

CHAPTER 8

Understanding and protecting the rights of children



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Outcomes

At the end of this chapter you will be able to:

- Understand the need to create a human rights culture to counter the negative effect of violence on children
- Understand the legislation passed and pending in South Africa to protect the rights of children
- Identify the different types of child abuse and neglect
- Understand the role of the health professional in court
- Understand special types of children in need of care
- Identify the effects and signs of abuse of the most commonly abused substances
- Know the procedure for handling a child dependent on drugs.

8.1

The effect of violence on children

8.1.1 Introduction

The prevalence of violence in South Africa has a particularly devastating effect on children.

The young adults of today grew up in the worst of the political violence of the late apartheid period, in which state violence brutalised them from an early age, and brutalised the adults in their lives. At a very early age, the youth were themselves involved actively in the struggle, and became accustomed to the use of violence to resolve the political conflict in South Africa.

8.1.2 Broken homes and disrupted families encourage violence

These young people grew up in homes that were disrupted by the economic exploitation and social segregation of the apartheid years. This meant extreme poverty, overcrowding and broken homes. General crime in poverty stricken areas is high as people jostle for scarce resources and tolerance levels are low. With no effective police services to protect people and create a community in which crime is unacceptable and curbed by authority, violence flourishes.

Broken homes and broken cultural ties means that children grow up with insecurity, with unclear patterns of behaviour and a lack of consistent rules. Family relationships tend to be confused and children may not learn the early bonding and emotional attachments that foster awareness of the pain of others. Without this emotional awareness, respect for human rights is meaningless.

Many of these bruised young people are the young offenders of today, perpetuating the climate of violence which moulded their own childhood experience.

8.1.3 Poverty continues to breed violence

Despite the enormous political changes of 1994, the children of today are still living in conditions in which violence thrives. Children are at great risk, along with other vulnerable groups, such as women, the elderly and the disabled.

Poverty is as abject as ever. The overcrowding in urban squatter settlements means that privacy and safety are severely compromised. The fate of children is intimately linked with the domestic scene in which women are commonly raped, abused and mistreated. Domestic violence impacts on children in that they suffer both physical and emotional harm from living with violence. Abusers frequently use the children as pawns to control the other parent.



BROKEN ENVIRONMENT

Broken homes and broken cultural ties means that children grow up with insecurity, with unclear patterns of behaviour and a lack of consistent rules.

Township lament

The sad state of affairs is reflected in this township resident's lament:

"When you leave your child alone in the home, she is not safe.

And in the street, she is not safe.

And in the school, she is not safe.

There is nowhere that she can walk and be safe.

Girls are afraid somebody in a car will stop them and say 'get in'.

When they walk in the street they are raped by men with guns.

Sexual abuse happens so much that some students stop going to school."

'Rape' or sodomising of boys

The 'rape' or sodomising of young boys is also more frequent than is commonly realised. Stereotypes of manhood prevent men from reporting these crimes due to the myth that men do not get 'raped' or battered. Psychologists maintain that uncounselled victims of this type of violence are not able to deal with their pain and anger and may, as a result, develop self-destructive or abusive behaviour patterns.



Children are brutalised by the violence around them, and are themselves the targets of abuse when their own human rights are violated. This refers particularly to their rights to equality, physical integrity, freedom and security. Children's rights are human rights.

8.2

Creating a human rights culture

The response globally to such violence has been to raise awareness of the widespread abuse of the rights of children in international forums and conventions.

International instruments relating to children

Until 1945 international law did not concern itself significantly with the rights of individual citizens of nation states. It was only in the aftermath of the Second World War that these issues came to be addressed in a significant way in international law. The key document that encapsulated this shift was the Universal Declaration of



8.2.1

RIGHTS OF INDIVIDUALS

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INTERNATIONAL DECLARATIONS

- *Universal Declaration of Human rights 1948*
- *Declaration of the Rights of the Child 1959*
- *UN Convention on the Rights of the Child 1989*
- *African Charter of the Rights and Welfare of the child 1999*

Human Rights adopted immediately after the War on 10 December 1948. The first international document on the rights of the child followed in 1959 when the General Assembly proclaimed the Declaration of the Rights of the Child, consisting of ten basic principles.

Thereafter, some 30 years later, the rights of the child were specifically recognised by international law in the United Nations Convention on the Rights of the Child (1989) which South Africa has signed and ratified.

This Convention provides that children have a right to be protected from all forms of neglect, cruelty and exploitation. The Convention goes beyond the earlier Declaration in that it establishes a Committee on the Rights of the Child to examine the progress made by States in achieving the realisation of the obligations undertaken in the Convention.

CHILD-CENTRED

best interests

right to opinion

protection from abuse

special assistance

special care for the disabled

promotion of health

protection from drugs

care of child victims

The United Nations Convention on the Rights of the Child (1989)

Article 3: The best interests of the child are to prevail in all legal and administrative decisions.

Article 12: Children have the right to express an opinion on matters affecting the child and to have that opinion heard.

Article 19: The State must protect children from all forms of abuse, neglect and exploitation by parents or others, and undertake preventive and treatment programmes in this regard.

Article 20: Children have the right to receive special protection and assistance from the State when deprived of a family environment and to be provided with alternative care.

Article 23: Disabled children have the right to special care and training designed to help achieve self-reliance and a full and decent life in society.

Article 24: Children have the right to the highest attainable standard of health and access to medical services.

Article 33: The State must protect children from illegal narcotic and psychotropic drugs and from involvement in their production or distribution.

Article 39: The State must promote the physical and psychological recovery and social reintegration of child victims of abuse, neglect, exploitation, torture or armed conflict.

More than fifty years later, closely coinciding with the tenth anniversary of the United Nations Convention on the Rights of the Child, in November 1999, Africa bore witness to the coming into operation of The African Charter of the Rights and Welfare of the Child.

This has been hailed as signaling a new era in the protection and promotion of children's rights in Africa. It is the first regional treaty on the rights of the child in the world.

The preamble of the African Children's Charter calls upon the member states, in fulfilling obligations under the Charter, to take into consideration the virtues of their cultural heritage, historical background and the values of African civilisation, which should inspire and characterise their reflection on the concept of the rights and welfare of the child.

The Charter does not define 'African values'. It also does not impose more obligations than a country already has in terms of the Convention on the Rights of the Child. The Charter is thus a restatement of existing international human rights law on the rights of the child, in an African context.

As a fully-fledged member state (which ratified the treaty in the National Assembly and the National Council of Provinces, in January 2000), South Africa can now participate in its monitoring structures.



THE AFRICAN CHILDREN'S CHARTER

The African Children's Charter is a restatement of existing international human rights law on the rights of the child, in an African context.

Violence against children: internationally outlawed

International law sends a clear message that violence against children is unacceptable and provides a guide to nations as to what the rights of children are and how the children of the world should be treated.

The question that remains is whether the international guidelines can have any real impact on the lives of children.

8.3

South Africa's response

South Africa has been an active player internationally in speaking on behalf of children's rights. When political change came to South Africa, the concern for human rights and children's rights found expression in the Constitution of 1996, with its Bill of Rights.

The Constitution of South Africa provides the fundamental framework for the protection of all its people, and gives special protection to the child.



AN ACTIVE PLAYER

South Africa has been an active player internationally in speaking on behalf of children's rights.

Definition

A CHILD

The Constitution defines the child as a person under the age of 18 years.

Who is a child?

The Constitution defines the child as a person under the age of 18 years. This vulnerable group includes the infant (under 2 years), the pre-school child (under 6 years), the pre-adolescent child (under 12 years), the adolescent child (under 15 years) and the emerging teenager (under 18 years). As a result of the changes that are occurring so rapidly in the maturation of the child during these first 18 years, special care is needed at times in dealing with each age subgroup. [See pg 268]

What the SA Bill of Rights says

The special rights accorded to children are found in Section 28 of the Bill of Rights. The most important provisions are:

- At all times the 'child's best interests' is the guiding principle in any situation or procedure. This means that the child's needs in terms of its age and maturity inform all decisions, treatment options and procedures, at all times
- Every child has the right to basic nutrition, shelter, basic health care services and social services
- Every child has the right to be protected from maltreatment, neglect, abuse or degradation
- Every child has the right not to be detained (imprisoned) unless there is no alternative.

If detention does occur, the child has additional safeguards:

- The child may be detained only for the shortest appropriate period of time
- The child has the right to be kept separately from detained persons over the age of 18 years
- The child must be treated in a manner and kept in conditions that take account of the child's age.

With such clear principles coming from international law and the Constitution of South Africa, the next challenge is to ensure that the common law and national legislation incorporates these principles and creates mechanisms (and services) to enforce and protect these rights.

Entitled to shelter

[**Grootboom and others v Government of SA and others 2000 (I) SA 46 (CC)**]

Mrs Grootboom was one of a group of 510 children and 390 adults living in appalling circumstances in Wallacedene informal settlement. The group then illegally occupied nearby land earmarked for low-cost housing but were forcibly evicted by the Cape Provincial government. Their shacks were bulldozed and burnt and their possessions destroyed. Their places in Wallacedene had been filled and in desperation they settled on the sports-field and in an adjacent community hall.

The Constitutional Court found that the children, and through them, their parents, were entitled to shelter under Section 28 (1)(c), and ordered the various levels of government to provide them with tents, portable latrines and a regular supply of water by way of minimal shelter.



1. What arguments could be made on behalf of the Cape Provincial government?
2. What arguments could be made on behalf of the homeless children and adults?
3. If you were the judge what would your judgement be?



8.4

National law and legislation

According to law, the High Court is the upper guardian of the child, when parents or guardians, its normal custodians, cannot adequately provide a safety network. The family justice system, the police, the social services and the health services are needed collectively to form the web of safety required to support and protect the child. A multidisciplinary approach, with all sectors working together at protection, healing, prevention and enforcement, is clearly called for in order to give expression to the true intent of the international conventions and the Constitution.

The health services have a specially important role to play when the child is in distress through violence or trauma. This role is caring, healing, advising, and additionally, in providing the medico-legal evidence that will enable the rights of the child to be enforced.

The Child Care Act, 1983 (as amended)

The critical national legislation that affects children is the Child Care Act and its many amendments, the most recent of which was in 1999.



WEB OF SAFETY

The family justice system, the police, the social services and the health services are needed collectively to form the web of safety required to support and protect the child.

8.4.1

This Act deals with the protection of the child when parents are unable or unfit to do so, the role of the children's court, and the role of the police and welfare officers in the protection of children. It also deals with substitute care, in the form of institutional care, foster care and adoption. It imposes a duty to report child abuse and covers the issue of consent to medical treatment of children. [See pg 87]

8.4.2

Proposed Child Justice Act

The proposed Child Justice Act will close a huge gap in the Child Care Act in that it will specifically deal with the sentencing, treatment and detention of children who are alleged to have, or have committed criminal offences. The legislation aims to give substance to the principles enunciated in the Constitution's Bill of Rights. [Section 28]

8.4.3

The Sexual Offences Act, 1957

The Sexual Offences Act defines the various sexual offences and stipulates the age of consent for sexual intercourse, which is different for males and females. A girl below 16 and a boy below 19 years of age cannot give consent to sexual intercourse, and thus sexual intercourse of this kind is an offence. This law is being reviewed.

The Act also defines mental incapacity which precludes consent if the alleged perpetrator could or should have known of the mental incapacity of the partner to consent to sexual intercourse. The definitions of mental incapacity are seriously outdated and this Act is currently under review.



CONSENT

A girl below 16 and a boy below 19 years of age cannot give consent to sexual intercourse.

8.5

Child Abuse in perspective

Today, in both developing and industrialised countries, practitioners, researchers and activists continue to struggle to raise awareness of the wide range of abuses suffered by children and to advocate appropriate responses. Many of the manifestations of maltreatment inflicted upon children within families show striking similarities across cultures worldwide, as do links with parental behaviour such as domestic violence, substance abuse, mental illness and attitudes to punishment. However, much of the misery experienced by children in the world is precipitated by events largely outside the control of their families, including the effects of trade, debt and aid policies, and most devastating of all the consequences of armed conflict.



Maltreatment inflicted upon children within families show striking similarities across cultures world wide.

Violence against children in SA

In South Africa, the magnitude of the violence against children is evident in the statistics compiled by the Child Protection Unit of the SAPS for the period January-June 1998. This may be only the tip of the iceberg as many of these cases go unreported because of fear or intimidation.

Offences:

Sexual offences (including rape)	9 661
Attempted murder	4 099
Abduction	1 115
Other offences	2 539

Children in substitute care:

Foster children	70 000
Residential care	15 000

[Source: *Human Rights, Advocacy and Victim Empowerment: Dept of Social Development, June 2000*]

What is child abuse?

Child abuse refers to the maltreatment of children that results in harm or potential risk of harm to a child, usually of a physical, emotional or sexual nature. Because of the conditions of poverty and dislocation [See pg 186], children are at great risk of being targets of violence. The violence may be in the form of general criminal violence from gangster activity that plagues poverty stricken areas, or may be specifically targeted at the child because of its vulnerability. This latter is known specifically as child abuse.

The primary responsibility for the well-being of children rests with

8.5.1

Definition

CHILD ABUSE

Child abuse refers to the maltreatment of children that results in harm or potential risk of harm to a child, usually of a physical, emotional or sexual nature.



DISCIPLINE

Parents have a right and duty to discipline their children and to correct their behaviour, but this should be done without resorting to violence.

their parents or guardians. There are times when they fail in that responsibility, and intervention by the state becomes necessary (through the health services, social services, the police and the court).

Do parents have the right to discipline their children physically?

Because there is a strong tradition among many cultures (and religions) to punish children physically, either using a hand, wooden spoon, belt or stick, many parents believe this is an inherent right.

Parents have a right and duty to discipline their children and to correct their behaviour, but this should be done without resorting to violence. There are today positive systems of discipline that give parents creative ways of relating to their children, communicating with children, and enforcing limits and rules through applying logical consequences. With these techniques, parents can be equipped to discipline their children without the need to resort to corporal punishment.

However, there is still a traditional view that parents have the right to punish their children physically. There is a thin line between corporal punishment and child abuse, and this line is becoming thinner every day. The parent who goes beyond what is reasonable (or acts out of spite) may be sued civilly and charged criminally with child abuse. This is an example of the way the rights contained in the Constitution apply not only between the state and the individual, but between individuals.

There is no right of physical punishment (chastisement) given to educators. South African courts have determined that parents cannot delegate this right to educators. It has also been outlawed by legislation.



TALKING POINT

The case of corporal punishment

[*Christian Education SA v Minister of Education 2000 (4) SA 757 (CC)*]

In April 2000 a voluntary association of 196 independent Christian schools appealed to the Constitutional Court against the Department of Education's prohibition of corporal punishment in all schools. The Christian Schools claimed that by prohibiting corporal punishment in all schools, Parliament had unconstitutionally limited the religious rights of parents of children in independent schools. In line with their religious convictions, these parents had consented to 'corporal correction' of their children by teachers.



1. If you were representing the Christian Schools, what would your arguments be?
2. If you were representing the Minister of Education, what would your arguments be?
3. If you were judges hearing the case, what would your judgment be?

8.6

Characteristics of child abuse and neglect

Health professionals classify the different types of child abuse as follows: physical abuse, sexual abuse, emotional abuse and neglect.

Physical abuse

This is the commission of intentional injury, such as burning, beating, whipping, punching, drowning, kicking or biting. The abuse may be a single episode, which may even result in death; or repeated episodes of violence. This type of physical abuse usually affects the infant or pre-school child, and is known as the battered child syndrome.

Sexual abuse

Sexual abuse may be of a contact or non-contact nature. Contact behaviour includes fondling the child's breasts, genital area, inner thighs, buttocks; oral-genital contact; penetration of the vagina, anus or rectal opening by a finger, object or penis. Non-contact behaviour includes exposure by the adult of their genitals; masturbation by the adult in front of the child; showing the child pornographic material etc.

Emotional abuse

This type of abuse has two components: physical neglect and psychological assault.

Psychological abuse includes verbal lashings, degrading the child, or subjecting the child to constant insults, threats and fear. It also includes locking up the child in a small space, or tying the child in any way that confines movement for a protracted period, for example, tying the child to a bedpost so that it can only move in a small radius around the bed.

Neglect

This type of abuse occurs when the parent, guardian or person who has custody of the child does not look after them properly.

Physical neglect means depriving the child of the essential care that is required for normal growth and development, such as food, clothing, shelter, medical or educational needs. This is only applicable to the extent that parents or guardians have the means to satisfy these basic needs and are doing their best to satisfy the child's needs.

8.6.1

8.6.2

8.6.3

Definition

PHYSICAL ABUSE

This is the commission of intentional injury.

SEXUAL ABUSE

Sexual abuse may be of a contact or non-contact nature.

8.6.4

EMOTIONAL ABUSE

Emotional abuse can take the form of physical neglect or psychological assault.

NEGLECT

Neglect means failure to look after and care for the child properly.

Prevention and early detection of child abuse

PREVENTION

PRIMARY LEVEL

- Normal awareness

SECONDARY LEVEL

- High risk children

TERTIARY LEVEL

- Victim assistance

8.7.1 Prevention programmes

It is important for professionals to know that there are prevention programmes that assist in the prevention of child abuse. These operate at three levels:

- The primary level – the aim at this level is to raise awareness in the child about its body and what is normal behaviour.
- The secondary level – the focus at this level is on high risk children, that is, children who have already been exposed to abusive situations.
- The tertiary level – the aim is to assist victims to gain some control over their lives and feel more confident and assertive.

These programmes are conducted by social workers in schools, although not on a systematic basis. Programmes can also be held for groups of parents to equip them to talk to their children from an early age about keeping themselves safe, and to introduce protective behaviours.

8.7.2 Early detection

Early detection is concerned with knowing the different types of abuse and being alert to the signs and symptoms of abuse. Signs should never be seen in isolation, but as part of a holistic picture of the child and its circumstances. The suspicions of a health care professional should always be communicated to a social worker.

8.7.2.1 How to recognise physical abuse

Physical signs

- bruises
- abrasions, lacerations, welts, and the resultant scars
- cuts in inappropriate places
- bite marks
- burns, especially cigarette burn marks
- black eyes
- injuries to the bones
- internal injuries

8.7.2.1.2 Behavioural and emotional signs

- mistrust of adults: the child tends to be totally self-reliant and to be silent even when it hurts itself
- extremes in behaviour (excessively aggressive or withdrawn)
- watchfulness: the child is noticeably suspicious of the environment, especially of sudden movements into its personal space
- attention seeking (in the absence of the abuser)

- harbouring of deep negative feelings (anxiety, fear, anger, hatred: directed and misdirected).

The battered child syndrome

The battered child syndrome or non-accidental injury syndrome is especially important to recognise. This is a specific syndrome of repetitive, deliberate infliction of injury, usually done by the person(s) responsible for the care of the child. It is seen in young children who are particularly vulnerable to injury. They are usually unable to express themselves verbally. There is often a deliberate attempt to mislead or to cover-up the true nature of the origin of the injuries by the person responsible.

Family Profile

The family background in such cases involves relatively young children who have immature parents who tend to be aggressive and neurotic. In many instances the parents themselves were battered as children. There may also be abuse of alcohol and/or drugs by one or both of the parents. The children tend to be restless and cry continuously. They are seen to be fidgety, constantly soiling or wetting themselves and demanding attention. Parents tend to get increasingly frustrated and resort to violence against these children. Such children display evidence of poor care and may look fearful, withdrawn or depressed. Older children display behavioural and emotional problems.

It is important to diagnose cases of child abuse. Research indicates that 60% of these children are liable to further injuries or death, if not followed up and 10% will eventually receive fatal injuries.

[Source: McQuoid-Mason and Dada *Guide to Forensic Medicine & Medical Law* (2000)]



Such children display evidence of poor care and may look fearful, withdrawn or depressed.

How to recognise sexual abuse

[See Collection of medico-legal evidence, pgs 282-283]

Physical Signs

Physical signs include:

- sexually transmitted diseases
- vaginal and penile infections
- foul-smelling discharge
- blood, pain, itching in the genital area
- tearing in the genital area
- difficulty walking, for no apparent reason.

These physical signs are often consequences of sexual abuse and should be seen as indicators in a bigger picture. Other medico-legal evidence will be collected when the episode of abuse has occurred very recently.

Behavioural and emotional signs

Behavioural and emotional signs include:

- strong negative feelings, such as anger, depression, anxiety and guilt

8.7.2.2

8.7.2.2.1

8.7.2.2.2

- aggressive behaviour, towards other children, objects, sometimes towards animals
- disturbed eating patterns
- disturbed sleeping habits, commonly with nightmares
- bed wetting or soiling
- hurting themselves
- sexual acting-out behaviours
- serious changes in school attendance and/or performance.

The pre-school victim of sexual abuse may typically also manifest these signs:

- excessive crying and clinging behaviour
- regression to more babyish habits of an earlier age, such as thumb sucking
- sexual knowledge inappropriate to the child's age, such as showing knowledge of sexual language and sexual behaviour; this may manifest in play with toys or other children.



TALKING POINT

Signs of sexual abuse

The children in the pre-school room are sitting at the table with their caregivers, eating lunch. Nancy (3 and a half years old) is wiggling around in her seat a lot. The caregiver asks her if she needs to go to the bathroom. Nancy says, "No, it's not that. My bottom hurts where Gary poked me." Gary is her 15-year-old brother.



- Does the above indicate sexual abuse? Why or why not?

8.7.2.3

How to recognise emotional abuse

8.7.2.3.1

Physical signs (in cases of extreme neglect)

- skin sores
- lack of personal hygiene
- unkempt appearance
- kwashiokor (malnutrition).

8.7.2.3.2

Behavioural and emotional signs

Behavioural and emotional signs include:

- extremes of behaviour (excessively withdrawn or disruptive)
- role confusion (taking on excessive responsibility, inappropriate for age and position in the home)
- attention seeking
- inability to make or keep friends
- failure to cope at school
- low self-esteem (strong negative feelings about the self).

Emotional abuse is a subtle form of abuse, the effects of which usually only become evident in adolescence or during the teen years.



Emotional abuse is a subtle form of abuse, the effects of which usually only become evident in adolescence or during the teen years.

Signs of emotional abuse

Martina, a social worker, is making her first home visit to the Peterson family: Mrs Peterson and her three young children. She rings the door bell and waits a long time for Mrs Peterson to come to the door. She can hear lots of noise inside the apartment: loud music, adults arguing, and children crying. She rings the bell again, thinking that perhaps they did not hear her. Finally, the door opens and a man pushes his way past her. She looks inside and sees Mrs Peterson bent over and holding her stomach. The three children are standing in the kitchen doorway holding onto each other. They look very scared, but they are not crying.



TALKING POINT

- If you were Martina what would you do?



8.8

Effective handling of child abuse

Guidelines for handling child abuse

(with special emphasis on sexual abuse)

1. Effective handling of child abuse requires an understanding of the context in which violence occurs in the different communities of South Africa.

CONTINUED



AGE AND MATURITY

The professional must take into account the age group and maturity of the child.



CONSEQUENCES

The consequences of disclosure can turn the family upside down and bring additional economic hardship to them.

REASONS FOR NON-DISCLOSURE

- Fear of consequences
- Self-blame
- Lack of awareness
- Difficulty in talking about it

2. The skills and techniques of interviewing and counselling, especially as appropriate to different age groups, must be borne in mind. [See pgs 141-142]
3. The most important rights of the child are that:
 - the best interests of the child are of paramount importance at all times and in all decisions that affect the child
 - children have the right to express their opinions in all matters affecting them, and
 - children's rights to their own culture and religion should be respected.
4. Effective handling means that the professional takes into account the age group and maturity of the child.
5. The professional should understand the behavioural and emotional state of the child victim and recognise the kinds of thoughts and feelings victims tend to have about what has happened. Child victims of sexual abuse may think that they are responsible for the abuse; that they are dirty; and, most of all that they do not deserve other people's love.
6. The professional needs to understand the confusing, anxiety-provoking situation of the child, when the alleged perpetrator is a close member of the family. She/he will sometimes be intimidated by the perpetrator or otherwise cajoled into keeping the abuse as 'their special secret'. The child probably loves the alleged perpetrator, but would like the abuse to stop. She/he will be confused by the mother's going along with the situation because of the parent's own dilemmas and needs. She/he may feel isolated and lost because of the split in the family and often because no one will believe the child. Although children will not understand the consequences of the disclosure, they will be apprehensive of what will happen. The anxiety is justified as the consequences will turn the family upside down, and usually bring additional economic hardship to them.

8.8.1

The process of disclosure

Telling someone about the experience of abuse is itself a traumatic experience, for both the child and the adult survivor. Research shows that the vast majority of survivors deny the abuse when first questioned about it. In general, the reasons survivors do not disclose abuse are: fear of the consequences, self-blame, lack of awareness, and difficulty in talking about the abuse.

It has also been observed that some children will disclose the abuse tentatively, thus they may describe the abuse and then dismiss the event or minimise it (e.g. "It only happened once"). Also common is for some children to withdraw their story and later reaffirm it. This is especially likely if the alleged perpetrator is a close family member. Research into disclosure by different age groups reveals that school-

age children (pre-adolescents) showed no real tendency to disclose whether on purpose or by accident. Pre-school children were more likely to disclose accidentally, and adolescents were more likely to disclose purposefully. Researchers conclude that *disclosure of child sexual abuse is a process, not an event. Talking to a child survivor about abuse is thus a specialised activity.*

8.9

The role of the health professional

Handling child abuse is a multidisciplinary effort, shared with social workers, the police and the courts. The role of the health professional is to care for the child, collect evidence and to report the allegation.

Caring for the child victim

DO'S

In order to help the child, it is important to:

- Believe the child
- Tell the child it was NOT their fault
- Tell the child that together you will try to solve the problem
- Help to raise the self-esteem of the child
- Know and act on the fact that child abuse rarely stops without intervention
- Talk to the child in a quiet, private and friendly environment
- Use the techniques of counselling, especially as regards the special needs of children (toys, play, creative media, role-play)
- Concentrate on the feelings and needs of the child
- Listen for feelings, both obvious ones and deeper ones
- Take time and don't interrupt [See pgs 141-142]

DON'TS

It will NOT help the child if professionals:

- Make promises they cannot keep
- Push the child to give details of the abuse
- Betray their own negative thoughts or judgements of what they hear
- Talk about similar problems or other cases – this tells the child their problem is not all that important in the larger scheme of things
- Discuss the abuse with others not directly involved with helping.

8.9.1



MULTIDISCIPLINARY
Handling child abuse is a multidisciplinary effort.

Caring for the mother (or caretaker) of the child victim



INTERESTS OF THE CHILD vs THOSE OF THE PARENT

The child requires protection and the non-abusing parent requires understanding.

Where the mother is the partner of the alleged abuser, she will be feeling guilty, ashamed and worried about what will happen to the family and possibly the income. The child requires protection and the non-abusing parent requires understanding. These needs have to be balanced in the interests of the child.

Helping the mother

In order to help the mother, it is important to:

- Understand that her silence, when it is likely she had a good idea of what was going on, was probably due to fear or economic dependence
- Convey to her that what ever happened was not her fault
- Encourage her to participate in stopping the abuse – this will help her reduce feelings of guilt.

Collecting evidence

Observation and Documentation



CLARIFY

Remember to clarify otherwise obvious points (e.g. ask: "Has anyone touched your private parts?" as well as "Have you touched anyone else's private parts?")

The first task for the health professional is to note and document in detail the signs observed that arouse suspicion, in terms of physical, behavioural and emotional indicators.

It is not the prime responsibility of the health professional to take a statement of what has happened, but to assist in this process. However, it is of the utmost importance that whatever the child does say is meticulously documented. In the case of the pre-school child, the professional will write down exactly what the child says. The older child can choose to write their own story.

Without pressing the child, if the child is ready to disclose, the health professional must ask open questions like *What? when? where? who?* and not leading questions (these are questions that suggest the answers the questioner expects to hear).

The importance of this careful documentation is that the first person to whom a traumatic experience is related is able to give evidence in court as to what was relayed to them. This becomes admissible as evidence because it indicates the state of mind of the victim at the time the first report is made.

Unlike other types of counselling, the health professional cannot guarantee total confidentiality to the child. This is because of the duty to report abuse that falls on all care professionals. [See pg 204] The professional needs to tell the child that they will have to talk to



DOCUMENTATION

It is of the utmost importance that whatever the child does say is meticulously documented.

other adults in order to ensure that the abuse stops. At the same time, the professional must take care to gain the permission of the child (according to age level) to proceed with each subsequent step. Careful counselling may need to be used to ensure that the professional stays attuned to the child. This allows the victim to feel she/he has some control of the process that has been unleashed.

Medico-legal evidence

The collection of the medico-legal evidence that will be needed in a court trial is extremely specialised. The first 72 hours after a sexual offence is the critical time for obtaining evidence of blood and semen that could be useful in linking the alleged perpetrator to the crime. [See pg 259, para 11.4]

Treating the child victim

As soon as possible after medico-legal evidence has been collected, the health professional should assist the child to get clean and comfortable, and attend to all wounds, infections etc.

In case of rape

The adolescent girl may need the 'morning after pill'. The child who has been raped may need HIV testing and treatment.

Legal rights of victim and alleged perpetrator as regards testing for HIV

At present, if victims need to know the HIV status of the alleged perpetrator, in order to take the most appropriate treatment available, there is no way of compelling the alleged offender to be tested for HIV and for that information to be revealed to the victim. The alleged perpetrator's consent for testing and revealing the results to a third party is required.

Neither currently available public health law nor criminal procedure makes provision for compulsory HIV testing of persons arrested for having committed sexual offences with a view to disclosing their HIV status to victims. At present, compulsory testing is regulated by the Criminal Procedure Act, 1977 [Section 37] which allows for compulsory blood testing only for use in evidence in a criminal court, subject to the Constitutional rights of the accused.

8.9.3.2



GIVING EVIDENCE

The first person to whom a traumatic experience is related is able to give evidence in court.

8.9.4

8.9.4.1



HIV TESTING

At present there is no way of compelling the alleged offender to be tested for HIV.



NO PROVISION FOR HIV TESTING

Criminal procedure does not make provision for compulsory HIV testing of persons arrested for having committed sexual offences.

Initiative to introduce compulsory HIV testing of sexual offenders

Because of the serious increase in the transmission of HIV infection, possibly deliberately, the SA Law Commission is currently investigating how to introduce compulsory HIV testing of persons arrested in sexual offence cases. The aim is to benefit victims while infringing on the arrested person's rights as little as possible.

The proposed new law includes the following provisions:

- Compulsory testing must be initiated by the victim or a person acting on her/his behalf, by means of oath or affidavit to a magistrate
- There must be *prima facie* evidence that the arrested person committed the sexual offence, and that the act was of a type that could indeed transmit HIV
- Compulsory testing may only be authorised by a court
- A deliberately false complaint would amount to perjury and such maliciousness could be actionable
- Confidentiality of the test results must be preserved so that the information is provided only to the victim (or her/his representative) and the arrested person.

8.10

Duty to report child abuse

Health professionals are bound by the law to report suspected child abuse. This duty is spelled out in the Child Care Act and the Prevention of Family Violence Act:

Duty to notify suspicion of ill-treatment

[The Child Care Act 1983]

"Every dentist, medical practitioner, nurse, social worker or teacher or any person employed by or managing a children's home, place of care or shelter who examines, attends, or deals with any child in circumstances giving rise to the suspicion that the child has been ill-treated or suffers from any injury, single or multiple, the cause of which probably might have been deliberate or suffers from a nutritional deficiency disease, shall immediately notify the Director-General or any officer designated by him for the purposes of this section, of those circumstances". [Section 42 (1)]

Any of the care givers mentioned above "who contravenes any provision of this section shall be **guilty of an offence**". [Section 42 (5)]

The caregivers who have a duty to report are also protected by law against being sued as a consequence of reporting their suspicion. "**No legal proceedings** shall lie against any medical practitioner, nurse ... in respect of any notification given in **good faith** in accordance with this section." [Section 42 (6)]

The prevention of Family Violence Act, 1993

"Any person who examines, treats, attends to, advises, instructs or cares for any child in circumstances which give rise to a reasonable suspicion that such child has been ill-treated, shall immediately report, such circumstances to a police official or a commissioner of child welfare or a social worker." [Section 4]

Procedure for reporting child abuse

Dealing with child abuse requires a multidisciplinary approach: police, social worker, court, and health professional. The child may be brought to the health facility by the police, or the health service may be the point of entry. If so, the police need to be contacted. Where it exists, this will be in the form of the Child Protection Unit (CPU) or the Family Violence, Child Protection and Sexual Offences Unit (FCS).

Unfortunately, these specialised units are being reintegrated into the mainstream of general police duties, although no official decisions are yet available. This move would certainly result in the loss of expertise that has accumulated over the last few years in the investigation of child abuse.

Detailed steps have been developed by child care agencies as to the procedure for involving all the role players, in the National and Provincial Protocols. [See pgs 288-289]

8.10.1



REPORTING CHILD ABUSE

Detailed steps have been developed by child care agencies as to the procedure for involving all the role players.

8.11 Going to court

The child witness and intermediaries

The court process is very damaging as a process, particularly to a child involved in a child abuse case. Much 'secondary abuse' occurs at this stage. Attempts to prevent this have been made by providing for separate rooms, videos and two way mirrors so that young victims do not have to appear in court and can give their evidence in the company of a social worker (or other intermediary). This only applies in some of the larger towns and cities.

The problems are extensive and have become the focus of intensive research by the South African Law Commission, with a view to widespread amendments to the way the court procedure is conducted. Nothing definitive is available at this time, but the issues are set out in the box below. [See pg 206]

8.11.1



THE COURT PROCESS

The court process is very damaging as a process, particularly to a child involved in a child abuse case.



THE ADVERSARIAL SYSTEM

This system is very damaging to a child who will be challenged in cross-examination in a way calculated to undermine their confidence and understanding.

Problems with the court process

- The fact that a case comes to court long after the report is made means that the child is at a severe disadvantage as regards ability to remember detail.
- The long delay interferes with the healing process that should be occurring in the meanwhile.
- The adversarial system is very damaging to a child who will be challenged in cross-examination in a way calculated to undermine their confidence and understanding.
- The use of intermediaries who can stand between the child witness and the legal representative of the accused has already become an accepted part of court practice, but is only available in some centres.
- The cautionary rule, which requires the court to exercise caution as to the credibility of single witnesses, victims of sexual crimes and child victims, is under scrutiny and likely to be scrapped as discriminatory.

8.11.2

How to use evidence in court

The health professional has a very important role in the courtroom.

Firstly, if the health care professional is the first person to whom the victim discloses the abuse, then this person's evidence is very important in establishing the victim's state of mind at the time as it can corroborate what the victim alleges.

Secondly, the professionals who are giving medico-legal evidence in court are regarded as expert witnesses. [See pg 127, para 5.5.2] The court will therefore need to be persuaded that the professionals have the qualifications and experience in this kind of examination that qualifies them to be regarded as experts whose opinion can assist the court in coming to a decision about the abuse. It is thus very important for health professionals to be adequately and demonstrably trained in forensic examination, and to gain experience in this field. This will assist in the court process.



CORROBORATING EVIDENCE

If the health care professional is the first person to whom the victim discloses the abuse, this person's evidence is important to assess the victim's state of mind at the time as it can corroborate what the victim alleges.

8.12

Types of abused children

8.12.1

Abandoned children

Some children are not abused, but are also in great need of protection because they have been abandoned.

The children at risk are newly born babies and infants below two years old. A health facility or hospital is a very common place for abandonment to occur. This is because mothers in a desperate situation know that their infants will be looked after in the health facility.

When the health care professional realises that a child has been abandoned in that no adult comes forward to claim the child, immediate steps must be taken to contact the nearest social worker. The procedure is laid out in the Child Care Act, and should be done by a social worker who must contact the police and open a court enquiry at the children's court.

If the child can stay temporarily in the health facility, the social worker must fill out Form 4 [see Child Care Act], which places the child temporarily in the custody of the health facility, while the court enquiry is opened and investigations proceed. Investigations will be in the hands of the police who will attempt to trace the parent(s), and possibly pursue a criminal charge against them. At the same time the social worker should explore substitute care for the child.

If the child cannot stay at the health facility, the social worker should immediately remove the child to a place of safety. The health professional should fill in the reverse side of Form 4, which requires medical details about the child's physical condition, in order for the child to be admitted to a place of safety.

The same medical form is needed if the child is abandoned anywhere outside of a health facility and the social worker (or a police officer, in emergencies) needs to place the child in immediate temporary care.

Children in places of safety

A place of safety may be a private home or an institution specifically geared to the short-term care of children, prior to their being placed in foster care, adoption or a children's home.

Children in places of safety arrive there through abandonment or are removed from parental care by a children's court order, because parents are found to be unable or unfit to care for them.

The medical needs of children in places of safety must be provided by a public health facility. The needs of such children will be the general medical needs of a child. Consent to treatment must be obtained from the person (or head of the facility) into whose temporary care the child has been placed by court order. [See pgs 87-88]

It is well known that abuse of children frequently occurs in institutional care. This includes conduct such as bullying by peers and care givers who choose to work in places of safety in order to pursue their own agendas. The health care professional should be alert to these possibilities and be prepared to observe and listen carefully to the child patient.



ABANDONMENT

A health facility or hospital is a very common place for abandonment to occur.

8.12.2



PLACES OF SAFETY

A place of safety may be a private home or an institution specifically geared to the short-term care of children, prior to their being placed in foster care, adoption or a children's home.

8.12.3



STREET CHILDREN

Street children are drawn to the streets of cities because their own homes have not been able to supply their needs.



STREET CHILDREN AND DRUGS

Street children often become drug, and possibly alcohol, abusers.

Street children

Street children tend to be young people who are drawn to the streets of cities because their own homes have not been able to supply their needs or keep control over them, or who have lost contact with their families because of political violence.

Potentially all street children could be dealt with by social workers from the Department of Social Welfare. This would mean removing each child to a place of safety, opening a children's court enquiry, and finding substitute care for the child until 18 years old. In practice, this has not been workable. Street children have become street-wise and do not adapt to the structured routine of institutional care. At the end of a long process of exploring, court process and placement, the end result is that the child returns to the street and tends to hide from authority.

Street children are best encouraged to make their way to shelters where they can be gently coaxed into accepting structure and routine. As they belong nowhere, and are in nobody's custody, their health care presents problems.

Street children are prime targets of drug traffickers – both as users and sellers. They often become drug, and possibly alcohol, abusers. [See pg 210] They are extremely vulnerable to criminal and child abuse.

The handling of such children is extremely difficult because there is little back-up from family or friends. If the child does frequent a shelter, it is necessary that contact be made with the organisation.

Where consent for medical treatment is required, this must be obtained from the superintendent of the health facility.

8.12.4

Mentally challenged children

Mentally challenged children are especially vulnerable to abuse, particularly sexual abuse.

The Sexual Offences Act provides little protection for mentally challenged youth. The Act defines persons with mental deficiency as 'idiots' or 'imbeciles'. These terms no longer accord with the definitions in the Mental Health Act.

The group that is particularly unprotected are young girls over 16 years and young boys over 19 years, where it has to be shown that the perpetrator knew that the victim was mentally deficient such that they could not give consent. As previously mentioned, the mentally challenged young girl is further disadvantaged in that the age of consent to secure intercourse for girls is younger than for boys.

8.13

Juvenile offenders

Children awaiting trial or who have been convicted of an offence, receive special protection in the Constitution. The Constitution

provides that children should not be detained except as a last resort, and then only for the shortest appropriate period of time. Such detainees must be kept separately from adults and in conditions appropriate to the child's age.

SA Law Commission Proposals

Extensive research is under way by the SA Law Commission to produce a new child justice system, based on international human rights standards and constitutional principles. The new system recommends that children who are assessed as being a danger to others and must be detained for trial, should be housed in secure centres, linked to, but separate from, existing places of safety.

It is also proposed that children accused of less serious offences should be diverted away from the formal criminal justice system. A preliminary inquiry will be held, presided over by a magistrate, as a pre-trial procedure, in order to divert as many juveniles as possible out of the criminal justice system to an approved diversion programme. This will also considerably reduce the time that young people spend in detention awaiting trial.

Children accused of serious, violent offences will still be prosecuted, but a range of new sentencing options will be provided as alternatives to imprisonment.

The draft Child Justice Bill has not yet been presented to Parliament.

At present children awaiting trial are detained in prison cells (where no suitable secure centres are available), and those convicted of crimes receive prison sentences.

The role of the health care professional is crucial in attending to the health needs of these juveniles. Abuse is rife in the prisons, both by fellow inmates and wardens, and health professionals are often called on to attend to sick or injured juveniles. Here the role of the professional is the same as for any abusive situation: caring, collecting medico-legal evidence and treating. [See pg 201, para 8.9]

The professional needs to be particularly observant because the detained juvenile will not be able to talk truthfully, for fear of intimidation. The health professional has the same duty to report suspicion of child abuse of juveniles under 18 years as in the case of young children. This should be carefully discussed with the detained juvenile, and the victim encouraged to report the abuse to a legal representative.

Another issue that arises in connection with juvenile offenders is the question of testing offenders for the presence of HIV in the case of an alleged rape. In order to conduct these tests and to respect the constitutional right of the alleged offender to bodily integrity, their consent must be obtained. If this is not forthcoming, nothing can be done unless legislation on compulsory testing for HIV is passed. [See pg 203, para 8.9.4.1]



JUVENILE OFFENDERS

Children awaiting trial or who have been convicted of an offence, receive special protection in the Constitution.



FEAR OF INTIMIDATION

The professional needs to be particularly observant because the detained juvenile will not be able to talk truthfully, for fear of intimidation.

8.14

Children and drugs

Statistics from treatment centres for substance abuse reveal that the age at which children are becoming involved with drugs (and alcohol) has become increasingly younger. Drugs are easily available even to children at primary school level. At the same time, the age of street children has become extremely young and their vulnerability to the cheap forms of substance abuse, such as glue sniffing, is well documented. The statistics indicate that the youngest substance abusers are sniffing and taking dagga. Somewhat older children are abusing ecstasy, LSD and speed. The older juvenile is involved with the dagga/mandrax combination, known as the 'white pipe'.

Drugs are easily available even to children at primary school level.



8.14.1

The National Drug Master Plan

The government has responded to the enormity of the substance abuse problem with the National Drug Master Plan. The aim of the strategy is to protect and rehabilitate children from the use of, and trafficking in, narcotic drugs. Every national department has undertaken specific tasks, mainly involving education programmes, for the prevention and protection of youth.

The Department of Justice

The Department of Justice has responded constructively with the new process to divert juvenile offenders out of the criminal justice system and provide alternative forms of punishment and/or treatment. This diversionary process is particularly important for juvenile substance abusers, as it is well known that the prison environment exacerbates substance abuse. The need currently is for more institutions which will serve as alternatives to imprisonment.

The Health Department

The Health Department has responded to the crisis by including substance abuse in the package of comprehensive primary health care services available to health care users. This will comprise detoxification, counselling and referral services.

The first step is for health care practitioners to keep abreast of the new names that are commonly given to drugs, as this will help in the recognition of the type of effects and consequences that will result with the specific addiction. Keeping abreast is extremely difficult as new names are constantly coined in order to keep the drug world a cult, the inner secrets of which are known only to the initiates. Thus, names like pills, acid, joints, uppers and downers, change rapidly and new names like rocks, smack, and ice become the common slang.

Recognition of commonly abused substances

The most commonly abused groups of drugs are listed in the accompanying table, indicating what the substance looks like, how it is commonly used, how it affects the body and the signs of abuse. [See pg 211, Table 8.1]

8.14.1.1

8.14.1.2



NEW DRUG NAMES

The first step is for health care practitioners to keep abreast of the new names that are commonly given to drugs.

8.14.2

TABLE 8.1

Commonly abused substances

Type	Name	Appearance	Abuse	Effects	Signs of Abuse
Narcotic and depressant	Heroin (smack, horse, hard stuff)	White to dark brown powder, tar-like substance	Injected, inhaled through nasal passages, smoked	Produces feeling of euphoria followed by drowsiness, nausea, vomiting	Apathy, neglect of personal appearance and hygiene, loss of appetite and weight, drowsy appearance
Stimulant	Cocaine (blow, coke, snow, nose candy, lady) Crack is the more potent form of cocaine	White crystalline powder	Injected, inhaled through nasal passages	Produces feeling of well-being, later anxiety, restlessness, nausea, insomnia, paranoia	Unusually energetic, exuberant, disturbed eating and sleeping patterns, mood swings, aggressive behaviour
Depressant	Mandrax (buttons, whites)	Tablets	Orally, ground into fine powder, mixed with dagga and smoked in a pipe or the broken-off neck of a bottle ('white pipe')	Produces feeling of calmness, euphoria and sexual disinhibition, later headaches, hangovers, dizziness, diarrhoea, numbness of the extremities. Also emotional instability and appetite loss	Happy and relaxed, but also drowsy, slurred speech and poor co-ordination. 'White pipe' users may also exhibit bloodshot eyes
Depressant & hallucinogen	Dagga (cannabis, boom, dope, grass, gunston, hash, herb, insangu, marijuana, pot, sinsemilla, skyf, weed, zol)	Dried plant	Usually smoked, also brewed and drunk, eaten in cakes or biscuits	Produces feeling of relaxation and well-being, enhances auditory and visual perception, increases appetite for food. May impair short-term memory, driving ability and coordination. Loss of sense of time, confusion and emotional distress can result. Hallucinations may occur on high dosages	Unusually talkative or drunk. Eyes may appear bloodshot. Dagga smoke has a distinct, sweet smell that permeates hair and clothes. Regular users may appear apathetic and lethargic

CONTINUED

Type	Name	Appearance	Abuse	Effects	Signs of Abuse
Solvent and depressant	Glue, aerosols for spray paints, hair lacquer, lighter fuel and deodorants, paints, paint strippers, petrol and cleaning fluids.	Cans of propellant, containers of cleaning fluid, paint etc.	Sniffed, breathing in the fumes, usually from a plastic bag placed over the nose and/or mouth or from a cloth or handkerchief soaked in the solvent	Produces light-headedness, dizziness, confusion and progressive loss of co-ordination. Also nausea, vomiting and headaches. Serious risk of suffocation and accidental death while intoxicated	Mainly adolescents, a chemical smell on the breath, traces of glue or solvents on the body or clothes. Also furtive behaviour, moodiness, unusual soreness or redness around the mouth, nose or eyes, and a persistent cough
Hallucinogen	LSD (acid)	Tiny, coloured tablets	Orally, or absorbed on to small squares of paper, gelatine sheets or sugar cubes	Initial effects: possible restlessness, dizziness and shivering. Subsequent effects: distortions in sound and vision perception, and a sense of time slowing down. Possible frightening hallucinations, loss of emotional control and overwhelming feelings of anxiety, despair or panic	A person under the influence may feel strange, but rarely shows outward signs of intoxication. Occasionally, a user may seem over-excited, or appear withdrawn or confused
Amphetamines	Speed, uppers, bennies, ecstasy	Tablets	Orally, sometimes sniffed or mixed with water and injected	Small doses: increases mental alertness and physical energy. Regular use: weight loss, constipation and emotional instability. Very large doses: may cause delusions, hallucinations, delirium, convulsions and coma. Withdrawals: severe depression and suicide	The user may appear unusually energetic, cheerful and excessively talkative while under the influence. Restlessness and agitation are also characteristic. There is a lack of interest in food and unusual sleeping patterns. Mood swings are common

8.14.3

Treating drug dependence



A NEW CHEMICAL ENVIRONMENT

When a person is dependent on a drug, the cells in the body have adapted to a new chemical environment.

When a person is dependent on a drug, the cells in the body have adapted to a new chemical environment. To move someone from that condition to a drug-free state is a complex medical process. A person must become completely drug-free before long-term rehabilitation can occur.

The first step, detoxification, can take different forms. In the case of alcohol dependence, abstinence may often be abruptly imposed. With other substances, the drug may be gradually withdrawn, or other safer substances substituted. There are, however, differing schools of thought, and some treatment centres argue for the abrupt cessation method of detoxification for substances besides alcohol.

Withdrawal can be mild, violent, and occasionally fatal, and thus expert medical supervision is required. Drugs may be given to provide symptomatic relief.

8.14.3.1

Symptoms of withdrawal



WITHDRAWALS

Under medical guidance, withdrawal symptoms can be relieved, sometimes with doses of the original drug, or with less addictive substitutes.

Withdrawal symptoms occur because the body has adapted to the action of the drug. When a drug is continuously present, the body may stop the release of a natural chemical, like endorphin, necessary to normal function.

Symptoms can range from the mild (sneezing, sweating) to the serious (vomiting, confusion) to the extremely serious (fits, coma). Alcohol withdrawal may be associated with delirium tremens, which is very occasionally fatal. Withdrawal from barbiturates can sometimes involve fits and coma. Under medical guidance, withdrawal symptoms can be relieved, sometimes with doses of the original drug, or with less addictive substitutes.

8.14.3.2

Counselling and referral



COUNSELLING

Counselling of the young drug addict is a very long-term process.

Counselling of the young person who has become involved with drugs is a very long term process. This is because drug taking results from complex social and personal forces. There are issues of peer pressure, self-esteem and life circumstances. The role of the health professional is therefore to encourage the young person to enter into a voluntary counselling relationship with a treatment centre, such as the South African National Council for Alcoholism and Drug Addiction (SANCA) or Lulama. Sometimes formal committal to a treatment (rehabilitation) centre is needed, but these options are best explored by referral to SANCA.

8.14.4

Medico-legal evidence

The young person on drugs will most frequently be encountered in a Crisis Clinic because the police have become involved with the issue of possession and/or dealing in illegal substances. And of course, substance abuse is closely tied to other criminal activity which may

involve injury, violence, and gang warfare.

The police are empowered under Section 37 of the Criminal Procedure Act of 1977 to request that the person arrested for drugs be medically tested in order to obtain evidence that could be used in a criminal trial. This is the only compulsory testing that is permitted. Frequently the family members of the young person may want confirmation that the young person is on drugs and may request health care practitioners to test for this. Such testing can only occur with the informed consent of the young person.

Admission to treatment centres

When drug addiction has reached a dangerous level such that the person is showing signs of distress and their normal way of life is disrupted, admission to a treatment centre may be an option. Admission to a treatment centre is regulated by the Prevention and Treatment of Drug Dependency Act, 1992, as amended. In terms of this Act, a person may request voluntary admission or may be committed formally to a treatment centre.

Voluntary admission means that the person may leave the treatment programme at any time and for any reason. Formal committal occurs by means of an affidavit of a concerned person (usually a relative) of the addicted person, presented to a magistrate, and accompanied by the report of a social worker.

In the case of a child, the magistrate may order temporary detention in a place of safety for designation to a treatment centre by the Director-General. It is common for the Director-General to direct that the young person remain in the place of safety for treatment. The young person is then committed to the treatment centre for the duration of the programme.



THE POLICE

The police are empowered to request that the person arrested for drugs be medically tested to obtain evidence to be used in a criminal trial.

8.14.5



TREATMENT CENTRES

Admission to a treatment centre is regulated by the Prevention and Treatment of Drug Dependency Act, 1992.

8.15 Networking

The handling of victims of violence is a multidisciplinary activity. It is thus vital that close links be maintained between all the government departments involved in the process.

There are in addition, numerous non-governmental agencies in civil society that provide support, healing and therapy for victims of violence. To ensure continuity of care, after the patient has been discharged from the public health services, professionals need to establish links with resources that can sustain the process of recovery, and encourage survivors to make contact with them.



MULTIDISCIPLINARY ACTIVITY

The handling of victims of violence is a multidisciplinary activity.

South Africa has actively participated in international arenas concerning children. It has also responded nationally with legislation incorporating the principles contained in the international conventions. Mechanisms and services to enforce and protect these rights are currently receiving serious attention.

In response to the widespread abuse of the rights of children, the international community has raised awareness of the plight of children through forums and conventions.

It is also important to remember that much as these resources are needed, this should not distract from the long-term needs of children and families, involving prevention, better conditions for community life and development, more treatment and rehabilitation, and more effort to lower levels of violence in South African society.



TALKING POINT

The reluctant rape survivor

Mrs K is the mother of Lulu, aged 16. Mrs K firmly believes in taking her teenage daughter for regular virginity testing. She is very proud of the certificates she collects affirming the virginity of Lulu. She believes this will keep her daughter safe from all the horrors she hears about from the other women – STDs, AIDS and equally stressful, another mouth to feed.

Last week when Mrs K announced it was time for the next test, Lulu put her hands to her face and began to cry. She eventually came out with the news that she had been raped. When? Five days ago. Why had she said nothing? She was ashamed and feared she would be punished. Mrs K had an impulse to beat the girl, but managed to control herself. The next day Mrs K took her daughter to the clinic.



1. What do you think of the practice of virginity testing?
2. Does it help keep teenage girls safe?
3. Role-play the interview at the clinic between Lulu and the Health Professional on duty.

The frustrated care giver

When Andrea finished school she was grateful to be taken on as a child care giver at the Bo Peep Pre-school.

After a few weeks, Andrea began to find that dealing with a group of pre-schoolers can be very demanding and stressful. She was exhausted by the end of each day. There were so many needs and demands from the children to attend to all at once.

One day, two of the children refused to put on their jerseys and join the rest of the group outside. Andrea grabbed them both by their arms and squeezed hard until the children began to cry. Andrea felt relieved that no one had seen her lose control.

The mother of one of the two children noticed blue bruise marks on her child's upper arm. She decided to bring the child to the clinic, first thing in the morning.



- **As the health professional on duty at the clinic, how would you handle this situation?**



