HARNESSING COMMUNITY PARTICIPATION IN CHILD ABUSE AND NEGLECT PREVENTION PROGRAMMES: A CASE STUDY BASED ON COPESSA, A COMMUNITY- BASED CHILD ABUSE CENTRE IN PROTEA GLEN, SOWETO

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Public Health

Declaration

I Nobulembu Babalwa Mwanda declare that this Research Report is my own, unaided work. It is being submitted for the Degree of Master of Public Health at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

29 October 2019 in Johannesburg

Dedication

In honour and memory of my beloved brother

Reverend Manelisi Mwanda

1966 - 2018

Abstract

Introduction

Child abuse and neglect (CAN) has reached epidemic proportions in South Africa (2014, Meinck et al., 2016, Petersen et al., 2005, Richter and Dawes, 2008, Jewkes et al., 2010a). This is despite many protective instruments such as the international treaties SA is a signatory to, and the laws it has promulgated as an obligation for signing such treaties (Government of South Africa, 1993, Government of South Africa, 1996a, Government of South Africa, 1996b, Government of South Africa, 1998, Government of South Africa, 2006, Republic of South Africa, 2013). Also, adverse childhood experiences are irreversible (O'Connor and Cailin, 2012). In light of this as well as the high prevalence of this social ill, there is consensus among experts in this field that the bulk of services should be focused on primary prevention (Daro and Dodge, 2009, MacLeod and Nelson, 2000, Richter and Dawes, 2008). Although most CAN preventive strategies have historically focused on improving parenting skills, there is evidence that broader community-based strategies are probably more effective and cost-beneficial (Daro and Dodge, 2009, MacLeod and Nelson, 2000, Petersen et al., 2005).

The aim of this study was to explore how to optimise community participation in CAN prevention programmes in Protea Glen, Soweto (PG) in 2017/18. This study drew on research that community participation can reduce CAN (World Health Organization, 2016) but the study purpose was not to examine the impact of community participation on CAN. Rather, the specific objectives were to: (1) describe how community members perceive CAN in PG; (2) describe the PG community's own perspective on community participation in general; (3) describe community participation in COPESSA's CAN prevention programmes; 4) describe factors that influence (enablers and barriers) community participation in CAN prevention programmes in PG; and 5) to explore how COPESSA can increase (recruit and maintain) community participation for CAN prevention programmes in PG, during the 2017/8 period.

Methods

A qualitative research study using a single case study approach which had descriptive, explanatory and exploratory components (Yin, 1994) was conducted at COPESSA, a child abuse and neglect centre in Protea Glen. The study was approved by the University of Witwatersrand Human Research Ethics Committee (HREC) and a clearance certificate number M170870 was issued on the 13th October 2017.

The study population comprised PG community members who were older than 18 years of age and had resided in this community for at least the last three years. Participants were purposively sampled for maximum variation from three categories, namely: (a) community members that were currently participating in the COPESSA CAN prevention programmes; (b) those who had since left these programmes; and (c) those community members who had never participated in any of the programmes. This yielded a sample size of 32 participants, a majority (27) of which were females.

Data were collected using focus group discussions and group discussions when there were not enough participants to constitute the former, between the 13th and 14th of November 2017. Data were electronically recorded, independently translated and transcribed and were coded using the MAXQDA software. Thematic content analysis was applied to analyse the qualitative data using a codebook, which was shared with the research supervisor for validity and intercoder reliability.

Results

With regards to the participants' perspectives on CAN, there was a fair to good knowledge about the definitions of the various types of abuse. Participants tended to talk more about physical abuse and provision for physical needs than other types of abuse and provision for emotional needs. They also tended to conflate discipline and physical abuse. They identified a range of factors, which included societal, community, family and those pertaining to children, as responsible for the perceived CAN in the PG

community. Chief among these were factors such as poverty and unemployment; government laws and policies that were biased towards children; drugs, alcohol and crime, and their own adverse lived experiences. There was a dominant negative narrative about children's behaviour, with parents referring to them as unruly, conniving and even blaming them for their own abuse. The common thread about the identified factors was that they were external to participants and as a result they felt that they had little influence to change them for better.

Levels of community participation (CP) varied between those who were involved in COPESSA CAN prevention programmes and those who were not actively involved. The latter group reported on generally lower levels of CP, limited to church going and community meeting attendance. Even involvement in these two activities was relatively superficial and just helping the participants to 'get by.' Various barriers, which again seemed out of the participants' control, lack of money and community amenities, time constraints and lack of leadership were identified. In contrast, those who were involved in COPESSA CAN prevention programmes tended to report higher levels of CP and seemed to 'get ahead' as a consequence of their participation in these programmes. This group identified enablers such as financial and skills benefits, physical and emotional health benefits, and greater informal support networks.

An unexpected finding was that knowledge, attitudes and practices were comparable between those involved in COPESSA CAN prevention programmes and those who were not.

Discussion

The mismatch between knowledge of and attitudes towards abuse and practices was not unique to our community (Mlekwa et al., 2016, Richter and Dawes, 2008). Corporal punishment at home, which seemed to be commonplace, was attributed, among other things, to cultural relativism that has been defined as an intersection of cultural norms, children's rights and

religious beliefs (Reading et al., 2009). The focus on meeting of physical needs in comparison to emotional needs could be explained by the fact that Africa in general is overwhelmed by complex and visible problems such as poverty, such that less apparent problems like emotional issues and mental health issues tend to be placed on the back-burner, a view that is supported by Thomas (2006). The relatively poor CP among those participants who were not involved with COPESSA CAN prevention programmes was attributable to the pervasive poverty, which is associated with poor quality and quantity of social capital (Block, 2008, Murayama et al., 2012, Thomas, 2006) and fatalism (Cidade et al., 2016) that are in turn associated with no collective efficacy to change existing circumstances for better (Campbell and Jovchelovitch, 2000, Daro and Dodge, 2009).

Conclusion and recommendations

Community participation, which is critical to preventing child abuse and neglect, can be harnessed by addressing determinants such as poverty that is interrelated to safety, security and crime, and which according to Maslow's Hierarchy Model are all lower level needs. We have however, seen how social relations, which according to Maslow are at the third level, are able to propel poor communities forward. Further research is needed to establish the cost-efficiency and effectiveness of building of social capital as opposed to directly addressing structural determinants such as poverty, which by nature are hard to change, particularly in resource-strained countries such as South Africa. Also, future research should explore what forms of community participation can result in improved knowledge, attitudes and practices in CAN prevention.

Acknowledgements

I wish to thank various people for their immense support and contribution towards this research project: Mr Sandla Nomvete for conducting the focus group discussions, Ms Ogopoleng Gopi Maremela for being a great sounding board and support during this arduous road, the staff of COPESSA who went an extra mile to help birth this possibility and more importantly the community of Protea Glen who shared generously of their lived experiences.

My deep and special gratitude goes to Dr Sara Jewett Nieuwoudt, my research supervisor. Thank you for patiently guiding me through this research. Your incisive and nuanced comments and critique brought energy and life to this research.

A special thanks to my husband and children for their encouragement and support. Thank you for creating the space.

Lastly, and certainly not least, I thank God for providence.

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Definition of Terms

"**Effective interventions** meet at least one of the following criteria:

- At least two high or moderate quality impact studies using randomized controlled trial (RCT) and/or high quality quasi-experimental designs have found favourable, statistically significant impacts in one or more violence against children domains (maltreatment, bullying, youth violence, intimate partner violence and sexual violence);
- The intervention is deemed recommended based on high-quality meta-analysis and systematic reviews of findings from evaluations of multiple interventions.

Promising interventions are those where:

- At least one high- or moderate impact study using a RCT and/or high quality quasi-experimental designs have found favourable, statistically significant impacts in one or more violence domains (maltreatment, bullying, youth violence, intimate partner violence and sexual violence);

- At least one high- or moderate-quality impact study using RCT and/or high quality quasi-experimental designs has found favourable, statistically significant impacts for one or more risk or protective factors for violence against children (such as education attainment, positive parenting skills, communication between parents and children about effective strategies for avoiding exposure to violence, increased parental supervision)," p.23 (World Health Organization, 2016)

List of Acronyms

ACRWC – African Charter on the Rights and Welfare of the Child
AR – Assistant Researcher
CAN – Child Abuse and Neglect
CBO – Community-based Organisation
COPESSA – Community-based Prevention and Empowerment Strategies in South Africa
CP – Community participation
CM – Community mobilization
CRT – Cluster randomized controlled trial
CSDH – Commission on Social Determinants of Health
FGD – Focus Group Discussion
GD – Group Discussion
HP – Health Promotion
IMAGE – Intervention with Microfinance for AIDS and Gender Equity
INSPIRE – Implementation and enforcement of laws; Norms and values; Safe environments; Parent and caregiver support; Income and economic strengthening; Response and support services; Education and life skills
KZN – KwaZulu Natal
OVC – Orphaned and Vulnerable Children
PG – Protea Glen
PHC – Primary Health Care
PR – Primary Researcher
RCT – Randomised controlled trial
SA – South Africa
SAPS – South African Police Service
UNCRC - United Nations Convention on the Rights of the Child
VAC – Violence Against Children
VAWG – Violence Against Women and Girls

1. INTRODUCTION

1.1 Background

Child Abuse and Neglect (CAN) is neither a medical nor a legal term, but as described by Richter and Dawes (2008) is an omnibus that includes all acts of physical, emotional, sexual ill-treatment and neglect of children under the age of 18 years. Furthermore, CAN is one of the domains of violence against children (VAC) (World Health Organization, 2016). It is critical to mention that the lumping together of these widely varied acts poses problems for the determination of the exact extent of this social ill. To compound this, no national studies have been done in South Africa (SA) to ascertain the exact extent of CAN; the extent is estimated by using either reported crimes to the South African Police Service (SAPS), the child abuse register (that has been reported to be inadequate), or facility-based studies (Petersen et al., 2005, Richter and Dawes, 2008). It is deemed unnecessary for the purposes of this research to look at all the definitions of the various acts that constitute CAN, as CAN is not the primary focus of this study per se. However, the definition of child physical abuse in relation to physical or corporal punishment will be closely examined later as it is the most controversial form of child maltreatment and black communities are reported to be highly punitive towards their children (DSD et al., 2012, Jewkes et al., 2010a, Richter and Dawes, 2008).

While there is a paucity of national studies on CAN, there is a consensus among researchers in this field that CAN has reached epidemic proportions in SA (Africa Check, 2014, Meinck et al., 2016, Petersen et al., 2005, Richter and Dawes, 2008, Jewkes et al., 2010a). For instance, in their recently published community-based study that looked at the prevalence and incidence of physical, emotional, and sexual abuse in two South African provinces, Meinck and colleagues (2016) reported a prevalence of about 69% of lifetime victimisation of one form of abuse or the other for adolescents. In another study conducted in the rural Eastern Cape, Jewkes and colleagues (2010a) reported that about 89% women and 94% men experienced physical abuse and 42% of women and 46% men experienced emotional neglect

before the age of 18. Considering that CAN is grossly underreported (Jewkes et al., 2010a), it is thus no exaggeration to say that CAN has reached alarmingly high levels in South Africa.

This shocking picture is set against a backdrop of protective instruments South Africa is either a signatory to or has promulgated to protect children. These instruments include the South African Constitution, the highest law of the land, which has a Bill of Rights specifically addressing the rights of children (1996a). Other specific legislation that have been promulgated by the Government of South Africa to safeguard the welfare of children in and outside of their homes include the Prevention of Family Violence Act 33 (1993), the South African Schools Act 84 (1996b), the Domestic Violence Act 116 (1998), and the Children's Act 38 (2006). In addition, South Africa ratified the United Nations Convention on the Rights of the Child (UNCRC), on which the Bill of Rights is based, in 1995 and the African Charter on the Rights and Welfare of the Child in 2000 (2013). The enforcement of these protections is clearly an issue.

In light of the very high prevalence of CAN, and the irreversibility of adverse childhood experiences (O'Connor and Cailin, 2012), many professionals agree that the bulk of CAN services should focus on prevention (MacLeod and Nelson, 2000, Daro and Dodge, 2009, Richter and Dawes, 2008). Furthermore, prevention, which on its own is a composite process that includes primordial, primary, secondary, tertiary, and quaternary levels (Ehrlich and Joubert, 2014), is very complex, as there are multiple levels of risk factors of CAN. Petersen and colleagues illustrated this complexity in their KwaZulu Natal (KZN) study, using an ecological approach to assess CAN risk factors, where they found, *inter alia,* distal risk influences such as traditional notions of masculinity and normalisation of inter-personal violence, and proximal risk influences such as poor parental monitoring and neglect, and "weak community protective shield" (Petersen et al., 2005).

Although most CAN preventive strategies have historically focused on improving parenting skills, there is evidence that broader community-based

strategies are probably more effective and cost-beneficial (Daro and Dodge, 2009, MacLeod and Nelson, 2000, Petersen et al., 2005). Draper et al. (2010) notably, makes a clear distinction between two easily conflated terms, community-based programmes and community-level programmes. According to these authors, the former is more about spatial positioning and any such interventions tend to result in change in individuals. In contrast, the latter is about interventions that seek community-wide changes often through participation. Community-level programmes are argued to yield even better results than those aimed at changing individual community members because of their wider reach (Ehrlich and Joubert, 2014, Glanz et al., 2015, Tomison, 2000, Tomison and Wise, 1999, World Health Organization, 2016). According to Daro and Dodge (2009), the efficiency and effectiveness of community prevention programs derive from the "reciprocal interplay" between individual family behaviours and the broader neighbourhood, community and cultural contexts.

COPESSA, which stands for Community-based Prevention and Empowerment Strategies in South Africa, was inspired by the gruesome rape and disembowelment of six-year-old Lerato (not her real name) in Alexandra. Alexandra is a densely-populated black township north-east of Johannesburg City, which is characterised by high levels of poverty and informal dwellings (Greater Johannesburg Metropolitan Council, 2000). COPESSA was birthed following multiple "*indabas*" (community meetings) that were led by a group of celebrity women that came to be known as the "Isililo, a Mother's Cry" Campaign. They sought to understand the roots of this social ill and bring awareness to the plight of the nation's children (Xaba and Motsepe, 2003, Khumalo and SAPA, 2003). Even though this incident happened in Alexandra the Isililo women felt that gruesome child abuse incidents were becoming commonplace in black communities and townships in general, something that was contrary to the collective parenting and nurturing that black communities are known for (Khumalo, 2003).

COPESSA opened its doors in March 2004 at Protea Glen (PG), Soweto (an acronym derived from South West Townships), Johannesburg. It

has grown over the years and has an ecological perspective in both the identification of the social drivers of CAN and the design of programmes aimed at preventing CAN in this community. Furthermore, our approach and strategies align themselves to the WHO 'INSPIRE' strategies (see Figure 1) (www.copessa.co.za).

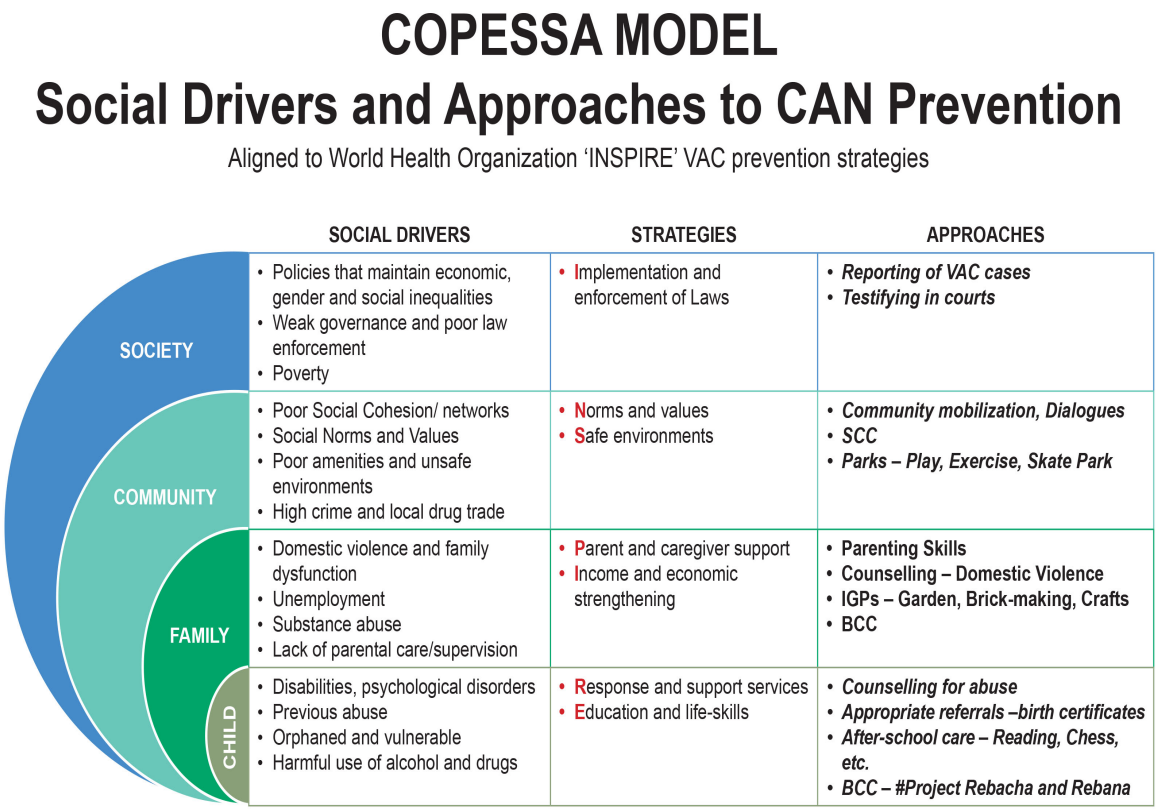

Figure 1: COPESSA Socio-Ecological Model

While the social drivers analysis comes from both literature and COPESSA's own assessments, the strategy framework in which COPESSA has organised its own approaches was derived from the World Health Organization (WHO) INSPIRE framework, based on seven "evidence-based strategies" that have been shown to be either effective or promising against the prevention of VAC (World Health Organization, 2016) (see 'Definition of terms' for the definition of 'effective' and 'promising'). Interestingly, according to some review studies, studies done in high-income countries (HICs) on the effectiveness of CAN prevention tended to focus more on strategies that focus

on preventing re-occurrence of abuse, in contrast to those that are done in lower- and middle-income countries (LMICs) (Ellsberg et al., 2015, MacMillan et al., 2009, Tomison and Wise, 1999, World Health Organization, 2016). The LMIC studies were mostly aimed at community-level changes and address the social determinants of abuse. INSPIRE included findings from RCT studies that have been done in the South African context (Cluver et al., 2017, Dworkin et al., 2013, Kim et al., 2007, Leddy et al., 2019, Pettifor et al., 2018, Pettifor et al., 2015, Pronyk et al., 2006), which are of particular relevance to COPESSA's approaches and this case study.

The approaches that COPESSA applies at each level draw from both theory and evidence (including INSPIRE) to prevent or mitigate CAN. For example, at the child level COPESSA offers counselling to abuse victims as secondary and tertiary prevention. Primary prevention is addressed through child abuse awareness programmes targeting both children, parents and the community, in general. Both the play park and the outdoor gym are examples of how COPESSA has facilitated creation of safe environments for community and children. At the park, children not only play safely, but also attend after-school care services. The outdoor gym reaches adults and was created with the view to improve among other things, the social cohesion and social capital of the community. Services offered at the family level include parenting skills programme and counselling for gender-based violence. Income-generating projects such as community gardens and crafts have been initiated to address the structural determinants of abuse, such as poverty and unemployment.

Children do not exist in isolation. They are embedded within systems, whether it is in families, which constitute their microsystem, or communities that form the meso-system, and society which is the macro-system (Bronfenbrenner, 1979). According to Meinck et al. (2017) 80% of CAN is not spontaneously disclosed directly by children in South Africa. COPESSA as a community-based organisation within the child's meso-system, is fully reliant on all the systems that are proximate to children, namely: family and community, as they are easily accessible, in its bid to protect children from abuse and neglect. Thus, it is incumbent on the families and communities to

be vigilant and also to know how to access supportive and protective services, such as COPESSA. In other words, all the systems within which a child exists need to be harmonised if the child's world is to be improved, as they are interrelated. This is the essence of the Ecological Model on which COPESSA child abuse multi-level and multi-dimensional prevention is grounded (Glanz et al., 2015).

1.2 Problem Statement

Despite the many statutory instruments adopted by the government to prevent CAN, it continues to be a major problem in SA. CAN is overwhelmingly intra-familial, with parents or guardians sometimes either implicit or complicit (Meinck et al., 2017, Meinck et al., 2016). Because CAN is often veiled in secrecy, it is crucial to optimise community participation in preventive strategies, as community is the next proximate level to families (Bronfenbrenner, 1979).

1.3 Study Justification

The importance of community participation in CAN preventive strategies is well documented (Ellsberg et al., 2015, Leddy et al., 2019, Petersen et al., 2005, Pettifor et al., 2018, Pettifor et al., 2015, Pronyk et al., 2006, World Health Organization, 2016). As such, it was not the purpose of this study to examine the relationship between community participation in CAN prevention programmes and its impact on CAN. COPESSA has created community development programmes to prevent CAN. Logically, the community would be expected to embrace those programmes that are meant to improve their children's and their own lives. However, COPESSA was experiencing poor and fluctuating levels of buy-in and commitment from the community in the CAN prevention programmes. In fact, it was experiencing increasing vandalism of some of these programmes. This study sought to unearth the reasons behind this perceived indifferent and negative sentiment from the community. It also sought to add to the discourse on community

participation in community development programmes in post-apartheid South Africa.

1.4 Study Aim and Objectives

The aim of this study was to explore how to optimise community participation in CAN prevention programmes in Protea Glen, Soweto (PG) in 2017/18.

The objectives were:

1 To describe how community members, perceive CAN in PG, in 2017/8.
2 To describe the community's own perspective on community participation in general in PG, in 2017/8.
3 To describe community participation in COPESSA CAN prevention programmes in PG, in 2017/8.
4 To describe factors that influence (enablers and barriers) community participation in CAN prevention programmes in PG, in 2017/8.
5 To explore how COPESSA can increase (recruit and maintain) community participation for CAN prevention programmes in PG, in 2017/8.

1.5 Literature Review

1.5.1 Community Participation

Community participation (CP) in health care is at the heart of many health principles such as Primary Health Care (PHC) (World Health Organization, 1978), Health Promotion (HP), (World Health Organization, 1986) and policies that seek to address health inequalities and social determinants of health (Campbell and Jovchelovitch, 2000, Solar and Irwin, 2010b). CP is advanced not only just for pragmatic reasons such as free or cheap community labour, but also for both ethical and human rights reasons (Solar and Irwin, 2010b). South Africa not only promotes CP through its adoption of PHC and HP principles, but also guarantees and protects the rights of CP at local government level through the South African Constitution,

the supreme law of the land (Government of South Africa, 1996a, Fuo, 2015, Williams, 2006).

Despite of the foregrounding of CP, many scholars lament the fact that the 'community participation concept' remains very elusive, difficult to define, and to measure (Baatiema et al., 2013, Campbell and Jovchelovitch, 2000, Rifkin, 1996, Rifkin, 2014, Rifkin, 2016). This has been attributed to the lack of standard definitions of "community" and "participation" (Baatiema et al., 2013, Rifkin, 1996, Rifkin, 2014), and a common frame of reference (Rifkin, 2014). For instance, communities can typically be defined as circumscribed geographical areas, or more generally by shared characteristics or identity, reality, interests, values, norms, and conditions and constraints of access to material and symbolic power (Campbell and Jovchelovitch, 2000, Glanz et al., 2015, Bartholomew et al., 2011). For the purpose of this study, the use of a geographical area will be used as a starting definition of community.

As alluded to above, the term 'participation' is a broad concept that includes an array of activities that are on a continuum and range from manipulation, consultation and ultimately citizen control, as classically portrayed in the Arnstein Ladder of Participation (Mchunu, 2009, Rifkin, 2016). In other words, at its worst, participation results in manipulation of communities and at its best, in empowerment. The lack of a clear and uniform definition and the context specificity of participation has led research scholars to argue that participation should not be regarded as an intervention, but should rather be framed as a process that supports outcomes (Claridge, 2004, Rifkin, 2014, Rifkin, 2016). Rifkin further asserts that the practical implication of this is that participation does not lend itself to RCT intervention evaluations as an exposure.

The use of diverse frameworks in explaining the CP concept and its 'under-theorisation' has been blamed for the lack of consistency in defining and measuring its effect (Campbell and Jovchelovitch, 2000, George et al., 2015). Yet, it is important to understand the approach and paradigm from which people view CP. For example, Rifkin describes two approaches of CP,

namely “bottom-up” (also known as (a.k.a.) “empowerment approach”) and top-down (a.k.a. “target-oriented frame”) (1996). The “bottom-up approach” has at its centre an organic transfer of power and control from the significant others, who often are authorities, to the poor and the marginalised (Baatiema et al., 2013, Rifkin, 1996). On the other hand, the “top-down” approach views CP as a pragmatic utilitarian strategy for increased access to, acceptability of, and availability of health services, wherein health workers have most of the ‘power-over’ programme design and implementation (Campbell and Jovchelovitch, 2000, George et al., 2015, Rifkin, 2014).

Typically, these two approaches were seen to be mutually exclusive for CP and Rifkin referred to this paradigm as “either-or”, whereas she suggested a new paradigm referred to as “both-and,” where these two approaches exist alongside each other, depending on the context in which CP is occurring (1996). Furthermore, in this paradigm there is mutual respect between locals and professionals, with both parties able to bring their “expertise” to bear on programmes and potential consequence of both improved health outcomes and community empowerment rather than one or the other as is the case with the “either-or” paradigm (Rifkin, 1996).

Various barriers to CP have been identified, such as poverty, where there are greater concerns about basic survival needs as propounded in the Maslow’s Hierarchy of Needs to explain human motivation (Glanz et al., 2015) and cost in terms of time, labour, material resources, training and education (Campbell and Jovchelovitch, 2000, Chifamba, 2013, Ndou, 2012). Furthermore, lack of trust in health workers and community leadership who are accused of making opportunistic and false promises during political campaigns, and lack of transparency, accountability, and credibility, have also been cited as barriers (Chifamba, 2013, Mchunu, 2009). Finally, poor communication between community participants and officials, characterised by power imbalance and communication being reduced to information dissemination rather than dialogue (Chifamba, 2013, Namatovu et al., 2014) and lack of monitoring and evaluation (Ndou, 2012), are other important barriers to CP.

Some factors that enhance CP are: respect for people (Chifamba, 2013); improved and good communication lines which encourage dialogue (Chifamba, 2013); communities that are easy to mobilise (Namatovu et al., 2014); on-going community sensitization and general awareness creation (Chifamba, 2013); training and capacity-building (Chifamba, 2013); and community perception that the initiative is relevant to their needs (Chifamba, 2013). In addition, Social Capital has been identified by many researchers as a very important resource that could enhance community participation, especially among poor communities (Murayama et al., 2012, Thomas, 2006).

Social Capital can be defined as "the glue that holds societies together" Serageldin and Grooaert (2000) cited in (Thomas, 2006), and has at least four types, namely: Cognitive Social Capital (described as "people's perceptions of the level of interpersonal trust, sharing, and reciprocity); Structural Social Capital (described as the "density of social networks or patterns of civic engagement"); Bonding Social Capital (that describes the "relationships within homogeneous groups" such as "family members, neighbours and close friends"); and Bridging Social Capital (that describes "the weak ties that link different ethnic and occupational backgrounds") (Murayama et al., 2012). The different types of Social Capital have different life outcomes. For instance, the Bonding Social Capital helps people to 'get by' in life – a term that has been used to describe the social support, which may be in the form of instrumental, informational and emotional support. Bridging Social Capital helps individuals or groups to 'get ahead' in life by accessing resources, opportunities and networks outside one's homogeneous group (Block, 2008, Murayama et al., 2012, Thomas, 2006).

To overcome most of the challenges and barriers of CP cited above, there is consensus that the level of participation needs to be increased (Campbell and Jovchelovitch, 2000, Chifamba, 2013, Namatovu et al., 2014, Ndou, 2012). The "Arnstein Ladder of Participation" cited in (Mchunu, 2009) and the "Rifkin's Spidergram" (Draper et al., 2010) are just two examples of frameworks that have been used to empirically measure the levels of

community participation. For the purposes of this research the Rifkin Spidergram framework was used to evaluate the level of CP (see Figure 2).

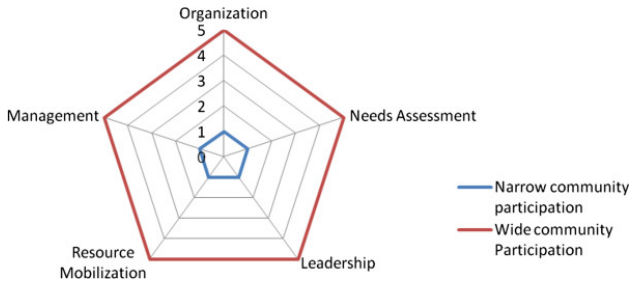

Figure 2: Rifkin Spidergram Framework: (Ref: https://www.researchgate.net/figure/242332454_fig1_Spider-gram-for-measuring-community-participation-15)

Rifkin views participation on a continuum and suggests that there are five indicators for the level of participation, namely: Needs assessment, Leadership, Organisation, Resource Mobilisation and Management (Draper et al., 2010, Rifkin, 2016). Each indicator is assessed on a continuum scale of 1- 5, with one indicating the lowest level. When all five indicators are joined together they form a Spidergram; the wider it is the more participation there is.

The Rifkin's Spidergram framework was preferred for its simplicity, visual nature and because it lends itself to a democratic participatory process for all those involved in the focus groups (Baatiema et al., 2013, Draper et al., 2010). It is also widely cited in literature (Baatiema et al., 2013, George et al., 2015, Barker and Klopper, 2007).

For the purpose of this study participation was viewed as a process that may be implicit or explicit in certain activities and pathways of change rather than an intervention, and included the whole range of activities along the Arnstein Ladder of Participation (Mchunu, 2009, Rifkin, 2016); the preferred paradigm for this study was the "both-and" as the PG community was understood to be heterogeneous, with multiple contexts; and the Rifkin's Spidergram (Draper et al., 2010) was used as a framework for quantitatively assessing the level of participation.

1.5.2 Child Abuse and Neglect (CAN)

As previously mentioned, CAN includes all acts of physical, emotional, sexual ill-treatment and neglect (Richter and Dawes, 2008), and is just one of the forms of VAC (World Health Organization, 2016). According to Tomison and Wise (1999) key community-level social drivers of CAN such as poverty, neighbourhood, culture and poor parenting practices are more applicable to physical abuse, emotional abuse and neglect than to sexual abuse. Sexual abuse is driven more by male dominance and power, especially in patriarchal societies, where children and women enjoy an inferior social status (Tomison, 2000, Tomison and Wise, 1999). According to the Commission on Social Determinants of Health (CSDH), gender, power and poverty are structural determinants of health inequities and hence appropriately addressing them results in significant and impactful positive health outcomes (Solar and Irwin, 2010a).

It is interesting to note that intimate partner violence (IPV) does not just only share the same social drivers as sexual abuse, but has also been overwhelmingly shown to be associated with CAN (Abramsky et al., 2016, Jewkes et al., 2010b, Tomison, 2000, Tomison and Wise, 1999) and HIV incidence (Abramsky et al., 2016, Jewkes et al., 2011, Jewkes et al., 2010b, Pettifor et al., 2018, Pettifor et al., 2015, Pronyk et al., 2006, Tomison, 2000, Tomison and Wise, 1999). In fact, Jewkes et al. (2010b) demonstrated in their longitudinal analysis of a previously published cluster-RCT the temporal sequencing of IPV and HIV infection among women. In addition, there is substantial scientific evidence to suggest that all forms of CAN are related and tend to co-occur (Afifi et al., 2017, DSD et al., 2012, Silverstein et al., 2008, Tomison, 2000, Tomison and Wise, 1999, Wilkins et al., 2014), and in fact, that all forms of violence are related (Wilkins et al., 2014). Consequently, a reduction of one form of CAN or VAC; reduction of poverty; improvement of parenting skills; decrease of IPV; and reduction of the other forms of VAC will result in the reduction of CAN overall.

1.5.2.1 Physical Punishment versus Child Physical Abuse

This section looks closely at one form of abuse: Child Physical Abuse, as it is one form that tends to be controversial and is currently topical in South Africa, as the country is grappling with the relevant legislation.

The South African Department of Social Development, which is primarily tasked with the protection of children countrywide, defines physical punishment as:

> *the use of physical force with the intention of causing a child to experience pain but not injury for the purpose of correction or control of the child's behaviour* and, child physical abuse as *actions which result in actual or potential physical harm from an interaction or lack of an interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust.* page 22 (DSD et al., 2012).

The same definitions will be used for the purposes of this study.

Researchers have argued that the corrective intent or context and the reasonableness of physical or corporal punishment, as it is synonymously called, are not enough to protect children from physical abuse, as the threshold beyond which physical punishment becomes physical abuse is ill-defined (DSD et al., 2012, Frechette et al., 2015). In other words, corporal punishment co-occurs with physical abuse, a fact that has been confirmed in recent studies (Afifi et al., 2017, Frechette et al., 2015). Also, a recent large nationally representative survey has found increased likelihood of co-occurrence of physical abuse with other serious forms of abuse, such as emotional abuse and neglect, sexual abuse, and exposure to domestic violence in childhood (Afifi et al., 2017). In addition, there is now overwhelming evidence that child physical abuse (DSD et al., 2012, Reading et al., 2009, Richter and Dawes, 2008, Seedat et al., 2009, Makhasane and Chikoko, 2016) and harsh physical punishment, (defined as shoving, pushing, grabbing, hitting, slapping without causing any visible injuries) (Afifi et al.,

2017) have deleterious effects both in one's childhood and adult life, which includes violent behaviour to one's own children.

As a consequence of the above research and also the incongruence of physical punishment with the rights of children as outlined in the UNCRC, which prescribe that children should be protected from all forms of violence (Cuddy and Reeves, 2014, Richter and Dawes, 2008, Seedat et al., 2009), corporal punishment is prohibited in many countries (Cuddy and Reeves, 2014, Hobbs et al., 1999). About 1 in 4 countries worldwide (52 out of 195 countries) have totally banned this practice in all settings while the rest have either partially banned it or continue to use it in all settings (Global Initiative to End All Corporal Punishment of Children, 2019). Those who have kept this practice cite religious and cultural reasons and the sacrosanctity of parents' rights to "discipline" their children (Cuddy and Reeves, 2014, Vieth, 2014), a euphemism that is often used for corporal punishment.

Post-apartheid South Africa has gradually been phasing out the use of corporal punishment in an attempt to align its Laws with both its Constitution and the obligations it has as a result of ratification of the UNCRC and the ACRWC, among others. The South African Schools Act (No.84 of 1996) and the Abolition of Corporal Punishment Act (No. 33 of 1997) banned corporal punishment in schools and prisons, respectively (DSD et al., 2012, Makhasane and Chikoko, 2016, Staff Reporter, 2018). The work to amend the Children's Act to provide for the requisite legal proscription of corporal punishment at home only began in earnest in July 2018 with the publication of the draft Children's Third Amendment Bill for public comment (Staff Writer, 2018), even though the need for amendment was mooted at least a decade ago (Richter and Dawes, 2008, Waterhouse, 2007).

For the longest time parents in South Africa were allowed to use the common law defence of "reasonable chastisement" in mitigation when criminally charged with assault of their children until the 2017 landmark judgement by the High Court, which outlawed its use (Staff Reporter, 2018, Staff Writer, 2017). This judgement and therefore the banishment of corporal

punishment in homes is currently in front of the Constitutional Court, the highest arbiter in the land (City Vision, 2018, Solar and Irwin, 2010b). Until the requisite laws are passed, corporal punishment will continue to be used by parents as a form of 'discipline' and scores of children will continue to suffer abuse at the hands of the very people who are supposed to safeguard their rights and welfare, with little or no recourse. We however, know that although laws are necessary they on their own are insufficient to change attitudes and behaviours (Makhasane and Chikoko, 2016), and so behaviour change interventions will have to be introduced alongside these laws.

1.5.3 Relationship of Community Participation and CAN Prevention

Community participation is both a critical process and is embedded in the concepts of community mobilisation, collective efficacy and empowerment (Bartholomew et al., 2011, Glanz et al., 2015, Schiavo, 2014). In fact, Pritchett and Woolcock (2004) cited in Draper et al. (2010), quips that while there may be evidence that "without community participation health and development programmes flounder," there is limited evidence that show the converse. Such associations and assertions infer that interventions that demonstrate effective community mobilisation, empowerment and/or collective efficacy have effective community participation.

At least four of the seven INSPIRE strategies shown to be effective for the prevention of VAC,(namely: changing of norms and values; creation of safe environments, parent and caregiver support and income and economic strengthening) can be classified as either family- or community-level interventions and have used a participatory process of one form or the other (World Health Organization, 2016). Studies that have been evaluated as either effective or promising in preventing CAN at community-level have used multiple approaches (Abramsky et al., 2014, Abramsky et al., 2016, Bandiera et al., 2018, Dworkin et al., 2013, Pettifor et al., 2018, Pettifor et al., 2015, Pronyk et al., 2006, World Health Organization, 2016). These include approaches, such as community mobilisation (Abramsky et al., 2014,

Abramsky et al., 2016, Kyegombe et al., 2015, Lippman et al., 2018, Pettifor et al., 2018, Pettifor et al., 2015) and empowerment (Bandiera et al., 2018, Kim et al., 2007, Pronyk et al., 2006); and outcomes such as collective efficacy (Leddy et al., 2019). At the heart of all of these approaches and outcomes is participation.

The mechanisms by which interventions reduce CAN are varied, but often involve indirect pathways and address the social determinants of CAN. Interventions that have reduced CAN addressed issues such as adult IPV, HIV, and gendered norms and ideologies, either singularly or in varied combinations (Abramsky et al., 2014, Bandiera et al., 2018, Dworkin et al., 2013, Leddy et al., 2019, Pettifor et al., 2018, Pettifor et al., 2015, Pronyk et al., 2006, World Health Organization, 2016). The targets of such interventions have varied; some studies comprised mixed populations of adolescent girls and women (Jewkes et al., 2010b, Lippman et al., 2018, Pronyk et al., 2006), men and women (Abramsky et al., 2014, Abramsky et al., 2016, Pettifor et al., 2018), and men only (Dworkin et al., 2013). Few interventions trials directly or exclusively addressed the various forms of abuse among children (Baiocchi et al., 2016, Cluver et al., 2017, UNICEF Office of Research, 2018, Bandiera et al., 2018). In addition, Jewkes et al. (2014) suggest that boys and men should be included in VAWG prevention interventions, not just as perpetrators but as agents of change. Given high levels of variations in these trials, e.g. age, gender, cluster numbers and their sizes, follow-up periods, different confounding factors and different outcome assessments, inter-study comparability and replication in other communities is not possible. However, despite all these methodological challenges, there is enough evidence that VAC and hence CAN, can be prevented either directly or indirectly through interventions that use participatory processes (World Health Organization, 2016).

2. METHODS

2.1 Overview

The methodology chapter chronicles the processes that were followed in conducting this case study that sought to answer the research question: 'How can COPESSA improve and optimise community participation in CAN prevention programmes in Protea Glen, Soweto?' Furthermore, it furnishes reasons for choosing the qualitative research methodology using a case study, as a preferred research method. Lastly, it explains how the data were collected and analysed. The positionality of the researcher is also addressed here.

2.2 Study design

In order to answer the research question, a qualitative research study using a single case study approach which had descriptive, explanatory and exploratory components was selected (Yin, 1994). In addition, a participatory method was used in the focus groups discussions to measure the level of participation using the Rifkin Scale (Draper et al., 2010). As previously mentioned, a participatory method was preferred because it lends itself to a democratic participatory process for all those involved in the focus groups (Baatiema et al., 2013, Draper et al., 2010).

The qualitative research method was deemed appropriate as it allows for in-depth and nuanced understanding of people's perspectives and experiences, and the context in which they live (Hennink et al., 2011). In addition, this method was more suitable for answering the "how" and "why" questions (Yin, 1994), such as those that are outlined in the study objectives. Furthermore, as child abuse and neglect is a sensitive topic this method is most suitable as the process of rapport-building allays anxieties and allows for better participation of the study participants (Hennink et al., 2011).

Case studies are the preferred approach when exploring contemporary real-life events that an investigator cannot manipulate (Yin, 1994), which in this case is the prevailing perceived poor community participation in CAN prevention programmes. Further, this approach is used to generate ideas and concepts that can be used in follow-up work, one of the rationales for conducting case studies (Gilson, 2012) and also the aim of this study.

2.3 Study site and setting

This case study research was conducted at COPESSA, the only not-for-profit organisation that offers CAN prevention services in PG, Soweto. PG is a relatively new and rapidly growing black suburb with mortgaged houses in contrast to the "match-box houses" built by the Apartheid government. It was established in the 1990s for "middle-class" civil servants such as South African Police, nurses, teachers, and the military, to the west of Soweto (Affordable Land & Housing Data Centre, 2012).

The population size is about 75 634, of which 45% are below the age of 25 years and 52% are females (Statistics South Africa, 2011). The population demographics have changed over the years, and are now predominantly lower-income families. There is also an informal settlement, Waterworks, about two kilometres away from this suburb, which utilises the same institutional infrastructure as PG.

2.4 Study Population and sampling

The study population comprised PG community members who were older than 18 years of age and had resided in this community for at least the last three years. Participants were purposively sampled for maximum variation from three categories, namely:

a) Those community members that were currently participating in the COPESSA child abuse and neglect prevention programmes, such as the garden project, out-door gym and crafts programme.

b) Those community members who had since left the above programmes, and
c) Those community members who had never participated in the various CAN preventive programmes, but are either parents or grandparents of the children, who attend the COPESSA after-school-care activities.

Grandparents were purposively sampled so as to get balanced multi-generational views, as they are often primary caretakers. They were identified from COPESSA registers for orphaned and vulnerable children (OVC). The rationale for including those community members who have never participated in COPESSA activities was to gain insights into the barriers to participation. On the other hand, those who had participated in one programme or the other would be able to shed more light for the reasons behind their level of participation.

2.5 Data collection

Data collection was done at the COPESSA boardroom to allow for privacy and some level of intimacy, over two days from the 13th to 14th November 2017. The study used focus group discussions (FGDs) and group discussions (GDs) when there were not enough participants to form a focus group, to collect data. Participants were offered an option of in-depth interviews if they did not feel comfortable talking in the group at the beginning of each discussion, but none took up this offer.

This FGD technique was preferred because the interaction among the participants assists in gaining rich and nuanced insights into shared attitudes, perceptions, and opinions on community participation in sensitive topics that are culturally-loaded and framed by normative belief systems (Ehrlich and Joubert, 2014). FGDs are also flexible, relatively lower cost than individual interviews, and have high face validity (Babbie, 1992). However, a disadvantage of FGDs includes possible peer pressure for those involved in group discussions (Babbie, 1992, Ehrlich and Joubert, 2014).

As the Primary Researcher (PR) is intimately involved with COPESSA, the services of an independent experienced social Assistant Researcher (AR) were sought to improve the objectivity of the research. The AR was a male PhD candidate studying at the University of Pretoria. At the beginning of each discussion, the Researchers would introduce themselves and the purpose of the discussion and then obtain written consent from each participant for participation in the study and audio recording of the discussion (see Appendices 1 and 2). The participants were given information sheet, which outlined, among other things, the purpose of the study, the rights of the participants and the confidentiality of the information shared during the discussions (see Appendix 3)

As an icebreaker the AR would ask the participants to choose either a fruit or an animal or a number that best represent them and to explain the qualities that influenced their choice. Although this was a bit time-consuming it was helpful to lighten the mood and ease the facilitation of the discussion. All the discussions were conducted in vernacular languages, namely: isiXhosa, isiZulu, seTswana and seSotho, and the participants were encouraged to participate and to give each other an opportunity to express themselves without interruption and opposing each other's views. While some participants used the vernacular languages, others switched between vernacular and English.

Once all the participants had signed the informed consent, which was also explained in vernacular, the AR commenced the discussions using the FGD guide, (Appendices 4 & 5), to flexibly guide them. The AR led most of the discussions, with the PR taking field notes and ensuring proper recording of the proceedings. The field notes comprised non-verbal and verbal communications, using the assumed pseudonyms and the first few words spoken for purposes of matching the audio recordings and the identification of each participant. The PR would from time-to-time ask for points of clarity whenever it was deemed necessary and did on-going quality checks to ensure that the discussion did not digress from the intended purpose.

The AR conducted all but one group discussion where the participants had never participated in the COPESSA CAN prevention activities, which was conducted by the PR. Both researchers felt that the PR would not have undue influence on the participants, as the PR did not know them personally.

A participatory exercise using Rifkin's Spidergram (Draper et al., 2010, Rifkin and Kangere, 2003) was conducted after the FGD with community members who had participated in the various COPESSA CAN prevention programmes (FGD1). The group was split into two, with the PR facilitating the group with the participants who had recently joined the programmes who were attending the gym group and the AR the group with long-standing members. The latter group split themselves into two subgroups, namely: Garden subgroup and the Sewing subgroup and did the exercise separately, as they felt that they were formed at different times under different conditions. This yielded three assessments and the findings will be presented separately.

The aim of this exercise was to assess the level of participation where a score of 1 represents low participation and 5 is the highest participation (Baatiema et al., 2013, Draper et al., 2010). After explaining the five different indicators of the Rifkin Spidergram in vernacular, the participants were asked to discuss, negotiate and agree on a score for each indicator, which best applied to their group. The participatory session with the long-standing members was both video- and audio-recorded so as to capture accurately the negotiations and interaction of participants, while the participatory session for those who had recently joined the programmes was only audio-recorded. A separate consent form was signed for video-recording (see Appendix 6).

The duration for various group discussions varied depending on the size, the level of engagement and when the saturation point was deemed to be reached for each discussion point (see Table 1). There were three FGDs and two group discussions, which were conducted.

Once each FGD was finished the PR and AR would thank the participants and dismiss them. They were given transport money and

refreshments. Those who needed referral as identified during the discussion would be referred to COPESSA social workers for counselling. A total four participants were referred for counselling. The Researchers would then reflect on each section, compare field notes and re-sharpen the focus guide to prepare for the next group discussion.

2.6 Data management and analysis

2.6.1 Data management

Once all the GDs were finished, the audio-recordings were given to the AR for translation and transcription. The parts of the recordings that were in English were presented verbatim and those in vernacular language were translated to English. To improve quality assurance, one audio-recording from FGD1 was given to a different transcriptionist for verbatim transcription. The PR first compared the translated transcript to the verbatim one, to check for the quality of translation and then verified each translated transcript against the audio-recording to check if true to raw data.

Each transcript was labelled for each group discussion and the participants were identified using the first words spoken as reflected in the field notes that were taken by the PR. The pseudonyms the participants assumed during the group discussions were used to anonymise data and where people's names were used these were replaced with the letters of the alphabet. Some of the colloquial terms were retained in the transcripts. The PR filed all the hard-copies of transcripts, the field-note pad, the Rifkin Spidergram exercise notes, and the signed consent forms in a file-cabinet to be kept safe for the prescribed two years after publication or six years if not published.

Unfortunately, the video-recording data was corrupted and could therefore not be used as part of the analysis. It was felt that this would not negatively impact data quality as the participant negotiations could be gleaned from the audio-recordings.

2.6.2 Data analysis

The PR (researcher) first manually coded one transcript from FGD1 to get a feel of the data and to develop some preliminary codes, as this transcript had the richest data. The researcher used thematic content analysis to analyse the qualitative data (Creswell and Poth, 2018). The topics in the interview guides were used to develop the deductive codes and others were derived from what the participants said, generating both inductive and *in vivo* codes. All the transcripts were then imported to MAXQDA, and using the preliminary codes developed during manual coding the other transcripts were coded using the MAXQDA software. The code development process was quite iterative, with some codes either modified or collapsed into already existing codes, as one went through the other transcripts, until a draft codebook was developed. The draft codebook, together with the FDG1 transcript, were shared and discussed extensively with the researcher's academic supervisor, for the purposes of validation of the coding process, the consistency of coding and to check for inter-coder reliability. The researcher then finalised the codebook, which included themes, sub-themes and inductive codes, using the feedback received from the supervisor. All transcripts were coded using the codebook and they were analysed thematically. The themes were then organised using matrices and interpreted. The use of thick description was applied to address issues of transferability to other contexts or settings.

2.7 Reflexivity

I am a founding member and a chief executive officer of COPESSA. In my opinion the community trusts me. However, as an insider, and PR, I am aware of the possible bias and undue power dynamics that may have been there between the participants, some of whom might feel they owe their livelihood to COPESSA, and myself. As a founder of the organisation I also have vested interests in the success of this organisation, and this may also bias the interpretation of the findings.

I share some of the cultures, values and experiences of this community, but I am also aware that the class differences between myself and the participants provides different frames of references.

I speak many of the vernacular languages spoken in this community, however my writing abilities are limited to isiZulu and isiXhosa. I am also cognisant of the bias and limitation that my bio-medical training, which often focuses on cause and effect, may have on social research.

The meticulous field notes and memos taken by myself and AR were compared after each group discussion to mitigate these shortcomings. The audio recordings also reduced the risk of selective coding. Once I had coded the transcripts I shared the codebook with my supervisor for independent coding and rigorous discussions where there was no agreement. This working together on both the coding and data analysis helped to mitigate to my biases.

2.8 Ethical considerations

The protocol was approved by the University of Witwatersrand Human Research Ethics Committee (HREC) and a clearance certificate number M170870 issued (Appendix 7). Furthermore, consent was granted by the Chairperson of The Board of Directors of COPESSA and the Local Councillor of Protea Glen, as the ordinary community members were participating in this study. All the participants in the FGDs were provided with written consent for the study as well as any recording before participation. Because there were those participants who have no formal education, the contents of the written consent were explained in vernacular language, and they were asked to either print their names or their signature.

All information sheets emphasised that participation in the study was voluntary and without any incentives, except for covering the cost of travel for participants. The AR explained this to the potential participants so that they may not feel pressured to participate. Each participant was given a participant

information sheet, which was written in simple language. Confidentiality and anonymity of the recordings was maintained by making use of pseudonyms, especially because translation/transcription services were to be used. Also, FGD participants were told that confidentiality could not be promised between participants. To mitigate this risk, all FGD participants were requested to keep all information discussed at the groups confidential. All recordings and transcripts are stored safely at the work safe, which has very limited access and copies will be kept in a safe at home, and will be destroyed two years after publication or else after six years.

3. RESULTS

3.1 Overview

This chapter presents the results from the analysis of data collected in the study in line with the stated study objectives. These were organised into an ecological framework during analysis, which will be introduced and used to guide the presentation of findings. Firstly, I present the participants' perspectives of CAN, which includes their understanding of the different types, the reasons behind child abuse and neglect and their effects on children. Then I explore their understanding of community participation in both general community affairs and COPESSA CAN prevention programmes. A presentation of barriers and enablers of participation in COPESSA CAN prevention programmes then follows. Lastly, I present study participant recommendations on how participation in these programmes can be improved.

3.2 Sample description

The three FGDs and two GDs that were conducted yielded a sample size of 32 participants, the majority of which were females (27 females and five males). FGDs comprised at least six participants and GDs were made up of at most five participants. Fourteen of these participants were currently involved in the programmes, eight were past members, and ten had never participated in any COPESSA CAN prevention programme. All the participants were adults, some parents and others grandparents. Table 1 summarises the characteristics of the different groups.

Table 1. Sampling of the participants

Sample Category	FGDs and GDs conducted	Sample Description (identifier in bold)	Duration of the discussion
a. Those currently participating in CAN preventive programmes	FGD 1 - Garden Project & Crafts, & Outdoor Gym FGD 2 – Parents and grandparents of after-school care children	**FGD 1**: 8 Participants – 5 female and 3 male **FGD 2**: 6 Participants – all female	1hr 30 min 1hr 27 min
b. Past participants in the last five years	GD 3 - Outdoor Gym GD 4 - Garden Project & Crafts	**GD 3**: 3 Participants – 2 female and 1 male **GD 4**: 5 Participants – all female	1h 43 min 1hr 21 min
c. Those who have never participated in the CAN Activities	FGD 5 - Parents and grandparents of children who attend at the nearby schools but do not participate in COPESSA's after-school care programmes	**FGD 5**: 10 Participants – 9 female and 1 male	2hrs 39 min

3.3 CAN in context: An ecological framework

The participants identified causes of CAN, which were arranged during analysis to align with the four levels of the Socio-Ecological (S-E) Framework, namely: Societal, Community, Family and Child (see Figure 3). There were common themes that were cross-cutting through different levels as can be seen from the framework and some that were limited to certain levels. These cross-cutting themes will be presented only at the highest common S-E level with the exception of 'poverty', which even though is a societal determinant will be presented at the community level. However, the application of these cross-cutting themes at the lower levels will be highlighted within that highest level at which they are presented. Some themes, which though dominant are not quite relevant to the objectives of this study, will be woven into the relevant themes as they provide more nuance and context to the participants' views.

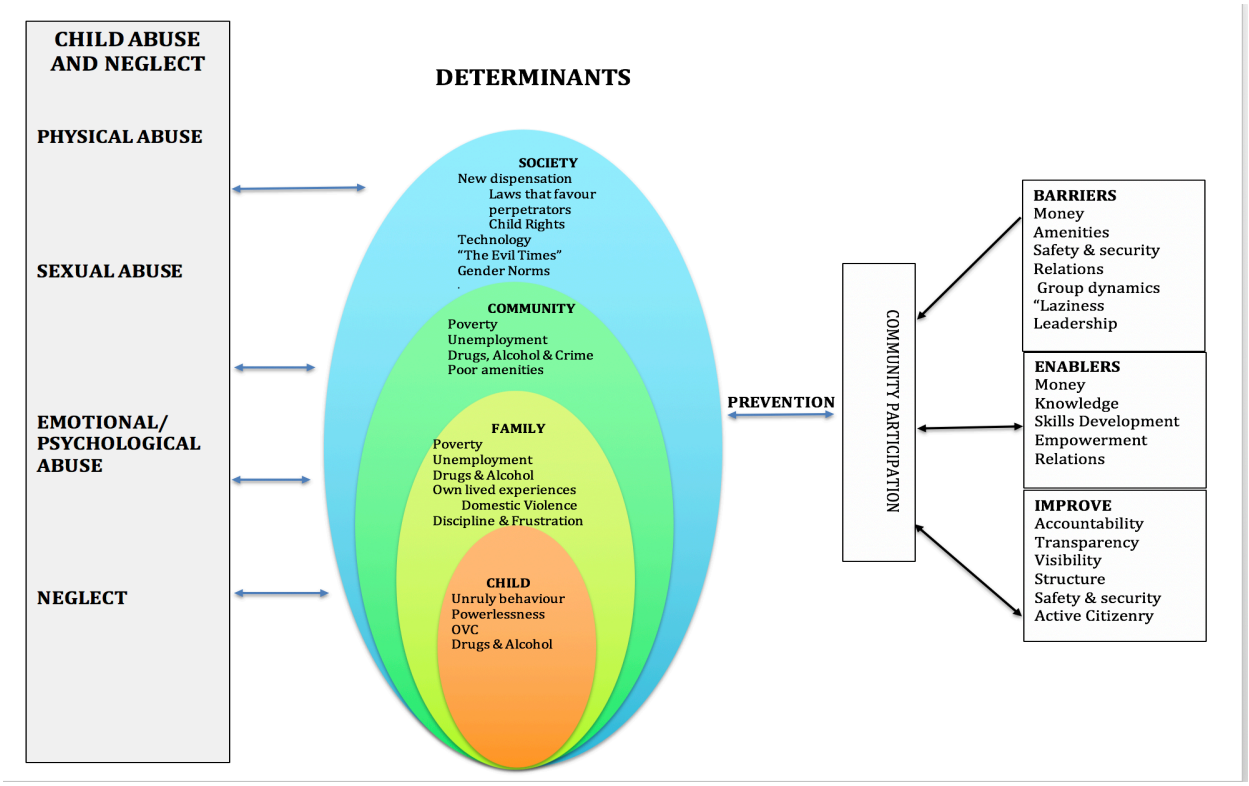

Figure 3: Socio-Ecological Framework of CAN and determinants of community participation in CAN prevention

3.4 Participants' perspectives of CAN

3.4.1 Definitions of CAN

There was a fair to good knowledge of what CAN means among the child caregivers, with some participants reflecting on those acts that are committed to children and others on those that are omitted. Terms related to neglect such as "provision," and "taking care of basic needs" as well as those associated with abuse, such as "protection from harm" are just some of the phrases that were used to describe CAN. However, when it came to the provision for children, the participants tended to talk more about provision for the concrete physical rather than emotional needs, which are often considered softer.

> *With my understanding, CAN is not meeting the needs of a child. For instance, as a parent you know that I must ensure that a child is bathed,*

has food and clothes, and gone to school. It is like meeting the needs and protection. Also no one should harm the child... (Lamb, female, FGD1)

The participants appreciated the various types and nuances of CAN, including the direct acts and omissions such as: physical, sexual, psychological abuse and neglect; and the vicarious forms of abuse, such as psychological abuse experienced by the child through witnessing domestic violence perpetrated to one of the parents, usually a mother. There was a clear distinction made between physical and emotional neglect, although there was greater emphasis on the former by all the groups. They were able to give correct examples and definitions, as typified by the following excerpt:

I think child abuse is not meeting the basic rights. Let us say for example, a child does not go to school - it is child abuse, or when a child does something wrong and you beat the child, we can say it is child abuse. It is the way that you treat a child…It may be beating the child or child abuse can be not beating the child but the way you speak with the child, maybe you are too harsh […] I think also child abuse can also be just parents in the house abusing each other. This is psychological abuse hence child abuse because now the child will be sitting and thinking a lot of stuff about his/her parents. There can be a lot of ways where a child may feel neglected and say in this situation as a child I do not fit and there is nothing I can do about it because I am a child. The child can't say if there is something going on at home or if you are going to buy groceries they cannot say something. It is child abuse because the child is living in a nutshell (sic) where he/she does not have a say. (Lion, male, FGD 1)

The participants in all of the groups spoke at great length about physical abuse in comparison to the other types of abuse and neglect. They often conflated discipline with physical abuse and sometimes control. Using their own childhood experiences as a frame of reference for disciplining their children, there were discussions of how they were physically punished, not

just by their biological parents, but by other elders in the community as a way of disciplining. The idea of being a good or responsible person as a consequence of physical discipline was raised more than once. In this rights-based era, which seems to elevate child rights, they struggled to understand how society expects them to discipline their children in the absence of corporal punishment. With the one tried and tested method of discipline taken away and the parents unable to adapt to the new methods of child discipline, they felt emasculated, inept, and frustrated, often finding themselves on the wrong side of the law.

> *So as parents, sometimes you just tell yourself, this child has gotten out of hand. What do I do? …We are responsible citizens because we were beaten. But today as Cow is talking about the biblical times, the Bible says: "spare the rod and spoil the child." But if I use a rod to discipline the child, you can't do that. They say it is abuse! [...] You lay your hand on that child two police vans will come. Then point to them where the drugs are, no one will go there. So as parents we are being overpowered and threatened by our children and our government, and that causes frustration. That frustration causes abuse on children and when the government sees what is happening in the families, they call it abuse. We call it discipline, they call it abuse!* (Rhino, male, FGD 1)

As parents discussed CAN, Israel raised the phenomenon of 'shipping out' children to the rural areas as constituting CAN. Her rationale was thus:

> *I think when you send off children to live in the rural areas and you stay behind in the city, that constitutes child abuse. I also think that when you often leave your children alone and gallivant doing your own things, that is also some form of child abuse…* (Israel, female, GD 3)

A parent in another FGD actually described doing this to a daughter who he could not control as follows:

> *You see in my house, I sent one [child] to Limpopo because I said: "Now you are starting to overrule me, it is better that you go and watch*

the cows there because there in Limpopo there is nothing you can do, it is rural." (Rhino, male, FGD 1)

These quotes demonstrate that there was not always an agreement or uniformity of understanding among the various participants of the definition of CAN. A solution to one might seem like abuse to another.

In contrast to the outspokenness about the other forms of abuse, especially physical abuse, the participants were not as forthcoming and forthright about sexual abuse and sometimes had to be coaxed and nudged to talk about it. There was also a lot of resentment and deep-seated anger that surfaced when this form of abuse was discussed. For example:

Researcher: There are different types of abuse and there is one in particular that has not been mentioned in your responses…

Lemon: You will find that a child lives with his mother and stepfather and in that case, you find that the stepfather starts sexually abusing the child with the knowledge of the mother. These are some things that we as women and mothers are hiding in our corners. In those cases, you find that instead of the mother protecting the child she turns against the child. (Female, FGD 4)

Unlike physical abuse where parents viewed themselves as disciplining their children when they mete out physical punishment, sexual abuse was often othered and exteriorised.

Child abuse can also be when a child is being sexually molested by an uncle or relative where you find that a child is touched in her private parts and yet the perpetrator is protected by family. (Dubai, female, GD3).

Participants had an acerbic attitude towards the perpetrators, calling for the harshest punishment and even alluding to the weakness of the present

"Black-led government" as an underlying cause, as suggested by the following statement:

> *There are other forms of abuse where elderly people like an 85-year-old abuses or rapes a child. Such perpetrators must be killed immediately or the white man give them an injection so that they may lose their potency. My people, these are evil times that also involve the elderly.* (Cow, male, FGD1).

3.4.2 Social Determinants of CAN

Having discussed what the participants thought abuse is, this section will present what they thought causes abuse. The determinants of CAN will be discussed using the multi-level approach of the S-E Framework in Figure 3. I present first the factors that are found at Societal level, followed by those at Community Level, with its various institutions, then those at Family level, and lastly those at the Individual level, the child.

3.4.2.1 Societal Level factors on CAN

Factors at this level do not necessarily directly translate to abuse of children but may predispose children to CAN through either family or community pathways.

The New Dispensation – The State vs. The People

There was consensus among all the groups that the abuse and violence children and communities were experiencing had either been birthed or exacerbated by the post-Apartheid government or officials. Participants spoke passionately about how the Government had promulgated laws, introduced human rights, especially child rights, and policies that took away any power and 'control' parents and communities ever had over their children. Consequently, parents and adults in general felt alienated and disempowered describing how their children were running amok and difficult to control. They

discussed role-reversal, with children becoming parents and them becoming children, as illustrated by the following impassioned excerpt.

> *I want to add: the problem is when we got freedom, they [Government] emphasised on rights and not on responsibilities. After that the very same Government that gave people rights took away responsibilities. There is now a new legislation for employment that requires that companies in the private sector should hire young people. So, who loses out? Those who have the responsibilities are kept out and they bring in younger people who get the money. Fancy, a child getting out of school gets a salary of R10 000. What will they do with it? Do they know how to use it? They stay at home. The first thing they do is to buy a "Vrrrr…pah"* (a fast car) *and then drugs. If you check, every month-end at the bottle store, young guys with nice cars are buying alcohol. Older people, you see them coming out of Shoprite with a single paper bag. What does that tell you? Everything is just demoralising. Now it has come to a point, like my brother said, that as a parent you become a child and the child becomes a parent. Your house is just going way out and who is to blame… We put the leadership in power and they make their own laws and those laws affect those who put them in power* (Rhino, male, FGD1).

There were however, a few participants that recognised the helplessness of children and therefore their need for protection through the laws and rights the new Government introduced. But peculiarly, even though they did, they displayed a sense of internal dissonance as they in the same breath decried their introduction. For example, one participant regarded the inclusion of the Child Rights in the Constitution as a "mistake" that had far-reaching consequences, such as the inability of teachers to teach assertive children. She at the same time appreciated the helplessness of the child, as expressed in the following quotation.

> *Another mistake by the Government is that the Constitution of the country states that children have rights and a child has a right to*

receive support and protection from the parent. Those rights are now a challenge in schools and children exercise them. You will find that teachers can no longer execute their responsibilities and teach children because children have rights… You see, these are the things that cause children to suffer… It's a massive load. This helpless child gets abused that way. (Elephant, female, FGD1)

The participants viewed themselves as victims of a "Government that does not care" for them, their children and their communities. For instance, they saw the new Government as favouring criminals over law-abiding citizens and even went further to suggest that the abuse of their children was deliberate in the part of Government so that they can be further oppressed:

(Very emotional) - *That children are abused in their homes I want to say - I'm sorry to say it - the Government is involved and the parents too, because when a perpetrator rapes a child, the Government protects the criminal and not the victim. You know when I pray at night I usually ask God to come down and people like Zuma [former president] to come forward because they are the ones doing these things. A person will rape a child, a charge will be laid and they get arrested, and tomorrow they are walking the streets. This is why it is like this, "yinto yanga bom, asukuthi yisimanga" (it is deliberate, it is not a mystery). We as the community need to see that thing is deliberate, so that "sicindezeleke" (we can be oppressed)* (Pear, female, FGD2).

The reason why "the Government does not care" about the plight of the community and the children was suggested by one participant to be because "their *[the government officials']* kids are rich and overseas and are not involved in drugs" hence "you won't find their children in the streets and not going to school*"* (Cow, male, FGD1).

"Technology has worsened things"

Many participants lamented a perceived "uncontrollable" access to mass media, Internet and social media platforms. They blamed this unfettered access to these platforms for the exposure of children to inappropriate material such as pornography, which in-turn precociously groomed children, thus making them vulnerable to abuse.

> *Technology has worsened things. When we grew up, we had specified hours of watching TV but now with the introduction of phones, things are out of hand. We parents mess up things by buying these phones for them. With us, our mothers or grandmothers would instruct us to go to sleep and stop watching TV after a certain time. Now technology has destroyed everything.* (Dog, female, FGD 1)

Even though some participants took responsibility for abetting this unfettered access to inappropriate material by buying these phones for their children, there seemed to be no proactive strategy to limit the access, but rather a reactive one. Listen to the following lament by one of the participants:

> *What is an 8-year-old going to do with the phone? You know what they do is to go into the social media…You know how I got my daughters with the phone? The things I discovered in her phone, I could not believe it. It's just that when I say bring my phone, I give them but they know it's my phones. There's pornography! There are WhatsApp groups they call devil's what-what etc. They send each other pornography. They send people they date on the social media… imagine! You know, the children you know, it's bad!* (Lion, male, FGD1)

“The Evil Times” – The Perilous times

The ‘perilous times’ was a common theme that came up in most group discussions as participants tried to explain the perceived astronomical levels of abuse. Participants referenced the Bible as predicting these evil and dangerous times as evidenced by the following impassioned exchange during FGD1:

> *Cow (male): I thank you for the opportunity to respond to this short question on child abuse and neglect. Yes, there are bad ways where children are treated badly by their parents and the community. But when I look and reflect, I say these are the times. The times where fathers and mothers, are not working and children have nothing. … When I look, I realise these are the times that we have heard of, that a time shall come when all these evil things will happen. When I look, I realise really those evil times are indeed upon us. Thank you.*
>
> *Researcher: Thank you for the comment however, when you say these are the times, what do you mean?*
>
> *Cow (male): I mean evil times on earth. It doesn’t happen because of parents’ or peoples’ actions, it just happens due to the fact it is the time and it is natural. Even if you try to raise a child in a particular way where you provide everything nice, good food etc., that child will still leave all that and go drink and get drunk…*

A female caregiver from another FGD made a similar claim:

> *You see my child, the times we are living in are the ones that were prophesied in the Bible. It’s the times referred to in the book of Revelations and in Matthew by Jesus that children will wage war against their parents. In the times we live in there is no “ubuntu” (empathy), no love, and no compassion.* (Pear, female, FGD2)

While on one hand there seemed to be a degree of fatalism and passive resignation given the external locus of control described in the Biblical verses, some also expressed hope that something could be done to stem the tide. Interestingly, this hope was derived from the very same Bible.

> *The times Cow speaks of can be avoided because as he says it's written in the Bible that the times are coming whereby children will rise up against their parents and the father against his offspring and all that. But, there is a remedy for that. When you go back to the same Bible, I think it's Chronicles Chap. 7 or 4, it says that 'If my people called by my name, humble themselves and pray, I will hear them from heaven and heal their land,' and all that. But now we don't even have time for God because our religious system is being governed by the Government who does not believe. So, it becomes difficult even if you pray."* (Rhino, male, FGD1)

Gender Norms

There were no specific questions about gender in both the focus group guides or probing questions, but gendered views often cropped up insidiously in participants' assertions. It was apparent from the various discussions that males are held to different moral standards than females. Participants talked about boys and girls involved in behaviours that they deemed to be inappropriate, but would place the responsibility and blame squarely on the girl's shoulders, thus failing to shine the spotlight on the role and the responsibility boys have in these 'misdemeanours,' as illustrated by the following quotation:

> *The girl would run away even when it was not her father or mother reprimanding her if she were standing with a boy. Children, oh my God, just in front of elders you will find that a girl is hugging with a male. She is not bothered whether you are a grandfather or grandmother, she isn't bothered that she is in front of you. All that is left is that you can catch them having sex* (Cow, male, FGD 1).

One male participant in a different group discussion went as far as to portray women as “reckless” and incapable of “controlling themselves, especially when they are drunk” *(Botswana, male, GD 3).* He further suggested that they need to be protected, presumably by men. The infantilization of women who needed ongoing protection from their male counterparts was not limited to male participants. Women too supported this view, as illustrated by the following excerpt:

> *We are no longer living the way we were raised in the past. We have changed because we are free. In the homes, even mothers have rights too, whereby they say no one will tell them anything. So, the new Government brought us a big problem when I look…* (Sheep, female, FGD 1)

Social norms are a societal frame of reference for attitudes and behaviours. The differential gendered norms when it comes to moral issues for boys and girls tends to predispose girls especially to emotional abuse by their parents and society. Girls got most of the blame and penalties for sexual misdemeanours and even rape, while their male counterparts seem to get away scot-free. In the words of one participant: “girls will always be victims because boys learn from their fathers (as they beat their mothers in front of the children)” *(Participant #7, female, FGD5),* suggesting the inevitability of boys/men being perpetrators and women/girls being victims.

Consequently, as women seem to internalise these societal norms, they self-censor both their attitudes and behaviour, as suggested by one self-contradicting female participant when she said:

> *I also think this thing of walking with short skirts exposes us to threats. This is not to say our people’s way of dressing is the problem but back in the day when we were not dressing like this these crimes were not as prevalent.* (Dubai, female, GD3).

Thus, women not only blamed themselves as the cause of their victimhood status but are also at risk of limiting their power to parent and to protect their children, as they regard themselves to be children that too need to be 'controlled' and protected.

3.4.2.2 Community Level

At the community level, both structural and intermediary social determinants of health, such as poverty and unemployment, drug and alcohol abuse and lack of recreational amenities, were cited in varying contexts for the perceived high levels of CAN in this community

Poverty and Unemployment

Unsurprisingly, poverty and unemployment were spoken of often simultaneously and interchangeably, as these two have a cause-effect relationship. They were cited as one of the significant causes of CAN in this community, with participants using adjectives such as "big" and "a lot" when talking about them. According to one participant poverty was masked in PG by the "high walls," which made residents think that they are "living in the suburbs rather than in the township" (*Dubai, female, GD3*). Some participants felt that women were particularly vulnerable to poverty and unemployment as it robbed them of the "power" to protect their children and even made them to be complicit in the abuse of their children, for fear of the loss of the financial support:

> *This [complicity of women in the abuse of their children] is especially in situations where you find that the man is the sole breadwinner or in cases where this figure has a lot of money and the mother does not want to lose their source of support.* (White, female, GD4).

Several pathways of how unemployment and poverty caused CAN were identified by the different groups. For example, one participant talked about the effect isolation caused by poverty and unemployment has on

parents, whereby parents isolate themselves from their neighbours because of shame. And because "there is no one to talk to, children end up abandoning their homes for the streets" *(Blue, female, GD4).* Yet another identified unemployment and poverty as a cause of frustration for parents, which in turn caused psychological abuse of their children, who then resorted to "using drugs" *(Participant #1, female, FGD5)*.

Alcohol, Drugs and Crime

There was a consensus among all the groups that substance abuse and crime, either singularly or in combination, were a number one problem for most families in Protea Glen, which was described as being full of taverns and shebeens. Alcohol and drugs were said to be so ubiquitous to even spill-over to public spaces such as parks, including the one created by COPESSA. Participants described the parks as "packed with people smoking '*nyaope*'" and a place where children "learn the habit" of smoking drugs (*Participant #* 8, female, FGD5). 'Nyaope' – is a relatively cheap, illicit and highly addictive street drug that is unique to South Africa. It is a cocktail that comprises narcotic ingredients such as heroine and dagga and other ingredients, which include anti-retroviral drugs and rat-poison (Health24, 2014).

Participants described the effects of alcohol and drugs to be deleterious, whereby parents were said to either neglect their children as they spent a lot of time drinking as they "live in taverns and shebeens" *(Banana, female, FGD2)* or become abusive towards their children in unimaginable ways as "consumption of drugs creates fearlessness" *(Botswana, male, GD3).* The concerns about the effects of alcohol and drugs were not only limited to parents but extended to children as substance abusers, resulting in them being "uncontrollable".

> *Children are uncontrollable these days, do you know why? The first thing I would want to blame is drug use and alcohol because these two things make people fearless. When you drink alcohol, you notice that you have the courage to say or do things that you would otherwise not*

say or do and if people do not reprimand you, your confidence grows and grows. (Botswana, male, GD3)

Parents blamed a wide range of persons for the proliferation of drugs in this community including the police, neighbours, teachers, and pastors. According to one participant there was a pastor who would every evening go straight from church to the park, carrying a Bible with "a hole that had drugs inside it" *(Lion, male, FGD1).* Police were reported to brazenly supply drugs to young people so that they could sell for them and would often be seen collecting money from them.

Do you know who supplies (asking about the drugs)? It is a police van… You will think the policemen are arresting them sometimes and yet they are picking them up to drop them in their respective selling points… don't trust the police. (Participant #8, female, FGD5).

This resulted in a pervasive sense of distrust of those in positions of power and authority, and powerlessness and resignation among the participants, and among the general community by extrapolation. For example, one participant commented that "there is nothing we can do about it," referring to the perceived rampant drug and alcohol status quo *(Sheep, female, FGD1)*. There were also those who raised safety concerns and even fears of victimisation among the participants. Their fears were not only that the police could out them if they were to act as whistle-blowers, and thus active citizens, but that because the police were directly involved in drug peddling, there was no one to report to.

Who will you report to [asking about the drugs that seem to be all over the township]? You will report but still the people you report to…In fact, if you want to live in peace and be happy, you must keep quiet and be concerned with your own business. (Sheep, female, FGD1)

Alcohol was also seen as affecting not only the moral landscape of parents and their children, but also the physical landscape as the building of taverns,

which according to the participants brought revenue for the privately-owned land, was prioritised to the detriment of non-revenue-generating community spaces.

Poor amenities

Participants in the various groups, with the exception of FGD1 and FGD2, who were participants in COPESSA CAN preventive activities, complained about the dearth or inaccessibility of amenities in PG, such as sporting facilities, libraries, clinics, clubhouses for children and community halls, where youth could gather. They, however, felt that there were too many churches, "one next to the other," and because PG was private land, priority was given to business people "when they want to open taverns" and build "town houses and flats but nothing for the community" *(Participant #9, male, FGD5)*. One participant felt that even those fewer facilities that are available in this community are mainly for boys, with nothing for girls.

The lack of recreational and safe community facilities was seen by the participants to contribute to the lack of participatory activities in this community and alcohol abuse, which in turn predisposed children to abuse. For example, one participant commented:

> *When people are bored they resort to drinking alcohol. There is no other way, say I cannot go and swim, or…* (Botswana, male, GD3)

3.4.2.3 Family Level

Some of the family level determinants of CAN such as: poverty, unemployment, drugs, alcohol and crime are cross-cutting and were thus discussed at the higher level, the community level. This section discusses those factors that were not already discussed, namely: Own lived experiences of abuse and domestic violence. Because of their intersectionality they are discussed together.

Own lived experiences of Abuse and Domestic Violence

When participants were asked about their perceptions on CAN, some talked more about their own adverse experiences, either as children or currently as adults, than their own children's abuse and neglect. Noticeably, there was no such sharing by participants of FGD 1, (which comprised participants who are currently involved in the COPESSA CAN prevention programmes). There were a lot of sad and angry emotions, with some participants breaking down as they shared their harrowing experiences. Participants either spoke at great length about their experiences or interjected while others were talking so that they too could relate their own stories, as if to use the opportunity for catharsis. There was also a fair appreciation of the vicarious trauma their children were experiencing as they witnessed the parents being abused. This often prompted the researchers to remind the participants about counselling services available at COPESSA.

> *Another thing that is breaking families here in PG is the level of divorce. The rates are just too high; it is ridiculous and it affects the children. I will make an example out of me: My husband started physically abusing me, accusing me of cheating and other stuff. Meanwhile he was devising a plan to break up with me.* (Story narrated with tears and anguish in her eyes). *Ultimately, I was served with divorce papers […] I remember one day he wanted to burn the house down. The whole house was doused with petrol, he wanted to burn me up actually. I ran to the neighbours without him seeing me. […] The point is, these things affect children and as a result I was called into one of my children's school who had reported the situation to his teacher and had asked her to intervene. […] Some time ago I was taken by my husband to a forest in Randfontein and beaten up very badly. I was badly injured. […] My child's behaviour started changing and he started using marijuana and behaving badly until he was suspended at school…* (Lemon, female, GD4)

> *Researcher: If I may ask, have you or your kids seen a social worker?*

Lemon: No, none of us, except the child, who was using marijuana at his school.

Domestic violence was not confined to the partner, but it often spilt over to the children. In fact, one participant suggested that partner violence preceded child abuse, so as to neutralise the mother's protective role over her children. In these circumstances, men seemed to treat and 'discipline' their partners in the same way that they treat and 'discipline' their children, a feature of a patriarchal society.

When a man wants to beat the children, he starts with you because he knows you are going to do everything to protect them. He ends up beating everyone. (Peach, female, FGD 2).

Despite their own harrowing experiences of abuse at the hands of their partners, these mothers displayed a lot of resilience and preparedness to go to all lengths to protect their children. This resilience was, however, not shown when it came to self-preservation, with mothers seeming to accept abuse by their partners as their given lot in life:

I come from exactly that type of marriage. I was being beaten really hard each and every day for no apparent reason. Even if you look at my arms today (showing others her disfigured arms), they are full of scars. I used to block knives. I will protect my kids with everything. (Orange, female, FGD 2)

Their acceptance of their 'given lot in life' seemed to derive from their faith in God, which seemed to play a significant role in the participants' life. This faith was not only to draw strength to be able to cope with daily demands in the face of ongoing partner abuse, but also seemed to justify the lack of action against the abuse or the perpetrator:

Where I stay I am also being emotionally abused by my partner and I keep wondering why he does that, why he continues to do that, and I

can't find an answer. I believe when things happen it is because God has allowed them to, there is a purpose. He is the one who will see to all of it, we are sent to just live and everything is in God's control (Dubai, female, GD3).

Irrespective of the coping mechanisms that these mothers seemed to have developed, one could not help but wonder how they could parent their children, when they themselves were hurting and being treated like children by their partners, often in front of the very children they are supposed to parent.

Ones' own lived experiences of abuse did not always result in anger, bitterness and resentment but ironically in empathy for the abuser. This is what one of the participants who when reflecting on her abuse by her uncle said: "I think that sometimes a person abuses you without realising that they are abusive. […] I think he was not aware that he was abusing me, instead he thought he was disciplining me" *(Watermelon, female, FGD2)*. Others remembered these childhood experiences positively and with great nostalgia as necessary experiences. Although painful at the time of being experienced these childhood experiences had nonetheless shaped them up to be "responsible citizens" they had become.

3.4.2.4 Child Level

As children were not part of the group discussions, the views presented here are those of their parents. Although the focus of this study was on CAN, parents tended to talk more on their own trauma and challenges than on their children's, hence there was relatively less said about children. Accordingly, the findings on the 'child level' will not be presented under sub-headings as was the case with the other three levels, namely society, community and family. Also, drugs and alcohol as pertaining to children were discussed at a higher level, and will be mentioned here in so far as they interact with other determinants.

The overwhelming narrative by parents about children was quite negative. Children were said to be disrespectful to the elders as they often talked back to them or disregarded parents' instructions. Parents felt under-appreciated by their children, who despite all their efforts and sacrifices did not reciprocate with good behaviour, but instead indulged in drugs, alcohol and lewd behaviour. Girls were particularly singled out for their love of alcohol, involvement in age-disparate relationships with men for money, and sex, sometimes going to the extent of blackmailing men:

> *A young girl can approach a teacher and say: "if you don't love me, I am going to expose you," when the teacher has done absolutely nothing […] You know chief (referring to the researcher), we don't have children any more in our houses* (Lion, M, FGD1).

Parents were very frustrated as they felt there was nothing much they could do to change their children's behaviour. According to them the abolition of physical punishment and the introduction of children's rights meant that there were no consequences any more for bad behaviour. Children were simply untouchable.

There seemed to be no agreement between parents about whether collective parenting that used to work during their childhood, whereby all parents in the community were responsible for all the community's children and parents reinforced each other's parenting, had a place in today's parenting. There were those who thought it would not work due to some parents taking offence to have their children disciplined by somebody else other than themselves or due to the assertiveness of young people who could tell adults straight in their faces that: "you are not my father […] even our fathers do not beat us" when they were being reprimanded *(Cow, male, FGD1)*. Others felt that if collective parenting was ever needed it was in these "perilous times".

> *We need to call the children and the community and talk among ourselves because when you deal with these children alone you might*

get hurt because they carry very dangerous weapons (Participant #4, female, FGD5).

Also, parents did not always agree about the determinants of child abuse. What was seen as a determinant by some, was seen as a license to bad behaviour by others. For example, one parent felt that orphaned children from "child-headed households" behaved "worse," as they would "tell you (as neighbours who are trying to advise them), 'you cannot tell us anything – you are not our parent'" *(Israel, female, GD3).* There were however, those who felt that being orphaned and vulnerable as children "with disabilities," put these children at an even higher risk of being abused. In their own words: "the situation of child-headed households is abuse in its own right" *(Participant #9, female, FGD5).*

Despite this dominant negative narrative about children there were participants who felt differently and realised the children's powerlessness and preciousness and thus a need to be protected and guided. For instance, Botswana, while admitting that "raising a child is difficult," declared that "a child is like gold". When probed further to find out what he meant by this he said, "like gold, gold, meaning a child is precious. You do not want to raise a child and later find out that they have been raped and so forth…" He expressed his concerns about how we should "care about children and their future." *(Botswana, male, DG3)*

To conclude, there were different and sometimes diametrically opposed views about children, with some participants feeling that they were disrespectful, unruly and even conniving, and therefore earned or even invited the abuse that came their way. Others felt that children were "like gold" and needed the protection from abuse, especially those who were orphaned and vulnerable.

3.5 Community Participation (CP)

In order to establish the participants' perspectives on CP, they were asked to reflect on their involvement in general community activities. There was a distinct difference in responses from the participants who were not personally and/or actively involved in COPESSA CAN prevention programmes and those who were involved. The former group comprised FGD2, GD3, GD4, FGD5 and the latter FGD1 (see Table 1 for description). FGD1 was a heterogenous group made up of participants who attend gym, those who participate in the garden programme and those who do crafts, with the latter having participated at one point or the other in the former two group activities.

The general view of the participants who were not personally actively involved in COPESSA CAN prevention programmes was that there was a paucity of community activities in which members could constructively engage in, in Protea Glen. They demonstrated their understanding of community participation as involvement in those activities that are positive and have a potential to build communities rather than cause hardships and strife as alcohol for instance, as illustrated by the following response of one participant:

> *They (activities that excite people and get people involved) are not there. They are not there. The problem in PG is that we have a lot of shebeens and the disadvantage of PG is that the land is privately owned. (*Dubai, female, GD3).

The participants spoke with despondency about the perceived paucity of community activities and expressed it as either a limited variety of available activities or a complete absence of constructive community activities to engage in.

Attending church and community meetings were identified by most participants as the two common community activities in PG. There were mixed feelings about participating in these activities, which were expressed at

times as internal dissonance. For example, while one participant portrayed church as a source of comfort and refuge from daily grind, she at a later stage irritatingly commented about their proliferation, describing them as a nuisance that took up space for other potential community activities, as demonstrated by the following quote:

> *We just go to church and back. Really when we go out it is time for evangelism, but to participate in other things! I would be lying. […] As for churches, don't even mention it. It is one next to the other. Really?* (Participant #2, female, FGD5)

Notably, church was not talked about as a centre for change or where ideas of community transformation could be discussed, but as a mechanism to 'get by' in life. Similarly, community meetings, which were largely political and called by the Local Councillor, were regarded as a nuisance as they were either called at inconvenient times or had predetermined outcomes. Again, there was no discussion about taking leadership, or lobbying for suitable times and calling for transparency of processes even though the participants had greater awareness about the change power such meetings had in community development issues. Instead, the participants seemed to look to 'others' to take the initiative on community issues, as illustrated by the following quotes:

> *Back in the year 2000 there was a lady responsible for Ext. 4 to 11. She fought tooth and nail trying to prevent the building of taverns here. We held meetings midweek trying to solve issues. We avoided weekends and month-ends because people would come drunk.* (Participant #9, female, FGD5)

In contrast, when the participants in FGD1 discussed community activities they were involved in, the mood was palpably lifted compared to when they were discussing their perceptions on CAN. This became a time to boast about the various activities they were involved in and their perceived benefits. The perceived benefits that they boasted about included relatedness – with one participant from the gym group remarking: "I do not have friends there, I have family" *(Rhino, male);* increased knowledge and

skills as they "learn from each other and grow" *(Elephant, female, crafts programme)*; and financial benefits that could be improved by adapting activities according to market demands. It is no exaggeration to say that this session became like a 'commercial break' as the various subgroups went further than just boasting, but also to invite each group to join and support each individual group's endeavour.

> *I was wondering to myself and saying, "if these guys are exercising I hope they can get something that will boost them and push them forward. They should come and join me in the garden even if it is for two hours and understand what it is that can give them strength to gym, because you cannot just gym without eating". Like the gentleman who said he is not working, he must come to the garden and gym with me and secondly come and take the thing that will give him strength to forget that he does not work. He can get spinach and go home to his wife and say: "Mom, here is spinach, tomatoes, onions and carrots. We should cook and eat." […] I will show you how big my produce is and you will use my sweet potatoes for weightlifting* (Cow, male, FGD1).

First-off the blocks were the gym attenders, who despite the fact that they were relatively new participants in COPESSA CAN prevention programmes, spoke at length about the emotional and social support and physical health benefits they were reaping. The discussion was not only centred on the perceived benefits, but was also used by one participant from the gym group to highlight the state of disrepair the outdoor gym was in. This earned him a history lesson from one of the original members about how the gym came to be, as she berated the gym users for poor stewardship. Such was the spirit among this group to not only talk about positive things but to also have the confidence to have the difficult conversations and call each other out when deemed to be necessary.

It was obvious from the exchange from the various participants that they were not only getting social support by their involvement in the various

groups, thus 'getting by,' but were also building social networks, deriving financial benefits and more importantly using these newly acquired social networks to 'get ahead' in life as exemplified by the following excerpt from an unemployed female participant, who had recently moved from a shack her family was renting to live in PG. Driven by "poverty" her family was now facing as a result of the added responsibilities of staying in a bonded house, she came to COPESSA to look for opportunities to improve her household status.

> *After harvesting the spinach, I would take it home, cook and eat together with carrots and tomatoes. I had all those things and they assisted a great deal in the house and the extra income. […] We stopped the gardening when the beads thing arrived. We left it because we thought the beads business generates more cash than spinach as we have to wait some time after planting before we can harvest. […] We were so many women doing the beads and we sold them. I departed and left other women and set up a table on the street, put my stuff there and started selling. I realised I was having an income* (Sheep, female, FGD1).

Although most of the participants spoke glowingly about their involvement in the conceptualisation and participation in the various COPESSA CAN prevention programmes thereof, it was noticeable that there was no mention of other activities outside the programmes. Neither community meetings nor church attendance were mentioned even though the participants had alluded to their religious beliefs when they were discussing their perspectives on CAN. Also, while some participants conceptualised the programmes, others joined the already existing programmes through being recruited by friends or COPESSA or when they had needs such as health needs or "poverty". Irrespective of how they got involved, it does seem from their discussion that there was an overwhelming sense of pride and a complete buy-in into these programmes.

At the end of the FGD 1, participants were asked to engage in an exercise which would rate their community participation using the Rifkin Spidergram Framework. The diagrams below represent the different group assessments, with the Garden Subgroup scoring all the indicators high, indicating a high level of participation. The Gym subgroup had concerns about needs assessment, while the sewing group had concerns about management and resource management. Overall, there was reasonable participation in all three subgroups.

Garden Subgroup

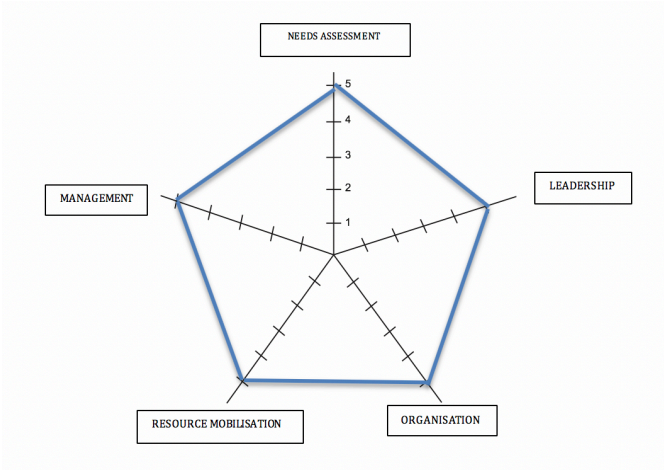

Figure 4: Garden Subgroup Rifkin Spidergram

Gym Subgroup

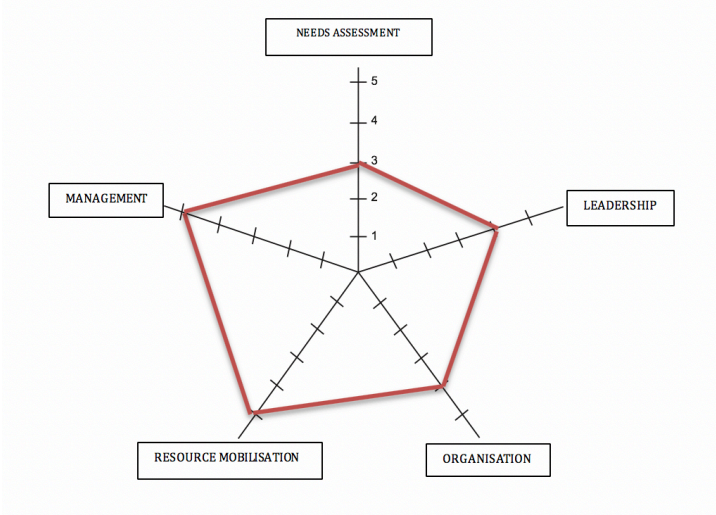

Figure 5: Gym Subgroup Rifkin Spidergram

Sewing Subgroup

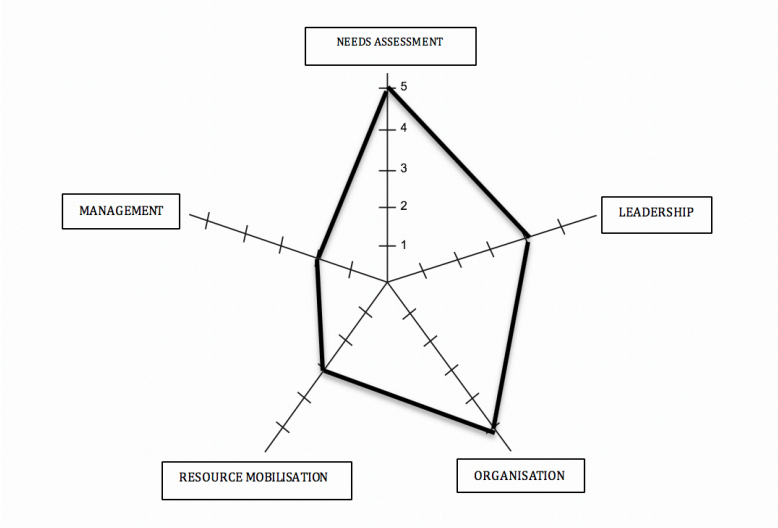

Figure 6: Sewing Subgroup Rifkin Spidergram

3.6 Barriers to and enablers of Community Participation

When participants were pressed about why there were few communal activities in PG, or why they were not participating in COPESSA CAN prevention programmes, they cited different reasons ranging from the "snobbish" or indifferent attitudes of the community members, to money, to unavailability of good community leadership and community facilities and lack of invitation by COPESSA. For example, one participant felt that the PG community had a "suburb mentality, where people mind their own business" as opposed to other older townships in Soweto she had previously lived in, which had better community relatedness (*Watermelon, FGD2, F).* Interestingly, when she elaborated about community activities she was involved in, in her previous community she spoke about contributions by neighbours of burial money whenever there was a funeral in the neighbourhood. Again, this community activity allowed the communities to "get by" rather than "get ahead." Other pertinent factors that influence community participation according to the research participants were:

3.6.1 Money

Money was overwhelmingly mentioned by most group discussion participants as an important factor that influences community participation. The contexts varied with some participants mentioning it as a barrier and others as an enabler. For instance, some participants felt that it inhibited volunteerism, which they regarded as crucial in community participation. These participants felt that community members wrongly used money as a precondition for community participation. For example, one participant felt whenever community members were invited to participate in activities that were for the greater good, their first question always was: "how much are we going to be paid?" *(Elephant, female, FGD1).*

Other participants who had an experience of poor accountability and misuse of funds contributed by some of the programme members strongly supported volunteerism in their CAN prevention programme, the gym. The gym members had decided out of their own volition to contribute money on a monthly basis, which escalated from R5 to R20 and then, R100 in order "to support the operations the gym and food" *(Botswana, male, GD3).* Operations included stipends for the gym instructors and purchase of equipment and the food would be shared by all the members after gym. While this was initially viewed by all positively, it soon became a barrier for entry for those outside who could not afford these fees and a barrier for continuation for those who were already inside, result in significant exodus of members. Not only was money used for gate-keeping, but it also became a source of dissension among members, as those given the responsibility to look after the money according to the participants, invariably misused it:

> *When the gym started everyone was a volunteer and all of a sudden, they changed. If we want the gym to go back to what it was, people must volunteer. They must leave money out of it. There must be no joining fees and gym committees. Let us just gym with love as it were… This gym is needed. We feel that we can change this*

community, we are volunteers, so no money otherwise you discriminate against those who cannot afford (Botswana, male, DG3*).*

So, for me it is wrong to make people pay because this [the gym] was for stress as I was unemployed and where I got love. It was a beautiful community initiative until people made us pay (Dubai, female GD3).

Yet others felt that volunteerism was out of question as they had pressing personal and household needs. These were garden programme participants who had been recently recruited and decided to leave after a while because their expectation of earning an income was not met. It would seem however, that there was a total misunderstanding of how they were supposed to generate revenue through their involvement as they viewed themselves as volunteers rather than social entrepreneurs, a concept which the long-participating members had seemed to grasp. The latter group brought their sweat equity and were able to grow with the assistance of COPESSA. They had won numerous awards with good prize money over and above supplying a local chain store with their produce. The following two excerpts display the contrasting views of these participants, who were from the same garden project:

What also got us tired is when we saw the expectant looks from our children each time we came back from the garden. You know voluntary work does not pay. That look from a child is really painful. As a result, my friend and I decided to go looking for work and now we are now two months out of COPESSA projects. (White, female, GD 4).

We worked hard and made a lot of money. If I still remember well we received about R20 000 (in prize money) *and managed to visit a hotel that even today we cannot afford to visit. […] We even went to Voortrekker in Pretoria, a hotel for Boers, and ate there because of farming. We got certificates and got R22 000.* (Cow, male, FGD1).

So, while others were able and could afford to invest in the results they wanted to see, others seemed to want promptly visible results for their efforts. This probably reflected the different contexts and personal circumstances people have to deal with. It is thus evident that volunteerism is not for everyone.

3.6.2 Amenities

The prevailing perception of lack of community facilities that could promote community participation was closely linked to that of paucity of community activities. Participants felt that even though some facilities were there, they were either not easily accessible or tended to bias certain community groups such as business people, churches, and boys over girls.

> *As you say we have no halls here* [echoing what a previous participant had said], *but when business people want land they get it, when they want to open taverns they are given land. There are townhouses and flats but nothing for the community.* (Participant #9, female, FGD5)

Some participants yearned for days gone by, and presumably townships built in the Apartheid era, where there was at least a provision of clubhouses, which were supported by the Government and "where children could compete against each other as families" *(Brown, female, GD4).* In this participant's view these clubhouses provided children with an environment to talk about issues bothering them.

3.6.3 Safety and security

Parents and grandparents who had younger children, some whom were attending the after-school care facility provided by COPESSA at the park, expressed concerns about the safety and security of their children at the park. There was great concern about the older children and youth who gather under the trees doing the drug, *nyaope.* This fear was not only limited to drug users, but some went as far as to suggest that the park had "evil spirits,"

resulting in the parents either prohibiting their children to go to the park or withdrawing them from the park activities. There was also concern about the lewd behaviour of young people, which children could learn and emulate. Responding to a question as to why children do not participate in the after-school care activities, one parent said:

> *It is in the park that these things are happening and thereafter the kids come back with bad behaviours. That is why we refuse to let them go there… so no more park for them and no more COPESSA… because for me it seems that these things have spirits in them, evil spirits, when you allow these children to go and play in the parks you notice a change in behaviour and you don't sleep at night with them jumping up and down. It really seems like there are evil spirits at the parks […] When I say spirits I mean bad spirits, Satanism, because it is contagious and it spreads very quickly. So, that is what I mean* (Participant #2, female, FGD5).

Safety concerns were also raised in other contexts. Firstly, by those participants who felt that community members were not fully participating in meetings for fear of victimisation by those implicated if they raised certain sensitive but pertinent issues. Also, they were raised by participants who felt that they cannot report those who were involved in illicit activities, whether these were police or ordinary citizens, again for fear of victimisation and intimidation. Lastly, there was an incident of rape of two ladies at a "gym house" - described by the participant as "a social space where we meet, talk and discuss our various issues after our gym sessions and sometimes have fun" and sometimes drinks *(Dubai, female, GD3*), - which reportedly happened after one of the gym sessions. Although the participant did not leave the group because of this reason, this unintended consequence of safety breach has direct negative consequences on community participation. Safety and security concerns inhibit the participants from fulfilling their civic duties, and hence community participation.

3.6.4 Relationships and group dynamics

Some participants spoke about friendships and camaraderie that developed organically among members of these CAN prevention programmes. They viewed the programmes as safe spaces where they could de-stress as they shared their hurts and concerns and lent support to each other without passing judgement. Some friendships that were formed extended beyond the group activities, with some participants socialising outside the activity and some forming support networks for each other's families.

> *We try to socialise, like if I am planning to do a party for my child, I send invitations and say guys I am having my child's birthday party you can come. We know each other better and the way we are at the moment, things and tensions we come with just disappear. We are able to relate. Like I have got X (*male*). If my son is giving me stress X and I help each other out at the gym like buddies. […] So, personally that is why I love this gym.* (Lamb, female, FGD1)

Sadly, relatedness within these groups did not always have positive outcomes. Sometimes, perceived poor group dynamics within these programmes could also result in other members disaffiliating from the group. This was particularly the case in the garden project, where the old members had formed a clique and the new members felt left out and actively pushed out, resulting in them leaving the programme. Also, at the gym there was disharmony between those who had been there longer and those who had recently joined, with some of the former group reportedly wanting to destroy the gym. Apparently, the squabbles came as a result of poor financial accountability resulting in the participants pushing for "financial transparency" (*Lamb, female, FGD1).*

3.6.5 "Now we are experts in farming" - Knowledge, Skills development and Empowerment

Participants spoke about how their personal growth and the growth of the initiatives they were involved in, as they gained new knowledge and learned new skills either from other members of the CAN prevention programmes or from experts that COPESSA invited for the groups. This sharing of skills among participants often translated into a positive sense of purpose and of self-worth, and financial gain for some participants. One female participant who participated in the garden project remarked: "*Manje, singoompetha bomhlabathi"* which can be translated to *"*Now, we are experts in farming", a sense that was pervasive in other group participants. The skills learnt were not only used at the programmes but were used to improve their lives in their homes, thus empowering participants:

> *But now as we* (referring to members of the programmes) *meet as fathers and mothers and work together we learn different ways of life, ways that grow your mind and general living.* […] *We learnt that in these times we live in, in our communities and homes we can do a door-frame-garden in our yards and can plant various plants using the space the size of a door-frame. This taught us that we must not pave all our small yards when we don't have tomatoes, onions or relish.* (Elephant, female, FGD1).

Some unemployed members within these programmes were able to find employment through referrals from other members or to grow their businesses through the network.

> *There are opportunities here that come through others. We have seen people getting employment through the gym, through others… From here we have people that have become firefighters, traffic officers and police officers* (Botswana, male, GD3).

Another perceived benefit for participating in the programmes was health, which participants attributed to the reduction of stress from either exercising and relatedness or access to other material resources such as food and money. This encouraged the participants to continue being involved in their respective CAN prevention programmes.

3.6.6 "Laziness"

Some participants attributed their disaffiliation from the various programmes they had once participated in or their lack of subscription to these programmes to "laziness". One female participant who had left the crafts programme because "laziness had set in" decided to come back. Upon her return she had to catch-up with both the skills and the level of financial benefit from the programme. There were those participants who despite seeing and knowing the benefits of participating in these groups just lacked the motivation to engage.

> *In my view, the organisation (COPESSA) is really doing a great job but we are lazy. Really there is a lot going on and a bit of money to be made, so there is no excuse but laziness.* (Brown, female; GD4)

3.6.7 Time constraints

Some participants expressed an interest to be involved in the CAN programmes but could not do so because of the perceived clash of schedules. This was related by a participant whose neighbour wished to participate at the gym but could not do so because they had to go to work, and could therefore only gym in the afternoon. Others perceived excessive demand of time for some of these activities, which would make it difficult to do their household chores and take care of their family responsibilities. For example, one participant who had never participated in the CAN programmes and lived not far from the garden "realised that those people (*members of the garden programme)* spend 24 hours in the garden, they work Saturdays and Sundays" *(Participant # 2; female, FGD5).* It was interesting to listen to the

debate that ensued with participants suggesting that they would get involved if shift-work could be allowed. It would seem from the above that at times community members find it difficult to negotiate suitable terms of engagement and rather 'throw the baby with the bath-water' as it were.

3.6.8 Leadership

There was a deep yearning for leadership, who could help to organise the community, prioritise their needs and be a catalyst for community participation, which was expressed by the participants, and best captured by the following statement:

> *We are just in need of someone to initiate really, that is it (*all nodding and murmuring in agreement). *We just need someone to start and we will all follow.* (Lemon, female, GD4).

One plausible reason for the reluctance for the participants to assume leadership role is that they have a Councillor "who they have voted in" for him to "serve the community and therefore he must take the initiative" *(Participant #1, female, FGD5).* In other words, there was an expectation from the participants that the elected officials should be 'servant leaders,' an expectation according to their assertions that was not being met at that point. Rather, he was referred to by others as biased, "useless," and not fulfilling even the basic minimum of his mandate such as calling meetings. When the participants were reminded about their admission of poor responses to invitations to meetings, one participant said:

> *The meeting will not be an ANC one, but the community's, and it is in their* (community) *interest to participate* (Banana, female, FGD2).

This could be interpreted to mean that the community is tired of political meetings and yearns for deeper, meaningful and more relevant meetings that will address their issues. But the question remains, who will take the

leadership role in this community? Perhaps, the following quotation is also revealing as to why the individual participants were not willing to play this role:

> *I think we should have a community forum where when you see a problem in the neighbourhood you call others and you attend to the situation or collectively go to the police to report. In that way they* (referring to police who were referred to earlier as those who could not be trusted) *can't cheat the system and we won't be victimised* (Participant #9, female, FGD5).

The COPESSA name was often thrown in the ring of those who should take up leadership in this community by the participants. The participants wanted COPESSA to act in an advisory role to the Councillor where they could inform him about the community needs.

> *The issue of getting the councillor is simple. You invite him to the meetings or you call him as COPESSA and advise him or get into an engagement that will enlighten him* (Participant #9, female, FGD5).

Even though this participant felt that getting hold of the Councillor was simple, her utterance thereafter suggests that the simplicity was for other people and not for her or other community members. There was also no discussion about how the participants could be enabled to assume these leadership roles and thus be capacitated to spearhead community issues.

3.7 How Community Participation can be improved

The community participation improvement question pertained specifically to COPESSA CAN prevention programmes as it was the main reason for this study. The following suggestions, which to a larger extent were addressing the identified barriers to participation, were made:

3.7.1 Become Ambassadors and Market services

Participants suggested that they could become ambassadors of the various programmes they were involved in. This could be achieved by spreading the word to their families and friends through "word of mouth," or by sharing the reasons for their improved quality of life, which could either be their general well-being or financial status. They could also do door-to-door campaigns and recruit other community members. The participants were well aware that not everyone would show interest but that the exercise could help mobilise interested community members.

There were those who, however, felt that COPESSA had decreased its interaction with the community, with one participant remarking: "you as COPESSA has deserted us" *(Botswana, male, GD3).* Suggestions to improve and maintain COPESSA visibility in the community by aggressively marketing the services it offers, were made. These suggestions came from across the focus groups, even from some of the members who participate in the CAN programmes who either found the programmes fortuitously and/or did not fully appreciate COPESSA's reason for being. These would be members who admitted to appreciating the programmes for what they offered but had never linked their participation in these programmes to CAN prevention.

3.7.2 Improve accountability and transparency with group funds

Lack of transparency and poor accountability were cited as major reasons for leaving the CAN prevention programmes by some participants. Although there were contradictory views about involvement of money within these programmes, with some members calling for volunteering, there was consensus that there should be complete transparency and accountability where money was concerned. Furthermore, there was a realisation that money was a necessary evil if there was to be growth, but that it should it should not be sourced from the programme participants but rather from external sources, as it could be a gatekeeper if internally sourced.

*Let us have a committee that will raise funds for us, write letters… I think that will help us bring the people (*those who had left the programmes) *back.* (Dubai, female, GD3).

3.7.3 Restructure programmes to accommodate others

Clashing of schedules was identified as another barrier. Participants felt that more community members would be involved if there were alternative times for some of the programmes to accommodate them. There was also a suggestion from those who wished to participate in the garden programme that if shift-work were to be introduced, this would allow more people to participate as there would be less demands on one's individual time.

*With them (*those neighbours who wish to participate*) I think the limitation is time. Their time and our times are not the same, because most people can only gym in the afternoons. We do not have gym in the afternoons. So, maybe going forward with our instructors and our committee we can like try and say how about accommodating those ones coming out of work and school to be able to gym because in the morning they are off to work and school and it's only us who do not work or are off who can gym* (Lamb, female, FGD1).

3.7.4 Improve safety and security

Some participants suggested that security personnel posted at the park would greatly improve safety of the younger children, thus making it easy for the parents to grant permission to their children to participate in the after-school care programmes. There were however, no further suggestions as to how the parks could be exorcised of "evil spirits," a great concern for participants in different discussion groups:

I just really think security is needed at the COPESSA parks. They can take shifts so that the children are safe. This will keep the 'nyaope' boys out at least during the day when there are little children playing

*there. In the evening it does not matter as there are 18-year-olds and older. I do not know what you guys think… (*all murmur in agreement*)* (Banana, female, FGD2).

3.7.5 Active citizenry

All participants seemed to agree that more could be achieved by working together, whether within the existing CAN programmes or in the community in general. Some contended that this could be achieved by having community meetings, even though there was no agreement as to who should call the meetings. Others felt that there was safety in numbers and thus structures such as community forums would give them the necessary collective efficacy to deal with their challenges. This was particularly important in an environment which is characterised by trust deficit, such as this community.

This chapter presented the understanding by the participants of what community participation is, their level of participation in community activities in general, and in COPESSA CAN prevention programmes. This was followed by what the participants perceived to be barriers to and enablers of participation. Lastly, we presented their suggestions as to how community participation could be improved. The next chapter will discuss these findings in the context of available research.

4. DISCUSSION

This chapter will describe and explain the current study findings in light of what is already known and published in literature. While the ecological framework was used to present some of the findings, the results will be discussed in line with the objectives of the study. Firstly, I will discuss the perspectives the participants had on child abuse and neglect, both in general and specifically pertaining to Protea Glen. Secondly, I will discuss the perspectives of the participants on community participation, both in general community activities and COPESSA CAN prevention programmes. This will be followed by a discussion of factors that influence community participation. Cross-cutting themes that emerged are integrated within this order. Participant recommendations of how we can improve community participation in COPESSA CAN prevention programmes are discussed under recommendations in chapter 5.

4.1 Participants' perspectives on CAN

The current study revealed that there was fair to good knowledge about the definitions of the various types of abuse and a mismatch between knowledge of and attitudes to abuse, and practice. This is consistent with other studies, where knowledge and attitudes about abuse of children do not always translate to refraining from actually abusing children (Mlekwa et al., 2016, Richter and Dawes, 2008). For instance, Mlekwa et al. (2016) found in their recent cross-sectional study carried out in Tanzania among community members a gross mismatch between knowledge of (95,6%) and positive attitudes (98,7%) regarding child sexual abuse (CSA) and good practice for the prevention and protection of CSA (27.3%). They attributed this mismatch to, among other things, parents' traditional norms and beliefs.

Another finding in the present study was that physical punishment was talked more about in comparison to the other types of abuse and was often conflated with discipline and distinguished from child physical abuse. This finding was common for both types of participants, i.e. those who participated

in CAN prevention programmes and those who did not. Reading and colleagues (2009) posit that how child abuse "is defined is central to how it is recognised, managed, and prevented." In addition, Finkelhor and Kornin, 1988 (cited in Richter and Dawes, 2008) further assert that professional and community definitions of abuse are often at odds. This seemed to be the case in this study, where parents did not regard physical punishment as potential physical abuse, but rather as part of discipline of their children and parental rights. This stance was further affirmed by their religious beliefs and their own childhood experiences of discipline, which in their sight shaped them to become the adults they have turned out to be.

The above findings are not unique to our study. Corporal punishment at home is very common in SA, as evidenced by a study done in rural SA which found that almost 9 out of 10 men and women had experienced physical punishment before the age of 18 years (Jewkes et al., 2010a). Also, it is not illegal as there are no laws to-date that inhibit its use, even though child rights activists (DSD et al., 2012, Waterhouse, 2007) and children with agency (Staff Writer, 2017) continue to rally for its prohibition. Furthermore, Jackson and colleagues (1999) found in their study that looked at factors that make parents to be abuse-prone towards their children that "parents for whom religion was important," and those who had "positive attitudes towards physical discipline," were more likely to have attitudes that devalue children and to use physical discipline with their children. Reading and colleagues (2009) refer to this intersection of cultural norms, religious beliefs and children's rights as cultural relativism, which according to them shapes the attitudes to child maltreatment and rationalises the way parents discipline their children. Nair (2012) adds to this discussion by noting that parents are more likely to default to the parenting approaches adopted by the previous generation, their parents, in the face of "fast-paced social and economic transformation."

Another emergent finding from the data was that parents were not as forthright when talking about sexual abuse as when they were talking about other types of abuse. This could be explained by the fact that most indigenous cultures and African parents in particular, consider sex-related

issues to be private and taboo (Wamoyi et al., 2010, Muhwezi et al., 2015) . The implications of this are that parents may have difficulties in teaching their children about preventive strategies of child sexual abuse and in turn, children may find it difficult to disclose sexual abuse to their parents, thus perpetuating the cycle of violence.

Another finding worth highlighting is the fact that most parents tended to talk more about meeting of physical needs in comparison to emotional needs. This could be explained by the fact that Africa in general is overwhelmed by complex and visible problems such as poverty, such that less apparent problems like emotional issues and mental issues in general tend to take a back-burner, a view that is supported by Thomas (2006). However, Jewkes and colleagues (2010a) warned that emotional abuse and neglect is highly prevalent and of considerable importance for health of girls and boys in Africa, even though there is disproportionately little research on these child adversities. They however, did not opine on the reasons for the scarcity of this research.

It thus seems from the above discussion that irrespective of whether the parents were involved in CAN prevention programmes or not, there was no palpable difference in their perspectives of CAN. Their knowledge of CAN did not necessarily translate into good attitudes and practices. In particular, they had similar views about punitive disciplinary actions, perhaps accentuating the concept of 'cultural relativism' as described by Reading and colleagues (2009).

4.2 Social Determinants of CAN

The social determinants of CAN as identified by the participants were presented using an ecological model. As previously mentioned the nub of the ecological model is in the mutual interaction and relatedness of the factors at the various levels not just their summative effect (Glanz et al., 2015). Consequently, these social determinants will not be discussed chronologically

and individually but the discussion will as far as possible reflect these interactions.

One of the most contentious issues raised by parents in this study was that of child rights, which not only caused internal dissonance within some parents but was also viewed as a zero-sum game by most. In other words, the dominant view among parents was that the government gave children rights at the parents' expense, resulting in role-reversal and parents' frustration. The rights issue in South Africa is against a backdrop of pervasive patriarchy (Richter and Dawes, 2008) and hegemonic masculinities, especially among relatively poor black men, which to some extent are historical and a legacy of Apartheid system (Jewkes et al., 2011, Morrell, 1998), and a dominant Christian religion. According to Carter (2014) patriarchy

> *is a system created and maintained by men of faith and politics who hold the levers of economic, cultural, and political power and who confuse strength and masculinity with domination and brutality, p. 2.*

Lindegger and Durrheim (2001) (cited in Petersen et al, 2005) argue that the introduction of women's rights by the new dispensation has resulted in further erosion of Black African masculinities, leaving them in crisis. The above exposition probably explains why in our study the elevation of child rights and the resultant possible banning of corporal punishment at home were perceived as further government interference with men's power and control in the last surviving and most proximate space, home. This also, in all likelihood, explains the findings of less affective assertions about children and also the punitive behaviour towards both women and children, in this study.

Interestingly, while there was good awareness of the existence of child rights among parents, there was no commensurate understanding of what these rights actually entail. It seems that, in light of this, children often take an advantage of this ignorance and just throw the word "rights" at their parents as a defence against any possible discipline for their misdemeanours. Our findings are consistent with those of a study that used mixed methods to identify factors that influence the parents attitudes and behaviour towards

children's rights (Voicu et al., 2015). They found that while socio-economic factors were important in shaping parent's attitudes and behaviours towards children's rights, parents' awareness and comprehension of these rights were just as important.

The issue of punitive disciplinary approach cannot only be viewed through a narrow racial lens with its associated Black masculinities. Parents in this study cited structural determinants such as poverty and unemployment as some of the factors that predispose children to abuse in this community. A recent nationally representative study in the United States that found decreasing levels of harsh punishment among Whites; largely unchanging but higher levels among Blacks; and increasing levels among Hispanics, attributes these racial variations to the "correlation of race and socioeconomic factors" over and above the apparent cultural differences (Taillieu et al., 2014). This underscores the co-occurrence of and interplay of various social determinants of health.

The current study also found that girls were particularly at greater risk of abuse due to such factors as inappropriate dressing, drinking alcohol and age disparate relationships. To add to this victim-blaming there was also high moral responsibility burden placed on girls than on boys. These gendered notions are not surprising as the community is largely patriarchal. There is overwhelming evidence in literature that violence against women and girls is entrenched in society by social norms that accord preferential rights that are often associated with a huge sense of entitlement and subordination of women, to men (DSD et al., 2012, Garcia-Moreno et al., 2014, Meinck et al., 2016, Richter and Dawes, 2008).

A rather surprising finding in this study was that a large number of participants turned the spotlight to their own adverse lived experiences, both in their childhood and in adult life, when they were asked to reflect on abuse of their children. This could either be due to the fact that for most participants domestic violence is more of a priority than child abuse and/ or women are just like their children, "not heard but seen" in this community. Either way

these are characteristic features of a patriarchal society. The finding that domestic violence towards women was linked to heightened violence against children is not unique to our study, as a number of studies have reported on this association (Afifi et al., 2017, DSD et al., 2012, Silverstein et al., 2008, Wilkins et al., 2014). Wilkins and colleagues (2014) go further and suggest that in fact, all forms of violence, whether child maltreatment or domestic violence or gang violence, are linked, as they share the same root causes.

Other interesting findings were that participants attributed some of the negative events in their lives to "evil times," New Dispensation, unruly children, and technology, to mention a few. These pointed to an "external locus of control" or fatalism. Martin-Barro (1988) cited in Cidade et al., 2016 defines fatalism as:

> *the psychosocial phenomenon that interferes in the way people develop explanatory systems about everyday experiences, in that they attribute their responsibility to deeds of divinity powers or luck, p. 51.*

The concepts of fatalism, external locus of control and self-efficacy are all linked and similar (Bernard et al., 2011), and are associated with poverty (Bernard et al., 2011, Cidade et al., 2016, Scott, 2001), also a finding in this study. While fatalism may be a coping strategy, it has many negative implications such as outsourcing of personal responsibility, powerlessness, and lack of investment in the future (Bernard et al., 2011, Scott, 2001). All three factors impact negatively in protection and guidance of children.

In spite of all the above, it was commendable to notice the ready awareness among most parents of the interrelatedness of the various social determinants and their association with CAN. This interrelatedness between various social determinants seems to elude us professionals if our siloed programme design and service delivery is anything to go by. It should also be noted that while they associated these factors with the abuse of their children, they as parents are the ones that are primarily affected by most of these factors, as demonstrated in Figure 3. In other words, parents in our community are grappling not just with one, but a constellation of social ills,

namely: poverty, unemployment, crime, drugs, alcohol, low levels of trust and domestic violence.

4.3 Community Participation

There were two very distinct responses from the participants who were not involved in COPESSA CAN prevention programmes and those who were. The former group bemoaned the scarcity of positive community activities they could participate in and only mentioned two common activities in this community, namely: attending church and community meetings. Church was spoken about in a very limited way as a place of social support and not change or transformation. Meetings were said to be political and useless as they had predetermined outputs and outcomes. Thus, although this group had Social Capital, it was Bonding Social Capital, which only helps communities to get by (Block, 2008, Murayama et al., 2012, Thomas, 2006).

In contrast, those participants who were involved in COPESSA CAN prevention programmes showed a relatively higher levels of participation, as was confirmed by their self-assessment using the Rifkin Spidergram (Figures 4-6). Consequently, they were able to find new employment and grow their businesses through the newly developed informal networks, for example. Their high participatory levels assisted them to 'get-ahead' in life, pointing to some level of Bridging Social Capital (Murayama et al., 2012). The findings of this study mirror those in Thomas's study (2006), who found that the church attendance of the women from Durban informal settlement yielded more of Bonding Social Capital compared to those from Lusaka informal settlement, who had relatively more Bridging Social Capital. She attributed the difference to the fact that the churches most women attended in Durban were outside the community than those attended by the Lusaka women, which were situated within the communities. She however, concedes that the Bridging Social Capital in Lusaka was limited due to the 'context of poverty' of the settlement.

Parents had identified poverty as a significant determinant of CAN in Protea Glen community. Consequently, it can be assumed that most parents in this community are constantly grappling with poverty. Maslow's Hierarchy of Needs Model suggests that human needs are hierarchical and that people tend to focus their efforts and behaviour towards satisfying the needs at the level at which they are before they can move to the next level. The priorities of this community are therefore both physiological, and safety and security needs, both lower level needs according to Maslow (Gorman, 2010, Aruma and Hanachor, 2017, Smit et al., 2016). According to White et al, 1995, (cited in Thomas, 2006: 43), pre-occupation with meeting survival needs in "low-income communities does not manifest a commitment to engaging in community activities." Thus, deep levels of poverty in this community explain both the low levels of community participation and the 'poor' quality social capital, which hinder communities to get ahead. It is therefore, not surprising to find low levels of community participation among those participants who are not involved with COPESSA programmes, and by extension the general community.

Another factor that possibly explains the low levels of community participation is that Protea Glen is a relatively new township (established in 1991) (Affordable Land & Housing Data Centre, 2012) when compared to the older parts of Soweto, which were established in the 1930s (South African History Online, 2011). As a result, there is in inadequate integration of the community members in PG, which is further exacerbated by the high perimeter walls that tend to isolate families, fewer common spaces and amenities. These findings concur with those of Thomas (2006) who ascribed the 'less dense informal social networks' found in her study to the "relative newness" of the study sites, and to be partly responsible for the limited community participation.

Another pertinent finding was that the parents who were involved in the various COPESSA CAN Prevention Programmes tended to be more upbeat and positive and reported better mental and physical health than those who were not involved. The resultant perceived higher levels of mental health

as a result of their higher levels of participation was confirmed by other studies, including a review article of 13 articles, which reported on the association of social capital and subjective social and emotional wellbeing (Murayama et al., 2012, Thomas, 2006).

It is interesting to note that both groups (i.e. those who participated in COPESSA CAN prevention programmes and those who did not) had similar perspectives (knowledge, attitudes and practices) on CAN. Though beyond the scope of this study, one would expect different patterns that would positively bias those with higher levels of community participation, in line with the logic of INSPIRE. Rifkin has argued that participation is a process and not an intervention (2014, 2016). A line of questioning to explore in future research, therefore, may be what forms of participation in CAN prevention programmes can result in improved knowledge, attitudes and practices. Also, future interventions should consider phenomena such as cultural relativism (Reading et al., 2009).

4.4 Barriers to and Enablers of Community Participation

A number of factors were identified by the participants as limiting their participation in COPESSA CAN Prevention Programmes. Some of these were linked to the topic of CAN, while others were more general barriers to community participation (regardless of topic). Specific to CAN, one of the major barriers for community participation in Protea Glen was fear of victimisation either by law-breakers or police who were reportedly in cahoots with law-breakers. The fear of CAN-related victimisation was combined with more general observations about increased crime whether at the parks or in the general community and fear of 'evil spirits.' These contributed to a pervasive concern about security and safety and high levels of distrust in this community. In the face of both the poor quality and quantity of social capital in this community, there seemed to be no collective efficacy among the community members to challenge the law-breakers, the police, or the 'evil spirits.' Collective efficacy has been found to be an efficacious asset in

combatting negative social determinants in neighbourhoods (Campbell and Jovchelovitch, 2000, Daro and Dodge, 2009).

The research further revealed that there was a perceived lack of community activities and common spaces where community could gather and interact. This was not specific to CAN. Community meetings were said to be political and to have pre-determined outcomes. The perceived narrow agenda of the community meetings and the prevailing determinism explain poor participation, as not all community members belong to the same political party. Thomas (2006) also reported on lethargic participation in community meetings in her study citing similar reasons.

Furthermore, other constraints that were identified by the participants were time constraints and lack of motivation to engage, which they called 'laziness,' and snobbish and indifferent attitudes of the community members. The latter were attributed to falsely-placed 'suburb mentality,' where people 'mind their own business'. This was despite seeing and knowing the benefits of participating in these groups. Unfortunately, if 'lazy' individuals are in the majority in a community and there are dominant inward-looking attitudes, community members may be difficult to mobilise resulting in poor community participation, a case in point in this study. Studies that have found easy mobilisation of communities have reported on good community participation (Namatovu et al., 2014).

Time constraints, whether they be clashes of schedules or excessive demand on one's time when there are other pressing priorities, were identified as barriers to community participation. The perception of the clash of schedule as a barrier may be due to a belief of diminished power and self-efficacy to negotiate better and suitable alternative schedules, which are born out of fatalistic attitudes (Bernard et al., 2011, Cidade et al., 2016). Poverty is intricately linked to fatalism as they both share pessimism, hopelessness and despair (Cidade et al., 2016, Scott, 2001). The finding of cost in terms of time as a barrier to community participation is congruent with other studies (Campbell and Jovchelovitch, 2000, Chifamba, 2013, Ndou, 2012).

There were other factors that were both barriers and enablers of community participation. For example, money and social relationships were found to have both characteristics, depending on how the research participants experienced them. Participants talked about money as: a gate-keeper; divisive when it was misused, and an inhibitor of volunteerism, all barriers to community participation. Lack of transparency and accountability were cited as barriers to CP by Mchunu (2009) and Chifamba (2013). Group dynamics in the CAN prevention programmes were on one hand described as positively resulting in bridging social capital and thus enhancing CP. On the other hand, other participants found it difficult to penetrate the strong bonds formed by the existing programme members, resulting in them not participating meaningfully in these activities. Putnam and Feldstein (cited by Block (2008)) warned that too much bonding social capital results in segregated "mutually hostile camps," and that the bridging type of social capital is necessary for pluralism and democracy.

Finally, in this study, perceived benefits such as acquisition of knowledge and skills, positive sense of self-worth, getting-ahead and empowerment and personal growth were found to enhance participation in these CAN prevention programmes. These findings are not unique to our study but are congruent with those of other studies (Chifamba, 2013, Thomas, 2006).

4.5 Limitations

This research is certainly not immune to limitations. As data were collected at one point only, participant perspectives could have been affected by events going on at the time of collection, such as service protests or publicised cases of abuse, although I have no knowledge of any specific events that could have coloured the experiences of the participants. Also, one could not be certain about causal direction especially when determinants of CAN were discussed and there is always the possibility of recall bias.

Some participants were personally known to me as they are participants in the various CAN prevention programmes, which could have resulted in social desirability bias when discussing some of their experiences in these programmes. This was mitigated by the use of an independent researcher to conduct most group discussions and through encouraging all the participants to express their views. My positionality, as a both A CEO and founder of COPESSA was discussed extensively in the Methods' Chapter, and could potentially cause bias particularly in the interpretation of results. This was mitigated by extensive and robust discussion with my supervisor.

Despite the limitations highlighted above, this study at the very least highlights the need to research further (the purpose of case studies (Yin, 1994)), the intersection of constructs such as fatalism, social capital and collective efficacy with poverty and their effect on community participation. This will assist with the further theorisation of this community participation concept, which various authors have identified to be weak (Campbell and Jovchelovitch, 2000, George et al., 2015) and also with how CP is measured particularly in an era where community assets rather than needs are emphasized (Block, 2008).

Lastly, it is hoped that this study will contribute to the body of knowledge about community participation and development in post-apartheid South Africa, with thick description used as a way to assist others in determining the transferability of findings to their own contexts. This study did not seek to evaluate causality between community participation and prevention of CAN nor was this study able to establish this link.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

The aim of this case study was to explore how to optimise participation in CAN prevention programmes that are offered by COPESSA. To answer this, the study was broken into five objectives, namely:

1. To describe how community members, perceive CAN in PG, in 2017/8.
2. To describe the community's own perspective on community participation in general in PG, in 2017/8.
3. To describe community participation in COPESSA CAN prevention programmes in PG, in 2017/8.
4. To describe factors that influence (enablers and barriers) community participation in CAN prevention programmes in PG, in 2017/8.
5. To explore how COPESSA can increase (recruit and maintain) community participation for CAN prevention programmes in PG, in 2017/8

This is what was found:

With reference to the first objective, participants have a fair to good knowledge of what CAN is, which does not always translate to non-abusive behaviour. CAN, although is viewed as a problem, is not necessarily a priority issue in this community. Women mostly are hurting as a result of domestic violence among others – their own lived experiences. It thus becomes difficult to protect children from CAN when they themselves are hurting. Furthermore, parents seem to default to physical punishment when disciplining their children. One of the reasons is that this is the only way that has a good track-record they are familiar with.

Community participation was low, both with reference to community participation in general and in COPESSA CAN prevention programmes specifically. This was attributed to poor social capital, particularly the bridging

type in this community, and pervasive poverty, combating of which seems to fully pre-occupy the community. In comparison, those members who participate in COPESSA CAN projects seemed to be benefiting from the resultant bridging social capital, both materially and in mental and physical health. However, for the CAN prevention programmes to realise the objective of preventing CAN, COPESSA needs to go beyond just encouraging community members to improve their participation, but should infuse within these programmes specific programmes that deal with the social determinants of CAN, and specifically social norms that condone VAWG and make violence perpetration acceptable.

Barriers and enhancers of community participation were identified, both deductively and inductively. Poverty, poor social capital, safety and security, trust issues, and poor amenities are just some of the barriers identified. Benefits such as relatedness, money and skills were also identified. COPESSA will obviously have to address some of these barriers and the low-hanging fruits are perhaps the improvement of social capital in this community.

5.2. Recommendations

The fifth study objective was to identify ways to improve community participation in CAN and specifically COPESSA. The recommendations made by the participants are presented first, followed by recommendations that are derived from the research. The latter will cover policy-related, programmatic and further-research areas.

5.2.1 Recommendations made by the participants

Participants were specifically asked to make suggestions of how we can improve community participation as it pertains to the COPESSA CAN prevention programmes. Participants suggested that COPESSA should aggressively market their services in the community and hence increase visibility and improve communication. Interestingly, it was not always clear from the group discussions whether the participants could join the dots

between the various programmes and CAN prevention, even among those who were already participating. This underscores the importance of clear and sustained communication, as communities are dynamic in nature. Poor communication that is characteristically information dissemination rather than dialogic has been blamed in other studies for poor community participation (Chifamba, 2013, Namatovu et al., 2014). Notably, participants were very keen to be COPESSA ambassadors in the community, spread the word about the benefits of being involved in these programmes and to mobilise other community members. COPESSA would be foolhardy to ignore this asset.

Other recommendations included improvement of financial accountability and transparency within the programmes, restructuring so as to accommodate others and to improve safety and security. These will be largely achieved through active citizenry.

5.2.2 Policy recommendations

The Department of Social Development needs to fast-track the abolishment of physical or corporal punishment in homes in order to protect children from physical abuse as evidenced by lower levels of abuse in those countries that have banned this practice (Global Initiative to End All Corporal Punishment of Children, 2019, Wilkins et al., 2014). For this policy to be effective, a participatory rather than just a top-down process will improve the community buy-in. This will also help to harmonise the laws the government is promulgating with its Constitution and the various treaties it is a signatory to, such as the UNCRC and the ACRWC. It is not enough to introduce policies, however (Mlekwa et al., 2016, Muhwezi et al., 2015). These need to be buttressed by implementation of programmes that encourage positive parenting, for example, that will replace the deeply-entrenched discipline practices.

5.2.3 Programmatic recommendations

It is evident from the findings above that churches abound in this community and religion is important to most of the community members. Carter (2014) acknowledges the huge role played by and the sway religious institutions have particularly in patriarchal communities. Furthermore, prominent and progressive religious bodies such as the South African Council of Churches have already endorsed rights-based child parenting practices and elimination of corporal punishment in homes, for example (Waterhouse, 2007). In light of all the above, COPESSA needs to challenge the religious bodies in this community to move beyond using this institution for just bonding social capital but also to build bridging social capital. Given the abundance of churches in this community not only can the quality of social capital be improved but also its density. As previously mentioned, when relatedness improves in any community, child protection also improves (Daro and Dodge, 2009, MacLeod and Nelson, 2000, Tomison, 2000, Tomison and Wise, 1999).

Not only should COPESSA work closely with churches as some of the community members do not attend church, they should also do an ongoing asset-mapping exercise (Kretzmann and McKnight, 1993) to identify other informal social networks such as stokvels, burial societies, shebeens, and sporting clubs. This asset-based approach can only enhance a 'both-end' approach rather than an 'either-or' in community participation, as defined by Rifkin (1996). This is particularly important in this community where there are hordes of other competing priorities such as poverty, domestic violence, drugs and crime. In this way, professional organisations such as COPESSA will not be accused of pushing their own agendas when they prioritise social ills such as CAN. This is particularly important as children are not heard but seen in most patriarchal societies. Also, working with and through these institutions and informal networks difficult topics that are considered to be taboo, such as sexual and reproductive health, will be demystified at a 'higher level' thus providing for more protection for children. COPESSA would do well to engage key stakeholders and individuals such as local councillors and business people that will be identified through asset-mapping in a bid to

optimise bridging social capital that is so needed in this community. Furthermore, there is a great need for COPESSA to elevate its programmes from being community-based to be true community-level to realise the full benefits of community participation and mobilisation (Draper et al., 2010).

5.2.4 Further research recommendations

Maslow's Hierarchy of Needs model seems to be fatalistic for poor communities as it suggests that people can only graduate to the next tier if they have satisfied the level they are at. We have however, seen how social relations which according to Maslow are at the third level, are able to propel poor communities forward. Further research is needed to establish the relevance of the strict hierarchy of needs as suggested in Maslow's model as opposed to building of Social Capital. This would assist poor communities and countries who are resource-deficient to know where to direct their limited funding to enhance community development, in building social capital as opposed to directly addressing the lower needs, for instance. This is particularly important in South Africa where there are service delivery protests that are characterised by wanton destruction of the very resources meant to address these lower-order needs.

This study was premised on the assumption that community participation is key to reducing CAN, and thus looks at how it can be enhanced. Further research is needed to examine the exact relationship between community participation and CAN prevention and the pathways through which the prevention is achieved.

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APPENDICES

<u>Appendix 1</u>. Consent for the participants in FGDs

- I hereby confirm that I have been informed by the study staff (_____) about the nature, conduct, benefits and risks of the Community Participation in Child Abuse and Neglect prevention programmes Study.
- I have also received, read and understood the above written information (Participant Information Leaflet and Informed Consent) regarding the study.
- I am aware that the results of the study, including any personal details such as those regarding my age and residential area will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher or on her behalf.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

PARTICIPANT:

Printed Name Signature / Mark / Thumbprint

_____

Date and Time

I, _____ herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

STUDY STAFF:

Printed Name Signature Date and Time

Appendix 2. Consent form for FGD Audio-recording

Permission to audio record the focus group discussion

I am aware that the focus group discussion will be audio-recorded and transcribed for data analysis purposes.

I understand that these recordings will be preserved for two years after the study results have been published or six years if there is no publication, after which they will be destroyed.

I give permission for my contributions to the focus group discussion to be audio-recorded.

PARTICIPANT:
_____ _____
Printed Name Signature/ Mark / Thumbprint
_____
Date and Time

Appendix 3. Information Sheet for Focus Group Discussions

Harnessing community participation in Child Abuse and Neglect prevention programmes: a case study based on COPESSA, a community-based child abuse centre in Protea Glen, Soweto

1. Introduction

Good day. My name is Dr Nobulembu (Nobs) Mwanda and I am with the assistant researcher, _____. I am a student from the University of the Witwatersrand in Johannesburg. I would like to invite you to consider volunteering to participate in the above-mentioned research study. This study is being conducted as part of my Master's degree in Public Health.

Before volunteering to participate in this study, it is important that you read and understand the following explanation of the purpose of the study, the study procedures, benefits, risks, and your right to withdraw from the study at any time. This information leaflet is to help you decide if you would like to volunteer. You should fully understand what is involved before you agree to take part in this study. The assistant researcher will also fully explain the contents of this leaflet in simple and understandable language if they are not clear to you. If you have any questions, do not hesitate to ask me.

We are inviting you to take part in a research study. This research study is about how you as community members understand by being active community members and citizens. COPESSA has various child abuse and neglect prevention programmes, such as the garden project, the outdoor gym, the crafts project and the brick project. We would like to understand why other people get involved in these programmes and while other people either exit them or do not participate at all.

This study involves participating in a discussion with between six to eight people. In this study, we would like to learn more about you, what you think about Child Abuse and Neglect. We are mainly interested in this information

because we would like to know how you can assist COPESSA and also how COPESSA can assist you to protect the children of this community from abuse and neglect, through active citizenship.

3. **Length of the Study and Number of Participants**

This study is being conducted at COPESSA. The total amount of time required for your participation in this study is no more than 90 minutes. The group discussion will take place in a private room and is a one-time event.

Up to 64 community members will take part in these discussions, but there will be no more than 8 people in total in the group discussion that you are being invited to join. The people in your group will either have or are still participating in the same group as you.

4**. Study Procedures**

If you take part in this study, we will ask you to participate in a group discussion on one occasion. This should take about 90 minutes. The researcher will facilitate the discussion, introduce the discussion topics and will ensure that everyone has a chance to speak, but for most of the time the focus of the discussion will be between you and the other participants. The discussion topics you will be asked about will be used to help us:

- Learn about what you think and how you feel about child abuse in Protea Glen.
- Learn about what you think and how you feel about participating in community activities.
- Learn about how you participate in the programmes that help prevent child abuse
- Understand what influences your participation in COPESSA projects.
- Improve the relationship you have with COPESSA and how you can work well with the organisation

While we hope that you will participate actively throughout the discussion, you may skip any questions you don't want to answer.

5. **Will any of these Study Procedures Result in Discomfort of inconvenience?**

While the group facilitator is trained, the discussion may raise issues that are personal and of a sensitive nature that may make you feel uncomfortable or upset. While there are not right or wrong answers in this type of discussion, you may disagree with what other people in the group are saying or others may not share your opinions or experiences. You may skip any questions that you don't want to answer or leave the group discussion at any point. Furthermore, as this is a group setting, it is not possible to promise confidentiality. There may be other risks and discomforts that are not known at this time.

6. Benefits

You may benefit directly from taking part in this study. Information gathered from this study may help us learn more about how to improve the programmes you participate in and thus protect the children in the community.

7. Costs and Reimbursement

There is no cost to you for being part of the study and you will be provided with R20 to help you with transport to and from the interview.

8. Right as a Participant in this Study to Refuse to take part

Taking part in the study is your choice. If you decide to take part, you can always change your mind. You can stop taking part at any time.

9. Ethical Approval

- This study protocol has been submitted to the University of the Witwatersrand, Human Research Ethics Committee (HREC) and written approval has been granted by that committee.
- The study has been structured in accordance with the Declaration of Helsinki (last updated: October 2008), which deals with the recommendations guiding doctors in biomedical research involving human participants. A copy may be obtained from me should you wish to review it.

10. Confidentiality

We ask that you keep anything that is shared in the discussion confidential. However, as this is a group discussion, we cannot guarantee that other participants in the discussion will keep what is said confidential. However, the researcher will make every effort to ensure that your comments are confidential in any reporting on the discussion, as follows:

- I will use a code instead of your name for any quotes transcribed directly from an audio recording.
- Audio recordings and transcripts of the conversations will be stored in locked and/or password protected files and destroyed three years after the study is complete.
- All information obtained during the course of this study, including personal data and research data will be kept strictly confidential. Data that may be reported in scientific journals will not include any information that identifies you as a participant in this study.
- This information will be reviewed by authorised representatives of the study team
- The information may also be inspected by the University of the Witwatersrand, Human Research Ethics Committee (HREC).

11. Sources of Additional Information

If you have any questions about this study, you may contact Dr Nobulembu Mwanda at 082 552 9449

If you have any questions about your rights as a participant, you may contact Prof Peter Cleaton-Jones at the University of the Witwatersrand, Human Research Ethics Committee: Secretariat (011 717 1234)

<u>Appendix 4</u>. Focus Group Discussion Guide (FGDG) for Community members who have participated in COPESSA activities (Categories A & B in Table 1)

Introduction Exercise:

Before the group discussion, the researcher and assistant will ensure that all the participants have received an information guide, read, understood, and signed the appropriate consent.

To build rapport and test whether the audio and video recording, where indicated is working, everyone will introduce themselves by using nicknames or just first names, and these introductions will be recorded.

The facilitator will go over the ground rules such as respect, speaking one at a time, no phones, while the co-facilitator will check the adequacy of the recording.

---

1. **What do you understand about child abuse and neglect (CAN)?**

    - Would you give an example of abuse? Of neglect?
    - Why in your opinion are children abused? Neglected?
    - In your opinion whose responsibility is it to protect children? (Parents, Community Society, School, NGOs, Government),

2. **What do you think of Child abuse and Neglect in Protea Glen?**
    - Extent
    - What do you think is influencing it?
    - What should happen when children are abused / neglected?

3. **We would like to explore your understanding on involvement in community affairs in general. What are some of the activities that PG community members get involved in? What would you say your level**

of involvement is and why?

- Initiator or participant?
- What would it take to initiate a community event?
- Who in your opinion should initiate?

4. **You are currently involved (have in the past been involved) in one of the projects supported by COPESSA such as the garden, outdoor gym, crafts, or brickmaking; or your child has been involved in the after-school care programme. How would you describe your current/past participation in the programme/s?**

For the current participants

- What made you to start?
- At what level did you get involved – planning/implementation/ etc.?
- What role are you currently involved in?
- What has made you to continue participating?

For the past participants

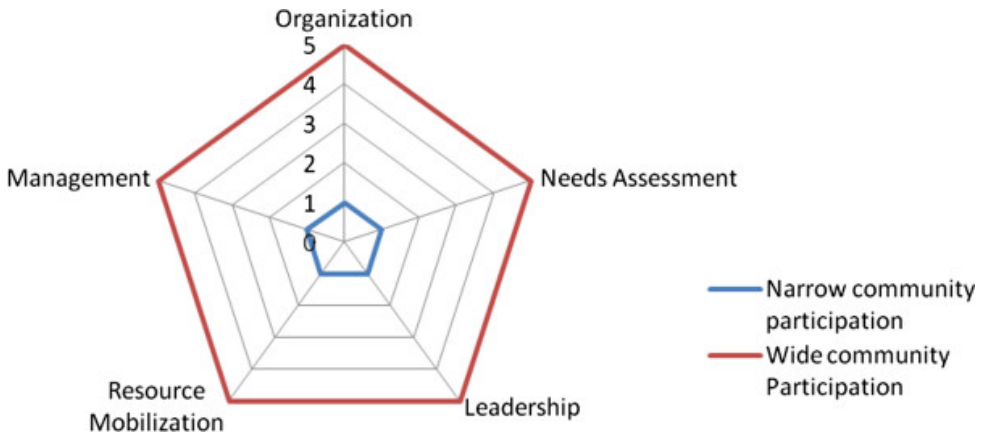
- How did you get involved?
- At what level did you get involved – planning/implementation/ etc.?
- Why did you leave?
- What would make you come back?

5. **Spidergram exercise – this is a visualisation exercise to help us assess participation levels in the specific programmes.**

NB: Exercise to be video-recorded if participants have consented.
Need flipchart and markers for the exercise.
Participants will discuss how they participated using five indicators, namely: organization, management, resource mobilisation, leadership and needs assessment, and reach a consensus about what score best

represents their participation as a group. Researchers to explain

- *Spidergram sample: (Ref: https://www.researchgate.net/figure/242332454_fig1_Spider-gram-for-measuring-community-participation-15)*



6. **How would you advise COPESSA to encourage community members to participate in Child abuse and neglect programmes?**
    - What can each of us do to make the CAN programmes better?
    - If you were to invite friends and family to participate in the CAN programmes, what would you say in the invitation?

7. **Wrap up summary**:

    If I have understood you correctly you have said that (summarize the salient points from the discussion). Have I understood you correctly?

8. **Is there anything else you would like to say about the CAN prevention programmes and CP?**

Thanks and dismissal of the group.

<u>Appendix 5</u> – FGDG for Community Members who never participated in COPESSA activities (Those in Category C in Table 1)

Introduction Exercise:

Before the group discussions, the researcher and assistant will ensure that all the participants have received an information guide, read, understood, and signed the appropriate consent.

To build rapport and test whether the audio recording is working, everyone will introduce themselves by using nicknames or just first names, and these introductions will be recorded.

The facilitator will go over the ground rules such as respect, speaking one at a time, no phones, while the co-facilitator will check the adequacy of the recording.

---

1. **What do you understand about child abuse and neglect (CAN)?**

    - Would you give an example of abuse? Of neglect?
    - Why in your opinion are children abused? Neglected?
    - In your opinion whose responsibility is it to protect children? (Parents, Community Society, School, NGOs, Government)

2. **What do you think of Child abuse and Neglect in Protea Glen?**
    - Extent
    - What do you think is influencing it?
    - What should happen when children are abused / neglected?

3. **We would like to explore your understanding on involvement in community affairs in general. What are some of the activities that PG community members get involved in? What would you say your level of involvement is and why?**

- Initiator or participant?
- What would it take to initiate a community event?
- Who in your opinion should initiate?

4. **You are currently not involved in any of the project COPESSA is offering such as the garden, outdoor gym, crafts, brickmaking or your child has never been involved in after-school care programme. Why are you not involved?**

    - Would you like to be involved?
    - What would it take to get you involved?

5. **How would you advise COPESSA to encourage community members to participate in Child abuse and neglect programmes?**

    - What can each of us do to make the CAN programmes better?
    - Are there any other programmes that you would like to see in Protea Glen that could help protect children?
        - How might you be involved in these?

6. **Wrap up summary**:

    If I have understood you correctly you have said that (summarize the salient points from the discussion). Have I understood you correctly?

7. **Is there anything else you would like to say about the CAN prevention programmes and CP?**

Appendix 6. Consent form for FGD Video-recording

Permission to video record the focus group discussion

I am aware that the focus group discussion will be video-recorded **and transcribed for data analysis purposes.**

I understand that these recordings will be preserved for two years after the study results have been published or six years if there is no publication, after which they will be destroyed.

I give permission for my contributions to the focus group discussion to be video-recorded.

PARTICIPANT:	
_____	_____
Printed Name	Signature / Mark / Thumbprint
_____	
Date and Time	

<u>Appendix 7</u>: Human Research Ethics Committee (Medical) Clearance Certificate

R14/49 Dr NB Mwanda

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M170870

NAME: (Principal Investigator)	Dr NB Mwanda
DEPARTMENT:	School of Public Health
PROJECT TITLE:	Harnessing community participation in child abuse and neglect prevention programmes: a case study based on COPESSA, a community-based child abuse centre in Protea Glen, Soweto
DATE CONSIDERED:	25/08/2017
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Dr S Nieuwoudt
APPROVED BY:	Professor PE Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	12/10/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on 3rd floor, Phillip V Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to resubmit to the Committee. **<u>I agree to submit a yearly progress report</u>**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. in this case, the study was initially reviewed in **<u>August</u>** and will therefore be due in the month of **<u>August</u>** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

13 OCTOBER 2017
Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES