sexual abuse and exploitation and supporting child survivors are essential.

To address these needs, this situational analysis on the sexual exploitation of children in South Africa was conducted to assess the current state of the problem in South Africa by means of a desk review, legal analysis and primary fieldwork with law enforcement and social service professionals working within the formal systems to respond to cases and support survivors.

Objectives

ECPAT International conducted this study to investigate, analyse and collate information on the scope, nature, context and trends of the sexual exploitation of children in South Africa through close partnerships with South African research partners and guided by an advisory committee of experts.

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[106] UBS Optimus Foundation. (2016, May). *Optimus Study South Africa Report, sexual victimisation of children in South Africa*. 11. Zurich: UBS Optimus Foundation.

The overall goals of the situation analysis were:

- To gather data from relevant government ministries, agencies, NGOs, academics and the private sector on the current situation of SEC in South Africa;
- To produce a comprehensive written report with country-specific findings in order to inform policy development and strengthen national legal frameworks;
- To identify emerging trends and provide the government and relevant NGOs/agencies with reliable, evidence-based, contemporary data in building realistic and effective intervention programmes to eliminate SEC;
- To generate a firm commitment from all stakeholders and mobilise duty-bearers for a coordinated approach to eliminate SEC.

ECPAT International led a desk-based review of existing secondary data relevant to understanding the context for children in the country in which to frame our understanding of SEC. This is captured in chapter 1. Available evidence illustrating the scope and nature of SEC is presented in chapter 2 as well as information about government policy and responses in chapter 3.

A partnership with the University of Western Cape was developed to analyse the legislative framework for fighting sexual exploitation of children in South Africa. This is presented in chapter 4.

Finally, the Youth Research Unit of the Bureau of Market Research at the University of South Africa (UNISA) was commissioned to conduct qualitative primary research with law enforcement and welfare professional responding to SEC cases and supporting child victims. This element of the research aimed to identify existing challenges and possible solutions.

Methodology

The main purpose of the study was to build an empirical base to establish better understanding of the profile of SEC. This was done using three qualitative research tools: a) desk review of literature; b) expert legal analysis; c) primary research with SEC professionals in two provinces.

Data from these three sources was compiled into a draft report that was presented to the committee of experts in South Africa for detailed feedback and validation in early 2019 before final publication.

Desk Review of Literature

The literature review focused on publications written in English (predominantly used for written publications in South Africa despite there being 11 official languages). Few documents that dealt specifically with the sexual exploitation of children were identified and much of the literature cited refers to more general documentation that contained relevant information.

Data on the sexual exploitation of children online, through prostitution or within the context of trafficking was largely unavailable. Despite growing efforts to address trafficking, very little continues to be published, particularly of the sub-category of trafficked children, in the South Africa context.

Expert Legal Analysis

A partnership with the University of Western Cape was formed in order for specialist South African expertise to be engaged to analyse the legislative framework for fighting sexual exploitation of children in South Africa. A number of relevant South African laws and regulations were analysed in

comparisons with internationally agreed legal standards. The process was enriched by analysis of relevant case law on specific issues around the sexual exploitation of children and the applicability of current legal provisions.

Primary Research with SEC Professionals

The design for this component of the study was developed in collaboration between ECPAT International and the UNISA Youth Research Unit. A methodology and tools were developed for individual interviews and focus group discussions to be conducted in Gauteng and KwaZulu-Natal – two of South Africa's nine provinces which were selected for their status as perceived hotspots for SEC.[107] The aims of the primary research were:

- To determine the understanding of SEC from professionals' perspective.
- To investigate the extent and nature of SEC cases from professionals' perspective.
- To establish which procedures are followed and what supportive networks are available when dealing with SEC cases.
- To explore the awareness and comprehension levels of legislation pertaining to SEC among professionals dealing with the phenomenon in South Africa.
- To determine the extent to which legislation related to SEC cases is being applied.
- To determine potential gaps and recommend appropriate strategies to improve the effective handling of SEC cases.

Sampling

To secure a selection of appropriate participants, a non-probability sampling technique, referred to as 'snowball sampling', was used to select qualifying participants. After identifying and interviewing the first selected participants, the researcher asked for assistance from the participant to identify other potential participants. This methodology secured the involvement of key informants directly dealing with SEC cases in the two sampled provinces. Involving relevant and high-level senior individuals/specialists largely contributed to diverse and rich specialist inputs, which added great value to the overall study. Interviewing key informants took place between August 2018 and January 2019 and all interviews were conducted by an experienced senior researcher.

Due to heavy caseloads and professional activities, the researcher was dependent on the availability of the participants. In addition, government institutions including the National Prosecuting Authority (NPA) and the South African Police Service (SAPS), have strict policies with regard to the participation of employees in research studies, which required formal approvals for participation in the research study prior to proceeding with any interviews. A copy of the approval letters received from the NPA and SAPS are included in Annexes B and C.

Individual Interviews

The objective of these interviews was to establish the level of understanding of key stakeholders on SEC and their perceptions on both the extent and existing attempts to assist victims and protect

[107] According to South Africa's provincial crime statistics (April 2017 – March 2018), the areas affected the most by crime – including sexual offences - are Gauteng (Johannesburg), the Western Cape (Cape Town) and KwaZulu Natal (Durban). Crime Stats Simplified (n.d.).

children in South Africa. A semi-structured interview guide (see Annex A) was developed in consultation with ECPAT International to ensure that the relevant information was obtained. Open-ended questions and probes were included to elicit deeper understanding. Twenty participants were targeted, however, an additional four were also included along the way due to their knowledge and experience.

TABLE 1. PROFESSIONAL CATEGORIES FOR PARTICIPANTS IN INDIVIDUAL INTERVIEWS

Professional category	Gauteng	KwaZulu-Natal
Law officials (senior prosecutors/advocates)	2	2
Police officials/investigators	2	2
Psychologists/counsellors	2	2
Social workers	2	2
Religious workers	2	2
Total participants	**10**	**10**

Focus Group Discussions

Focus group discussions were organised to expand the reporting of stakeholders regarding their experiences and insights on SEC in South Africa. A semi-structured interview guide (see Annex A) was developed in consultation with ECPAT International to ensure that the relevant information was obtained. Open-ended questions and probes were included to elicit deeper understanding.

Two focus group discussions were arranged in Gauteng, consisting of participants from the Education and Health Sectors, which are considered key sectors in dealing with SEC in South Africa. A total of 16 participants from the Education and Health sector participated in the focus group discussions.

TABLE 2. PROFESSIONAL CATEGORIES FOR PARTICIPANTS FOR FOCUS GROUP DISCUSSIONS.

Professional category	Gauteng
Health care professional	**8**
Educator/Education specialist	**8**
Total participants	**16**

Analysis

The individual interviews and focus group discussions were audio recorded and extensive notes were taken during the interviewing process. Despite assurance that participation was anonymous and confidential, two participants refused to grant permission for audio recording and the researcher had to rely on written notes taken during these interviews.

'Thematic analysis' was used to collate the outcome of the interviews according to the main themes emerging from the discussions. This technique is one of the most widely-used qualitative research

analysis methods and focuses on identifying pertinent themes emerging from the discussions[108]. Pertinent themes emerged from the notetaking and recording processes, which involved theme development and revision in an attempt to consolidate and align all inputs of participants according to the research objectives of the study.

Ethical Approval

Ethical approval to conduct the primary research component was obtained from the Bureau of Market Research's Ethics Review Committee at UNISA.

FINDINGS OF THE FIELD RESEARCH

Profile of SEC Professionals and Working Conditions

The primary research began by exploring the professional background and experience of the participants. All the participants had been involved in cases related to SEC in South Africa, for several years,

During the personal interviews and focus group discussions, it was clear that participants had extensive knowledge, experience and professional expertise. However, it was identified that despite knowledge and expertise, working with SEC on a daily basis requires an individual to display distinctive personality characteristics and strengths, as shown in the following verbatim response: *"It is a very specific person, who is prepared to walk the extra mile and not be afraid of what they work with."*

In most instances, professionals confirmed that they had heavy caseloads and that each case was unique and involved different dynamics, there is no one size fits all approach when dealing with SEC. This requires on-going dedication from professionals and results in spending long hours and investing a lot on a personal level. On the basis of the heavy caseloads and intense dedication, it is understandable that most professionals feel overwhelmed by their involvement in cases and matters involving SEC. In addition, it was found that professionals experienced secondary trauma by repeatedly listening to victims' sufferings. Consequently, several participants mentioned that they experience occupational fatigue that also affected their ability to deal with cases:

Despite the current scenario, further exploration revealed that in most instances, organisations do not provide the support needed by professionals working with SEC, which further impacts on the efficiency of the individual.

Participants emphasised the need for support and that the availability of adequate support greatly depends on managerial commitment. However, it was mentioned that management did not always see SEC as a priority area, which greatly influences the allocation of resources and how cases are dealt with, "*We do not have the support to make a difference" (Participant 3, KZN).* Furthermore, several key institutions in South Africa responsible for dealing with SEC, experience a high staff turnover,

[108] Ayres, L. (2008). Thematic Coding and Analysis In Given L (Ed.) The SAGE Encyclopedia of Qualitative Research Methods.

especially on managerial level. Consequently, individuals are placed in authority positions without the required knowledge and compassion.

Another challenge identified by participants, is that the pool of professionals in South Africa is gradually decreasing and that only a limited number of individuals are willing and capable of working with SEC.

Some participants shared the opinion that young, upcoming professionals are not prepared to get involved in SEC due to reasons stated in this report, including the complexity of the crime, demands on one's personal life and limited knowledge. A lack of trained and caring professionals willing to work with SEC present a fundamental challenge in addressing SEC within South Africa.

Perspectives on the Nature and Extent of SEC

Participants described SEC as a complex, continuously evolving crime, instigated and operated by professional criminals. Further exploration of the changing nature of SEC found that the increasing use of technology has greatly influenced criminal practices involving children.

Overall, themes in the participant responses indicated that SEC is a global problem that primarily involves trafficking of children for sexual purposes, exploitation of children in prostitution and online child sexual exploitation.

The following themes were identified in the participants' responses as aspects unique to South Africa and that impact on the sexual exploitation of children.

First the geographic location of South Africa is considered a prime destination for international sex trafficking syndicates to operate from, due to easy access to travel routes to other countries, or to travel from other countries via land, air or sea. Furthermore, the majority of participants indicated that border and immigration control was perceived to be weak in South Africa and high levels of corruption existed amongst officials.

Second, due to South Africa's high poverty and unemployment rates, economic and social inequalities and high rates of child-headed households, the vulnerability of children to exploitation increases.

Third, participants named South Africa's high rates of violent and sexual crimes, with rape cases being among the highest in the world

Fourth, due to certain cultural beliefs and practices, such as *'Ukuthwala'*[109] and *'Muti murders'*,[110] children are more susceptible and vulnerable to being exploited sexually. In addition, the Blesser-Blessee

[109] Department of Justice and Constitutional Development. (2015). *Ukuthwala*.

[110] *Muti* is a Zulu word '*umuthi*' meaning medicine. *Muti* murder can be defined as a murder in which body parts are removed from a live victim for the sole purpose of using the victim's body parts medicinally. These body parts are then often mixed with other ingredients or used alone to make a medicine called *muti*. *See e.g.* Labuschagne, G. (2004). Features and investigative Implications of Muti Murder in South Africa. *Journal of Investigative Psychology and Offender Profiling*. *1*(3), 191-206.

phenomenon was mentioned as an evolving practice in South Africa, during which young girls are sexually exploited by older men in exchange for monetary incentives. However, according to participants, it is disturbing to note that in many South African communities, this practice is not considered as sexual exploitation of children.

It was concerning that participants agreed that the number of cases they dealt with involving SEC, were increasing and becoming more complex.

Training for SEC Professionals and Law Enforcement

It was concerning that participants repeatedly identified knowledge gaps among professionals who are often at the forefront when it comes to cases involving SEC. In particular, SAPS was specifically mentioned in this regard. Participants emphasised the pertinent role SAPS officials play with regard to SEC. They are often the first point of contact for community members and their response is critical in reporting and investigating cases. Participants expressed their concern that the lack of knowledge among SAPS officials expose children to secondary trauma, and also led to cases falling through the system and not being addressed. This again, has a negative effect on determining the true magnitude of SEC in South Africa. The need for dedicated training of police was emphasised.

Despite the identified need for information and training it was noteworthy that participants confirmed that at present, limited training opportunities are available:

The participant responses further identified that in an attempt to address the need for information and training, a few institutions provide in-house, peer-to-peer training. It was mentioned that the National Prosecuting Authority (NPA) provides in-house training to colleagues. However, due to heavy caseloads and limited staffing this seldom occurs. The Department of Social Development (DSD), the Department of Health as well as other institutions such as the International Organization for Migration, National Freedom Network and Salvation Army provide much needed training. Nonetheless, it was clear that at present, this was not adequate and that without comprehensive training, education and guidance the South African sector's ability to respond and prevent SEC will not improve.

In addition to receiving information and training at a professional level, participants further elaborated that information sharing needs to start at an early stage of an individual's career. A particular need was identified to include formal information (not ad-hoc lectures) at tertiary education level in relevant helping professions. It was mentioned that since this was lacking, key professionals' abilities to effectively deal with SEC cases they encounter when entering a working environment, was negatively impacted on. If information is shared at an early stage, it will ensure that young professionals such as social workers, social service practitioners and legal officials are properly trained and can begin to provide appropriate services especially concerning children.

Because of the complexity of SEC, it is clear that information sharing and training needs to be structured and closely monitored. Concerns were raised regarding several civil society organisations and individuals embarking on awareness campaigns. There is no control over the information shared and often campaigns exclude important information related to SEC. In addition, participants highlighted the fact that certain individuals and organisations embark on awareness campaigns for personal gain, which can lead to further exploitation of vulnerable individuals:

Participants proposed that a possible means to increase awareness and knowledge among all South Africans, would be to involve available structures such as the media (including social media) in sharing information about SEC in South Africa. However, this needs to be done in a constructive way by continually sharing relevant information.

As noted in section 5.3, the South African government has undertaken a range of activities over the past decade to create more awareness about SEC, in particular in relation to human trafficking. This increased focus was ascribed by participants during the interviews and focus group discussions to the 2010 Soccer World Cup hosted in South Africa and an increase in sex tourism at the time. It was noted that the increased awareness regarding human trafficking has also resulted in the establishment of several Task Teams on national and provincial level, focusing specifically on issues related to human trafficking. Despite the increase in awareness in some related areas, participants agreed that there was still a fundamental general lack of awareness across South African society, regarding SEC.

The lack of awareness and knowledge has a ripple effect and greatly impacts on identifying and reporting cases involving SEC. This is evident from the following response: *"We found every time we go and do a talk at a school, reporting increases, kids come forward and report" (Participant 2, KZN).*

Existing Policies and Legislative Instruments Addressing SEC

The participant responses indicated that at present there are numerous policies and legislative instruments in place to protect children and address issues related to SEC in South Africa. Participants even noted that some organisations and government departments have standard operating procedures that clearly specify the steps that need to be followed when dealing with cases involving SEC. However, it needs to be kept in mind that the professional systems, such as child welfare and criminal justice, were developed independently and have different mandates. This leads to differences in the way in which these departments respond to SEC and may restrict their involvement.

Further exploration with participants of available policies related to working with victims of SEC identified that current policies look good on paper but are often not deliberated and the practical implementation becomes problematic. Apart from not being practically applicable, some of the existing policies set up vulnerable children to be further at risk. Specific reference was made to certain policies within the education and health sector that urgently needed to be reviewed. For example, reference was made to foreign children that cannot access the education system because they do not have any documentation as required by educational policies. Consequently, the system is setting them up for further risk of exploitation.

South Africa has national laws that prohibit a range of sexual offences against children. Participants agreed that South Africa has adequate, well-written legislative instruments, with some participants being of the opinion that it is the best in the world.

The current available legislative instruments were described as currently being workable for case responses. However, SEC is not a static crime, perpetrators involved in SEC constantly think of new ways to exploit child victims, including through rapidly advancing online technology. Consequently, the available legislative instruments need to be amended and professionals need to strengthen their understanding of the available instruments and adapt their approach.

South African professionals do still face major challenges with the implementation of the available legislation, due to a lack of knowledge and expertise, technical difficulties with definitions and

terminology used as well as overlapping of sections (duplications) within available legislation. With regard to current definitions, participants shared the opinion that many formal definitions related to SEC in laws (for example in the PACOTIP law and Sexual Offences and Related Matters Act 2007) are too broad and can result in cases being not prosecuted or lost due to technical difficulties. The way in which SEC is defined influences understanding and dealing with cases on a daily basis.

Participants expressed their frustration with the improper use of available legislation by professionals, which has disturbing consequences. Examples were provided of difficulties with penalties and sentences resulting in perpetrators being released due to the improper application of available legislation. This was especially frustrating for investigators who spend months investigating a SEC case.

Participant shared their concern that the justice system in South Africa is not child-friendly and is orientated more towards the perpetrator. Despite protective mechanisms to make testifying more child-friendly for victims of sexual offences, specific reference was made to the required court process that force children to testify in the physical presence of offenders. The victim can be re-traumatised through the system, which may even result in the case being withdrawn.

It became clear from the participant responses that in investigating and prosecuting cases, a linear approach does not work well when dealing with SEC. SEC is a complex crime that involves several criminal activities and requires the involvement of inter-sectoral professionals as well as consultation of various policies and legal instruments. Therefore, it is critical for professionals dealing with SEC to have a professional support network and be well-informed about different policies and legislative instruments available in South Africa. An ability, as well as the legislative framework and resources to be able to step back and look at the big picture is essential to success.

Networks for Responding and Supporting SEC Victims

Throughout the study, all participants made it clear that an extensive networks of professionals are critical to successfully responding to SEC cases and supporting victims. Each case involving SEC is unique and requires the expertise of an inter-sectoral team with the necessary expertise. However, it is critical to establish and build relationships with individuals, organisations and government departments to be able to effectively deal with SEC.

Besides support networks being required to effectively deal with SEC, they also provide a way for addressing vicarious trauma. Having a professional support network available lessen the impact of vicarious traumatization. Based on the participant responses, it was clear that professionals form a strong relationship with other professionals who deal with similar situations which provide protection against traumatic and stressful situations*).* The research study also identified that there is a lack of self-care among professionals.

Unfortunately, the issue was raised that because the child protection system in South Africa is flawed, you cannot rely on the system and need to know the right people to ensure that a case is dealt with effectively, *"If you know the right people, it gets done" (Participant Gauteng).* Furthermore, it was emphasised that some organisations are not approachable. During the individual interviews and focus group discussions, specific mention was made of the Department of Social Development (DSD). DSD is the lead Department responsible for child protection in South Africa and was therefore identified as

a key Department in addressing SEC. However, most participants had negative experiences when dealing with DSD.

In addition, the participants identified that some organisations and departments work in isolation. This independent functioning impacts negatively on the effective and desired collective approach to handling SEC cases.

These barriers result in a lack of a systematic approach when dealing with SEC, *'Everybody does what they want'… (Participant 2, KZN), People are doing things, their own things" (Participant 1, KZN).* Inter-departmental collaboration between key government departments including The Department of Social Development, Department of Health, Department of Education, Department of Justice, the National Prosecuting Authority and SAPS remains problematic. The metaphor of gears working together to achieve a common goal, was provided to describe the importance of a collaborative, effective approach to SEC. If there is no cohesion, the overall process is hindered and the system collapses. To resolve this issue, participants proposed the establishment of an oversight body that can supervise and guide all activities related to SEC in South Africa. In addition, it was proposed that the oversight body needs to be a central hub of information regarding SEC. Reference was made to the centralising role that the NGO, International Centre for Missing and Exploited Children plays for advocacy, training and research. Participants proposed that a government centre for South Africa could provide some similar responsibilities, as well as have the ability to also take on a formal mandated coordinating role amongst government and civil society actors.

Statistics and Monitoring

During the interviews and focus group discussions, participants explained that government support depended on available statistical information, which is minimal due to a number of factors including the underground nature of the crime, a knowledge and skills deficit, as well as inadequate systems. The lack of statistical information highlighted the need for appropriate, standardised data systems that would enable organisations to keep accurate records. It was clear that at present information about SEC is not being captured accurately.

Available Resources for SEC

The participants consistently identified limited availability of resources (human and financial) to effectively deal with SEC in South Africa. Despite a notable increase in reported cases, available resources remain minimal and insufficient. This was mainly attributed to the South African government not being perceived to prioritise SEC.

The impact of SEC on the individual and society is significant. Victims of sexual exploitation experience severe abuse, are faced with psychological and physical health problems and have difficulty reintegrating back into society due to a lack of education, work experience as well as stigmatization. In South Africa, Non-Governmental Organisations (NGOs), primarily deal with the impact and provide services to victims of sexual exploitation. These services mainly include safe housing, counselling, medical and/or legal support. Specialised services are needed while NGOs have limited resources available and get minimal support from the South African government to deliver the required services. This results in poorly resourced intervention and prevention services.

Furthermore, participants alluded to the potential for corruption to be influencing the availability of funds for SEC responses and support. The lack of government prioritisation opens the door for unethical individuals and organisations to misuse the system and exploit vulnerable individuals.

It was emphasised that working with SEC requires the highest standards of efficiency, competency and integrity. Participants expressed the opinion that key government departments do not ensure that the person being appointed is the right person for the task.

Another challenge identified is a lack of accountability and poor work ethics among individuals, especially within the South African government sector. This was mainly attributed to the fact that individuals face no consequences for poor professional conduct.

Due to a lack of governmental commitment and support, several participants even mentioned that they use their own personal resources to continue with their day-to-day work activities. In addition, they greatly depend on support from private individuals and international organisations to continue with initiatives and activities related to SEC. International organisations assist with generating resources or funding to support many programmes dealing with SEC in South Africa. They play a role in setting international obligations for creating certain legislation relating to SEC and offer support for reuniting survivors with their families and their country should they have been exploited internationally.

Summary

The review of literature, analysis of legislation, and interviews with SEC professionals in this report demonstrates the range of risks for sexual exploitation that South African children face. The report findings evidence the need for complex and multi-faceted responses. Participants in the field research even perceived an increase in the extent of the problem rather than reporting that they saw any progress was being made.

An increasingly online population means that more South African children are encountering sexual content online – with up to a third in one study reporting that they had received sexual messages.[111] In that study, parents' risk response was very low, with more than half never giving their children any guidance about safe Internet use.[112] Interviews with SEC professionals identified a clear sense that technology was increasingly a part of the SEC cases they are seeing, and has created a huge demand. The 2018 establishment of the Cybercrime Unit of the SAPS is a welcome development from law enforcement.

Despite recommendations from the Committee on the Rights of the Child in 2016[113], South Africa is still yet to develop and implement an integrated system for data collection on the sale and trafficking of children. Interview respondents reinforced this fact).

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[111] Centre for Justice and Crime Prevention. (2016, September). *South African Kids Online: A glimpse into children's internet use and online activities*. 7. Cape Town: Centre for Justice and Crime Prevention.

[112] Ibid.

[113] Committee on the Rights of the Child. (2016, October 26). *Concluding observations on the initial report submitted by South Africa under article 12 (1) of the Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography*. CRC/C/OPSC/ZAF/CO/1. Para 6-7. Geneva: Committee on the Rights of the Child.

Cases of sexual exploitation through trafficking occur from rural to urban areas, where economic opportunity is used as a guise to recruit.[114] As field research participants confirmed, poverty is a huge driving factor: Research has also identified the illegal movement of children across the country's porous borders[115]. The introduction of the 2013 PACOTIP law has helped to address sexual exploitation through trafficking, yet use of the law for prosecutions continues to be limited.[116] Field research suggested this was affected by law enforcement not being trained in the law.

The tourism industry contributes substantially to the South African economy, with foreign visitors and as many as 44 million overnight domestic trips occurring in the country in a year.[117] The risk of sexual exploitation of children in this context is known to be high, and South African is considered a major destination for traveling sex offenders.[118]

While a formal review of prostitution legislation has begun, South African law currently criminalises all forms of buying and selling sex. However, the law includes provisions that allow exceptions to applying the law to prosecute child victims of exploitation in prostitution[119] though this exception is not consistently applied, meaning children are often punished by law enforcement. In fact, participants noted serious concerns with the response of law enforcement.

The risk of sexual exploitation of children through child, early and forced marriage continue in a country where as many as 6% of children are estimated to marry before 18.[120] The traditional custom of *Ukuthwala,* or bride kidnapping is practiced in some areas and can be used to facilitate trafficking or other forms of sexual exploitation of children. Prosecutions through the courts have happened which may go some way to helping eradicate this practice. On the government side, despite a draft bill in circulation, no legislative reform on this issue has yet occurred.

The government has undertaken initiatives to promote awareness of sexual exploitation of children, for example via trafficking awareness training and activities through Provincial Child Labour Intersectoral Support Groups, or the annual Child Protection Week campaigns.[121] However, the success of these general activities has not necessarily cut through broadly with the general public. Participants believed this should be driven by government.

Findings from the field research described that this lack of awareness was even present amongst relevant professionals. Participants described that individuals within key departments sometimes lack basic knowledge on the topic, which significantly impacts on the reporting and dealing of SEC cases.

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[114] *Ibid.*, 390.; Germaner, S. (2018, April 28). Two men on six human trafficking charges. *IOL News*.
[115] ECPAT Netherlands, (2014). Don't Look Away: Be aware and report the sexual exploitation of children in travel and tourism 79.
[116] Van Der Watt, M. and Burger, J. (2018, November 30). *The perplexities of human trafficking in South Africa*.
[117] Statistics South Africa. (2018). *Domestic Tourism Survey 2017*. 8. Pretoria: Statistics South Africa.
[118] ECPAT International. (2016, January 28). *Terminology Guidelines for the Protection of Children from Sexual Exploitation and Sexual Abuse, adopted by the Interagency Working Group in Luxembourg*. 55. Bangkok: ECPAT International., 44.
[119] South African Law Reform Commission. (June 2015). *Report Sexual Offences Adult Prostitution*. 8-10. Pretoria: South African Law Reform Commission.
[120] UNICEF. (2017, December). *The State of the world's children 2017*. 184. New York: UNICEF.
[121] South African Government. (2019). Child Protection Week 2019. [Press release].

Major findings related to awareness and knowledge among professionals were also linked to overwork and limited resources, a lack of early career technical education on the topic, limited exposure to working with SEC cases and limited structured training opportunities. In the field research, professional indicated that the pool of professionals in South Africa is gradually decreasing and that a dwindling number of individuals are willing and capable of working with SEC. Working with SEC within the limitations of the current child protection system was emphasised to be difficult and stressful.

These findings show that there is a clear need to provide education and training to all workers that is inclusive of the role of the professional as an integral resource. Without comprehensive information, training and guidance across the welfare, law enforcement and justice sector, SEC in South Africa will not be effectively addressed despite perhaps a strong availability of legal and policy tools.

It is clear for the literature review and legislative analysis that South Africa has made significant progress with regard to the development of a legislative network and supporting policies addressing SEC. So much so, that legislation instruments are considered to be among the best in the world. However, the study clearly identified that there is a shortfall with regard to the implementation of policies and legislation. Interview participants concurred: *"No, the legislation on paper it is very good. But in practice it is non-existing. Nobody follows through with it" (Participation 1, KZN).* Collaborations between service provider and policy-makers that focus on facilitating implementation are essential for addressing practical considerations.

Another finding of both the legislative and policy review and field research was the importance of collaboration between different agencies involved in the care and protection of children. Sexually exploited children range over many structures and requires multi-sectoral intervention. In structure and in practice, the lack of coordination among various government entities dealing with SEC issues results in an unclear division of tasks and overlapping responsibilities. The unclear mandate, lack of authority and limited funding provided to the Children's Rights Intersectoral Coordination Committee was noted by the Committee on the Rights of the Child in 2016.[122] Likewise, more coordination is also needed between central government departments and local organisations. Furthermore, the potential for corruption, and need for greater accountability were also identified by interview participants.

SEC is greatly under-resourced in South Africa. In particular, increased support from the South African government is required. Resource constraints present a major barrier to professionals and their ability to effectively deal with and curb SEC, presenting a need for policy action for more resources to support various organisations. These challenges will not be eliminated immediately, but will require dedicated commitment, resources and political will.

RECOMMENDATIONS

Recommendation 1: Raise awareness

1.1. Share public information on different platforms and about SEC in the community.

1.2. Create resources and provide training to media, and social media actors to highlight the role they play in increasing public awareness and understanding of SEC by providing accurate

[122] Committee on the Rights of the Child. (2016, September 30). *Concluding observations on the second periodic report of South Africa*. CRC/C/ZAF/CO/2. Para 7. Geneva: Committee on the Rights of the Child.

information about criminal cases involving children.

1.3. Parents and caregivers are a critical target group, as with the right risk knowledge, they can make prudent choices in protecting their children, and can also prevent exposing them to risks.

1.4. Empower children in schools with adequate, age-appropriate information about SEC. This should include an increased focus on sexual exploitation of both boys and girls and focus on risk awareness and protective strategies for children online.

1.5. Engage with the faith-based community to increase awareness and empower leaders to encourage prevention and identify cases through existing pastoral care mechanisms for referral.

Recommendation 2: Train and support SEC professionals

2.1. Provide professional and psychosocial support for all professionals dealing with SEC to avoid burnout and the human resource loss in this area. Resourced professional supervision and mentoring mechanisms could encourage transfer of skills from experienced to emerging professionals.

2.2. Provide training for all professionals working with child service systems including; child welfare, law enforcement, health and education to better identify children at risk, provide specialised services and support.

2.3. Early career welfare workers need adequate, specific and practical training about SEC. Build their capacity to identify victims and effectively respond to SEC.

2.4. Increase appropriate training on SEC for law enforcement, justice officials, health and education workers, with the emphasis on identification and effective handling of cases without re-victimisation of individuals and proper record keeping.

2.5. Train and support SAPS at all levels on SEC, the relevant legislation (such as PACOTIP), appropriate procedures and victim support.

Recommendation 3: Prioritise SEC and commit resources

3.1. The South African government needs to take a strong standpoint against the sexual exploitation of children and ensure political willpower behind the issue. A clear overarching strategy via a National Plan of Action must be developed for addressing SEC.

3.2. Substantial and dedicated funds are vital for programs and implementation of the current strong legislative and policy framework for SEC in South Africa.

3.3. Further policy and procedure development must focus on implementation and needs to be monitored and evaluated.

3.4. Resource the Cybercrime Unit and the Human Trafficking Desk of the SAPS. Support these units to spread knowledge on SIC through a combined mandate of response and further training across the force.

3.5. Identify good practice therapeutic interventions and provide resources to make these available to victims across the country, including to victims outside urban areas.

3.6. Support victim empowerment programmes that are reintegration-focused and offer livelihood options, including basic education and skills training for victims of child sexual

exploitation.

Recommendation 4: Promote collaboration across all the necessary actors

4.1. Establish a central body to coordinate both government actions and to promote collaborative relationships and efforts between government departments and civil society in the range of related sectors (this may be achieved through clarifying the role and responsibilities of the National Children's Rights Intersectoral Coordinating Committee).
4.2. Enhance awareness and information sharing among civil society and professional sectors by funding opportunities for multi-sectoral teams and referral networks.
4.3. Involve the South African business sector. Employers and employees need to be knowledgeable about SEC.
4.4. Engage faith-based actors in referral networks and responses.
4.5. Corruption can dramatically undermine any response to SEC. Irregularities, especially within key government departments, need to be investigated and dealt with as a matter of urgency.
4.6. The responsibilities of individuals involved in SEC need to be clearly specified and people need to be held responsible when not handling their responsibilities or meeting expectations.

Recommendation 5: Research and good data collection systems

5.1. Develop a central, national mechanism for data collection on cases related to all types of SEC.
5.2. Undertake, support and enhance research activities investigating the extent, nature and impact of SEC within a South African context.
5.3. Establish a central research hub that can make information available to all stakeholders dealing with SEC.
5.4. Build on existing research, lessons learned from other countries, emerging and promising practices and survivor input.

A BALANCING ACT - A WIDER TAKE ON CONFIDENTIALITY AND COMMUNICATION "CONFIDENTIALITY IS A DELICATE BARGAIN OF TRUST." MARTIN UGWU

Janet Bytheway

A Wider Conversation

As a clinical psychologist in private practice, I do not see confidentiality and communication as mutually exclusive. How can we communicate confidential information in a way that protects both our clients, and ourselves? I hope through questions and open up possibilities for wider conversations around confidentiality. Tim Johnson (2019) suggests that "It is by asking questions that an individual becomes ethical".

I share my journey with young clients who have taught me about trust, respect and holding and sharing their voices. Five year old twins shared the importance of their words and how to communicate them.

Confidentiality is that agreement between the practitioner and client to provide a safe space where clients can speak freely. It allows people to reveal shames, fears, and secrets, and receive non-judgmental help and support without fear of that information leaving the room. (APA) Therapists who break confidentiality can fall foul with professional boards. Clients could sue them. So the urge to protect confidentiality is strong. We are trained to protect it at all costs.

What if sharing such conversations is in our client's best interests? Working with high conflict families in distress opened my eyes to the need for a more open communication between parties. My aim was to develop the voice of the child and her ability to communicate her needs in a stressful environment. The right to confidentiality and the need for communication are two ends of the see-saw. We need to balance them.

When can confidentiality be unhelpful?

A message to call an attorney, forensic practitioner or facilitator when parties want feedback on therapy, can feel intimidating, intrusive and scary. Therapists sometimes hide behind confidentiality as a way of protecting themselves. It is easier to say: "I can't disclose anything". when speaking out can make a material difference in the lives of children. Not saying in my view, becomes unethical. When the therapy process focuses solely on the needs of the individual child without taking the wider context into account, useful information can slip through the floorboards. . . If the individual is

changing in therapy but returns to the same environment, what is the impact of this? What shared information could support the therapy process and what might compromise it?

There are times when working collaboratively could enrich the encounter while keeping it safe.

Chloe and Caitlyn's story (names changed)
Non-identical 4 year old twin girls identically dressed down to their hair clips and earrings were referred for an emotional assessment. The purpose was to assess their functioning living with chronic parental high conflict. There were numerous allegations between the parents of various wrong doing, including sexual abuse. Subsequently they were court ordered to attend sessions for support and monitoring. I saw them until they were 8 years old when they were referred to a therapist closer to their home.
Both parents experienced longstanding unhelpful interpersonal styles of engaging i.e. personality disorders. The parents' long hostile relationship changed little in spite of a number of professional interventions. I saw the children on a monthly basis and every 6 months sent a report to the facilitator on any progress and new concerns. This was to support them living with their parents' ongoing battles while avoiding unnecessary assessments, given the parents' constant allegations against one another.

I asked myself:

- What right do 4-8 year olds have to confidentiality?
- What are their rights to have a voice with both parents?
- How can we communicate the voice of the child more accurately in legal processes?
- What rights do their parents have to information about the therapeutic process?

I was struck by the need for the children to have travelling voices. Their voices, heard within the therapy process, often did not travel beyond the walls. I began to feel it was my was job to not only amplify their voices, but to do so in a way that was ethical, respectful and in their best interests. I felt a responsibility as a professional to advocate in processes that had direct bearing on their lives. These ideas nudged me from my safe and comfortable traditional position as therapist with a sole focus on my client, onto a road with a wider view, where the context of therapy influenced the journey.

Guidelines
Everyone needs to know what to expect from the process from the start. Part of our job is to translate the often garbled and chaotic presenting problem parents provide, into an understandable and manageable description of what this problem is and how we are going to go about dealing with it. The more chaotic the presentation, the more important this step.

Here is an example of a letter to parents:

Dear Mr and Mrs Smit (name changed)

Thank you for approaching me to try and help you understand some of the challenges Caitlyn and Chloe are currently facing. I understood that you experience a long-standing difficult co-parenting relationship characterized by many conflicts about the children. You made me aware that among these were allegations of sexual abuse, physical abuse as well as problems about general care of the children including schooling, cleanliness, cutting hair and what activities they should be exposed to.

The emotional assessment for the girls involves:

1. Parent interview with both parents (together or separately) - to get relevant background, developmental history, etc. 1-2 hours

2. Emotional assessment of Caitlyn and Chloe – 2 x 1 hour interviews where they talk about themselves

3. Collateral from the school (with your consent) 2x 30 min

4. Feedback to parents (together or separately) about findings of assessment and planning how to move forward. 1-2 hours

Kindly advise if you would like to proceed with the assessment.

I often am surprised when I supervise at how often, even experienced and competent therapists do not explain to the child why they are in therapy and what the purpose is.

The initial interview with the parents includes ensuring that they understand the assessment process, what I will be doing and why. We discuss what they have told their child about coming to see me. If required, I help them craft an explanation for the child.

Trust

All this leads me to the nature of and creation of trust. That's why I prefaced my talk with Martin Ugwu's quotation, "Confidentiality is a delicate bargain of trust." Trust is a firm belief in the reliability, truth, or ability of someone.

I needed to trust:

- That the children had something to say worth weaving into a collaborative process.
- That I would be able to translate/ communicate their needs into other processes.
- That best interests of my young clients were served.

Chloe and Caitlyn were prepared from the start. They could say whatever they wanted to Tannie Janet and she would only tell what we had agreed upon. These children had been assessed multiple times where various professionals had written down their words that had made their way to court and to their parents' ears. They were understandably distrustful. The girls slowly learned to trust (it took a long time) that I would not disclose anything they said without their consent.

They began to say things like,

"*What are you writing down? ", I told them.*

"Daddy doesn't know we are here.", I reminded them "Mom and dad know you are here every time, because I have told them.

"Dad says he can hear what we say when we are here." We toured the building, looking out of the window and down the passage.

"Only tell mommy this". I clarified that I could not do that.

It is common practice to get your client to sign consent for you to speak to another party. When you have a good relationship, your client may say, "Tell them whatever you like or need to." I am always

cautious when I hear this. I prefer to explain what I will be saying and what I won't be saying. Ask your client: "What you would you like me to say? What would you not like me to say? "Ask yourself: "What do I want to say? What do I need to say?"

We have to consider: What are the effects of what you DO /DO NOT say? Ideally, the client will participate in the process and have a sense of agency about what will be said; or not said.

Other questions to consider

- Who decides what is in the best interest of your client?
- Who will you be checking in with (teacher/parents/coach)?
- Who will get feedback on the progress?
- What feedback will be given?
- How it will be given – written (report/email), who will be copied in?
- If feedback is verbal, who will be present?

Keeping everyone on the same written page.

I started including parents, children and doctors/teachers (depending on the need) in my correspondence to ensure that all parties were on the same page. While you are building trust you could send client a draft. "This is what I would like to send. Anything you would like to change or add?"

Writing documents the process. It protects your client and you. We need to learn to write in a way that is respectful, clear i.e. no jargon. Albert Einstein said, "If you can't explain it simply, you don't understand it well enough."

The twins and I shared many conversations about the telling of what happened in the sessions – what would be told, to whom, how, when. Slowly but surely, they learned to trust. That meant I told them whenever I had a meeting with their parents and asked them, "Is there anything you want me to say to your parents?" I would also tell them when I was writing a report to the facilitator. He became the man helping mom and dad with their disagreements. I asked, "Is there anything you want me to tell the facilitator?" They came to accept this (I had to walk my talk and prove this to them by standing by my words). When they told me things I could say, I wrote them down in front of them and read them back to them. Sometimes they asked to write in my notes, which I allowed as I saw this as a way of taking ownership. Their writings remained part of the file.

Apart from notes and reports, professionals tend to avoid writing more than they need to. Emailing has made writing to multiple parties easy and more accessible. Emailing can be less formal that a report. Check for accuracy, as mistakes or typos to slip through so easily. "Words are the source of misunderstanding" the Little Prince reminds us in Antoine de Saint-Exupéry's children's book (1943).

Balancing the See -Saw

I am grateful to the children who brought to my attention through their experiences, the importance of their voices travelling beyond the therapy space. They helped me translate, their experiences and guided me about how to say what they wanted to say.

I learned that confidentiality and transparency are not mutually exclusive, but two sides of the same coin. (Thomas de Maizier). Aristotle and Kant, proposed that unethical behaviour is a consequence of people not thinking about their behaviour." (Johnson 2019). I learned that questioning established practices, can open doors to more effective ways of working.

Confidentiality and Communication? May we achieve this see-saw balance.

Works Consulted

Allen, A & Grisso, T (2014) Ethical principles and the communication of forensic mental health assessments Ethics & Behavior Vol. 24, 6, 2

Allen, K (2012) What is an ethical dilemma? In the new social worker, Spring, Vol. 19, No. 2

American Psychiatric Association www.apa.org

Botha, J (2019) Patient autonomy/informed consent in The Specialist Forum, Jan/Feb

de Saint-Exupéry, Antoine (1943) Harcourt, Brace & World, New York

De Jongh, J (2016) Ethics and professionalism WCPPG Workshop, Durbanville

Dresner, S (2018) Strong recordkeeping – a strong defence in Casebook Vol. 26 Issue 1

Good therapy Blog (2017) Client Confidentiality https://www.goodtherapy.org/blog/psychpedia/client-confidentiality

Haugaard, C (2016) Narrative Therapy as an ethical practice Journal of Systemic Therapist 35 (1) 1-19

Howarth, G (2019) The explosion of defensive medicine in The Specialist Forum , Jan/Feb

Johnson, T (2019) Magic Maths and Money, the relationship between science and finance Ethics and actuaries: issues and opportunities 17 May 2019

Medical Protection Society, Ethics for all workshops notes 2012, 2015, 2016 Cape Town Convention Centre

Medical Protection Society (2009-2018) Personal correspondence with various legal representatives regarding cases.

Reidbord, S (2019) Some mainstream psychotherapy is called "evidence based" some is not. But the distinction is arbitrary and often misleading www./therapist/steven-reibord-san-franciso-us

Whitehouse, S (2012) A duty to treat …and to tell? MPS Casebook, January

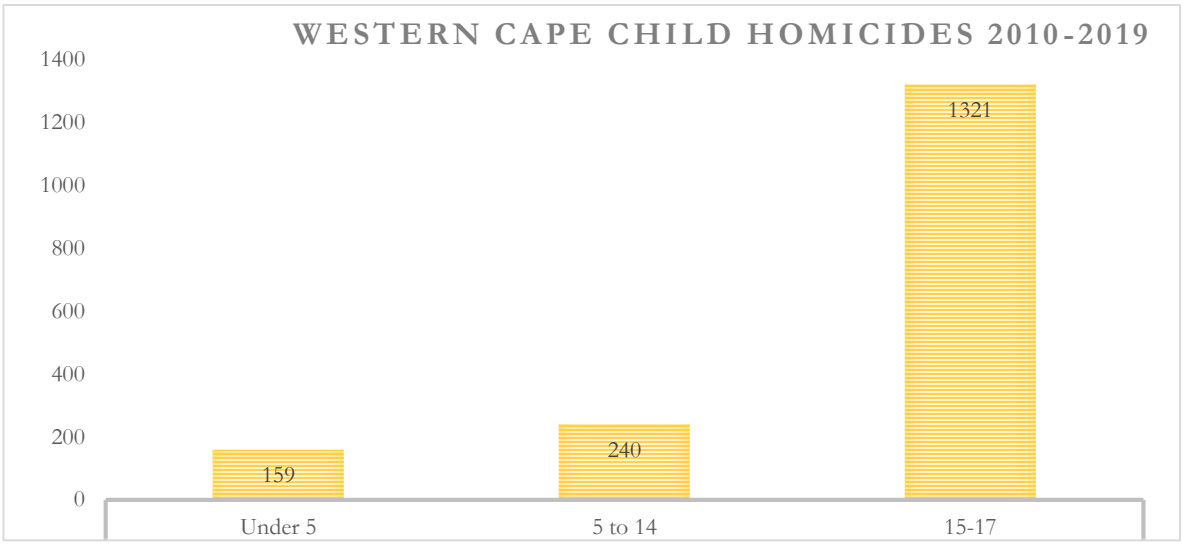
PHYSICAL AND MENTAL HEALTH OF CHILDREN AFFECTED BY VIOLENCE

Nomafrench Mbambo, Provincial Minister for Health in the Western Cape

Outline of the presentation

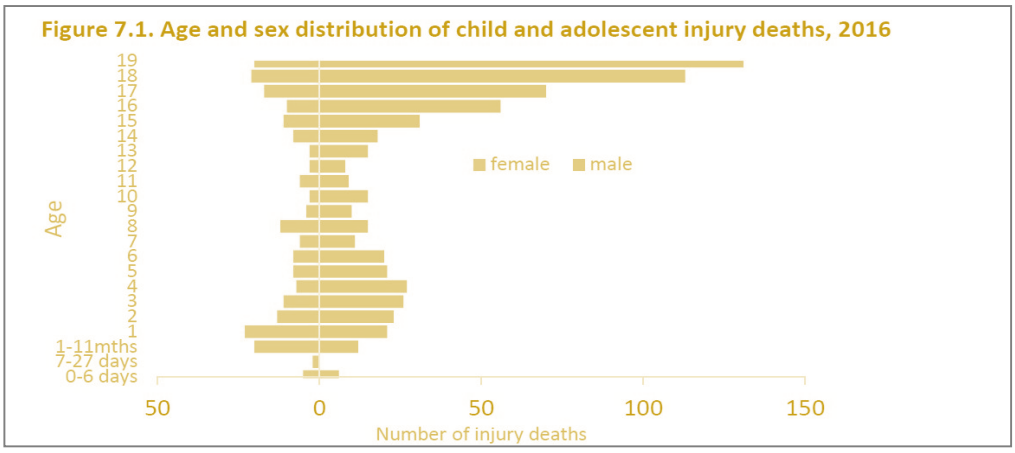
- Homicide in the Western Cape
- Child Trauma in Western Cape Health Facilities
- The Western Cape Department of Health Response
- Partnerships to reduce child injuries in the Western Cape.

Table 1: Between 2010 to 2019, there were 1720 child murders in the Western Cape.



During this time 399 children under 14 were murdered. Every year, 20 children under 5 are murdered. 76% of child murders occurred in the Cape Town Metropole.

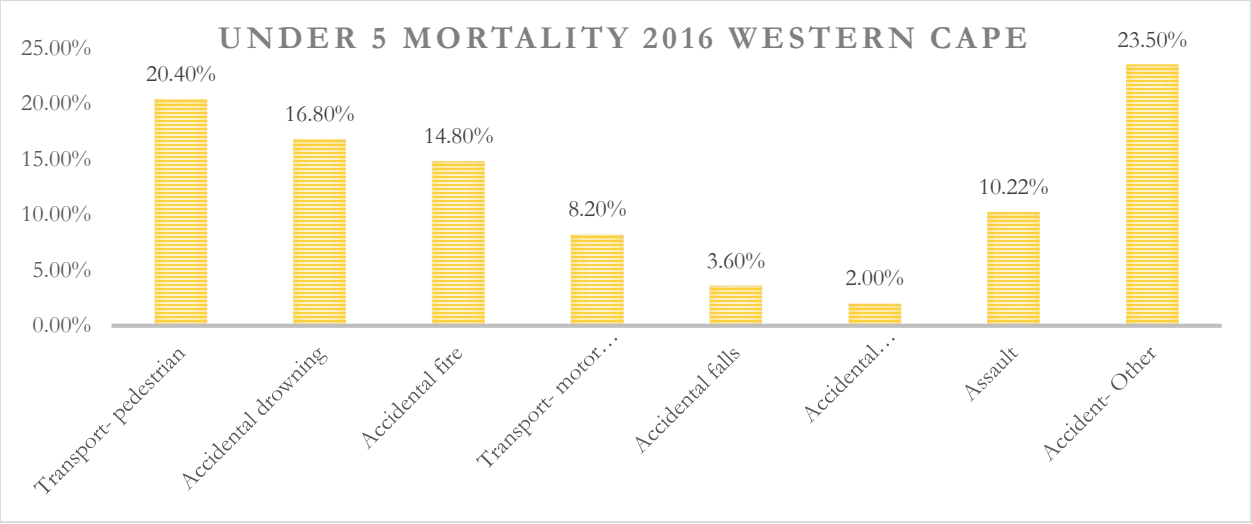
Table 2: Injury Deaths



The World Health Organisation defines a child as a person under the age of 18, and an adolescent between 10 and 19 years old. In 2016, 13 % of all injury deaths in the Western Cape occurred in children and adolescents under the age of 19. From the graph we can see that the majority of injury deaths occurred in males 15-19 years old and in children under 5 years old

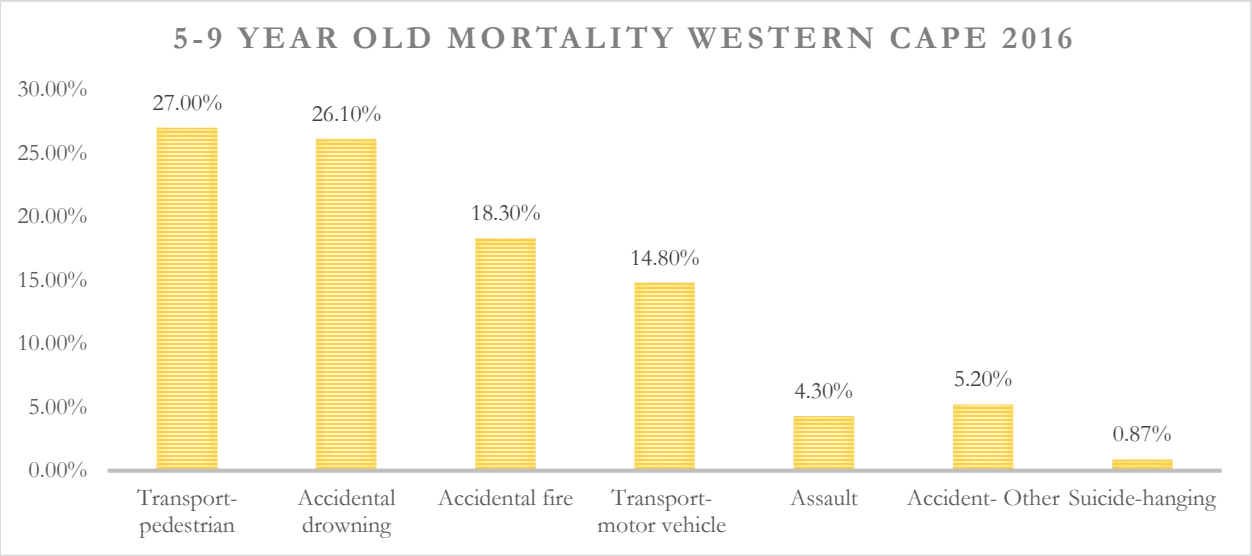
When considering child deaths, we must understand that there is a significant difference in the causes of death, depending on the age of the child. To fully understand the problem, it is best to break it down into age categories.

Table 3: Injury deaths- under 5 years old



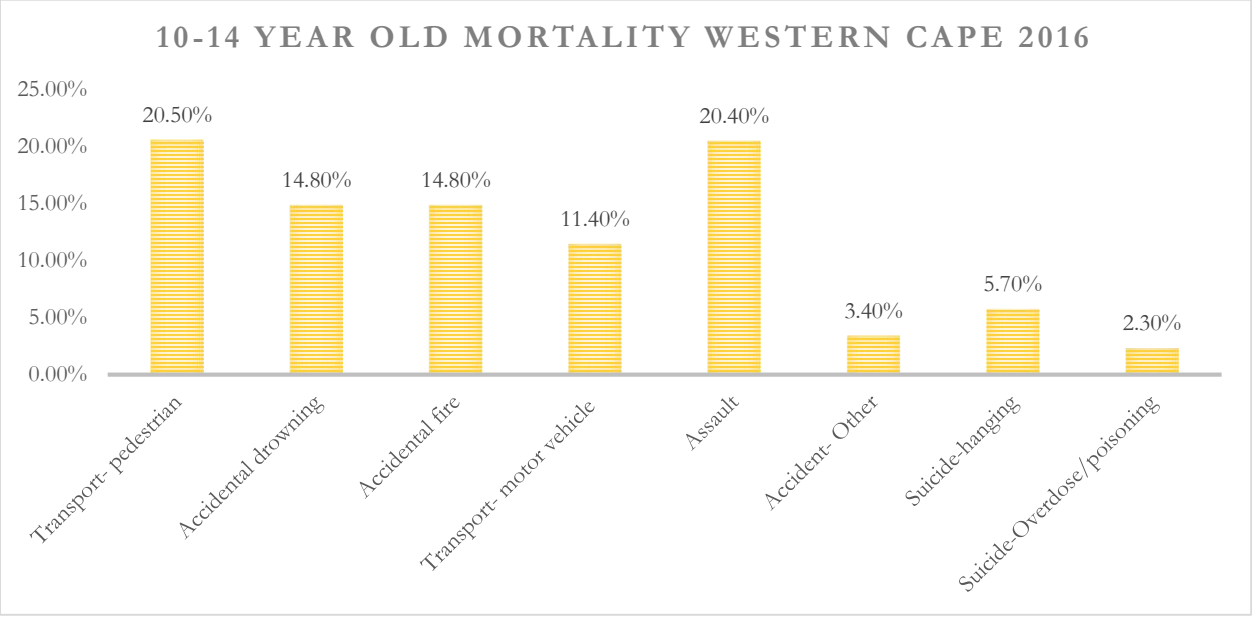
The leading cause of death in children under 5 was pedestrian fatalities (21%). This was followed by accidental drownings, accidental fires and assault. In 2016, 10. % of all injury deaths in under 5 year olds in the Western Cape was due to assault.

Table 4: Injury Deaths in the Western Cape: Children 5 to 9 years



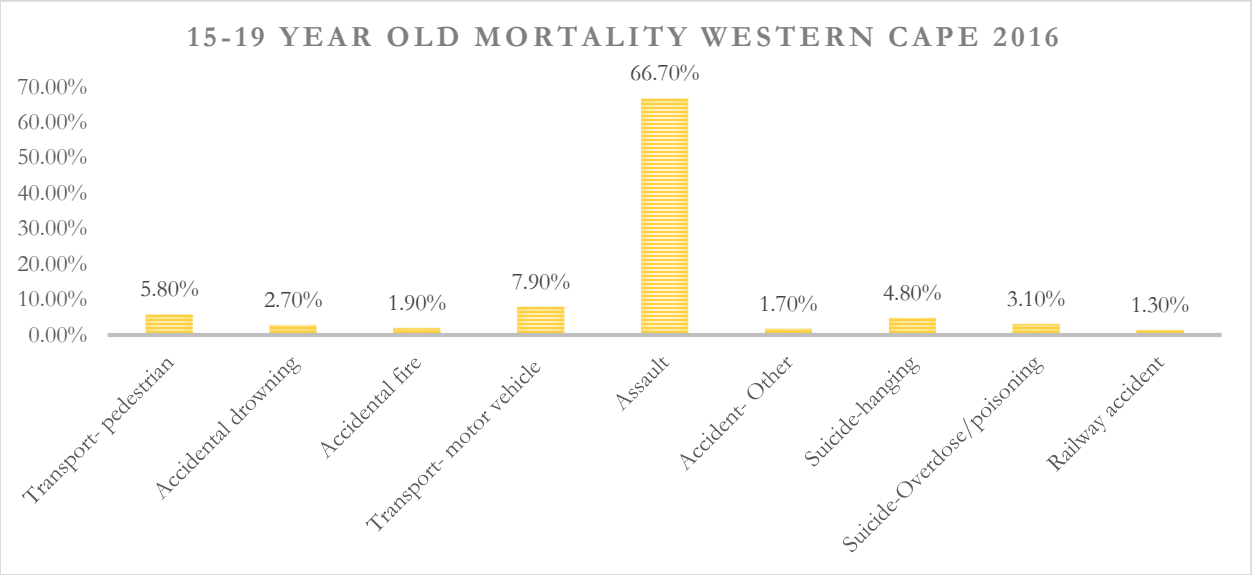
The 3 leading causes of death in 5 to 9 year olds remain the same, but drownings form a higher proportion of deaths in this age group. It is worth noting that suicides make an appearance in this category. The youngest suicide reported between 2010-2016 was 9 years old.

Table 5: Injury deaths Western Cape 2016: 10 to 14 years



If we look at the 10-14 age group, we see that the percentage of assault increases and between 2010-2016 there was an average of 18 homicides per year. We start to see an increase in suicide rates with 7 suicides a year from 2010 to 2016. Transport related deaths remain high.

Table 6: Injury deaths Western Cape 2016- 15 to 19 years old



Homicides surge in the 15-19 year old age group.

In summary, the leading categories of child death due to trauma are pedestrian accidents, drownings, assault, accidental injury, and suicides. The causes of death vary greatly in the age groups, necessitating different strategies to meaningfully address the challenge of reducing child deaths due to trauma.

Child trauma seen at hospitals

Table 7: Transport Injuries Red Cross Children's Hospital 2018

Transport related injuries seen at Red Cross Children's Hospital in 2018	
Motor Vehicle Accident (MVA) Pedestrian	892
MVA Passengers- restrained	15
MVA Passengers- unrestrained	88
MVA Passengers-Bakkie/minibus	56
Cycle	36
Motor cycle	5
Other (Boat, train, plane, horse)	55

The vast majority of transported related injuries seen at Red Cross Children's Hospital involve pedestrians. Of great concern is that in more than 50% of motor vehicle passenger injuries, the children were unrestrained.

Table 8: Assault Injuries Red Cross Children's Hospital 2018

Assault related injuries seen at Red Cross Children's Hospital in 2018	
Blunt	147
Sharp	16
Rape/Sexual Assault	84
Human bite	0
Other	19

Table 9: Burn Injuries Red Cross Children's Hospital 2018

Burn related injuries seen at Red Cross Children's Hospital in 2018	
Flame	80
Fluid	892
Heat Contact	80
Electrical	27
Chemical	20
Explosion	7
Other	11

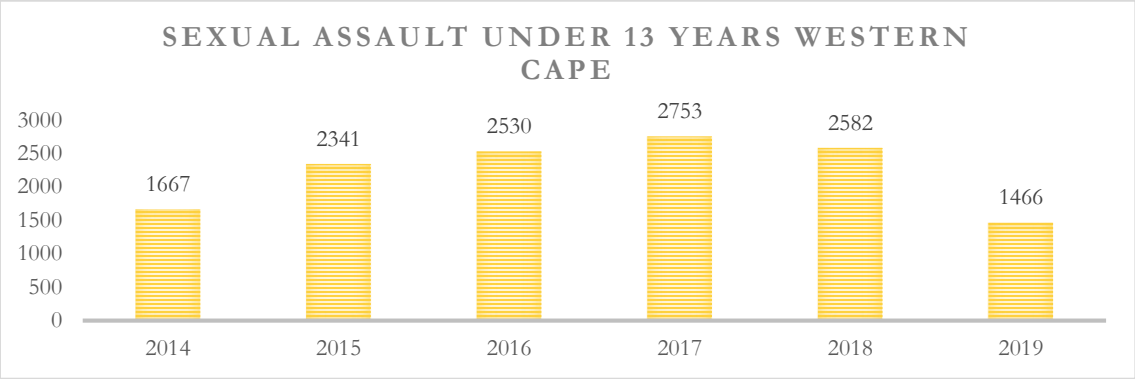
In 2018, Red Cross Children's Hospital saw 1117 burn patients. Accidental burns were the third highest cause of death in children under 14 years old

Table 10: Other Injuries Red Cross Children's Hospital 2018

Selected injuries seen at Red Cross Children's Hospital in 2018	
Falls	2750
Firearms	33
Dog bites	116

Falls contribute to 3.6% of all under 5 trauma deaths. In 2018, 33 children were treated for firearm related injuries.

Table 11: Sexual Assaults seen in the Western Cape 2014 -2019



In 2018, 2582 sexual assaults in children under 13 years old, were recorded across the Western Cape

Child Injuries- What can be learned from Red Cross Children's Hospital?

- The hospital cases are similar to the leading cause of mortality in children.
- Hospitals deal with a significant amount of falls and sexual assaults.
- A significant portion of MVA injuries occur in unrestrained children.

Now that we understand the problem, how do we respond? How do we manage the mental state of injured children at Red Cross Children's Hospital? How do we manage a child with a non-accidental injury?

In the event of a non-accidental injury:

- The social worker meets with the parents to explain the findings.
- The case is reported to the police
- The child is removed from the care of the parents/guardians
- The case is referred to the Department of Social Development
- The child will remain at the hospital until suitable placement has been found. This may be with relatives or in foster care.

This is never easy. This process is fraught with emotion, with upset, often angry parents. It requires skill, patience and exceptional communication.

A child requiring counselling after a non-accidental injury is seen by a doctor, and referred to a social worker. The social worker will counsel the child and the family. Once discharged, the social worker may continue the counselling on an outpatient basis or refer the child to the Department of Social Development.

Child and adolescent psychiatry

For a child requiring a psychologist or psychiatrist, the child is first assessed by the doctor and the social worker. This child may then be referred to the psychiatric service, where they will be seen by a multidisciplinary team including psychiatrists, psychologists and social workers.

Substance abuse is a contributing factor in 42% of adolescent psychiatric admissions in the Western Cape in 2018. The most common substances were cannabis and "tik". 45% of adolescent admissions in 2018 involved self-harming or suicidal behaviour. In the Western Cape in 2016, suicide accounted for 8% of deaths for children aged 10-14, and 15-19.

Inpatient and outpatient facilities are available for children and adolescents with mental illness at Red Cross Children's Hospital, Tygerberg Hospital and Lentegeur Hospital. Patients are cared for by a multidisciplinary team including psychiatrists, specialised nurses, psychologists, occupational therapists, and physiotherapists. Once stabilized, patients will be followed up at the outpatient clinic, and eventually they are referred to the primary health care level for ongoing treatment.

First 1000 Days Programme

The first 1000 days, from conception to 2 years old, is a critical time in a child's life. Disturbances, stress or trauma in this period could lead to a wide range of health problems including developmental delay, intellectual disability and mental illness. Intervening in the first 1000 days of a child's life is therefore an opportunity to drastically improve their chances of a healthy life. With this in mind, the Western Cape Department of Health in partnership with the Department of Social Development launched the First 1000 Days programme.

Strategies and Goals of the programme

The goal is pregnant women and mothers are physically and mentally well and are supported and children are healthy, nourished and loved, and are able to reach their full potential.

The programme focuses on 3 strategies:

1. Communication
2. Strengthening Health responses
3. Partnerships – inter-sector working together.

The DOH strategy on trauma is divided into 2 parts

- When a child is injured, the Department of Health provides access to quality healthcare.
- We work with partners to address child trauma caused by factors outside the direct control of the Department of Health e.g. we work with the Department of Public Transport to reduce pedestrian accidents.

Conclusion

The Department of Health is committed to reducing child trauma. We are committed to treating and caring for every child that enters our facilities. But that is not enough. This challenge is bigger than the Department of Health, and we cannot do this alone.

- We will have to work with all our partners to address the factors that lead to child trauma.
- We will have to address poverty, unemployment and inequality.
- We will have to address education, crime and violence.
- We will have to fight to keep our children safe

WE CAN ONLY ACHIEVE THIS IF WE WORK TOGETHER

References

Childsafe South Africa. (2019). Childsafe Annual Report 2018-2019. Cape Town: Childsafe South Africa.

Evans, J., Morden, E., Zinyakatira, N., Coetzee, D., Mgugudo-Sello, Z., Thompson, V., Dempers , J. (2018). Western Cape Injury Mortality Profile 2010-2016. Cape Town: Western Cape Department of Health.

Malek, E., & Goeieman, H. (2019). First 1000 Days Initiative as a key intervention to address childhood morbidity and mortality. Cape Town: Western Cape Government Health.

Mental Health Review Board Western Cape. (2019). Mental Health Review Board14th Annual Report. Cape Town: Western Cape Government-Health.

Miller, G. (2019). Trends in Child Murders in the Western Cape 1 April 2013 to 31 March 2018. Cape Town: Department of Social Development.

Western Cape Government Health. (2019, August 18). https://www.westerncape.gov.za/static/health-facilities/ . Retrieved from www.westerncpae.gov.za: https://www.westerncape.gov.za/static/health-facilities/

Additional Sources

Forensic Pathology Services
Ms. V Thompson, Mr. Michael Vismer. Prof Johan Dempers. Prof. L Martin
Childsafe South Africa
Professor S Van As
Red Cross War Memorial Children's Hospital
Dr A Parbhoo, Professor S Van As
Strategic Cluster
Ms. Erna Morden, Ms. V Petersen

STRENGTHENING PROTECTION OF CHILDREN THROUGH THE NATIONAL INTEGRATED CASE MANAGEMENT SYSTEM: A CASE OF SELECTED COUNCILS IN MAINLAND TANZANIA

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Introduction

The association between experienced childhood sexual violence and the increased risk of HIV infection has been well documented.(Chiang et al., 2015) There are over 23 million children in Tanzania – over half of the population, but until 2011, the extent and distribution of childhood sexual abuse was unknown. According to the United Republic of Tanzania(2017), there are an estimated 6.2 million Most Vulnerable Children (MVC) in Tanzania. In 2011, The United Republic of Tanzania responded to the United Nations Secretary General's (UNSG) World Report on Violence Against Children (VAC) call for action by becoming the first country in Africa to undertake, through a population based survey, a National Study on Violence Against Children that measures all forms of violence (sexual, physical and emotional) against both boys and girls-who are below age 18 years.(URT, 2011b)

Results from the VAC report revealed that 30% of girls and 13% of boys had experienced sexual violence, and over 70% of children had experienced physical violence (i.e. they were punched, whipped, kicked, and/or threatened with a weapon by relatives/authority figures e.g. teachers). Approximately 1 in 25 females age 13 to 17 years reported that they have been given money or goods in exchange for sex at least once in their lifetime. Nearly 6% of females have been physically forced to have sex before the age of 18. The health outcomes of sexual violence also revealed that over 6% of girls who were ever pregnant reported that at least one pregnancy was caused by sexual violence; 20% of girls reported having their first experience with some form of sexual violence when they were younger than 14 years old. Ten percent (10%) of girls reported that the perpetrator of at least one incident of sexual violence was a teacher. (URT, 2011a)

Data Analysis using DHIS2 for the period of October 2017-September 2018 reported a total of 20,036 (15,085 female and 4,951 male) documented cases of Gender-based Violence (GBV)/ Violence Against Children (VAC). According to PEPFAR, violence against children (VAC) is a public health and human rights crisis of global proportions, with damaging consequences to the health and well-being of individuals and their communities. (PEPFAR, 2018)

National Integrated Health Management System: a mechanism to combat VAC

In 2017 the USAID funded Community Health and Social Welfare Systems Strengthening Program (CHSSP) implemented by JSI Research & Training, Inc., in collaboration with the Government of Tanzania (GoT)**,** developed the National Integrated Case Management System (NICMS). The NICMS Framework, coordinates service providers working with children across the health, protection, and social welfare sectors, and was accepted as a standardized system and taken over by two GOT Ministries: the President's Office-Regional Administration and Local Government (PO-RALG), and the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC).

CHSSP incorporated the NICMS framework into the National Plan of Action to End Violence Against Women and Children (NPA-VAWC) training package to strengthen the violence against women and children committees (VAWACs). The VAWCCs are community structures within the Local Government Authorities under PO-RALG that advocate for prevention of GBV. The NPA-VAWC emphasizes the actions needed for both preventing and responding to violence and recognizes that investing in violence prevention initiatives has a positive impact on inclusive growth to achieving other development outcomes for children(URT, 2016). NPA-VAWC now ensures coordination and provides guidance on the identification, management, and referral of all categories of most vulnerable children/orphans and vulnerable children (MVC/OVC) and adolescents at risk of HIV exposure.

As Tanzania's first national integrated case management system, NICMS strengthens bi-directional referrals and linkages among social welfare, protection, and HIV clinical providers. NICMS has 9 approved data collection forms that CHSSP has helped develop and disseminate: *National MVC registration form; Screening and enrolment form; Child care plan form; HIV risk service and adherence form; National MVC referral form; National MVC monthly service tracking form; National MVC Monthly Summary Form; Graduation assessment form and Case closure form.* These data collection tools enabled 18,890 JSI-trained community case workers (CCWs) by 2019 to support orphans and vulnerable children/most-vulnerable children (OVC/MVC) data collection in 81 councils.

In 2018, the PO-RALG issued an official circular that emphasised all implementing partners to use NICMS data collection and reporting tools. This circular cited the importance of NICMS implementation at local government authority/council level. The circular mandates all councils, partners, and stakeholders supporting OVC/MVC to implement NICMS to strengthen data collection, reporting and sharing through the national database; improve functionality Violence against women and children protection committees (VAWC-PCs) and ensure specific budgets are set for VAWC-PCs activities.

Table 1 presents the Key Steps for the National Integrated Case Management System, and articulates which forms are used, what data is collected, and the measures taken by community case workers (CCWs) who are also social welfare assistants representatives in VAWC-PCs; to identify and serve protection cases for MVC and their families.

TABLE 3: KEY STEPS FOR THE NATIONAL INTEGRATED CASE MANAGEMENT SYSTEMS

Key Step	Case management	National Forms	National Tools	What Happens During this Step?
Step 1: Intake	Intake begins when someone notices a potential protection, health, or social welfare concern and brings it to the attention the CCW or LCCW. Anyone can notice a potential concern; it can be the LCCW or the CCW, a member of the Women and Children Protection Committee, a neighbour, village leader, and teachers or any concerned community member. Intake is the first step in the process of addressing a concern. *Key questions: Should the CCW refer to the* Women and Children Protection Committee*? Open a case? Or call the SWO?*	National MVC and Household Registration Form	– Registration Job Aid – Protection Triaging Job Aid – HIV Risk Triaging Job Aid	When a concern about a child comes to the attention of the CCW, there are three possible courses of action: The CCW decides it is possible to resolve the concern immediately without opening a case. They resolve the concern, fill out the National Registration Form, and do not open a case. The CCW may refer the child to the Women and Children Protection Committee for further assistance. The CCW decides that they need to open a case to start resolving the concern. They fill out the National Registration Form, open a case, and proceed to step 2 – assessment. The CCW realizes this is a Protection issue. They call the Social Welfare Officer (and if necessary, the Gender and Child Desk Police) The SWO opens a case and registers the child in the National Child Protection System. The protection case is managed by the SWO, not the CCW. However, the SWO may call upon the CCW for assistance.
Step 2: Assessment	The "**assessment** "is the way that the CCW learn more about the situation of the child and the family so that they can develop a care plan. The assessment explores both the strengths/resources of the child and family as well as their needs. *Key questions: What are*		Child Assessment Job Aid	The CCW conducts the assessment to learn more about the situation of the child and the family. This involves talking with the child and the caregiver, as well as other individuals who may be involved with the family.

	the strengths and resources of the child and the family? What are the challenges?			
Step 3: Developing a care plan	**Developing a care plan** that outlines the services and referrals the child and their family will receive. *Key questions: What services does the child and the family need? Where are those services located? How can the child or family access them?*	National Child assessment and Care Plan Form	Service Mapping Job Aid Local Service Directory[123]	The CCW develops a care plan. After they develop the care plan, the CCW talks to both the child and the family to make sure they have good information and understand what is supposed to happen next.
Step 4: Implementing the care plan	The CCW **implements the care plan.** Referrals are managed in collaboration with the relevant service providers and community case workers. *Key actions: Visit the child and family regularly to support them as needed to access services.*	National MVC Monthly Service Tracking Form	Service Mapping Job Aid Local Service Directory	During the implementation of the care plan, the CCW tries to make sure that the child and the family access all the services in the care plan. Implementation includes both services that the CCW can provide directly like home visits, psychosocial support - as well as referrals for other services at a health clinic, referral to join a savings group, parenting skills, etc. The CCW uses their Service Directory when making referrals. The Service Directory should always be up to date so that the CCW is providing good information to the family. During the implementation the CCW will continue to visit the child and the family. Depending on the concern the CCW may visit a few times a week, or a few times a month. The CCW records their visits in the National Monthly Tracking Form.

[123] 6This is a tool that is created, used, and updated by the CCWs

Step 5: Monitoring and Review	**Monitoring and Review** includes periodic review of the child's care plan through monthly case review sessions. *Key questions: Is the situation of the child and their family improving?*	National Monthly Summary Report Form	Case Review Sessions	CCWs meet to discuss and review their cases together with the LCCW. CCWs can help each other to decide if the care plan needs to be adjusted, or if additional services or actions are required.
Step 6: Case Closure	**Case closure** happens when the review concludes that all issues of concern regarding the child's welfare have been addressed or a case has been moved to another location or a child is has passed away. *Key question: Has the case plan goal been met?*	National Case Closure Form	Case Review Sessions	During a case review session, if the CCWs and LCCW feel that the concerns of the child and the family have been addressed, the case can be closed.

Source: URT(2017)

Results

Since 2017, CHSSP has trained over 15,560 volunteer Community Case workers (CCWs) order to strengthen and expand the social welfare workforce at the community level, and support VAWC committees. As a result, there have been significant achievements in the identification, linkages and referral of OVC in need of social protection and welfare supportive services. In 2018-19 CCWs have used the tools to record the identification of 1,089,785 OVC/MVC; of which 160,089 VAC/GBV cases were linked to VAWC-PCs, among them 14,900 referrals were completed.

Conclusion

Strengthening and coordinating social protection, health and welfare systems through NICMS and NPA-VAWC is a key step in eliminating, and mitigating, trauma amongst Tanzania's children. This strengthened system also provides a unique mechanism to addressing the HIV epidemic. Since inception, NICMS and NPA-VAWC have shown significant results by:

- Ensuring protection of children through **identification, coordination, management, and referrals** to various services in a coordinated manner.
- **Linking the NICMS** with the **NPA-VAWC** supports the 90-90-90 goals by identifying children, victims of abuse and violence, and other people who are at high risk of HIV infection and linking them to social protection and health systems.

References

Chiang, L. F., Chen, J., Gladden, M. R., Mercy, J. A., Kwesigabo, G., Mrisho, F., Dahlberg, L. L., Nyunt, M. Z., Brookmeyer, K. A., & Vagi, K. (2015). HIV and childhood sexual violence: Implications for sexual risk behaviors and HIV testing in Tanzania. *AIDS Education and Prevention*, *27*(5), 474–488. https://doi.org/10.1521/aeap.2015.27.5.474

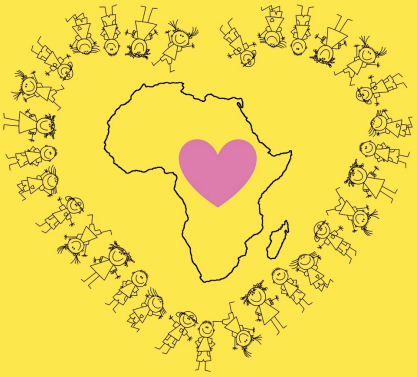
PEPFAR. (2018). *Accelerating Action To Address Violence Against Women and Children: Key Lessons From the Together for Girls Partnership in Tanzania*.

URT. (2011a). *Stopping Violence Against Children*.

URT. (2011b). *Violence Against Children in Tanzania*.

URT. (2016). *National Plan Of Action To End Violence Against Women And Children In Tanzania 2017/18 – 2021/22*.

URT. (2017). *National Integrated Case Management System Framework*.



The Charter: Leaving No Child Behind
Ending Violence Against Children in Africa

Adopted on 21 August 2019 on the occasion of "The African Regional Child Trauma Conference"

STATEMENT OF URGENCY

Projections of world populations indicate that by the year 2050, 40% of the world's births will occur on the African continent. This means that Africa will be home to 37% of the world's children. By the end of the 21st century, 40% of the world's population will live on the African continent (UNICEF 2014). Currently, African households have the highest child dependency ratio in the world. Life expectancy for African children has risen but is still shorter than the global average. Three in ten of Africa's children are currently living in fragile and conflict affected environments (UNICEF 2014), and this has a major influence on the violence against children and the continent.

The predictions for the quality of life for Africa's future are far from ideal. Policy interventions and implementation can still help create a better future and now is the time to effect the changes that will ensure a safer environment for Africa's children. No child should be left behind.

As actors in the field of preventing and responding to violence against children from the African continent gather in Cape Town in South Africa for the African Regional Child Trauma Conference, and recognising critical challenges of realising the Sustainable Development Goals, we recognise the significance of this time by:

CONSIDERING that the Constitution Act of the African Union recognizes the paramount importance of the promotion and protection of human and peoples' rights in accordance with the African Charter on Human and Peoples' Rights,

BEING CONSCIOUS that the African Charter on Human and People's Rights proclaimed and agreed that everyone is entitled to all the rights and freedoms recognized and guaranteed therein, without distinction of any kind such as age, race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status,

RECALLING that the African Charter and the Declaration on the Rights and Welfare of the Child recognise and reiterate the need to promote and uphold the best interest principle in all matters that affect children. At all times in all areas, to protect the rights and welfare of African child, including those that are affected by conflict, tension or strife.

BEING COGNISANT that the African Union adopted Agenda 2063 as a strategic development framework that aims to deliver on inclusive and sustainable development through the recognition of the need to have an Africa whose development is people-driven, relying on the potential offered by the African people, especially its women, youth, and caring for children. In addition, that the African Committee on the Rights and Welfare of the Child has adopted Agenda 2040 which focuses on children and youth as the drivers of Africa's Renaissance, and embraces the Sustainable Development Goals.

FURTHER RECOGNISING that Agenda 2063 identifies that the Sustainable Development Goals can be harnessed by human rights bodies to promote and protect the rights of the children,

NOTING WITH CONCERN that the situation of most African children remains critical due to the unique factors of their socio-economic and developmental circumstances, natural disasters, armed conflicts, exploitation and hunger, and that as children they need special safeguards and care,

RECOGNISING that children occupy a unique and privileged position in African societies and that for the full and harmonious development of their personalities, children should grow up in an environment of happiness, love and understanding,

RECOGNISING that children require particular care with regards to health, physical, mental, moral and social development and are entitled to legal and political protection in conditions of freedom, dignity and security,

TAKING INTO CONSIDERATION the virtues of the cultural heritage, historical background and the values of the African civilisation and traditions which should inspire and characterise the rights and welfare of children,

CONSIDERING that the promotion and protection of the rights and welfare of children also implies the performance of duties on the part of everyone,

REAFFIRMING ADHERENCE to the principles of the rights and welfare of the child contained in the declaration, treaties, conventions and other instruments of the African Union and the United Nations, and in particular the United Nations Convention on the Rights of the Child; and the OAU Heads of State and Government's Declaration on the Rights and Welfare of the African Child.

PATHWAYS

We the signatories of the charter, '*The Leaving No Child Behind: Ending Violence Against Children in Africa Charter'*, call upon inter-country regional networks, national, sub-national and local governments and non-state actors to upscale action that will accelerate efforts towards ending violence/trauma against African children by committing to the following:

1) Preventing violence against children in Africa by going back to our roots

Addressing the interwoven issues of poverty, deprivation, abandonment of babies, violence in homes, schools and communities, hunger and malnutrition, substance abuse, and a host of other issues that lead to trauma in the lives of children and adults. Specifically, we call for expansion of parenting programmes that include the involvement of fathers, social mobilisation across religious, traditional and educational institutions and youth communities, and early interventions packages for child care services. Reinforcing and rebuilding the ethos of UBUNTU in order to emphasise collective responsibility for children remains an essential component of prevention. Prevention needs to start at the perinatal level and should incorporate relational support for all.

2) Preventing and responding to the many faces of intergenerational trauma in Africa:

Breaking the cycle of intergenerational trauma involves recognising and addressing each generation's traumatic experiences. Traumatic experiences range from gang violence to war, systemic abuse and exploitation, community trauma and person-centred trauma. Treatment and research should be prioritised to increase the understanding of these phenomena and to generate effective response mechanisms. Perinatal and child services around the mother-father-infant triad are critical and need to be redesigned.

3) Promoting positive discipline as a strategy and lobbying for the elimination of corporal punishment in Africa:

A key factor in supporting vulnerable children is building positive relationships – between children and caregivers, between families and childcare institutions, between all sectors providing services and between institutions and law makers. Positive relationships are informed by positive discipline to help children solve problems, manage conflict and mediation without resorting to violence. Efforts should be made to internalise positive discipline practises by caregivers, and harsh corporal punishment should no longer have a place in homes, schools or other child environments.

4) Regulating the online environment and educating children and their caretakers in online rights and responsibilities

The online environment and how it is used by children needs to be regulated by legislative and non-legislative measures. Children and their caretakers have the right to be equipped with knowledge and tools for making online environments safer so that they can respond when they encounter

inappropriate and dangerous content and contacts in order to prevent unhealthy conduct and exploitation. Laws should not only be clear, but also have the mandate and resources to act swiftly and effectively.

5) Preventing and dealing with the disadvantages associated with poverty and the layers of exploitation of children
Break the cycle of vulnerability by providing access to a holistic suite of sustainable support services which underpin the basic rights of children and families. Paying particular attention to the vulnerabilities that poverty creates such as child exploitation and labour. Reframing our current view on the experiences of poverty-stricken young people within their context and creating empowering opportunities to enable them to become active and citizens.

6) Preventing the involvement of African children in armed conflict: including war and gang violence
There is alarming evidence of the trauma inflicted on children in armed conflict. This is seen in the recruitment of children to fight or support armed groups, killing or maiming of children, attacks on schools or hospitals, abduction, and sexual and psychological violence. Children who are both victims and/or compelled into perpetrating violence need help to deal with their traumatic experiences. Timeous provision of basic documentation is required for children on the move to access the resources and services that fast track their homogenisation into society.

7) Prioritising the protection of children marginalised by disabilities
Educate communities to reduce the stigma of disability and champion the inclusion of children with disabilities to participate in all aspects of society. Prioritise access to justice through applying immediate procedural accommodation within all components of the justice system. Providing structures to support and educate families with children with disabilities in order to enable these children to reach their best potential.

8) Providing appropriate responses to children affected by all forms of sexual violence, including interventions for children, families and communities
Sexual violence against children is widespread and this impacts on the health, psychological wellbeing and future relationships of children. Children are abused and exploited by adults as well as other children. This abuse may be direct or indirect and children remain particularly vulnerable to suffer sexual exploitation, such as slavery, forced and early marriages and pregnancies, rape and compelled prostitution. Growing evidence shows the extent of boys experiencing sexual abuse, but the lack of response services and cultural norms silence these experiences, which render the abuse invisible. Rape culture and the socially sanctioned deviance of sport and boundary blurring needs to be debunked. Children should be given the vocabulary and mechanisms to recognise and report the abuse.

9) Providing multi-faceted approaches to dealing with children in conflict with the law
By creating safe and nurturing environments for children we will reduce the risk of children in conflict with the law. To realise a reduction in crime committed by children and youth, prevention is recognised as a strategy to avoid children coming into conflict with the law rather than intervening when it is too late. When intervention is the only available option, holistic approaches inclusive of evidence-based diversion programmes should be implemented. It should be ensured that child recipients of an intervention are not placed back into an unchanged environment.

10) Developing strategies for coordinating and integrating interventions and knowledge for preventing and responding to child trauma
Preventing and responding to violence against children requires trans-sectoral collaboration. All stakeholders of regional networks, government, civil society and communities need to co-ordinate efforts and share resources to ensure effective service delivery to children. Professionals from all disciplines should collaborate in ensuring integrated and coherent strategies and programmes. Access to psychological support, well-ness programmes, and self-care are essential for professionals at risk of secondary trauma. A clearing house for evidence-based programmes that have relevance in African contexts is required to enable the sharing and dissemination of knowledge and best practice.

We the signatories of the charter, '**Leaving No Child Behind - Ending Violence Against Children in Africa'** present this Charter to the heads of State of the African Union and United Nations General Assembly and Secretary General by way of elevating the rights of the African child in the global discourse.

Name:……..

Designation: …….

Representing (organisation):……..

Country: …….

Email: ……..

Signature……