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Referral of sexual violence against children: How do children and caregivers use a formal child protection mechanism in Harare, Zimbabwe?

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ABSTRACT

Despite widespread expansion of policies to prevent and respond to violence over the past three decades, sexual violence against children remains common globally. Zimbabwe has expansive legal and policy frameworks to prevent, and formal services to respond to, sexual violence. Yet evidence is lacking about how children and caregivers use formal referral mechanisms. This study conducted secondary qualitative analysis of sexual violence cases [N=74] processed in Harare Magistrates Court and referred to Childline Zimbabwe, in October-November 2020, to examine which experiences children and/or their caregivers formally refer as sexual violence; how they perceive and manage these experiences; and how this relates to national policy contexts.

Caregivers, particularly female, were central to reporting sexual violence. Data suggested that some forms of sexual violence were formally referred, including community sexual assault and abuse within families, however some adolescent girls faced blame and shame. There were gaps in reporting of sexual violence against boys, and sexual violence from dating partners or authority figures, with data suggesting that gendered stigma, shame, and fears of institutional authority, were barriers for reporting. Caregivers also reported consensual adolescent sexual relationships to police. These findings contribute to the limited evidence on forms of sexual violence that are and are not formally referred globally, and in sub-Saharan African settings. Existing policy frameworks in Zimbabwe can be strengthened around age of maturity, adolescent sexuality, sidelining of boy survivors, and the role of schools in child protection. Interventions should support caregivers' efforts to report violence, while also addressing gendered blame and stigma, and stigmatisation of adolescent sexuality.

1. Introduction

Violence against children has been declared a world health emergency (WHO, 2002), with one billion children globally experiencing some form of physical, sexual or emotional violence each year (Hillis et al., 2016). Sexual violence is defined by the WHO as sexual acts using coercion; trafficking; or unwanted sexual comments and advances (WHO, 2002); and, for sexual abuse in childhood, as linked to children's inability to comprehend or consent to sexual activity, and where perpetrators have 'responsibility, trust or power' (World Health Organization, 2006). An estimated 16–20% of girls and 7–9% of boys experience sexual violence in childhood globally (Stoltenborgh et al., 2011), with severe impact on mental, physical and sexual health (Devries et al., 2014; Kessler et al., 2017; Loeb et al., 2002; Maniglio, 2009; Spataro et al., 2004). The majority of children who experience sexual violence do not formally seek help for their experiences (Boudreau et al., 2018; Meinck et al., 2017; Nguyen et al., 2018; Pereira et al., 2020; Sumner et al., 2015), often due to feelings of shame and self-blame (Nguyen et al., 2018; Pereira et al.,

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2020), yet little is known about the nature of sexual violence experiences that do and don't reach formal child protection mechanisms, and why.

In Zimbabwe, a national survey found that 9% of girls and 1% of boys experience any form of sexual violence, with 5% of girls experiencing pressured or forced sex (Ministry Of Health And Child Care Zimbabwe, 2019). Too few boys reported sexual violence for further estimates. Most often sexual violence against girls occurs in adolescence and perpetrated by intimate partners (Ministry Of Health And Child Care Zimbabwe, 2019). It also affects young children, and then most often perpetrated by family members, strangers and neighbours (Ministry Of Health And Child Care Zimbabwe, 2019). As found elsewhere (Nguyen et al., 2018; Pereira et al., 2020; Sumner et al., 2015), many child survivors in Zimbabwe never disclose informally, for example to friends and family, or formally, for example to police, healthcare or social workers (40% and 83%, respectively) (Ministry Of Health And Child Care Zimbabwe, 2019). Qualitative evidence from Mashonaland, Zimbabwe found that child survivors could be vulnerable to blame, shame and stigma, leading to fears of speaking out (Obong'o et al., 2020), and that sexual abuse within families is underpinned by generational imbalances of power, and gender norms that subjugate girls and place taboos around boys' experiences (Musiwa, 2019). More evidence is needed, however, to qualitatively examine how gendered and age dynamics influence formal reporting of violence.

Policy frameworks addressing violence against women and violence against children have expanded considerably over the past three decades. These frameworks exist at global (UN General Assembly, 1979, UN Security Council, 2008, United Nations, 1989) and regional (African Commission on Human and Peoples' Rights, 2017, African Union, 2003, Organization of African Unity (OAU), 1990) levels, and are accompanied by widespread national policy frameworks, with almost all countries globally having laws against sexual violence (WHO, 2020). Despite this remarkable progress, sexual violence against children is still common. Examinations of policy processes across sub-Saharan Africa, including Zimbabwe, highlight challenges that can thwart effective implementation, including insufficient resources; gaps and inconsistencies within and between policies; legal pluralism; lack of guidelines and training for policy actors and service providers; differing definitions of key terms; poor multi-sectoral collaboration; and gendered inequalities (Kangaude & Skelton, 2018; Kilonzo et al., 2009; Muridzo et al., 2021; Musiwa, 2018; Parkes, 2016; Parkes et al., 2020; Wangamati et al., 2019). These challenges influence services that child survivors receive and may affect their initial reporting to these services. However, little is known about how child survivors and their caregivers use formal referral structures provided for within current policy frameworks, and how frameworks facilitate and constrain help-seeking for sexual violence.

In this study, we qualitatively examine sexual violence cases being processed in a Harare Magistrates Court in October-November 2020 (N=74), and referred to Childline Zimbabwe [Childline] for pre-trial counselling. We seek to understand which experiences children and/or caregivers formally refer as cases of sexual violence, how they perceive and manage these experiences, and to examine this in light of legal and policy frameworks in Zimbabwe. While we sampled children involved in court-related service provision, we examined their experiences surrounding the violence itself and initial reporting of these cases, but not their experiences of service provision or legal proceedings. With these findings, we aim to contribute to understandings of why children and caregivers do, and do not, seek formal help for sexual violence in Zimbabwe, and how this is supported by the policy context.

1.1. Legal and policy frameworks for sexual violence against children in Zimbabwe

Zimbabwe has ratified the UNCRC and the ACRWC and is ranked among African countries with the most extensive frameworks for preventing violence against girls (16 out of 52) (African Child Policy Forum, 2020). There are some limitations to these policy frameworks in practice, however. The Criminal Law (Codification and Reform) Act (2004) prohibits sexual relations with a child under 16 years, classifying sex with children under 12 years as rape, aggravated indecent assault or indecent assault. The Domestic Violence Act (2006) prohibits abusive 'cultural or customary rites or practices', and sex between men and daughters-in-law, and the Sexual Offences Act (2001) further prohibits sex with a 'child, step-child, or adopted child', however other male perpetrators within the family are not explicitly listed. For sexual abuse in schools, sexual relations and harassment between teachers and students are covered by age of consent laws, however specific wording for teacher perpetrators of sexual violence do not exist in either the Sexual Offences or Education Acts.

There are likewise frameworks for responding to violence and offering services to survivors, with the Children's Act (2001) requiring mandatory reporting of sexual abuse; the National Case Management System [NCMS] (2007) for child protection; and the Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence [Multi-Sectoral Protocol] (2012) stipulating response pathways, involving police, schools, health, legal, social service and civil society actors, such as Childline. Schools and teachers are listed in the NCMS and Multi-Sectoral Protocol as key actors for referring cases of abuse, however description of these roles is not detailed. The Multi-Sectoral Protocol (2012) caters for both male and female survivors of sexual abuse, however orients more clearly towards girls, stating that it has the 'flexibility to 'also' support men and boy survivors (Judicial Service Commission, 2012).

At the time of data collection, age of sexual consent was 16 years, as stipulated in the Criminal Law Act (2004). In May 2022, this was raised to 18 years, yet to be enshrined in law. This is not consistent across the legal age of maturity for marriage and healthcare (Legal Age of Majority Act, 1982; Public Health Amendment Act, 2018), or the Multi-Sectoral Protocol, which stipulates a child as under 18 years. The legality of adolescent sexuality is also unclear in current policy frameworks. While consensual sex between adolescents under 16 years has largely been interpreted as legal, this has been patchily implemented and generated much open debate, through which attitudes condemning adolescent sexuality have been publicly expressed (for examples see S v CF (2011) ZWHHC 143, Harare High Court; S v Masuku (2015) ZWHHC 106, Harare High Court). Homosexuality is illegal in Zimbabwe, with consensual sexual relations between men termed as sodomy and punishable by a fine and prison sentence (Criminal Law Act, 2004). Sexual offences against boys feature both under sections pertaining to indecent assault and sodomy. The Criminal Law Act defines rape as a male perpetrator and female victim, with non-consensual sexual intercourse involving a boy under 16 years classed as (aggravated) indecent assault.

1.2. Childline Zimbabwe and entry points to formal referral mechanisms in Zimbabwe

Childline is one of the largest national service providers for children experiencing violence in Zimbabwe. It operates 23 community-based drop-in centres across Zimbabwe that offer free and confidential counselling and refer children to health, legal and other social work services, and a free phone helpline and postal service. It is primarily funded through private donors but receives government support for the phone helpline. Childline functions alongside, and is part of, official government referral structures in two ways: Firstly, cases may be first identified by Childline and forwarded to government departments, such as child welfare, police or healthcare; and secondly, cases may be first identified by government departments and forwarded to Childline for provision of psychosocial support. Children involved in cases undergoing court proceedings are referred to a service provider for pre-trial counselling. The Childline Rotten Row drop-in centre (one of four in Harare) is attached to the Harare Magistrates Court and provides psychosocial support for all children under 18 years involved in court cases. The court issues an automatic referral to Childline, who offer pre-trial counselling and develop an ongoing care plan, with case files usually generated on the day of the court case.

2. Methods

2.1. Research aims

This study draws on secondary qualitative analysis of Childline Zimbabwe's routinely collected case file data. We aim to understand how child survivors of sexual violence and their caregviers use formal referral structures in Zimbabwe, and how this relates to policy frameworks. Our research questions are:

1) Which children's experiences are referred through formal structures - continuing to court proceedings and pre-trial service provision from Childline - as cases of sexual violence in Zimbabwe?
2) How do child survivors of sexual violence, their families and community members perceive and manage these experiences?
3) How do these referral patterns relate to the legal and policy context in Zimbabwe?

2.2. Study setting

We sampled cases from the Childline Rotten Row drop-in centre, attached to Harare Magistrates Court. This is one of three permanent courts in Harare, and covers a varied demographic of Harare, including affluent urban areas, low-income high-density urban areas, and peri-urban areas. Most children in this sample lived in urban Harare, with caregivers earning from modest to comfortable basic incomes, through livelihoods such as shopkeepers, guards, drivers and market workers in the informal economy. However, a small number of families were noted as living in poverty, or had affluent lifestyles. The children most often lived with one or both parents, but many lived with grandparents or other relatives as prirmary caregivers.

2.3. Sampling and data collection

All of Childline's routinely collected case file data were collated from the Rotten Row drop-in centre for October–November 2020. Following national Covid-19 lockdowns between March-September 2020, that had involved partial closure and/or reduced capacity at Childline and the Magistrates Court, this period constituted the first two months of resumed normal service provision. This sample reflects all case files of children involved in court proceedings for sexual violence at Rotten Row Magistrates Court for October-November 2020 and receiving pre-trial counselling from Childline: Therefore children who had themselves, or their caregivers, formally referred their case, and which had proceeded to legal proceedings, during this period.

The date of first formal referral for cases was one day, to many months, prior to the court date, therefore included both during and after the lockdown. These case files do not reflect all incidences of sexual violence occurring during this period, and also do not likely reflect all cases referred formally. Referred cases may be dropped before trial for several reasons including: Children or caregivers withdrawing the case; judicial actors unable to locate complainant or defendant; or children or caregivers' lack of funds to attend court.

We extracted two forms of data from case files: 1) social workers' notes, including incident details, child's family situation, health and wellbeing, care needs assessment, and follow-up notes; and 2) a short, handwritten narrative from the child describing the incident, in some cases written by caregivers or accompanying adults (particularly for young children). We did not extract the care plan or further details of case management as we were not examining service providers' handling of cases, or court case outcomes.

Overall, we received 101 anonymised case files from Childline, of which 73% [N=74] pertained to sexual violence. Due to restrictions related to feasibility of anonymisation, our sample includes both full and partial case files. Of the 74 sexual violence cases, 42 files included both social worker notes and child/caregiver's narrative; 30 files included only child/caregiver's narrative; one file only social worker notes; and one file included neither in full. Case files and narratives were compiled at the Childline Rotten Row offices using standardised pro-formas, and social workers had received training from Childline on compiling case files. There are limitations of working with secondary qualitative data, which we explore further below. Social worker notes were written in English, while child or caregiver narratives were written in both Shona [N=59] and English [N=12].

2.4. Data analysis

All child/caregiver handwritten narratives [N=73] were transcribed in English by study researchers and translated from Shona where necessary, checked by the lead researcher. Social worker notes [N=43] were analysed in the original English. Analysis was conducted iteratively in several rounds, assisted by NVIVO 12 software (Qsr International Pty Ltd, 2018). Analysis was led by the lead author [ET], with the third author [RN], and involved a team of social epidemiologists and social scientists working internationally; qualitative researchers experienced in Zimbabwean contexts; academics working in Zimbabwe with expertise in child protection and education, and Childline social work staff. Case categories were first identified and data were then analysed thematically (Braun & Clarke, 2006) through a two-stage process: Firstly, identifying key themes (e.g. relating to age, gender, perceptions of blame and vulnerability), derived through comparison across the data, and secondly, examining Zimbabwean policy frameworks in relation to these themes, and discussing with the study team for interpretive input. The thematic framework was iteratively refined through several repetitions of these two stages.

2.5. Ethical considerations

This study was approved and afforded exemption from full ethical approval by LSHTM and the Medical Research Council of Zimbabwe [MRCZ], due to its use of secondary data analysis only. Childline has consent from its service users for routine data collection and for sharing anonymised data with partners for reporting purposes. Case files were anonymised by Childline prior to sharing and analysis.

3. Findings

Overall, we analysed 74 case files, relating to 73 accounts of sexual violence. The child survivor was almost always female [N=72]. The accompanying adults supporting referral were almost always adult relatives, predominantly mothers, then aunts and fathers. One case was referred by a residential home manager, but no cases through teachers or healthcare workers. We identified four categories of cases: 1) sexual violence in the community; 2) sexual violence within families; 3) consensual adolescent sexual relationships; 4) other sexual violence cases, including boy survivors, violence from dating partners, and from authority figures. All cases (other than category 3) involved rape, attempted rape, coerced sex or unwanted sexual touching.

3.1. Sexual violence in the community

The most common cases involved older community males, constituting two fifths of the cases. Half involved community members known to the child, such as neighbours, older brothers of peers, shopkeepers and tradespeople, and half were perpetrated by community members that the child may or may not have known, but were not clearly identified in the file. Most often these involved isolated incidents of assault, when children were shopping, playing, visiting neighbours, or walking in the community. Children were of all ages (4–18 years) and a girl in all cases but one.

Such incidences were often reacted and responded to by children, families and community members, as a form of child abuse that required

immediate referral to the police, particularly for younger girls (4–11 years):

> X walked in. Upon seeing what was happening, he rushed to report the incident to the child's father, who then reported the case to the police [7 years; social worker notes]

Often female caregivers learned about abuse of young girls either when girls told them, or through spotting signs during caregiving actions, such as bathing.

> She started crying after that and she went to tell her aunt about the incident. They had to wait for her grandmother who asked me what had happened and immediately rushed her to hospital [6 years; aunt's narrative]

Abuse of young girls was most often responded to by immediate referral to healthcare services and/or the police. Female caregivers were almost always the most important actors in recognising and formally reporting abuse, and often adult female relatives collaborated to do so, as seen above.

Older girls' experiences of assault in the community were similar to those involving younger girls, yet girls aged 11 and over tended to be more active in describing their feelings, response to the abuse and their decision to disclose, often after threats from perpetrators to keep quiet.

> Our neighbour came to the back of our house where I was playing with our dog and abused me […] I was not feeling comfortable. I went inside the house where my father was … I told them what had happened and X was arrested [13 years; child's narrative]

While girls most often reported to adult caregivers immediately, with caregivers reporting swiftly to the police, some girls described feeling too scared to report, and either delayed doing so or caregivers separately learned about the abuse:

> I have this story; I was raped on the 30th of April. I never told my parents because I was afraid. I later told them on the 3rd of May on Sunday […] The person was arrested on the 5th of May [14 years; child's narrative]

Some older girls also faced retaliation, blaming and shaming from family or community members. This occurred among adolescent girls and was not described for girls under 11 years:

> I didn't manage to shout because I had left home without saying anything because I thought I will not [be long], so I thought my image will not be good in society […] I didn't tell my mother but I [locked] myself in the house and cried. I was afraid my mother will beat me saying why did you go to other people's houses yet she had said I stay at home. My mother knew about it on Sunday when a faith healer […] said your child is dirty she now sleeps with men [15 years, child's narrative]

In some cases, adolescent girls described fearing to tell their mothers for fear of being beaten and chastised, as shown here for perception of reckless behaviour and defying adult authority, or 'society' reactions. Here a female community member told the mother, leading to shame and emotional abuse. In one case, a teenage girl experienced blame from the community:

> She is emotionally drained and depressed about the incident … she is now suicidal as people in her community are labelling her […] She is facing constant threats from the perpetrator's wife and people in the community are taunting her and calling her names, blaming her for the incident [13 years; social worker notes]

While in most cases sexual violence of girls of all ages was reacted to by adult caregivers reporting swiftly to police and/or healthcare services, some older girls also experienced blame and shame for sexual violence. This contrasted widely from the response in other cases, as was often with younger girls, of girls being seen as vulnerable and needing protection. Experiencing negative repercussions either from the family or community members may elucidate why some, particularly older girls, described their fear and reluctance to disclose abuse.

3.2. Sexual violence within families

Sexual violence from older male family members constituted just under one third of cases. These were most often perpetrated by uncles, but also by older brothers, stepbrothers or brothers-in-law, fathers, and one grandfather. Children were of all ages and a girl in all cases but one.

Incidents for girls of all ages were almost always described to be reported to the police, often with some form of prior collaboration or discussion between adult family members (mostly female):

> She said to me, Granny I have some pain […] I called my husband's brother so that the children can narrate their story so that we are certain with what they were saying. My husband's brother requested us to tell the aunt, then the children be taken to X for examination and to prove if it is true. They went with the aunt and opened a police case [9 years; female relative's narrative]

> She complained of some pains […] The mother then removed her clothes and examined her body […] The mother called for her sister […] She had previously seen Uncle X with these children [4 years; social worker notes]

> I did not tell my mother because I was afraid […] The next day I was sick, and my mother asked me what was going on. I told her that grandfather had raped me, and she went to the police to report [14 years; child's narrative]

Adult female relatives often supported girls through reporting abuse directly to the police, or through investigating first within the family, then reporting formally. While in some cases girls faced blame from family members, or blamed themselves, this was considerably less common than with abuse from community members. Across all ages, most girls' descriptions suggested these experiences were perceived by themselves, and others, as an unequivocal wrongdoing and criminal act on behalf of the perpetrator.

Some cases also suggested that sexual abuse within families could be covered up, however. A small number of files described family discord over handling the case. For the 4-year-old girl above abused by her uncle, the social worker notes describe the mother's determination to pursue formal support and legal services, despite resistance from the mother's parents. In another case, a girl described her aunt attempting to conceal abuse, in light of its criminality:

> I told my aunt that was what uncle did to me and she said I should not tell anyone else because it's a criminal offence. When I went home that is when I explained to my mother when aunt was outside [13 years; child's narrative]

Despite the widespread perception, therefore, of familial sexual abuse as abusive, wrong and illegal, for girls of all ages, its formal disclosure to the police often relied on willingness and agreement of adult family members to report. In almost all cases, adult family members (particularly female) appeared to be a strong source of collaboration and formal reporting, however in others, there was also a suggestion that some (particularly extended) family members resisted formal referral.

3.3. Consensual adolescent sexual relationships

Just under one fifth of cases were of adolescent girls who saw themselves in consensual sexual relationships and whose relationship was reported to the police by caregivers, mostly against their will. Girls were aged 14–16 years, and boyfriends were often aged 18–28 years

(although many boyfriend ages were not noted). While most girls explicitly described their consent and agency in the relationship, in a small number of cases girls described relationships as consensual but their narratives indirectly suggested these situations may have entailed coercion or violence. Where girls' narratives included more direct discussions of violence within relationships, this is explored separately below.

Where families reported girls' boyfriends to the police, in four cases the girl had become pregnant and this was described as a reason for referral (for example to seek boyfriends' financial support). However, in nine such cases, there was no pregnancy involved and parents were described to report to the police to address the boyfriend's perceived wrongdoing. This was related to protection of girls' virginity, situated under parental control:

> My boyfriend and I […] started dating in August. When my parents learnt about it, they took me for virginity test. I had slept with him three times. When the result showed that I was no longer a virgin they wanted to have my boyfriend arrested [15 years; child's narrative]

Some girls portrayed a strong sense of agency in the relationship and love for their boyfriends, and described feeling guilty and upset that their boyfriends were arrested:

> This wasn't X's fault … he didn't know my age and also sometimes I used [to] force him to sleep with me. I love my boyfriend and want him to be bailed out because it wasn't his fault [15 years, child's narrative]

> [My parents] wanted to have my boyfriend arrested. I did not want him arrested so I thought of running away from home. I called my boyfriend about the plan because I am in love with him [15 years; child's narrative]

As seen here, some girls described going to great lengths to avoid detection and protect their boyfriends from arrest, and felt guilt for their boyfriends facing charges, and anger or confusion at perceived injustice. However, some girls also felt guilt for behaving poorly and letting down their parents, as described here:

> She has feelings of guilt as she feels that she failed her parents. However, she is emotionally drained that they agreed to sleep together yet X is the only one suffering and she is blaming herself for that [14 years; social worker notes]

The data thus often showed girls' feelings of responsibility, guilt and shame, for both their boyfriends and families. Parental or caregiver authority and/or control over girls' sexuality emerged clearly in these cases. While some girls portrayed themselves in conflict with caregivers over desire to make their own sexual choices, others felt shameful for having disappointed them.

A small number of girls experienced abuse from family members for sexual relationships:

> Me and X we were in love […] After we had slept together, my mother was told that your child has slept with a man […] I said yes, it's true. Mother said let's go to your grandmother […] I was beaten by my grandmother […] She shouted at me which pained me as well as being beaten. My mother went to the police we went together with my mother, X admitting his crime to the police. But he didn't force me, we were in agreement and we didn't know that [we] were committing a crime [14 years; child's narrative]

Here the child is both physically and emotionally abused by her grandmother, as older female relatives collaborate in her discipline. The girl advocates for her boyfriend and also states incomprehension that sex between them was a crime. At times abuse that girls faced was severe:

> I am in love with my boyfriend, and we agreed to sleep together. Until now I still love [him]. […] I got pregnant. My mother aborted me. I reported the case at X police station but nothing was done because she bribed the police. The police officers that she bribed were now saying I should say I was raped, yet I consented. I had run away from home because my mother wanted me to abort […] She grabbed me and gave me a cup full of concoction to take and I started bleeding continuously. She chased me out of the house and had my boyfriend arrested [16 years; child's narrative]

Here the girl describes being forced to have an abortion by her mother, and a failure of police officers to handle her case confidentially and to offer meaningful support. She reaffirms consent to the relationship and describes her highly active rejection of the police and her mothers' actions. Such cases showed girls attempting to negotiate their own choices and desires in the face of profound, at times abusive, adult control.

While most girls described agency, choice and desire, some saw themselves in consensual relationships, yet also suggested coercion or mistreatment. One girl described consenting to sex with her boyfriend, but then felt mistreated after his failure to support her with an unplanned pregnancy. In other cases, girls described acquiescence to sex led by someone they considered romantic partners, but did not also describe their own desire. In one such case, the child described sexual contact that was led by her married boyfriend (age not given), then related the following:

> The police phoned my mother to come and pick me up. I then went home on the 10th, the wife came and said to me you think I don't know you are in love with my husband, if you continue being in love with him, he will have sex with you until you have bruises. I kept quiet. She came with her husbands' relatives showing [pointing at] me [15 years; child's narrative]

Here the wife's reported language suggests undertones of abuse from the man, and also clearly shows emotional harassment that some girls experienced following sexual relationships or abuse.

While some cases of consensual sex involved undertones of coercive, neglectful or abusive relations, in most cases, girls emphasised their desire and agency. Caregiver actions to prosecute daughters' boyfriends, and to discipline girls, suggests that adults could position girls in sexual relationships both as victims of a crime whose boyfriends were responsible, and simultaneously as badly behaved and needing punishment. This presented a double bind for girls, who negotiated contradictory discourses around sex: At once seen as vulnerable to male violence and yet responsible for preventing it; and whose sexuality was stigmatised and controlled, and yet also a sign of their vulnerability. The case files show the complexity of girls' responses to these positionings. While almost all adolescent girls described feelings of self-blame and guilt, at times shame, they often also viewed themselves as agents acting out of choice and consent, confidently expressing their desires, and taking steps to promote their interests and protect their boyfriends. It is possible that some girls who described themselves as being in consensual relations, however, may also have experienced coercion or abuse that they did not share in their narratives.

3.4. Other sexual violence cases

Some cases emerged that were very few in the Childline case files. These included cases involving male survivors; sexual violence from dating partners; and from authority figures.

3.4.1. Cases involving male survivors

Two cases involved adolescent male survivors and involved older female perpetrators. One 14-year-old boy described being seduced by a 21-year-old female maid, who knowingly led him to contract HIV. Few details were given, however the child's mother was concerned for his emotional wellbeing and was waiting for him to process his experience before sharing the upsetting news of his HIV status. The second case

involved a 12-year-old boy who described forced sex by his mother (or step-mother) after giving him a drink that led to a 'headache' and 'dizziness'. There were no cases of pre-pubescent boys, or of cases of boys with male perpetrators. While these two cases suggested the boys were viewed as survivors of violence, the lack of cases involving male survivors, and particularly from male perpetrators, was striking.

3.4.2. Sexual violence from dating partners

Cases where girls stated an experience of sexual violence from dating partners or boyfriends were also infrequent. In three cases, girls aged 14–16 described rape by men they were dating, aged 18 years, where noted. Two cases were clearly described by the child as rape, and where adult caregivers supported referral to the police:

> [My boyfriend said] don't say anything. Some two boys saw me and went to tell my dad. [He] was caught after a week […] X who raped me is 18 years old and I am 14 years old when he went into police custody, I then rejected him [14 years; child's narrative]

Here the child describes with certainty that she was raped, and her father reports to the police. This girl also expresses agency by affirming that she 'rejected' him, or ended the relationship, following the abuse.

In a third case, a 16-year-old girl described an experience of sexual violence where her level of consent was unclear. The girls' language used to describe the incident was much less clear than in the above examples:

> We were in love but he was forcing me to come to their house […] When he was done, I went back home and he said I should not say it. When the phone was seen by my mother that is when I told her everything and she beat me up [16 years; child's narrative]

In this case, the girl does not clearly state her perception of rape, but also did not state her consent and describes being forced to visit his home, and (elsewhere) locked in the room. She then faces physical abuse from her mother. While some incidences of forced sex from dating partners were thus perceived and responded to as rape, this third case suggested some girls also/instead faced punishment and blame, and some did not perceive their experiences in such clear terms.

3.4.3. Sexual violence from authority figures

The sample also included three incidences of sexual abuse from authority figures. These cases involved girls aged 17–18, experiencing assault from two schoolteachers and one sports coach. One girl was raped by her teacher one year prior, and her friend was also receiving support from Childline for distress and feelings of self-blame:

> I asked her if we should tell her parents and she refused because she was afraid of the teacher and how the public would take it […] I asked her if she had talked to the teacher, to make him know that he had done something wrong to [her]. She said 'yes' and that he had shouted and chased her away […] I again insisted to [her] that we should tell her parents about these incidences, but she was still afraid of the teacher [18 years; child's narrative]

Despite these case files showing both girls' certainty that the teachers' actions were wrong, the girl here describes her friend's fears of disclosure, both from the teacher and the 'public' reaction. In all three incidences the girls talked with anger and a strong sense of perpetrator wrongdoing, however the above case also shows girls' fear due to the teacher's authority and public reactions.

4. Discussion

This study examined how child survivors and their caregivers use a formal child protection mechanism for sexual violence in Harare, in light of the national policy context. Our first finding points to experiences that were formally referred, including sexual violence in the community, sexual violence within families, and adolescent sexual relationships. We note a gap around other cases, including sexual violence against boys, sexual violence from dating partners, and sexual violence from authority figures. Second, we found that adult caregivers, predominantly female, play a key role in formal reporting of sexual violence against girls, and in emotional and logistical support for child survivors. In addition, we also note (third) the complex responses of adults to girls' experiences of abuse and/or their sexuality: with perceptions of vulnerability and need of protection on the one hand, and responsibility and blame on the other. Our fourth finding is that adolescent girls often played active and agentic roles in negotiating, and often refuting, these constricting binary positionings of vulnerability and blame.

Older girls experiencing blame for assault in the community, that younger girls did not, resonates with similar findings from elsewhere (Birungi et al., 2011; Tavrow et al., 2013), and may here be understood through age and gendered sexual norms. In traditional Shona culture, childhood is defined around onset of puberty, as well as age (Mangena & Ndlovu, 2014). Young children are viewed as an extension of parents, lacking autonomy or ability to protect themselves, with adult protection of them deeply rooted in Shona and Ndebele cultures (Mangena & Ndlovu, 2014), while adolescent girls are seen as more responsible for protecting themselves. This, combined with gender sexual norms in Mashonaland prizing girls' chastity and positioning girls' sexuality under parental control (Matswetu & Bhana, 2018; Obong'o et al., 2020), may shed light on this stigma and shame for some adolescent girls, even under 16 years. The current policy framework is inconsistent about the legal age of maturity across different policies, and lacks clarity about exactly what constitutes different acts of abuse across policies, also shown in poor knowledge of these policies among survivors of abuse and policy actors in one district (Musiwa, 2018). Age of consent has shifted since data collection from 16 to 18 years, which is likely to cause further confusion. As highlighted in Zimbabwe and elsewhere, such lack of clarity leaves policy open to interpretation and by policy actors holding different beliefs and definitions about violence (Johnson Ross & Parkes, 2020; Kilonzo et al., 2009; Parkes et al., 2020; Tallarico et al., 2021). This may make it possible for girls to experience blame and shame.

The lesser blame and shame we found for girls experiencing sexual violence within families may relate to a second way that childhood is defined in Shona culture, with age coming second to family relationships and generational hierarchies (Mangena & Ndlovu, 2014). It is possible that violence perpetrated by relatives from older generations is de facto viewed as abusive, regardless of a girl's age. Interestingly, in Kenya, adolescents were more likely to disclose sexual violence within families than from other perpetrators (Boudreau et al., 2018).

Our analysis suggests that many families are rejecting such practices and using the policy framework to do so. Despite gaps existing in the Domestic Violence and Sexual Offences Acts (for example, brothers and uncles not mentioned), it therefore does appear that families can use existing frameworks to label intrafamilial abuse as criminal and pursue legal repercussions, despite not all such acts being explicitly detailed in the policy. This resonates with findings from elsewhere (Johnson Ross & Parkes, 2020; Parkes et al., 2020), showing that community members can contextualise how they use policy to address practices of concern in particular settings, even where there are shortcomings in the policy frameworks. Data also suggested, however, that some families cover up abuse, echoing previous evidence from Zimbabwe (Musiwa, 2019; Mutandwa, 2012). This may be due to shame, desire to keep harmony in the family, fears of loss of perpetrators' income, or mistrust of formal mechanisms. The important role of female relatives was particularly striking for referral of family violence cases, as they often collaboratively conducted family investigations, then reported to police. While caregivers are known to be important for disclosure of violence in Zimbabwe and elsewhere (Meinck et al., 2017; Mutandwa, 2012; Nguyen et al., 2018), our findings extend this to suggest that collaborative action between women in the family was central to formal referral processes.

The findings also showed that caregivers are reporting girls' sexual relationships with (older) boyfriends to police, often against girls' will.

Existing policy contexts around adolescent sexuality in many sub-Saharan African contexts are rooted in colonial legal frameworks that positioned girls' sexuality under patriarchal control (Kangaude & Skelton, 2018; Tallarico et al., 2021). Today in Zimbabwe the legality of sex when both parties are under 16 or 18 years has been left open to interpretation by legal actors, and is unclear to the general public (Kangaude & Skelton, 2018; Tallarico et al., 2021). This suggests that caregivers are mobilising these policy frameworks to report girls' relationships to the police as a way of controlling girls' sexuality, and for punishing young men. These dynamics have also been found in a study in Uganda, where national legislation aiming to protect girls and increase sentencing for sexual predators, could be used in practice to reinforce adult control of girls' sexuality (Parikh, 2012).

Simultaneously, the data suggested that adolescent girls also experience male violence in intimate relationships, and this is not being formally referred. Male partners are significant perpetrators in Zimbabwe, as found in a national survey (Ministry Of Health And Child Care Zimbabwe, 2019). Qualitative evidence from a range of settings show how girls can negotiate contradictory positions of empowerment and subordination when navigating sexuality in relationships (Jewkes & Morrell, 2012; Matswetu & Bhana, 2018; Muhanguzi, 2011; Nyanzi et al., 2001; Parkes et al., 2016). Our findings show adolescent girls in Harare negotiating their sexuality and consent within policy contexts that are confusing and stigmatising around adolescent sexuality, and that entail inconsistencies around the legal age of sexual consent. Such lack of clarity can create confusion, expose adolescents to stigmatisation and create barriers to accessing healthcare (Ahinkorah et al., 2021; Amnesty International, 2018; Tallarico et al., 2021), and, as argued by policy actors in Zimbabwe, can allow perpetrators to take advantage (Muridzo et al., 2021; Musiwa, 2018).

Overall, girls in this study negotiated the dual constraints of parental control and threat of male sexual violence as they explored their sexual desires, relationships and responses to violence. We found that adults could place girls in a double bind: Of vulnerable to male violence, yet at times also responsible for preventing it; and whose sexual relationships were both a sign of vulnerability and of errant sexuality. This speaks to work examining contradictory discourses around girls' sexuality conducted elsewhere, such as in Uganda (Muhanguzi, 2011; Ninsiima et al., 2018; Nyanzi et al., 2001). Girls in this study challenged such binary positions, and often spoke with clarity, confidence and emotion, both around their sexuality, and experiences of violence. Simultaneously, girls also experienced difficult and contradictory emotions, such as self-blame, shame and anger. This challenges discourses of girls' victimhood around sexual violence, and contributes to the small but important literature examining the nuances of girls' active negotiation of such constricted positionings (Jewkes & Morrell, 2012; Muhanguzi, 2011; Ninsiima et al., 2018; Nyanzi et al., 2001).

Our findings suggesting that sexual violence against boys, particularly from male perpetrators, is underreported formally in Zimbabwe, echo quantitative evidence (Devries et al., forthcoming). Evidence suggests that sexual violence against boys may be more prevalent in many countries than large-scale estimates have shown, due to shame, stigma and taboo (Devries & Meinck, 2018), also highlighted by court professionals in Zimbabwe (Musiwa, 2019). Boys' experiences of sexual violence are sidelined in current policy frameworks around sexual violence, with male survivors being presented as additional to female survivors in the Multi-Sectoral Protocol, and acts defined as 'rape' for girls, being termed '(aggravated) indecent assault' for boys in the Criminal Law Act. While legal sanctions are comparable, such linguistic distinction creates clear gendered distinction between girls' and boys' experiences. Further, its positioning within the section pertaining to illegal 'sodomy' associates sexual assault with consensual homosexual sex. Such framing sidelines boys' experiences and reinforces heterosexist norms (Musiwa, 2019).

The few reported cases perpetrated by teachers and other authority figures is striking, given qualitative evidence has suggested teacher sexual violence occurs in Zimbabwe and is shrouded in gender, age and institutional hierarchies (Obong'o et al., 2020; Shumba, 2001, 2009). Such institutional hierarchies can be seen in girls' fear and reluctance to disclose in the few cases examined here. While this may relate to recent school closures, it also tallies with quantitative analyses showing that teacher violence is underreported in Zimbabwe nationally (Devries et al., forthcoming; Cerna-Turoff et al., forthcoming). While sexual harassment and relationships between teachers and pupils is covered in existing frameworks, policies are lacking that explicitly mention teachers as perpetrators. We also note the lack of cases referred by teachers, found to be key referral actors elsewhere (Meinck et al., 2017). This resonates with gaps in the policy framework, where despite being listed within the NCMS and Multi-Sectoral Protocol pathways, the role of teachers and schools lacks clarity and there is no national policy for child protection specifically in schools.

Our study has strengths and limitations. First, the findings offer important insights for the limited evidence base on what experiences of sexual violence do and do not reach formal referral mechanisms globally, and in sub-Saharan African settings, and is, to our knowledge, the first study to examine all children involved in sexual violence court proceedings for a given time period in Zimbabwe. The qualitative methodology enables an understanding of child survivors' experience of disclosing and reporting violence, and elucidates where gendered social barriers may exist. This study also has limitations, however. Firstly, while secondary analysis of routinely collected data can be an important method to understand, and ethically capture, violence against children, particularly during the COVID-19 lockdowns (Bhatia et al., 2020; UNICEF, 2020), there are limitations to a secondary qualitative analysis approach. This includes working with data not collected for the purposes of this analysis, not by the research team and where accuracy and completeness cannot be fully ascertained (Sherif, 2018). Data was collected by Childline for the aims of service provision. Further, while Childline aims to standardise its approach to compiling cases, with all social workers undergoing training, the social workers' notes are undoubtedly shaped by the views and perspectives of the social workers. Additionally, not all case files were complete and this sample entailed some missing data, for example the unrecorded age of intimate partners in some cases. Our approach acknowledges these limitations and has attempted to clearly delineate the boundaries of what this analysis can, and cannot, reveal.

As normal service provision was resuming following national lockdowns, it is also possible that a small number of cases may have been missed by Childline. Numbers are, however, roughly consistent with Childline's standard case load. Due to logistical constraints of anonymisation, some case file details were missed and their inclusion would likely have enriched our findings further. Further, this analysis does not examine sexual violence cases that were not referred, or that were dropped earlier on in the process, or reasons why. While our study offers new findings for how children and/or caregivers use a formal referral mechanism in light of policy frameworks, it does not examine their knowledge of these policy frameworks. Further research is needed: Firstly, examining children's, and separately their caregivers', knowledge of policy frameworks around sexual violence and how this influences use of formal referral mechanisms; and secondly, the barriers to taking and/or continuing with formal referral action at key stages in the process.

This study also has clear implications for policy and practice. For policy frameworks in Zimbabwe, our findings suggest that the legal age of maturity and sexual consent, and legality of adolescent sexual relationships, needs further clarification and widespread efforts to disseminate and communicate such policies to communities. It is important to revisit the wording around boys' experiences of sexual violence, and to consider amendments to the wording in legal and policy documents to align boys' experiences as survivors with girls'. Finally, for schools, our findings suggest that policy amendments are needed to encourage reporting of male teachers as perpetrators of sexual violence, such as more clearly articulating their potential role as perpetrators and developing a national child protection policy for schools.

There are likewise implications for the practice of preventing and responding to sexual violence in Zimbabwe. Firstly, the data shows that Childline is offering important support to child survivors of sexual violence, particularly girl survivors of community and family violence. This service provision should be strengthened and extended to more child survivors. Secondly, for cases that are being referred through the police, interventions to strengthen confidentiality of case handling are needed. Interventions with communities are needed to address gendered blame, shame and stigma that surround girls' experiences, and sideline boys' experiences, of sexual violence, and to raise awareness of the existing policy context supporting formal reporting. Second, there are clear opportunities to work with older, particularly female, family members, to support them in their efforts to protect children and report abuse. However, this should be accompanied by positive parenting intervention work around consensual adolescent relationships and sexuality, and challenging blame of girls. This will strengthen the important role older female family members play in formal referral of violence, and will reduce the potential for negative repercussions for girls. Finally, in light of the poor experiences with formal referral that some girls in this sample experienced, for example with gendered blame and shame from community members, or poor confidentiality from the police, interventions that encourage child survivors of sexual violence need to carefully examine how to encourage survivors to disclose their experiences without leading to the potential for further harm. How interventions can meaningfully do this is a key area for future research.

5. Conclusion

Some forms of sexual violence are formally referred by child survivors and/or their caregivers in Harare, Zimbabwe, while others are shrouded in stigma, blame or fear and are referred less often. Caregivers, particularly female, are important actors for child protection. Caregivers are also using formal referral mechanisms to report adolescent sexual relationships to police and therefore at times exercising control over girls' sexuality, while girls themselves are active in negotiating their desires and positions of constraint. Such referral patterns resonated closely with the gaps, areas lacking clarity and the sidelining of some experiences of violence that exist in current policy frameworks. These policy areas should be addressed, while interventions can strengthen the functioning of existing policies and support adult family members to refer sexual violence, through tackling gendered stigma and blame.

Ethical statement

This study was approved and afforded exemption from full ethical approval by LSHTM and the Medical Research Council of Zimbabwe [MRCZ], due to its use of secondary data analysis only. Childline has consent from its service users for routine data collection and for sharing anonymised data with partners for reporting purposes. Case files were anonymised by Childline prior to sharing and analysis.

Special justification for author list

We have listed 10 authors as the team contributing to this paper, involving partners from all organisations involved in the study. All authors were involved in: the conceptualisation of research aims, interpretation of data and the writing and editing of the paper.

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This study was funded by Porticus.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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