GUEST EDITORIAL

Tackling child abuse and neglect in South Africa

Child abuse is disturbingly common in South Africa (SA). As such, it presents an outrageous scourge that calls for greater attention, skills, resources and political support. Also termed 'maltreatment', health professionals need to know how to deal with it better. 'Maltreatment is one of the biggest paediatric public health challenges, yet any research activity is dwarfed by work on more established childhood ills.'[1]

This knowledge/practice gap is compounded by another deficit, namely the need for more effective national collaboration between the departments of Social Development (DSD) and Health regarding integrated systems for data and service provision. Regarding allegations of child maltreatment, the Children's Act No. 38 of 2005[2] requires the DSD to record the child's name, perpetrator's name and type(s) of abuse committed against the child in the National Child Protection Register. Despite the fact that digital online open access to an up-to-date national list of paedophiles is standard practice in the developed world, in SA this is not yet in place. Furthermore, widespread resistance to the use of this specific term/identifier has resulted in the DSD referring more generically to 'perpetrators' instead.

Significantly, the Child Protection Register relies upon the submission of Form 22 for the initial report of alleged maltreatment, followed by Form 23. The latter must be completed by a registered social worker or specified professional and confirms that maltreatment is verified/proven. Note that health professionals are legally obliged to complete and submit Form 22 whenever abuse is suspected. However, hospital cases via dental or medical/surgical units are not always reported, revealing a major shortcoming in our national professional standards.

This is particularly concerning, as Mathews and Martin's[3] analysis of fatal child abuse and associated injury patterns reveals that the greatest burden of fatal child abuse and neglect was found among the under-1-year-old group. Abandonment at birth was most common, followed by blunt force injuries and strangulation/asphyxiation deaths. Their article presents the findings from 707 cases analysed by child death review teams at two SA pilot sites during 2014. It also describes necessary components for the efficient functioning of these teams and reflects on their feasibility within the SA setting to strengthen identification of child abuse deaths and to influence practice. In conclusion, they emphasise the importance of prioritising prevention efforts to break the cycle of child maltreatment, especially at home.

Linking directly with this concern, Turner and Honikman[4] provide insightful guidance regarding the assessment of, and care for, maternal mental health within the first 1 000 days. Approaching the mother/caregiver and infant/child as a dyad, their evidence-based directives for identification and treatment of common mental disorders are firmly grounded within the realities of the SA context. This is further enhanced by their deep understanding of the necessity of good-quality perinatal mental healthcare. Their valuable contribution provides clear information and other tools for practice.

The issue of child rights and national efforts to strengthen prevention and responses to violence against children is taken up by Lake and Jamieson.[5] They provide an expert outline of patterns of violence towards children, risks, effects and protective factors before moving to a detailed discussion of key implications for healthcare practice. Specific and practical, they include key referral resources and clear guidance about what could and should be prioritised, including future advocacy initiatives.

Importantly, and in line with qualitative findings the world over, violated patients most need a human being on the other side of the clinical encounter. Whether adult or child, female or male, patients miss the attending clinician's acknowledgement that they have survived a horrific experience. They need reassurance that their traumatised reactions are a normal response to abnormal events. In conclusion, this edition of CME aims to further enhance health professionals' skills and knowledge so as to be better equipped to bring perpetrators to book as well as to care more effectively for traumatised children and their families.

Kate Joyner
Division of Nursing, Department of Interdisciplinary Health Sciences, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa
katejoyner.kj@gmail.com

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