

CHALLENGES FACED BY PROFESSIONALS WORKING IN CHILD SEXUAL ABUSE MULTI-SECTORIAL FORUMS: A CASE OF THE VICTIM-FRIENDLY SYSTEM IN ZIMBABWE

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This article discusses the challenges faced by role players who work with survivors of child sexual abuse within the Victim-Friendly System. The Victim Friendly System represents a confluence of multi-sectorial professional interventions targeting child sexual abuse survivors in Zimbabwe. Professionals involved in the Victim-Friendly System include social workers, medical doctors, nurses, police, as well as role players within the justice system such as magistrates and prosecutors, counsellors, educationists and psychologists. The findings of this qualitative study show that professionals work within the context of a shrinking economy that has given rise to a plethora of challenges that include, among other things, staff and skills shortages, lack of financial and material resources, poor access to proper infrastructure and other logistical constraints. The authors end the paper by discussing recommendations that have policy, administrative and professional implications.



## **CHALLENGES FACED BY PROFESSIONALS WORKING IN CHILD SEXUAL ABUSE MULTI-SECTORIAL FORUMS: A CASE OF THE VICTIM-FRIENDLY SYSTEM IN ZIMBABWE**

Noel Muridzo, Victor Chikadzi, Edwin Kaseke †

### **INTRODUCTION**

This article explores the challenges faced by social workers, medical doctors, nurses, police, magistrates, prosecutors, counsellors, teachers and psychologists working in the Victim-Friendly System (VFS). Studies from several countries show that child sexual abuse (CSA) is indeed an international problem (Lalor & McElvaney, 2010; Collin-Vezina, Daigneault & Hebert, 2013; Finkelhor, Stattluck, Turner & Hamby, 2014; Bhaskaran & Seshadri, 2016). Various scholars challenge the assumption that CSA is an exclusively Western problem (Jones & Jemmott, 2009; Sossou & Yogtiba, 2009; Zimbabwe National Statistical Agency, United Nations Children's Fund and Collaborating Center; Lalor & McElvaney, 2010; Judicial Service Commission 2012; Bhattacharya & Nair 2014 and Jones & Florek, 2015). In Zimbabwe, where this study was done, the National Baseline Survey on the life experiences of adolescents in Zimbabwe reported that almost one third of females and one in ten males aged between 18 and 24 years experienced sexual violence (Zimbabwe National Statistical Agency, United Nations Children's Fund & Collaborating Center for Operational Research and Evaluation (2013). It is also estimated that more than 400,000 cases of CSA are reported every year in Zimbabwe (Médecins Sans Frontières, 2011). Jones and Jemmott (2009), Horner (2010), Lalor and McElvaney (2010) and Birdhstle, Floyd, Mwanasa, Nyangadza, Gwiza and Glynn (2011) show a correlation between CSA and many adverse medical, psychological, behavioural and socioeconomic outcomes, which can be short and long term in nature. CSA negatively affects the child and his/her ecological environment. Accordingly, the VFS was established to provide a community of medical, psychological, judicial and social services that mitigate the negative effects of CSA (Judicial Service Commission, 2012).

### **STATEMENT OF THE PROBLEM AND RATIONALE FOR THE STUDY**

The phenomenon of CSA is a multifaceted global children's rights issue and a problem of considerable extent (Stoltenborgh, Van Ijzendoorn, Euser & Bakermans-Kranenburg, 2011). CSA is a serious problem with adverse medical, psychological, behavioural and socioeconomic outcomes which can be short, medium and long term in nature (Hansen & Tavkar, 2011; Birdhstle, *et al.*, 2011; Stoltenborgh *et al.*, 2011). CSA effects operate at individual, familial and societal levels within CSA survivors' ecological environments. At the individual level CSA may have physiological, psychological and behavioural effects. CSA may result in unwanted pregnancy, STI infections and injuries to reproductive organs (Muridzo, 2018). CSA has been linked to a number of psychological disorders such as anxiety problems, suicidal tendencies, low self-esteem, anxiety, depression, anger and post-traumatic stress disorders (Lalor & McElvaney, 2010; Maniglio, 2012; Devries, Mak, Child, Falder, Bacchus, Astbury and Watts, 2014). CSA survivors may also develop behavioural problems such as poor school performance, risky sexual behaviour, substance misuse and violence (Jones & Jemmott, 2009; Hansen & Tavkar 2011). At the familial level CSA may have considerable social, emotional and economic consequences such as stigma, increased feelings of isolation, loss of partner or disruption of the family, and loss of income (Elliott & Carnes, 2001; Foster, 2014). At the societal level CSA is associated with community anxiety, human rights violations and an economic burden on society (Jones & Jemmott, 2009; Chitereka, 2012).

Various intervention strategies have been introduced to mitigate these effects. Interventions such as the Victim-Friendly System (VFS) have been put in place to address and manage this growing problem in

Zimbabwe. Official records from the Zimbabwe Republic Police point to the phenomenon being on the increase and being topical in Zimbabwe (Chitereka, 2012; Muridzo, 2014). This is despite the various intervention strategies employed by the different stakeholders constituting the VFS, such as the police, Department of Probation Services and Child Protection, Judicial Service Commission, the health sector and non-governmental organisations. The health sector is made up of government hospitals, municipal clinics and health clinics run by non-governmental organisations (NGO). Despite an increase in both publicity on child sexual abuse and initiatives from the government and voluntary agencies, it is by no means obvious that the position of the majority of sexually abused children has been significantly improved (Muridzo, 2018). Thus it has been argued that new ways of approaching the problem of CSA are needed (Browne, 1996; Lalor & McElvaney, (2010; Mwangi, Kellogg, Brookmeyer, Buluma, Chiang, Otieno- Nyunya & Chesang, 2015; Muridzo, 2018). This article therefore reports on some of the key challenges faced by professionals working in the VFS. The findings of the study contribute to strengthening of strategies on CSA prevention policy in view of the magnitude of the problem, its effects and consequences.

## **EFFECTS OF CSA**

The effects of CSA are multiple and varied (Muridzo, 2014). According to Smallbone, Marshal and Worley (2008), CSA effects are not uniform. Chitereka (2012) undertakes an ecological analysis of the effects of CSA. The ecological theory is an extension of the systems approach, which allows exploration of a wide circle of systemic influences. The systems approach argues for the exploration of this wide circle of systemic influences and the way that environmental forces influence things. The systems approach further argues that individuals exist within a social context and hence, to best understand the effects of a phenomenon such as CSA, you have to look at the effects in context and at various levels (Doyle, 2012; Sincero 2012). Our understanding of the phenomenon of CSA should therefore be bounded by the context of effects within different ecological systems (Chitereka, 2012; Muridzo, 2018). Bronfenbrenner (1979) suggests five systems that make up the ecological system. These systems are the micro system, the meso system, the exosystem, the macro system and the chronosystem. In line with ecological thinking, the effects of CSA are layered according to way that they affect different ecological systems.

### **Micro-ecological effects of CSA**

At the micro level, CSA affects CSA survivors and non-offending family members. CSA affects CSA survivors psychologically, physiologically, behaviourally and socially. Nurcombe (2000) document the psychological effects of CSA on CSA survivors. Lalor and McElvaney (2010) found psychological problems to include low self-esteem, anxiety, depression, anger and aggression, post-traumatic stress, dissociation, substance abuse, sexual difficulties, somatic preoccupation and disorders, self-injurious or self-destructive behaviour, and most of the various symptoms and behaviour seen in those diagnosed with borderline personality disorder. According to Devries et al. (2014), CSA is associated with increased odds of suicide attempts. CSA may result in physiological challenges for the child survivor. Muchinako, Chikwaiwa and Nyanguru, (2013) found that children who suffered CSA were exposed to sexually transmitted infections including HIV. Other physiological effects of CSA include injuries to reproductive organs, unwanted pregnancy, abortion and associated risks (Lalor & McElvaney, 2010). In addition, Mugawe and Powell (2006) and the Population Council (2008) note that sexual abuse is a major cause of problems among girls, such as ill health and even death and disabilities as a result of injuries. The child survivor may develop behavioural problems in the form of poor school performance, gambling, risky sexual behaviour, substance misuse, masturbation or compulsive sex play and violence (Finkelhor & Browne, 1985; Jones & Jemmott, 2009; Hansen & Tavkar 2011; Zhu, Gao, Cheng, Chuang, Zabin, Emerson and Lou, 2015). Perez, Aldrian and Stender (1997) identify the social effects of CSA at the micro level, emphasising that the social value attached to female virginity automatically robs abused or seduced young girls of their sense of social dignity.

Hansen and Tavkar (2011) are of the opinion that CSA also affects other constituent members of the micro ecological system. According to Chitereka (2012) and Foster (2014), the whole family system is affected by CSA. Elliott and Carnes (2001) argue that at the familial level non-offending family members experience considerable social, emotional and economic consequences such as stigma, increased feelings of isolation, loss of partner or disruption of the family, loss of income, and dependence on government assistance. Jones and Jemmott (2009) note that CSA may result in family problems that include divorce and family break-up, distorted boundaries, betrayal of trust and intergenerational abuse. In the aftermath of CSA, families often face multiple challenges that are often accompanied by psychological distress, such as depression, guilt, embarrassment, grief symptoms, anger, helplessness, disbelief, shock, worry, deep sadness, self-blame, betrayal, having failed the child, confusion, insomnia, change of appetite or other physical complaints and secondary trauma as a result of the stress and fear associated with learning that their child has been abused (Hansen & Tavkar, 2011; International Rescue Committee, 2012). The effects of CSA at the family level may be economic. CSA may result in loss of income that may lead to change of residency and dropping out of school for the survivor and the other children (Hansen & Tavkar, 2011).

### **Macro-ecological effects of CSA**

The wider society in which the child lives is the macro level. CSA also has consequences at the societal level. Jones and Jemmott (2009) associate CSA with social ills such as teen pregnancy and associated consequences for young mothers and their children, unwanted pregnancy and abortions, abortion complications, drug and alcohol abuse, transmission of STIs and HIV, crime and violence, cycle of devastation, psychosocial impact on others, and the economic consequences of the above. CSA is a human rights, a child rights and child protection issue in society and a legal issue at national and international level. CSA violates national and international laws. CSA constitutes a violation of the child's rights bestowed by society. The International Rescue Committee (2012) and Sossou and Yogtiba (2009) argue that in addition to the above effects, CSA constitutes social injustice and an abuse of human rights. They argue that CSA is an abuse of power over a child and a violation of a child's right to life and normal development through healthy and trusting relationships. CSA will have an economic burden on society as human, economic and infrastructural resources will have to be committed to prevent and respond to the phenomenon. According to Ouellette-Morin, Fisher, York-Smith, Fincham-Campbell and Arseneault (2015), violence experienced in the context of relationships has an economic burden on society. Interventions are therefore costly, and highly resource intensive in terms of the skills and training of those involved (Jones & Jemmott, 2009).

Chitereka (2012) is of the view that CSA may affect the macro-ecological environment in a number of ways. Firstly, the incarceration of the perpetrator, who may be the breadwinner, may result in financial setbacks because of loss of the breadwinner's income. Secondly, the family may experience food shortages. Thirdly, the family house or property might be sold to offset the financial burden. Fourthly, some of the children might drop out of school. Dropping out of school will have an impact on their economic and earning abilities in the future. Fifthly, irrespective of the outcome of the court proceedings, perpetrators who have been charged with sexual abuse face stigmatisation and ostracism. CSA produces anxiety for communities. Lastly, CSA offenders may never be arrested, as a result of the secrecy and threats to the children, further traumatising children and communities.

Putman (2003), however, argues that not all sexually abused children are affected by most of the above problems. Effects will vary depending on the child's personal coping skills, and the family and societal context. The above effects are a function of an array of factors. Mitigating factors include the child's personality, the support system, duration of the abuse, frequency of the abuse, age of the child, the degree of force used by the perpetrator, relationship with the perpetrator, intrusiveness, and the severity of the abuse (Rudd & Brakarsh, 2002; Putman, 2003; Jones & Jemmott, 2009; International Rescue Committee, 2012).

## **CHILD SEXUAL ABUSE INTERVENTIONS**

Child sexual abuse interventions can be categorised as medical, psychological, judicial services and social services. CSA interventions are specialised, requiring professionals from several disciplines such as social workers, doctors, nurses, police officers, magistrates, prosecutors, counsellors and psychologists. Professionals are engaged within the various services targeting CSA survivors and their ecological environment.

### **Medical management of CSA**

Medical interventions are aimed at addressing the physical consequences of CSA (Population Council, 2008). There are a number of issues that medical treatment seeks to address. Firstly, there is the treatment of physical injuries. CSA may result in sexual violence-related injuries, for example, bleeding, swelling and bruising of the genitalia. Secondly, medical interventions seek to provide preventive services, such as access to free post-exposure prophylaxis, emergency contraception and termination of pregnancy after authority to do so has been granted by a magistrate. CSA may result in pregnancy and the contraction of sexually transmitted infections. Medical interventions aim at providing the child survivor with medical treatment in Zimbabwe, including the provision of HIV diagnostic testing and counselling, and post-exposure prophylaxis (PEP) to combat HIV, sexually transmitted infections (STIs) and pregnancy. According to Médecins Sans Frontières (2011), it is vital for CSA survivors to seek medical treatment within 72 hours of the sexual abuse incident. The immediate medical risks are unwanted pregnancy, contracting STIs including HIV. In Zimbabwe medical intervention is treated as an emergency and given priority. This involves access to post-exposure prophylaxis to HIV and STI within 72 hours. In addition, medical intervention seeks to prevent pregnancy that may result from the sexual abuse. According to the Judicial Service Commission (2012), children in Zimbabwe should access emergency contraception within 5 days of the sexual abuse to prevent pregnancy.

Most importantly, medical intervention includes the collection of forensic evidence, which is very critical in responses to CSA. Forensic evidence can be used in the identification of perpetrators, where they are not known. However, with the limited availability of DNA technology and advanced science in the investigation processes, the identification of unknown perpetrators can be difficult to achieve. Furthermore, forensic evidence helps to substantiate the testimony of the child in the judicial system. Professionals in this sector include medical doctors, nurses, radiographers, social workers and psychiatrists. According to Malinga and Mupedziswa (2009), social workers at this level work in a secondary setting in which they are part of a multi-sectorial team.

### **Psychological interventions**

CSA is consistently linked with a host of adverse psychological, emotional and mental health outcomes, often requiring psychological intervention to address the trauma and distress (McPherson, Scribano & Stevens, 2012). The Population Council (2008) recommends psychological intervention to help CSA survivors recover from CSA consequences that are often long-lasting and difficult to deal with. The interventions seek to address the effects discussed above as well as any potential psychological effects that may develop later in life. Psychological services may be categorised as individual and group services. For Hansen and Tavkar (2011), individual psychological interventions start with crisis interventions. Subsequent interventions will focus on time-limited services that address specific emotional issues that might emerge. According to Chitereka (2012), individual psychological intervention covers a range of activities, including play therapy, bibliotherapy, group therapy and family therapy. Group psychological interventions seek to provide support to the survivors and families in a group environment. While the target is the individual, the group is used as a medium for support, therapy and growth for CSA survivors. The value of group work for CSA survivors is that they can share experiences, cultivate a sense of belonging, and thus create an environment for psychological support. Groups can be educational, therapeutic and recreational, but in this context mainly therapeutic. Professionals in the health sector include social workers, psychologists and counsellors.

### **Judicial, legal and policy interventions**

The judicial and legal interventions constitute a third intervention component in Zimbabwe. Jones and Jemmott (2009) identify the judicial, legal and policy needs of CSA survivors. Child survivors will also have protection needs. These needs relate to the establishment of arrangements and processes to identify, reduce and respond to the circumstances that place children at risk. There are various international statutes that protect children from CSA. Every community generally cares for its children and wants to protect them. The Convention on the Rights of the Child (CRC) adopted by the UN General Assembly in 1989 is the widely accepted UN instrument ratified by most developed as well as developing countries. The principal frameworks for addressing child justice and safety in international and regional contexts are the United Nations Convention on the Rights of the Child (1989) and the African Charter on the Rights and Welfare of the Child – ACRWC (1999). Zimbabwe is party to both conventions. Chitereka (2012) argues that by ratifying the Convention and the Charter, the Government of Zimbabwe (2001) committed itself to implement the provisions of both instruments. According to Gwirayi (2013), CSA is a criminal offence in Zimbabwe that is punishable by law. Zimbabwe has five key legal instruments that protect children against CSA which have been harmonised with international law in an effort to protect children against sexual abuse (Chitereka, 2012; Gwirayi, 2013). However, Gwirayi (2013) questions the efficacy of existing laws on CSA, and argues that despite the ratification of international conventions on CSA and the domestication of the laws, CSA remains a serious problem in Zimbabwe. Legal services providers include the police, magistrates, prosecutors, court interpreters and support persons. Professionals within the legal sector include lawyers, social workers and psychologists.

### **Child care and protection services**

Child care and protection services constitute another intervention component in Zimbabwe. Services at this level aim to prevent or ameliorate the socio-economic effects of CSA. Services are largely provided by the Department of Social Services and other non-governmental organisations. Social services include child protection, safety services as well as pre-trial and post-trial support services. The Department of Social Welfare is a statutory body mandated to implement and enforce statutes such as the Children's Act Chapter 5:06 (2001) and the Constitution of Zimbabwe, which ensure protection from CSA (Mupedziswa, 1997; Judicial Service Commission, 2012). The Department of Social Welfare in Zimbabwe is a primary setting for social workers. Chitereka (2012) notes that safeguarding and promoting children's welfare are intertwined aims central to social work intervention in childcare in any circumstances. This role may include moving CSA survivors from unsafe environments into places of safety such as Children's Homes or place them with foster parents. The Children's Act (2001) and the Social Workers Act (2001) provide for the appointment of social workers as probation officers. As probation officers, social workers provide overall case management services, provide alternative places of safety for CSA survivors, accompany CSA survivors to medical and legal service providers, provide reports to courts as well as pre-trial counselling. In addition, social workers support families of CSA survivors, keeping them abreast of case developments. Probation officers are also responsible for implementing case plans. Social workers at this service level also advocate for timely assistance of CSA survivors in the intervention chain (Judicial Service Commission, 2012).

### **Aim of the study**

The broad aim of the study was to explore the phenomenon of child sexual abuse in Zimbabwe.

### **Research question**

What are the challenges faced by VFS stakeholders in Zimbabwe?

## RESEARCH METHODOLOGY

### Research design

The study adopted a qualitative research approach. A qualitative approach is adopted to help the researchers uncover, describe and understand what lies behind any phenomenon, in this case the challenges faced by professionals working with CSA survivors (Rubin & Babbie 2011; Creswell 2014). The Victim-Friendly System (VFS) was chosen as the unit of analysis in order to understand child sexual abuse and the challenges faced by VFS stakeholders. VFS stakeholders include participating governmental and non-governmental organisations, CSA survivors and their families, and professionals working in the VFS.

### Sample

The VFS role is carried out by 29 government and non-governmental organisations divided into the National VFS Committee and Regional VFS Committees; 38 participants were selected from the national and regional representatives. In addition, the study purposively sampled four key informants. Patton (2002) describes key informants as people who are knowledgeable about the inquiry setting and able to articulate their knowledge. Yin (2009:107) states that “key informants provide the case study investigator with insights into a matter and can also initiate access to corroborative or contrary sources of evidence.” The key informants’ category was made up of an academic, a traditional leader, a lawyer and an expert in the field of child sexual abuse. The study also sampled and made use of VFS official documents that included 300 VFS court files of completed CSA cases and VFS committee meeting minutes. A combination of purposive sampling and simple random sampling was used to select 300 CSA court files and minutes of VFS meetings.

### Sampling procedure, data-collection methods and data analysis

The study used theoretical sampling to sample VFS role players, official documents, key informants and research sites. Corbin and Strauss (2008) and Bryman (2012) describe theoretical sampling as a form of purposive sampling used in exploratory research such as this one in which the collection of data and its analysis respond to emerging concepts and themes. In-depth interviews guided by the use of semi-structured interview schedules were conducted as the main data-collection method. Bryman (2012) and Creswell (2014) state that semi-structured interview schedules entail the use of open-ended questions that allow participants to express their perspectives. Supporting data were collected through reviewing 300 official court documents and minutes of VFS meetings. The interviews were tape-recorded to obtain the actual narratives from interviewees (Patton, 2002). Applied thematic analysis was used to analyse data. Recurring issues from the data were grouped into themes that guided the writing up of the findings (Guest, Macqueen & Namey, 2012).

### Ethical considerations

According to Bryman (2012) and Creswell (2014), social research raises ethical issues. Babbie (2007), Willis (2007) and Engel and Schutt (2013) describe ethics as the standards, principles and guidelines that have to be followed when carrying out research. This study adhered to ethical standards and principles of research. The researchers took a number of steps to adhere to the principle of confidentiality, informed consent, voluntary participation, avoidance of harm and giving feedback to participants after the study was concluded. The study was cleared by the Wits non-medical ethics committee under protocol number H15/02/20. The study was also cleared by Medical Research Council of Zimbabwe under protocol number MRCZ/A/1969.

## PRESENTATION AND DISCUSSION OF FINDINGS

The findings of this qualitative study show that professionals work within the context of a shrinking economy, which has given rise to a plethora of challenges including, among other things, staff and skills shortages, lack of financial and material resources, poor access to proper infrastructure and other logistical constraints.

## Human resource challenges

Human resource limitations were identified by participants as a challenge affecting professionals in the VFS. Participants explained that human resource challenges include staff shortages, lack of specialised training and experience and lack of professional support. These themes are discussed in more detail below.

### Staff shortages

The study identified a gap between the available number of personnel and the desired, or even the optimum, number of personnel in the VFS as a whole. According to participants and the documents review, the VFS faced serious staff shortages, which was detrimental to the function of VFS. The challenge of staff shortages within the VFS is evident from the following comments by participants:

*“You are pulling out resources from an already depreciated health facility for you to man that centre [CSA survivor friendly clinic]. Considering the sensitive nature of the cases that we are dealing with in that unit, they cannot wait for longer, they need attention as soon as they arrive, so it has to be well staffed. Already we have a shortage of staff.”* (Participant 8)

Similarly another participant said:

*“I think there is ratio of one social worker to fourteen thousand kids in Zimbabwe, so child welfare protection services indebted with clients they are serving 1 to 14 000; if there are two officers in this one office they got 28 000 kids, so they are not able to fully write a report, they need 28 000 months to do it.”* (Participant 2)

Another participant lamented:

*“We have one child officer in every district and some districts are very large. It is very difficult for the officer to follow up all cases of child sexual abuse.”* (Participant 5)

Minutes of the VFS also capture staff shortages as follows:

*The VFS court facilities in Kadoma are, there but the personnel to man these courts are the missing link. The current freeze has negatively affected operations* (Minutes of the National VFS meeting of 15 September 2015).

From the participants' comments and minutes of VFS meetings above, it is clear that the VFS faces serious staff shortages, which affects its operations. Staff shortages have the potential to undermine the VFS in a number of ways. Firstly, staff shortages may result in delays and failure to meet turnaround targets. CSA is regarded as a medical emergency in Zimbabwe (Judicial Service Commission, 2012). Survivors of CSA must receive medical attention within 72 hours of the incident to prevent pregnancy and STI infections, including HIV. Staff shortages may result in children being attended to at health facilities outside the 72-hour window period. Child survivors of CSA may thus miss out on the opportunity to receive prophylactic treatment due to delays. This may expose children to medical effects of CSA that cannot be reversed 72 hours after the incident.

Secondly, delays caused by staff shortages may have a ripple effect in the VFS. Given the possibility of such delay in VFS and organisations' reliance on each other, this may affect outcomes of other players and impact negatively on the entire processes. For example, delays in the health system may result in contamination of forensic evidence, compromising the court outcomes in the justice delivery system. The VFS legal system depends on the collection and presentation of evidence and facts of the matter before the court. Shortages in the medical staff may therefore lead to delays in the collection of evidence affecting the other VFS processes downstream. In addition, staff shortages in the VFS may lead to performance deficiencies among VFS professionals. Performance of the staff can also diminish due to fatigue from attending to too many cases that are not only limited to CSA. Overworking of staff may have knock-on effects of demoralisation, poor job satisfaction and weak staff retention. Staff shortages in Zimbabwe are largely triggered by mass exodus of professionals triggered by the unstable

socio-political environment and a high demand for Zimbabwean professionals in the region and elsewhere (Mupedziswa & Ushamba, 2006; Martin, 2007; Kanyenze, Kondo, Chitambira & Martens, 2011; Mugumbate, 2016).

### **Lack of specialised skills, training and experience**

From the participants' narratives, it was also evident that the VFS has a deficit of specialised and experienced professionals. A lack of specialist professionals was noted as a key and peculiar human resource challenge in the entire VFS. Participants explained that the VFS has a deficit in required levels of highly skilled and experienced professionals in policing, medicine, forensic science, court interpretation, education, nursing, psychiatry, radiography, social work, clinical psychology, prosecution, justice and counselling. The lack of specialised and experienced professionals within the VFS is evident in the following comments by participants and extracts from documents reviewed:

*“The other challenge which is related to resources is the issue of human resources. We have challenges. We do not have specialists. This is lacking within the system and there is need for specialised services such as clinical psychologists, psychiatrist and forensic scientists who are not even available and we cannot talk about them.”* (Participant 22)

*“(The) lack of specialised and experienced professional leads to loopholes [legal loopholes]. The loopholes are caused by poor investigation. The police, for example, are always rotating. Today they train officers in VFS, the next day they are transferred to other sections* (Participant 36)

The above participants' narratives and VFS minutes present a notion of the VFS lacking specialised and experienced professionals. CSA is a sensitive specialised area with peculiar medical, legal, social and psychological effects on the child and families. CSA interventions at various levels require specialisation in particular fields. All processes in the VFS should ideally be carried out by highly skilled, competent and experienced specialists. Specialised interventions seek to mitigate the negative short- to long-term effects of CSA. The shortage of specialist doctors, nurses, social workers, psychologists, radiologists, psychiatrists, police officers, interpreters, magistrates, prosecutors, counsellors and teachers may have implications for the intervention outcomes. CSA intervention done by professionals without specialised training may perpetuate harmful practices that can cause further emotional distress and prevent healing. Similarly, September, Matne, Adam & Kowen (2000) note that professionals working with CSA survivors may unintentionally cause secondary trauma if they lack specialised training and experience.

Participants went further to single out the lack of specialised communication skills. Participants explained the difficulty they had in communicating with children with hearing and speech impairments. The VFS professionals' lack of sign language proficiency proved a major hindrance in delivery of services to the survivors with hearing and speech impairments. Participants also explained that professionals rely on outsourced interpreters to bridge the communication divide. The communication challenge is further compounded by the lack of universal sign language in the country. The following remarks bring out the communication challenges professionals face while working with children with hearing and speech impairments.

*“We have identified issues, for example, communication barriers ... the police, the magistrate even other sectors who are supporting the system and health and we realise they do not have communication skills, for example, sign language to communicate with these people [child sexual abuse survivors].”* (Participant 10)

*“So you understand the issue [communication barriers] put such children [children with disabilities] at a disadvantage. The other problem that generally happens is reporting at police stations; that do not have sign language experts.”* (Key Informant 1)

It is clear from the participants' narratives above that professionals in the VFS largely lack specialised communication skills to communicate with children and families with disabilities, particularly the deaf. The lack of specialised training and experience has been confirmed by other studies (see Chambers 1997; Chikadzi, 2014). Such extreme scarcity of specialised training and experienced manpower has serious potential consequences. For professionals, lack of communication skills is evident working with children and families with disabilities, particularly the deaf. This denies children with a disability participation in the VFS at various levels. At the level of prevention, children with disabilities do not benefit from officials' messages and communication. Children are thus denied vital information and knowledge on CSA. This may bring into question the diagnosis and interventions made, which may not reflect what the child will have communicated.

The need for specialist CSA intervention is supported by Smith, Pearce, Pringle and Caplan (1995), who argue that a specialist approach to child sexual abuse is beneficial to child survivors. Given the adverse short- and long-term effects of CSA, a specialist approach to child sexual abuse is beneficial to child survivors. A study by Phasha (2013) gives weight to the argument that lack of specialised skills is a barrier to provision of services. Phasha (2013) found that the inability to use sign language among professionals was a significant communication barrier that contributes towards reports of CSA not being made. The current argument that lack of specialised and experienced professionals at the VFS forum results in deterioration of services for CSA survivors is also consistent with the argument made by Chikadzi and Mafetsa (2013:498), who found that specialised services "translated into improved services for clients".

### **Lack of professional support**

From the participants' narratives, it is apparent that professionals in the VFS lack professional support. According to participants, lack of professional support is potentially harmful and compromises their health and general wellness. In this context professional support refers to a structured and formalised professional support system that prevents burnout, stress and vicarious trauma, as well as staff debriefing meetings, supervision sessions, in-house support training and time out. Participants highlighted the lack of professional support as follows:

*"I think we need psychological support so that we pour out our feelings and share the experience that we go through [in cases that] traumatise us."* (Participant 7)

Another participant said:

*"We need psychological support to enable us to pour out and share experiences. We need more of the staff debriefing."* (Participant 18)

Despite the negative potential problems associated with working with survivors of CSA, it can be seen from the selected participants' narratives above that the VFS lacks institutionalised support systems for its professionals. The provision of support enhances the professionals' health, i.e. the physical, social and mental wellbeing of professionals (Westermann, Kozak, Harling and Nienhaus, 2012; Softestad & Toverud, 2013; Cieslak, Shoji, Douglas, Melville, Luszczynska & Benight, 2013). Bhaskaran and Seshadri (2016) confirm that working with sexually abused children and their families is stressful for professionals, evoking feelings of uncertainty, frustration and emotional turmoil. Similarly, Sexton (2009) notes that working with survivors of trauma such as CSA makes therapists vulnerable to the detrimental effects of secondary trauma, with consequent negative effects on individual counsellor effectiveness and organisational dynamics in the workplace. The apparent lack of support for professionals in the VFS may have an impact at various levels. It can be argued that the absence of professional support systems in the VFS negatively affects professionals, in turn affecting the nature and quality of their professional interventions.

### **Resource limitations**

In addition to the challenges associated with human resources noted above, it was also evident that professionals in the VFS experience resource challenges. These challenges relate to interruption of

service delivery due to withdrawal of funding, logistical constraints and the burden of cost on survivors and their families.

### **Lack of continuity in service delivery due to withdrawal of funding**

One of the notable challenges of the VFS is the lack of continuity in service delivery due to withdrawal of donor funding. Participants explained that the VFS is largely donor funded and the withdrawal of donor funding affects continuity of service delivery in both government departments and non-governmental organisations. The lack of continuity in VFS service delivery due to withdrawal of funding is evident from the following comment:

*“The reliance on donor funding is like there is no guarantee of continuation of the interventions of the civic society. We may not have the funding at that moment, some donors renew like, for instances, we have been renewing, but there will be grey periods where money is not available.”* (Participant 10)

It is clear that erratic funding is a problem that affects organisations working within the VFS. At the level of VFS organisations, withdrawal of funds affects organisational operations. The withdrawal of funding also impacts the ability of VFS organisations to attract and retain competent staff. Specialist and competent personnel leave for greener pastures in private practice or emigrate to other countries. According to Kanyenze *et al.*, (2011) and Chitereka (2012), Zimbabwe has experienced a brain drain, losing professionals to other countries. The current finding that the VFS lacks continuity in service delivery due to withdrawal of funding may also explain other challenges such as lack of specialised training and experience, staff shortages and low competency and skills levels discussed above.

### **Limited access to appropriate infrastructure, equipment and logistical constraints**

The study participants painted a grim picture of a system fraught with logistical constraints. Participants explained that professionals working in the field of CSA have limited access to appropriate infrastructure and logistics needed to accomplish their professional roles. Participants singled out lack of transport and accommodation as examples of limited access to appropriate infrastructure as well as being logistical constraints. Transport is needed to make home visits, follow-ups, investigations, and escorting the child to service providers and the justice system. A lack of necessary equipment such as furniture, stationery and computers was evident in VFS organisations, particularly government departments.

The claims above are evident from the following comments by participants:

*“One of the major hindrances is not having the money to travel. It becomes a challenge if you are a key witness and you do not have money to travel. Sometimes people (witnesses) are made to travel in an open truck. They ask themselves why they should travel to give testimonies in court. They may withdraw their cooperation.”* (Participant 11)

*“Yes there are challenges. You know with Gokwe, places are located in remote areas and there are no normal buses which travel to those distances because of bad roads. So these people resort to using private cars. You see they are exorbitant.”* (Participant 29)

The challenge highlighted above was also collaborated by court files. One of the files read:

*“The probation officer failed to interact with the survivors due to distance and transport challenges.”* (Gokwe case 65)

*“They [VFS organisations] do not even have computers and so forth.”* (Participant 3)

*“For every survivor who is seen here and had an examination, you should fill in a medical affidavit and we always have them. The rape kits are provided for by the police. We are not allowed to have our own rape kits. They should come with the police together with the survivor. At the moment the police do not have these rape kits. They are not coming with them. The last time I heard they were expired. And for now I don't know why they are not*

*coming with them and if they are not, which means they are not available, or I am not quite sure.” (Participant 13)*

From the participants’ accounts above, it is clear that professionals working with child survivors have limited access to appropriate infrastructure and experience logistical constraints. This leads to a situation where organisations end up providing piecemeal interventions that affect the quality of services. The current finding confirms the claim that professionals lack necessary resources, which adversely affects their interventions. Using the example of social work, Mupedziswa (1997) argues that limited resources hamper the fulfilment of professional obligations such as enforcement of statutes relating to the welfare of children. The lack of transport, for example, affects the quality and nature of investigations. Poor investigations also affect the quality of evidence that is produced. The poor evidence has ramifications for the judicial judgments made. Limited access to appropriate infrastructure and logistical constraints limit the number of visits and contacts that professional have with the CSA survivors. In view of the current finding of limited access to appropriate infrastructure and logistical constraints, it is clear that some CSA survivors are not be getting quality interventions in line with global best practices. This has serious implications for the treatment and recovery of CSA survivors and it also dampens the morale of professionals who work within the VFS.

### **Inaccessible remote areas**

It was also evident that professionals in the VFS face challenges in accessing remote rural areas. Participants explained that they face accessibility problems due to long distances, poor terrain and bad roads.

*“I cover 39 wards that are geographically spaced. Within the same ward you can travel 80 km in the same ward. Volunteers are supposed to use bicycles. Some of the places are sandy and you cannot travel with a bike. Yes we have new bikes. We have never used the bicycles because of the [bad] state of the roads.” (Participant 38)*

*“In terms of our terrain it is difficult in the fact that from here to the furthest point it is approximately 100 kilometres. Some of the areas are not accessible during the rain seasons. It is a challenge to get to services providers here at the centre [Gokwe] in the event of CSA. It is difficult to travel, for example, from Gokwe centre to the furthest point, for example, Msala which is about 100 kilometres or more. Access during the rainy season is even a greater challenge.” (Participant 28)*

From the above participant narratives it is notable that professionals find many areas physically inaccessible. Given that most roads in Zimbabwe are in a bad state, professionals cannot reach outlying areas. For professionals working in CSA prevention and education, inaccessibility may mean that information does not reach the outlying areas. When police travel long distance to communities, this may result in the contamination of collected evidence. On the other hand, the need for long-distance travel may also lead to many cases not being reported, as victims of the families of victims are indigent and do not have the necessary resources to bear the burden of cost that comes with reporting CSA cases. To this end, accessibility as a challenge may result in reduced access of the VFS by potential users. This corroborates the findings by Kaseke (2015) that the location of service providers and users in remote areas proves to be a barrier to accessing services. Similarly, Peters, Garg, Bloom, Walker, Briegr and Rahman (2008) note that the virtual absence of good roads in the poor areas of developing countries interferes with service delivery.

### **CONCLUSIONS AND RECOMMENDATIONS**

Given the potential negative effects of CSA on survivors and their ecological environment, the following recommendations are made.

- It is recommended that the VFS make it mandatory for participating organisations to introduce professional support services such as debriefing sessions and clinical supervision to help professionals cope with the demands of working in stressful environments.
- To address social work staff shortages, it is necessary to deliberately increase the intake of social work students. However, such increase must be matched by a corresponding increase in resource allocations to the schools of social work.
- In addition, staff retention initiatives, such as better working conditions and salaries, may assist retaining professional already in the VFS.
- Staff shortages may also be addressed through introducing policies and enabling legislative frameworks that facilitate locum and use professionals such as social workers outside government employment.
- Lack of specialised training and expertise may be addressed through introduction of undergraduate and postgraduate specialised courses that focus on child protection and working with special groups such as CSA survivors.
- Given the resource challenges discussed above, there is a need for the government to prioritise child protection by funding and supporting the VFS. A funding mix comprising corporate, government and NGO funding may potentially assist given the current serious economic challenges facing the state (Government of Zimbabwe, 2013; Mupedziswa & Ushamba, 2006).
- The provision of cars that can cope with the terrain, as well as other logistical support services, is needed as this will increase access to remote areas.

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## Notes

1. The Victim Friendly System (VFS) is a multisectoral forum consisting of statutory and non-statutory organisations providing services to survivors of child sexual abuse in Zimbabwe.
2. This article is based on a PhD study submitted to the University of the Witwatersrand.

## REFERENCES

- AFRICAN UNION. (ACRWC) 1999. African Charter on the Rights and Welfare of the Child. [Online] Available: [http://www.achpr.org/files/instruments/child/achpr\\_instr\\_charterchild\\_eng.pdf](http://www.achpr.org/files/instruments/child/achpr_instr_charterchild_eng.pdf). [Accessed 21/08/17].
- BABBIE, E. 2007. **The Practice of Social Research**, Belmont California: Wadsworth Publishing Company.
- BHASKARAN, S. & SESHADRI, T.S. 2016. Child Sexual Abuse: Critical challenges and recommendations. **Journal of Indian Association for Child and Adolescent Mental Health**, 12(2):143-162.
- BHATTACHARYA, A. & NAIR, R. 2014. Girls on the Street: Their Life Experiences and Vulnerability to Sexual Abuse. **The Indian Journal of Social Work**, 75(1): 33-48.
- BIRDHSTLE, I.S., FLOYD, S., MWANASA S., NYANGADZA A., GWIZA E. & GLYNN, T.R. 2011. Child sexual abuse and links to HIV and orphanhood in urban Zimbabwe. **Journal of Epidemiol Community Health**, 65(12):1075-1082
- BRONFENBRENNER, U. 1979. **The ecology of human development**. Cambridge, Mass: Harvard University Press.

- BROWNE, J. 1996. Unasked Questions or Unheard Answers Policy Development in Child Sexual Abuse. **British Journal of Social Work**, 26(1): 37-52. [Online] Available: <https://doi.org/10.1093/oxfordjournals.bjsw.a011072> [Accessed: 15/04/2016].
- BRYMAN, A. 2012. **Social Research Methods**, Oxford: Oxford University Press.
- CHAMBERS, R. 1997. **Who's Reality Counts? Putting the First Last**, London: Intermediate Technology Publications.
- CHIKADZI, V. 2014. A Case for Definition: Key Features Guiding the Conception of Social Enterprise in South Africa. **Mediterranean Journal of Social Sciences**, 5(14): 593-600.
- CHIKADZI, V. AND MAFETSA, S. 2013. Facilitating Integrated Service delivery via Networking Forums: Lessons from a case study. **Social Work/Maatskaplike Werk**, 49 (4): 498. [Online] Available: <http://dx.doi.org/10.15270/49-4-40>. [Accessed: 24/06/2016].
- CHITEREKA, C. 2012. **Child Sexual Abuse in Zimbabwe**. [Online] Available: <http://dx.doi.org/10.1080/21650993.2010.9756073> [Accessed: 24/06/2016].
- CIESLAK, R., SHOJI, R., DOUGLAS, A., MELVILLE, E., LUSZCZYNSKA, A. & BENIGHT, C.C. 2013. A Meta-Analysis of the Relationship between Job Burnout and Secondary Traumatic Stress among Workers with Indirect Exposure to Trauma. [Online] Available: <https://www.apa.org/pubs/journals/features/ser-a0033798.pdf> [Accessed: 2/08/2015].
- CORBIN, J.M. & STRAUSS, A.L. 2008. **Basics of Qualitative Research: Techniques and procedures for Developing Grounded Theory**. Thousand Oaks, CA: Sage Publications.
- COLLIN-VEZINA, D., DAIGNEAULT, I & HEBERT, M. 2013. Lessons learned from child sexual abuse research: prevalence, outcomes, and preventive strategies. **Child and Adolescent Psychiatry and Mental Health**, 7(22). [Online] Available: <http://www.capmh.com/content/7/1/22>. [Accessed: 01/09/2016].
- CRESWELL, J. 2014. **Educational Research: Planning, Conducting and Evaluating Quantitative and Qualitative Research**. Boston: Pearson.
- DEVRIES, K.M., MAK, J.Y.T, CHILD, J.C., FALDER, G., BACCHUS, L.J, ASTBURY, J & WATTS, C.H. 2014. Childhood Sexual Abuse and Suicidal Behaviour: A Meta-analysis. **Paediatrics**, 13(5): 1331-1344. [Online] Available: <http://http://pediatrics.aappublications.org/content/early/2014/04/09/peds.20132166> [Accessed: 10/06/2015].
- DOYLE, C. 2012. **Working With Abused Children**. Hampshire, Palgrave Macmillan.
- ELLIOTT, A.N. & CARNES, C.N. 2001. Reactions of Nonoffending parents to the sexual Abuse of their child: A review of the literature. **Child Maltreatment**, 6: 314-331.
- ENGEL, R.F. & SCHUTT, R.K. 2013. **The Practice of Research in Social Work**. London, Sage Publications.
- FINKELHOR, D. 1997. Child Sexual Abuse. Challenges Facing Child Protection and Mental Health Professionals. In: ULLMANN, E. AND HILWEG, W. (eds) **Childhood and Trauma Separation, Abuse, War**. Brookfield USA: Ashgate Publishing Company.
- FINKELHOR, D. AND BROWNE, A. 1985. The Traumatic Impact of Child Sexual Abuse: A Conceptualization. **American Journal of Orthopsychiatry**, 55(4): 530-41. [Online] Available: <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.437.7531&rep=rep1&type=pdf> [Accessed: 26/02/2014].
- FINKELHOR, D., STATTLUCK, M.A, TURNER, H.A. & HAMBY, S.L. 2014. The Lifetime Prevalence of Child Sexual Abuse and Sexual Assault. Assessed in Late Adolescence. **Journal of Adolescent Health and Medicine**, 55(3): 329-333. [Online] Available: [http://www.jahonline.org/article/S1054-139X\(13\)00854-9/pdf](http://www.jahonline.org/article/S1054-139X(13)00854-9/pdf) [Accessed: 30/04/2017].
- FOSTER, J.M. 2014. Supporting Child Victims of Sexual Abuse: Implementation of a Trauma Narrative Family Intervention. **The Family Journal Counselling and Therapy for Couples and Families**, 22(3):

- 332-338. [Online] Available: <http://journals.sagepub.com/doi/pdf/10.1177/1066480714529746> [Accessed: 10/06/2016].
- GOVERNMENT OF ZIMBABWE. 2001. **Children's Act**, [Chapter 5:06] [Online] Available: <http://www.veritaszim.net/node/145> [Accessed: 9/02/2015].
- GOVERNMENT OF ZIMBABWE. 2001. **Social Workers Act**, Chapter 27: 21. [Online] Available: <http://www.veritaszim.net/node/257> [Accessed: 01/08/2018].
- GOVERNMENT OF ZIMBABWE. 2013. **Constitution of Zimbabwe Amendment (No.20) Act, 2013**. Harare: Government Printers.
- GUEST, G., MACQUEEN, K. M & NAMEY, E.E. 2012. **Applied Thematic Analysis**. London: Sage Publications.
- GWIRAYI, P. 2013. Fighting Child Sexual Abuse: Perspectives of Pupils from a Developing Country. [Online] Available: [www.sgo.sagepub.com/contents/3/1/215844012472687.full](http://www.sgo.sagepub.com/contents/3/1/215844012472687.full) [Accessed: 16/05/2016].
- HANSEN, P. & TAVKAR, D. 2011. Interventions for families victimized by child sexual abuse: Clinical issues and approaches for child advocacy centre-based services. *Aggression and Violent Behavior* 16 (3): 188–199.
- HORNER, G. 2010. Child Sexual Abuse: Consequences and Implications. *Journal of Pediatric Health Care* 24(6): 358 -364.
- INTERNATIONAL RESCUE COMMITTEE. 2012. **Caring for Child Survivors of Sexual Abuse Guidelines for health and psychosocial service providers in humanitarian settings**. New York: International Rescue Committee.
- JONES, D.N & FLOREK, A. 2015. **Child Sexual Exploitation: A study of international comparisons Desk Review for the Department for Education**. Nottingham, The Virtual Staff College.
- JONES, A.D & JEMMOTT, E.T. 2009. Child Sexual Abuse in the Eastern Caribbean. [Online] Available: [http://www.unicef.org/infobycountry/files/Child\\_Sexual\\_Abuse\\_in\\_the\\_Eastern\\_Caribbean\\_Final\\_9\\_Nov.pdf](http://www.unicef.org/infobycountry/files/Child_Sexual_Abuse_in_the_Eastern_Caribbean_Final_9_Nov.pdf) [Accessed: 26/02/2014].
- JUDICIAL SERVICE COMMISSION. 2012. **Protocol on the Multi- Sectorial Management of Sexual Abuse and Violence in Zimbabwe**. Harare, Judicial Service Commission.
- KANYENZE, G., KONDO, T., CHITAMBIRA, P. & MARTENS, J. 2011. **Beyond the enclave: towards a pro poor and inclusive development strategy for Zimbabwe**. Harare, Weaver Press.
- KASEKE, E. 2015. National Social protection Floors and income security for older persons: prospects for Zimbabwe. *Social Development Issues* 37 (1): 25-37.
- LALOR, K & MCELVANEY, R. 2010. Child Sexual Abuse: Links to Later Sexual Exploitation/High-Risk Sexual Behaviour, and Prevention/Treatment Program. *Trauma Violence Abuse* 11(4): 159-177. [Online] Available: <http://tva.sagepub.com/content/11/4/159.short> [Accessed: 07/03/2014].
- MALINGA, T & MUPEDZISWA, R. 2009. Hospital Social Work Practice in Botswana: Yesterday, today and tomorrow. *Journal of Social Development in Africa*, 24 (1): 91- 117.
- MANIGLIO, R. 2012. Child Sexual Abuse in the Etiology of Anxiety Disorders: A Systematic Review of Review. *Trauma, Violence and Abuse* 14 (2): 96-112.
- MARTIN, M. 2007. Mugabe: **Power, Plunder and the Struggle for Zimbabwe's Future**. New York: Public Affairs.
- MCPHERSON, P., SCRIBANO, P. & STEVENS, J. 2012. Child physical and sexual abuse in a community sample of young Adults: Results from the Ontario Child Health Study. *Child Abuse and Neglect* 37, 14– 21. [Online] Available: [www.sadvreatmentcentres.ca/MacMillan\\_2013.pd.pdf](http://www.sadvreatmentcentres.ca/MacMillan_2013.pd.pdf) [Accessed: 26/02/2014].

- MÉDECINS SANS FRONTIÈRES. 2011. Baseline Study Report on the Perceptions of Sexual and Gender Based Violence in Mbare, Harare, Zimbabwe. Harare, Médecins Sans Frontières and University of Zimbabwe.
- MUCHINAKO, G.A, CHIKWAIWA, B.K AND NYANGURU, A.C . 2013. Children Living and or Working on the Streets in Harare: Issues and challenges. **Journal of Social Development in Africa** 28 (2): 93-112.
- MUGAWE, D. & POWELL, A. 2006. **The Second International Policy Conference on the African Child, Born to High Risk: Violence Against Girls in Africa**, Addis Ababa: Plan International.
- MUGUMBATE, J. 2016. World Social Work Day celebrations in Zimbabwe: An opportunity to promote social justice. **International Social Work**, 59 (4), 452- 458.
- MUPEDZISWA, R. 1997. Training Social Workers in an Environment of Economic Reforms: The Mother of All Challenges, **Social Work Maatskaplike Werk** 33 (3), 233 – 243.
- MUPEDZISWA, R & USHAMBA, A. 2006. Challenges and prospects: Social work practice in Zimbabwean an environment of economic meltdown. In HALL, N(Ed) **Social Work making a world Difference: Social Work around the World IV in the year of IFSW 50 Jubilee** (pp. 163- 172).Berne, IFSW and Fafo.
- MURIDZO,N.G.2014. Child Sexual Abuse in Zimbabwe: A Social Work Agenda. **Indian Journal of Social Work** , 75, ( 1), 49- 68
- MURIDZO, N.G.2018. An exploration of the phenomenon of child sexual abuse in Zimbabwe (Unpublished PhD thesis), University of the Witwatersrand, Johannesburg.
- MWANGI, M. W., KELLOGG, T. A., BROOKMEYER, K., BULUMA, R., CHIANG, L., OTIENO-NYUNYA, B. & CHESANG, K. 2015. Perpetrators and context of child abuse in Kenya. **Child Abuse and Neglect** Volume 44, 46 -55. [Online] Available: <http://www.sciencedirect.com/science/article/pii/S0145213415000952> [Accessed: 27/05/2016].
- NURCOMBE, B. 2000. Child sexual abuse I: Psychopathology. **Australian and New Zealand Journal of Psychiatry** 34(1), 85–91. [Online] Available: <http://onlinelibrary.wiley.com/doi/10.1046/j.1440-1614.2000.00642.x/full>. [Accessed: 15 /04/2016].
- PATTON, M.Q. 2002. **Qualitative Research and Evaluation**. London, Sage Publications.
- PEREZ, P. ALDRIAN, A .& STENDER, H. 1997. Child prostitution and sexual abuse in Latin America, with a special look at Paraguay. In Ullmann, E and Hilweg, W (Eds) **Childhood and Trauma Separation, Abuse, War**: Brookfield USA, Ashgate Publishing Company.
- PETERS, D.H, GARG, A., BLOOM, G., WALKER, D.G, BRIEGR, W.R. &RAHMAN, M.H. 2008.Poverty and Access to Health Care in Developing Countries. [Online] Available: <http://onlinelibrary.wiley.com/doi/10.1196/annals.1425.011/full> [Accessed: 22/05/2015].
- PHASHA, T.N. 2013. Influences on underreporting of Sexual Abuse of Teenagers with Intellectual Disability: Results and Implications of a South African Study. **Journal of Psychology in Africa** 23 (4), 625-629. [Online] Available: <http://www.tandfonline.com/doi/abs/10.1080/14330237.2013.10820677>.
- POPULATION COUNCIL. 2008. Sexual and Gender Based Violence in Africa [Online] Available: [https://www.k4health.org/sites/default/files/AfricaSGBV\\_KeyIssues.pdf](https://www.k4health.org/sites/default/files/AfricaSGBV_KeyIssues.pdf) [Accessed: 22/05/2015].
- PUTMAN, F. W. 2003. Ten-year Research Update Review in Child Sexual Abuse. **American Academy of Child and Adolescent Psychiatry** 42(3), 269 – 278. [Online] Available: <http://www.ajol.info/index.php/ajsw/article/view/133940>. [Accessed: 22/05/2015].
- OUELLETE-MORIN, I., , H.L., , M., , S., MOFFITT, T.E. & ARSENEAULT, L. 2015. Intimate partner violence and new-onset depression: A longitudinal study of women's childhood and adult histories of abuse. **Depression and Anxiety** 32 (15), 316 – 324. [Online] Available: <http://onlinelibrary.wiley.com/doi/10.1002/da.22347/pdf>. [Accessed on 13/08/17].

- RUDD, C. & BRAKARSH, J. 2001 . **Counselling Children Who Have Been Sexually Abused: A Family Support Trust Training Manual**. Unpublished Material.
- RUBIN, A & BABBIE, E. 2011. **Research Methods for Social Work** (7<sup>th</sup> Ed). Belmont, CA: Thomson/Brooks/Cole.
- SEPTEMBER, R., MATNE, A., ADAM, I & KOWEN, D. 2000. **Commercial sexual exploitation of children: An Explorative study conducted with child victims of prostitution in the Western Cape Town**. Bellville, University of the Western Cape.
- SEXTON, L. 2009. Vicarious traumatization of counsellors and effects on their workplaces. **British Journal of Guidance and Counselling**, 27(3):393–404.
- SINCERO, S. M. 2012. **Ecological Systems Theory**. [Online] Available: <http://exploeable.com/ecological-system>. [Accessed: 26/02/2016].
- SMALLBONE, S., MARSHAL, W.L & WORLEY, R. 2008. **Preventing Child Sexual Abuse: Evidence, Policy and Practice**. Devon: Willan Publishing.
- SMITH, D., PEARCE, L., PRINGLE, M & CAPLAN, R. 1995. Adults with a history of child sexual abuse: evaluation of a pilot therapy service. **British Medical Journal** 310 (1), 175- 178. [Online] Available: <http://www.bmj.com/content/310/6988/1175.short>. [Accessed: 15/04/2015].
- SOFTTESTAD, S.& TOVERUD, R. 2013. Challenges and Opportunities: Exploring Child Protection Workers' Experiences of Ensuring Protection of the Child during Child Sexual Abuse Suspicion. **British Journal of Social Work**, 43 (8): 1510-1526.
- SOSSOU, M. & YOGTIBA, J.A. 2009. Abuse of Children in West Africa: Implications for Social Work Education and Practice. [Online] Available: <https://doi.org/10.1093/bjsw/bcn033> [Accessed: 15/04/2015].
- STOLTENBORGH, M., van IJZENDOORN, M. H, EUSER, E. M & BAKERMANS-KRANENBURG, M. J. 2011. A Global Perspective on Child Sexual Abuse: Meta-Analysis of Prevalence around the World. [Online] Available: <http://www.marinusvanijzendoorn.nl/wpcontent/uploads/2012/07/StoltenborghVan-IJzendoornEuserBakermans-Kranenburg2011ChildMaltreatmentmetaCSA.pdf> [Accessed: 2/03/2014].
- UNITED NATIONS. 1989. United Nations Convention on the Rights of the Child.[Online] Available: [https://downloads.unicef.org.uk/wpcontent/uploads/2010/05/UNCRC\\_united\\_nations\\_convention\\_on\\_the\\_rights\\_of\\_the\\_child.pdf?\\_ga=2.154301432.1591570973.1503328725-549200663.1503328725](https://downloads.unicef.org.uk/wpcontent/uploads/2010/05/UNCRC_united_nations_convention_on_the_rights_of_the_child.pdf?_ga=2.154301432.1591570973.1503328725-549200663.1503328725). [Accessed 21/08/17].
- WESTERMANN, C. KOZAK, A.HARLING, M. & NIENHAUS, A. 2012. Burnout intervention studies for inpatient elderly care nursing staff: Systematic literature review [Online] Available: <http://dx.doi.org/10.1016/j.ijnurstu.2012.12.001> [Accessed: 2/02/2016].
- WILLIS, J.W. 2007. **Foundations of Qualitative Research**. London: Sage Publications.
- YIN, R.K. 2009. **Case study research. Design and methods** (4<sup>th</sup> ed). Thousand oaks': Sage Publications.
- ZHU, Q., GAO, E., CHENG, Y., CHUANG, Y., ZABIN, L. S., EMERSON, M, R & LOU, C. 2015. Child Sexual Abuse and Its relationship with health risk behaviours among adolescents and young adults in Taipei. [Online] Available: <http://journals.sagepub.com/doi/abs/10.1177/1010539515573075>. [Accessed 15/04/2015].
- ZIMBABWE NATIONAL STATISTICAL AGENCY, UNITED NATIONS CHILDREN'S FUND & COLLABORATING CENTER FOR OPERATIONAL RESEARCH AND EVALUATION. 2013. **National baseline survey on life experiences of adolescents 2011**. Harare, Zimbabwe National Statistical Agency.

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† Sadely, Prof Edwin Kaseke passed away before the publication of this article (*Editor*).