

CHILD SEXUAL ABUSE IN ZIMBABWE: PREVENTION STRATEGIES FOR SOCIAL WORKERS

Muridzo, Noel. G^a and Malianga, Effie^b

ABSTRACT

The phenomenon of child sexual abuse (CSA) remains topical in Zimbabwe. Statistics, literature and debate reflect not only increased scientific interest in child sexual abuse and its potential effects but also growing public concern about this form of child maltreatment. The sexual abuse of children crosses cultural and economic divides. Sexual abuse can lead to long-lasting, even life-long consequences and is a serious problem on individuals, families and societies. Social workers by nature of their work, intervene at the individual, family and societal level. This paper will explore the definition of CSA, its effects and prevention strategies. The paper adopts Meili's model of prevention which suggests prevention of CSA at primary, secondary and tertiary levels. The authors conclude that social workers in Zimbabwe have a role to play at all the three levels of intervention.

KEY TERMS: Child sexual abuse (CSA), social work, prevention, Meili's model.

^aSocial Sciences and Gender Development Studies, Women's University in Africa, Brighton Road, Harare, Zimbabwe, Mt Pleasant, Harare. E-mail: nmuridzo@yahoo.com

^bNational Association of Social Workers, Harare Branch.

INTRODUCTION

The phenomenon of child sexual abuse (CSA) remains topical in Zimbabwe. Statistics, literature and debate reflect not only increased scientific interest in sexual abuse and its potential effects but also growing public concern about this form of child maltreatment (Muridzo 2014). The sexual abuse of children crosses cultural and economic divides. Sexual abuse can lead to long-lasting, even life-long, consequences and is a serious problem on individuals, families and societies. Social workers by nature of their work, intervene at the individual, family and societal level.

About 25 to 50% of children suffer from physical abuse globally and 20% of girls experience sexual abuse (International Congress on Child Abuse and Neglect, 2012). This supports Childline (2015)'s estimates that approximately one in three girls and two in five boys of the world's children are survivors of sexual abuse. The National Baseline Survey on the Life Experiences of Adolescents of 2011 concluded that almost one third of

females and one in ten males aged 18 to 24 years reported experiencing sexual violence in childhood in Zimbabwe (Zimbabwe National Statistics Agency (ZIMSTAT), United Nations Children's Fund (UNICEF) and Collaborating Centre for Operational Research and Evaluation (CCORE), 2013).

This paper explores CSA and what social workers can do to deal with it. The paper adopts the Meili's model of primary, secondary and tertiary prevention. The writers argue that social workers in Zimbabwe have a role to play at all the three levels of intervention.

BACKGROUND

CSA is a complex life experience, not a diagnosis or a disorder (Putman 2003). Finkelhor (2009) states that it involves an entire spectrum of sexual crimes and offenses in which children up to the age of seventeen years are victims. There are various definitions of CSA. These are based on different theoretical views and models. In this discussion the authors will look at the definitions of Rudd and Brakarsh (2002) and Horner

(2010). Rudd and Brakarsh (2002) view CSA from legal, cultural and psychological perspectives. These perspectives are discussed in proceeding sections.

Legal definitions

The Zimbabwean legal profession recognizes that there are various types of sexual abuse ranging from indecent assault to rape (Muridzo 2014). Loewenson (1997) and Rudd and Brakarsh (2002) allude to different legal definitions in the following sections.

Rape

Rape is the intentional and unlawful sexual intercourse by a male over 14 years of age, with a woman without her consent. Vaginal penetration even in the slightest degree is sufficient and ejaculation by the male is not necessary to constitute rape. Boys under the age of 14 years are regarded in the law as too young to commit rape. Hence if they are involved in forced sex they are sent for rehabilitation but not tried in a court of law. There is however a new phenomenon of women who are also sexually abusing minors. The above legal definition

only presupposes that it is men who rape. In the case of women being perpetrators the law classifies such acts as indecent assault. The argument is that women are incapable of raping.

Having sexual intercourse with a young person

This is unlawful sexual intercourse with any girl under the age of 16 years with her consent. Girls under the age of 12 years are legally incapable of consenting to sexual intercourse. Consensual sexual intercourse with a child between the age of 12 and 16 years is having sexual intercourse with a young person because a child is not regarded as old enough to make an informed decision.

Having sexual intercourse within a prohibited relationship

This is a situation when a person intentionally has sexual intercourse with another person who is a blood relative or relative by marriage or adoption. It is often described as incest.

Sodomy

Sodomy is intentional anal intercourse with another male. The legal offence is seen as greater if the victim did not consent. A child under the age of 14 is again seen by the law as too young to consent.

Indecent assault

This describes intentional assault involving the sexual organs. This would include such actions as oral sex, fondling, and attempted rape.

Abduction

Abduction is the act of intentionally taking a minor against the will of the parents, guardians, or custodians of the minor with the intention of the person or another party marrying or having sexual intercourse with the minor.

Psychological definitions

CSA is seen as abuse of power in order for one person to obtain sexual gratification from another. The abuse of power can occur on three levels. CSA is contextualised as the use of physical ability, intellectual capacity and

authority by the perpetrator to obtain sexual gratification from the child.

The first level is the physical. Abuse occurs due to the superior physical strength of the abuser. The next one is the intellectual level. At this level, the abuser is usually older and knows how to manipulate children. The last one is the authority level where abuse occurs when one person uses their superior authority to force the other person to gratify their sexual needs.

Cultural perspective

Lastly, Rudd and Brakarsh (2002) posit that CSA exists within complex cultural and social contexts. Gumbo (1993) and Kaime (2009) are of the view that CSA occurs within the child's environment and cultural practices do contribute to the phenomenon.

On the other hand, Horner (2010) looks at CSA as any sexual conduct or contact of an adult or significantly older child with or upon a child for the purposes of the sexual gratification of the perpetrator. The paper adopts

the definition that asserts that CSA occurs when an older or more knowledgeable child or adult uses a child for sexual pleasure.

These include intercourse, attempted intercourse, oral-genital contact, fondling of genitals directly or through clothing, exhibitionism or exposing children to adult sexual activity or pornography, and the use of the child for prostitution or pornography.

FACTORS CONTRIBUTING TO CSA

Researches by Gumbo (1993) and Meursing Vos, Coutinho et al. (1995) cited in Lalor (2004) which were done with various communities in Zimbabwe indicate that rape is the major form of sexual abuse recognised by the community. However, there are cultural practices which support CSA. These are discussed below.

Appeasing spirits (*Kuripa ngozi*)

In this practice, a girl child given as payment to the offended family. Offences would include murder. The girl is given away as a wife to the offended family. She

would be expected to have children with a chosen family member within the offended family and perpetuate the lineage of the offended family.

Child pledging (*Kuzvarirwa*)

It is a custom where girls are pledged in marriage in exchange for food support during famine or in fulfilment of a pledge at birth of child that family will look after the child with the assistance of the future husband. At 13 or 14 years when the girl starts her menstrual period she is taken to the husband.

Sexual orientation or socialization of in-laws (*Chiramu*)

Custom where elder sisters' or aunts' husbands flirt with their wives' younger sisters or brothers' daughters.

A girl child is given as wife in case of death of her elder sister or aunt (*Bondwe* or *chimutsa mapfihwa*)

A deceased wife's husband is given the deceased's younger sister or brother's daughters by the in-laws

There are also religious practices which predispose children to CSA especially in the Apostolic or White Garment churches. These are mainly Africans initiated churches like Johanne Masowe or Johanne Marange. They include:

Prophetic dreams (*Kurotswa*)

This is when church leaders or prophets prophesise that they are given through a dream for a man to take one of the young girls as a wife. This is related to the practice of *kutambidzwa/kupihwa pamweya* (receiving from the Holy Spirit). This is when one claims or prophesises that he has been given a girl by the Holy Spirit.

Prophetic healing (*Kushandirwa*)

At times girls (and adult women) with health problems are taken by the prophet into the forest or mountain and are given purportedly holy water for treatment and sexual abuse is used as one of the methods for treatment.

Finally, there are also economic factors which can contribute to CSA. Poverty is an underlying factor which

can predispose children to CSA e.g. over crowdedness where families live in one room, children living on the streets or children living in difficult circumstances.

EFFECTS OF CSA

Stoltenborgh, van Ijzendoorn, Euser et al (2011) agree that there is no question about the negative effects of CSA on children's psychological well-being and their development into adulthood. Zollner, Fuchs and Fegert (2014) observe that sexual abuse can lead to long-lasting, even life-long, consequences and is a serious problem on an individual, familial and societal level.

It also results in devastating short and long-term consequences on the health, development, and mental well-being of boys and girls. In addition to its effects on the individual child, violence undermines national efforts in public health, social welfare and human rights and economic development.

Studies show a correlation between CSA and many adverse medical, psychological, behavioural and

socioeconomic outcomes which can be short and long term in nature (Hornor 2010; Birdhstle, Floyd, Mwanasa, Nyangadza, Gwiza and Glynn 2011; Jones and Jemmott 2009). Lalor and McElvaney (2010) note that in addition to socio-emotional and mental health effects, studies have consistently found that child survivors are vulnerable to subsequent sexual victimization in adolescence and adulthood.

Rudd and Brakarsh (2002) observe that child survivors of CSA experience psychological and behavioural effects. Psychological effects include increased awareness of sexual issues, anger, difficulty in concentration, confusion of sexual identity-difficulty in forming heterosexual relationships, difficulty as a parent-overprotection, confusion about sexual norms-incest, confusion of sex with love and care, depression, guilt and thoughts of suicide, fear and phobias-frequent vigilance, anxiety, nightmares, insomnia and feeling of isolation and loneliness.

According to Muridzo (2014) behavioural effects of CSA include precocious sexual activity, aggressive sexual behaviours, promiscuity, prostitution- due to low self-esteem, sexual dysfunction, sexual intimacy avoidance, inappropriate sexualisation of parenting and being future abusers.

It is important to note that effects of CSA are variable, depending on the age of onset, number and identity of perpetrators, severity, degree of family support and other factors. The absence of these should not be taken as the absence of CSA and that there will be no effects. Some of the effects and scars of CSA manifest later in life (Sanderson, 1995).

While CSA affects the child survivor it is important to note that it also poses serious mental health risks, to non-offending family members. According to Tavkar and Hansen (2011:189), "...the aftermath of CSA, families often face multiple challenges (e.g., loss of income, loss of a caregiver, change of residence, and limited community support) that are often accompanied by

psychological distress, such as depression, guilt, embarrassment, grief symptomatology, and secondary trauma”.

PREVENTIVE INTERVENTION

The IFSW describes social work as a profession that promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. This is done through utilising theories of human behaviour and social systems; social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work. Social work assists people in difficulty, supports them and their families to regain confidence, influences social policy and political outcomes and makes contributions of consequence. Social workers work in just about every country and community, dealing on a daily basis with hard stuff: homelessness, depression, abuse, addiction, poverty, broken families, illness, fear and recovery (Truell 2013). Social workers are at the forefront of social consequences and social realities including CSA.

The paper assumes that intervention is at the primary, secondary and tertiary level.

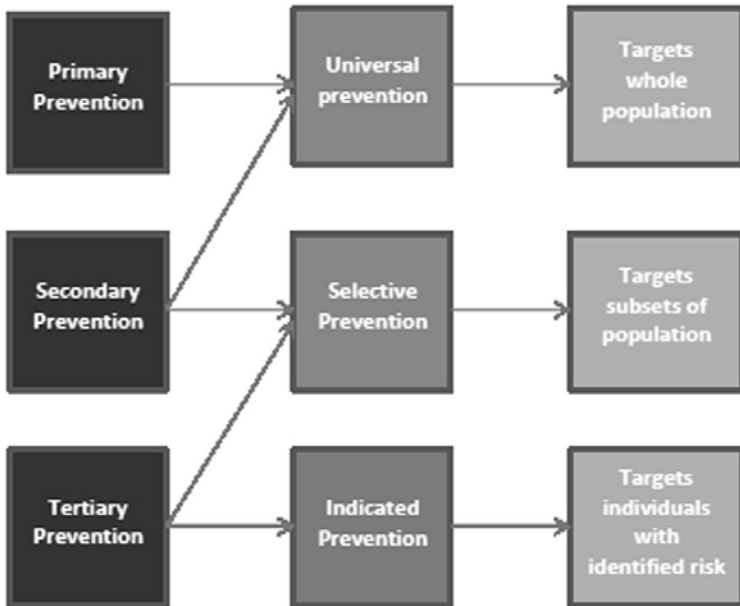
Levels of preventive intervention

Prevention of CSA means creating healthy and safe circumstances and behaviours so as to prevent sexual crimes before they can even take place (Zollner, Fuchs and Fegert, 2014).

This paper adopts the concept often used in curricular prevention programmes. It notes that prevention can be on three levels that is primary, secondary and tertiary prevention. According to Zollner et al (2014), primary prevention refers to each and every measure that is taken to reduce sexual violence from the onset and secondary prevention includes measures used in high-risk situations. The reaction to sexual crimes already committed is the domain of tertiary prevention which aims at mitigating the immediate consequences of abuse and at minimizing secondary consequences. The authors argue that social work has a role in the prevention of

CSA. Figure 1 below summaries three prevention levels in which social workers can be involved.

Figure 1: *CSA prevention levels*



Adopted from Meili in Zollner et al 2014:2

Primary prevention of CSA

In this role social workers will have to assume a proactive role, preventing CSA from taking place. This

role is in line with the developmental social work approach advocated by Mupedziswa (2000). The argument is that social work should nip the problem of CSA in the bud. Social workers should assume this role to prevent CSA in view of the effects on the social functioning of the survivors and the families. In this role, social workers are engaged in outreach and awareness programmes that educate children, families and communities. The efforts here are directed at reducing the factors that place children at risk through awareness and outreach programmes. This role will also call for social workers to educate and remind children of their rights and responsibilities.

Secondary prevention of CSA

At this level, social workers are involved in the remedial role that includes working with child survivors and families. This role attempts to minimize the effects of CSA and to help the child and the significant other to cope with the abuse. Social work services consist of assessment; diagnosis; treatment, including psychotherapy and counselling; client-centered

advocacy; consultation; and evaluation. In this role the social worker links and makes referrals to agencies to assist the child survivor with all of these services. This can be crucial when children need additional services that may include placement when the safety of child is compromised. This is critical as most cases of CSA happen in familial relationships (Lalor and McElvaney 2010). At this level social workers may assume a statutory role depending on their agency mandate.

Tertiary prevention of CAS

Prevention at this level goes further. It involves the advocacy, lobbying, and social action roles to influence beliefs, culture and increase awareness and knowledge of the social ill among people of Zimbabwe. Social work here targets social policy and legislation on child protection. This role goes beyond helping child survivors and their families cope with CSA. The paper argues that social workers need to influence policy so as to prevent CSA. This is in line with the definition of social work offered by the Social Workers Act 27:21 (Zimbabwe), The definition acknowledges that professional social

work promotes social policy (Mugumbate and Maushe, 2014). Social work intervention is knowledge based. The role of research at this level is crucial if social workers are to influence policy. Social workers should play their advocacy role. The National Association of Social Workers of Zimbabwe (NASWZ), a professional body representing social workers in the country can be a vehicle through which the social workers' voices are heard in relation to child protection and other policy issues regards CSA. Zimbabwe has a significant legal framework aimed at curtailing CSA. The legal framework commitment is shown by the domestication of the international commitments like the Convention on the Rights of the Child, and the African Charter on the Rights and Welfare. By ratifying the Convention and the Charter, the Government of Zimbabwe committed itself to implement the provisions of both instruments. Muridzo (2014) however makes the argument that the challenge for Zimbabwe is not the absence of legal frameworks and legislation to protect children but rather the lack of implementation of the existing laws. NASWZ can play a role in holding duty barriers to account when

rights holders claim their rights and enforcement of the law and international commitments. Research in social work is important as the profession's interventions should be evidence based (Engel and Schutt, 2013).

CONCLUSION

CSA has consequences and is a serious problem on individuals, families and societies. It affects the social functioning of the child survivors and the significant others. This paper argues that the problem of CSA concerns social workers. Given the magnitude of the problem, social workers must be visible in the issues related to CSA. Social workers can and should be involved in the prevention of CSA at the primary, secondary and tertiary role.

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