Sexual violence against children in South Africa: a nationally representative cross-sectional study of prevalence and correlates

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Summary

Background We aimed to complete a nationally representative study of sexual violence against children in South Africa, and its correlates, since we could identify no other such study.

Methods For this nationally representative, cross-sectional study in South Africa, households were selected by use of a multistage sampling frame, stratified by province, urban or rural setting, and race group, and schools were selected on the basis that they were closest to the area in which households were selected. Interviews and self-administered questionnaires in each location inquired into lifetime and last-year prevalence of sexual abuse, and its correlates among children aged 15–17 years, whose parents gave informed consent and they themselves gave informed assent.

Findings The final household sample was 5631 (94·6% participation rate). 9·99% (95% CI 8·65–11·47) of boys and 14·61% (95% CI 12·83–16·56) of girls reported some lifetime sexual victimisation. Physical abuse, emotional abuse, neglect, family violence, and other victimisations were all strongly associated with sexual victimisation. The following were associated with greater risk of sexual abuse (adjusted odds ratio [OR]); school enrolment (OR 2·12, 95% CI 1·29–3·48); rural dwelling (0·59; 0·43–0·80); having a flush toilet (1·43, 1·04–1·96); parental substance misuse (2·37, 1·67–3·36); being disabled (1·42, 1·10–1·82); female (but not male) caregivers' poor knowledge of the child's whereabouts, friends, and activities (1·07, 0·75–1·53) and poor quality of the relationship with the child (ie, poor acceptance; 1·20, 0·55–2·60). The child's own substance misuse (4·72, 3·73–5·98) and high-risk sexual behaviour (3·71, 2·99–4·61) were the behaviours most frequently associated with sexual abuse, with mental health conditions found to be less prevalent than these factors but still strongly associated with sexual victimisation (post-traumatic stress disorder 2·81, 1·65–4·78; depression 3·43, 2·26–5·19; anxiety 2·48, 1·61–3·81).

Interpretation Sexual violence is widespread among both girls and boys, and is associated with serious health problems. Associated factors require multisectoral responses to prevent sexual violence or mitigate consequences.

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Introduction

Child sexual abuse and other forms of maltreatment have serious health consequences that can persist into adulthood, including mental health problems, injuries, increased risk for HIV infection, and other consequences associated with poor health behaviours (eg, obesity).[1,2] In settings such as South Africa, where child-protection services are both fragmented and overburdened,[3] and with high prevalences of potentially related problems such as HIV,[2] representative data on the sexual abuse of children are essential for effective service provision.

Violence against children has long been thought to be prevalent in South Africa,[3] but estimates vary depending on the methods and location of studies. For instance, one national study[4] found a prevalence of 1·6% for rape before age 15 years, whereas another study[2] in a rural area and using a broader definition of sexual abuse found prevalences of 39·1% for women and 16·7% for men.[2]

We could not identify any previous representative study of child sexual abuse that explored the full range of possible abuses (including contact abuse [ie, physical contact between the child and the abuser], exposure abuse [eg, exposure to pornography], and sexual harassment) in South Africa. The Optimus Study South Africa (following on from the Optimus Studies in Switzerland[5] and China[6]) thus aimed to provide this information.

Methods

Study design and participants

We did a nationally representative cross-sectional study of sexual abuse of children aged 15–17 years in South Africa. We recruited participants via two mechanisms: a nationally representative household survey and a school survey. We included both locations because the Optimus Study protocol requires participants

Research in context

Evidence before this study

We searched Academic Search Premier, Africa-Wide Information, CINAHL, the Education Resources Information Centre (ERIC), MEDLINE, PsycARTICLES, PsycINFO, SocINDEX, and Google Scholar for papers on child maltreatment (child abuse and neglect), and related terms (physical abuse, corporal punishment, emotional abuse, psychological abuse, sexual abuse) in South Africa. Searches were restricted to publications in English because any relevant literature from South Africa would have been published in English. Inclusion criteria were that the paper should report a quantitative study, some form of child maltreatment, and that it be based in South Africa. We used no other inclusion or exclusion criteria. We did our initial search between April 4, and June 24, 2011, with no start date restrictions, when we were proposing our work to the UBS Optimus Foundation. The search was repeated and updated in June, 2017. Our goal was to assess whether any other nationally representative study had been done in South Africa, and none had (in fact, in no other study was representative sampling used). Previous studies thus all had a high risk of bias.

Added value of this study

This study reports findings from the first (and only) nationally representative study of sexual abuse of children in South Africa. It also reports the correlates of sexual abuse, including other forms of child maltreatment.

Implications of the available evidence

Prevalences reported in this Article will be useful to practitioners in terms of estimating the burden for which services should be prepared. Findings with regard to correlates suggest avenues for prevention. Findings with regard to methods have implications for the methods future studies should use. In brief, we found that sexual violence against children is widespread among both boys and girls in South Africa, and has severe health consequences. Risk and protective factors identified require a multisectoral response to prevent sexual violence, and future studies should focus on samples selected from schools, to maximise the disclosure of abuse, and allow children to complete the questionnaire themselves in a confidential format.

to be aged 15–17 years (for cross-national comparability) and data suggested that many South Africans of this age no longer attend school.[7] Also, data could be subject to different forms of bias, depending on location—eg, household data could be biased by abusive parents' refusal to consent to their child's participation, and school data because schools are often sites of violence.[8] This approach also allowed us to test whether different approaches to data collection gave different results; however, we caution that only the household survey is nationally representative, and therefore we present those results in this Article.

In the household survey, active parental (ie, informed) consent was obtained. In the school survey, after discussion with school governing bodies and principals, and with the permission of the National Department of Basic Education, we used passive parental consent to minimise bias. Active adolescent assent was required in both surveys. The study was approved by the Human Research Ethics Committees of both the Faculty of Health Sciences and of Humanities at the University of Cape Town, Cape Town, South Africa. The ethics protocol complied with national sexual offences and child protection legislation; reports of child maltreatment were made to relevant child care and protection agencies when necessary.

Sampling

A multistage stratified sampling frame (based on that in the 2001 South African census[9] and updated by use of modern sampling frames) was designed for this survey, stratified by province, urban versus rural area, and race group (under apartheid, the South African Government recognised four race groups: black African, coloured, Asian or Indian, and white; because access to many resources [eg, health interventions] is still structured around the apartheid categorisations,[10] we included race as a stratification variable; however, we do not endorse these racialised categories). This method gave a total of 80 787 census enumerator areas, of which 725 were randomly selected. We oversampled smaller strata to ensure their representation in the survey. In each enumerator area, five to ten households were randomly selected, with replacement if they refused to participate or if there was no child in the required age group; therefore, five to ten interviews were done in each enumerator area. When a given household had more than one child in the required age group, one of the children was randomly selected with the Kish Grid or by choosing the child whose birthdate was earliest in the year.

We approached the school either in or geographically closest to the enumerator area for permission to recruit learners (ie, students). All the learners whose parents provided consent constituted the sampling frame for the school sample. We used a random number table to select ten learners each from grades 10, 11, and 12 (ie, aged 15–17 years) to be interviewed.

We estimated the sample size needed across school and household surveys together as 5800. This estimation assumed a design effect of 3·0, item completion and an overall response rate of 90%, and a conservative estimated prevalence of sexual abuse to lie between 5–15% of the population, which would provide a 95% CI of 1–3%.

Given the sensitivity of the subject of our research, we worked with a small team of well trained and closely supervised interviewers rather than a dispersed team that might have collected data faster. This precaution

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