AN INVESTIGATION INTO THE EFFECTS OF SEXUAL VIOLENCE ON THE HEALTH OF WOMEN IN GWERU URBAN

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Abstract

Sexual violence could be a menace to the health of women, so this study sought to investigate the effects of sexual violence on the health of women. The research hypothesis was that there is no relationship between sexual violence and the reproductive, psychological and physical health problems. The objectives were to expose the types of sexual violence and how women react to it in addition to establishing the prevalence of the psychological, physical and reproductive health (including STI and HIV/AIDS) problems resulting from sexual violence. A mixed methodology with a pragmatic approach was used to carry out the research. The research design was the casual comparative method where two groups that is the sample and control groups were selected to allow comparing of the results. The purposive sampling method was used at Msasa Project and Gweru hospital to obtain the sample group of 30 women who were sexually violated. The control group of 30 women who were not sexually violated was obtained by convenient sampling at Gweru Hospital MCH department. The data was obtained by triangulating interviews, focus groups and documentary analysis and analysed by descriptive statistics as well as using the SPSS for ANOVA, t-test and chi square. The research revealed that sexual violence does affect the health of women reproductively, psychologically and physically. The prevalence of STI and HIV related to sexual violence was 0.33 and 0.37 respectively. However the women were reluctant to report sexual violence because of their culture which makes it difficult to define sexual violence. The researcher suggests that men be educated on the rights of women and the effects of sexual violence and the
organisations dealing with women health issues should involve men. The women who report sexual violence should also be assessed for psychological problems as it was found to be the most common health problem associated with sexual violence. Abortion should be made accessible to the victims of sexual violence so that they are not burdened by an unwanted child.
Acknowledgements

I would like to express my heartfelt gratitude to Dr. Wellington Samkange for his guidance which made this research a reality. To my children and husband, thank you so much for the support and tolerance. Special thanks go to my colleagues for their unwavering support and assistance. To Mr. S. Magonde, thank you for the moral support.

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Finally but not least, I would like to thank the ZOU Higher Degrees Directorate for the workshops which provided the much needed research skills.
Dedication

To my husband, Taka and my children Tata, Roro, Fudhu and Munyus
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CHAPTER ONE

INTRODUCTION

1.0 Introduction

Every human being (women included) has a right to safe and satisfying sex and also to consent to sex. However, there are some men in society who force themselves on women and this is called sexual violence. One wonders what the effects could be on the health of the woman who is forced to have sex against her wishes. This study sought to find out the physical, reproductive and psychological effects of sexual violence on women in Gweru urban, Zimbabwe. In order to contextualize the problem, the chapter covers the background to the problem, statement of the problem, purpose of the study, research questions that guided the study, objectives of the study, justification for the study, delimitation and limitation to the study.

1.1 Background to the study

Sadik (2002) points out that sexual violence occurs throughout the world. Because of its private nature, estimating the extent of the problem is difficult in most countries. Previous research has suggested that sexual assault is one of the most under-reported crimes where ‘there are numerous "hidden" victims who do not report their victimisation to the police or to health officials, making them invisible in official statistics (Schwartz, 1997). A review of available ‘indicators’ of violence against women in Australia found that police data and crime victimisation survey data continue to underestimate the
extent of violence against women (Putt & Higgins). In the same vein, a child and adult sexual assault survey by Fergusson and Mullen (1999), found that in Australia, non contact sexual abuse like pornography, photography, watching, exposing/flashng comments have a prevalence rate ranging from 8 per cent to 62 per cent, where as with sexual abuse involving penetration or intercourse, including digital, oral, vaginal and anal, the prevalence rate ranges from 1.3% to 28.7%. Whilst these numbers may be low, what is disturbing is that victim of sexual assault rarely report the crime to police(Satin 1992)The area of sexual violence therefore needs to be researched hence this study to investigate the effects of sexual violence on the health of women.

Sexual assault by an intimate partner is neither rare nor unique to any particular region of the world (WHO; 2000). For instance, 23% of women in North London, England, reported having been the victim of either an attempted or completed rape by a partner in their lifetime. Similar figures have been reported for Guadalajara, Mexico (23.0%), Leon, Nicaragua (21.7%), Lima, Peru (22.5%), Canada 8.0%, England, Wales and Scotland(combined) 14.2%, Finland 5.9%, Switzerland11.6% and the United States 7.7%.(WHO;2000). In addition, studies done in Mexico and the United States estimate that 40–52% of women experiencing physical violence by an intimate partner have also been sexually coerced by that partner though sometimes sexual violence occurs without physical violence (Granados ;1996). Women are violated in their homes and what is this doing to their health?
Statistics from the Royal Women’s Hospital journal reveal that 7.1% of Australian women over 18 years experienced an incidence of sexual violence in the previous 12 months whilst 23% of women who had been married or in a relationship experienced violence by a partner at some time during the relationship. In a national survey conducted in the United States of America, 14.8% of women over 17 years of age reported having been raped in their lifetime (with an additional 2.8% having experienced attempted rape) (Tjaden & Thoennes; 2000). In another survey of the general population of women over 15 years of age in the Czech Republic, 11.6% of women reported forced sexual contact in their lifetime, 3.4% reporting that this had occurred more than once. The most common form of contact was forced vaginal intercourse (Weiss & Zverina; 1999). Pregnant women are not exempted from sexual violence as shown by statistics from the Royal Women’s Hospital which indicated that 42% of the violated women who experienced violence by a previous partner were pregnant at the time of the violence and 20% experienced violence for the first time during pregnancy (World Sexual Violence Report; 2011).

Sexual violence is also a menace for adolescence as nearly half of the sexually active adolescent women in a multi-country study in the Caribbean reported that their first 4 sexual encounters was forced (Halco´n, Beuhring & Blum, 2000). In Lima, Peru, the percentage of young women reporting forced sexual initiation was 40% (Caceres, Vanoss & Sid Hudes 2000). From these findings it is very clear that, in their lifetime, women are sexually violated by an intimate partner worldwide.
Sexual violence is also rampant in the continent of Africa. Research in South Africa and Tanzania reflects that nearly one in four women may experience sexual violence by an intimate partner (Nikojima, 2002). In addition, a survey of women aged 18–49 years carried out in three provinces of South Africa found that 1.3% of women had been forced, physically or by means of verbal threats, to have non-consensual sex (Jewkes & Abrahams, 2000). On the other hand up to one-third of adolescent girls report their first sexual experience as being forced (Watts & Zimmerman; 2002). A number of studies, from sub-Saharan Africa, indicate that the first sexual experience of girls is often unwanted and forced (World Sexual Violence Report, 2011). The report goes on to cite the findings of a case study of adolescent girls attending antenatal clinic in Cape Town, South Africa which showed that 31.9% of 191 pregnant adolescents and 18.1% of 353 non pregnant adolescents (matched for age and neighborhood or school) reported that force was used during their sexual initiation. Forced sexual initiation and coercion during adolescence have been reported in many countries and this suggests that sexual violence is rampant in many countries.

Zimbabwe is not spared from the crimes of sexual violence. In Harare, a survey of 1006 women was done in 1996 and revealed that 2.2% of the sample reported sexual violence (United Nations Report; 1998). In a survey conducted by WHO in the Midlands Province of Zimbabwe on intimate violence, 25.0% of the 966 women interviewed, reported sexual violence by a husband, boyfriend or an acquaintance. Although the women who report the crime of sexual violence are low, the percentage is higher for women who seek help from organizations which help victimized women. In Gweru,
sexual violence is a reality as shown by statistics from institutions dealing with domestic violence such as Msasa Project, Medicines’ San Frontiers (MSF) and Gweru District Hospital. These show a significant rise of 78% in the 2 years 2009 and 2010. The above evidence show that sexual violence is a problem worldwide including Zimbabwe.

Sexual violence, according to Campbell (2009), has a profound impact on physical and mental health as well as an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences. Blanc (2003) revealed that deaths can occur following sexual violence as a result of suicide, HIV or murder. On the same note, Sadik (2002) laments that reproductive and sexual health is far from being a reality as a result of the violation of women’s sexual rights. While rape will always be a traumatic experience and a violation of human rights, the effects of this trauma for an individual may be different in different contexts (Cameron & Boyd; 2011).

1.2 Problem Statement

World Health Organisation and the Ministry of Health, together with other stakeholders are fighting for the rights of women to be reproductively and sexually healthy. However, this goal remains a dream to women as their sexual rights are violated. It is a cause of concern to note that sexual violence is on the increase in Gweru as shown in Table 1.1
Table 1.1 Reported cases of sexual violence in Gweru

<table>
<thead>
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<td>2009</td>
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<tr>
<td>MSF</td>
<td>150</td>
<td>260</td>
<td>110</td>
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<td>50</td>
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Table 1.1(Source: Institutional Records)

The real cases may be more as not all cases are reported. However, from the statistics in table 1.1, there is an average increase of 78% in the three institutions over the 2 years 2009 and 2010. This is clear evidence that sexual violence is on the increase in Gweru and one wonders at the effects this is having on the health of the women. In developed countries such as the United States of America, research shows that sexual violence has adverse effects on the health of women. Since the effects of sexual violence for an individual may be different in different contexts, there is need find out the effects in a Zimbabwean context. However, this information is not readily available in Zimbabwe hence the need to carry out a research to identify the effects of sexual violence on the health of women in Gweru urban.
1.3 Purpose of the Study

The surge in the reported cases of sexual violence in Gweru prompted the researcher to investigate how it was affecting the health of women. This study therefore sought to identify those effects on the women of Gweru urban. The study focused on the reproductive effects, psychological effects and physical effects of sexual violence.

1.4 Objectives of the Research

In order to answer the research questions, the following objectives were used;

- To expose how women are sexually violated
- To establish the percentage of women affected reproductively, mentally and physically by sexual violence
- To identify the prevalence of HIV/AIDS and sexually transmitted infections resulting from sexual violence
- To expose the reactions of women to sexual violence

1.5 Research Questions

To find answers to the research problem, the researcher sought to find answers to three research questions stated below;

- In what way are women sexually abused?
- How is the health of women affected by sexual violence?
- Is there a relationship between sexual violence and STI and HIV/AIDS?
- How do women react to sexual violence?
1.6 Hypothesis
In order to find out if sexual violence has an effect on the health of the women, the researcher had to test the following hypothesis;

\( H_0 \) There is no difference in reproductive, psychological and physical health between sexually violated and none sexually violated women.

\( H_1 \) There is a difference in the reproductive, psychological and physical health between sexually violated and none sexually violated women.

1.7 Assumptions
In this study the researcher assumed that;

Women are being violated sexually in or outside marriage

Women’s health is affected by sexual violence

1.8 Rationale and Significance of the Study
The 1983 WHO Report said that women were facing challenges in terms of their reproductive health. To address this, the United Nations then came up with the Millennium Development Goals (MDG) of which the MDG number 5 addresses the reproductive health of women. The MDG number 5 states that all member countries should make great efforts to improve maternal health by the year 2015. The Zimbabwean Government, as a member of the United Nations, made a commitment to address the reproductive health challenges of women through the Ministry of Health and Child Welfare. One of the components of the reproductive health package is protection and prevention of women from sexual and gender violence. This can only be achieved if
the sexual rights of women are observed. However, from the reports in the press, which are supported by the statistics in the statement of the problem, the Zimbabwean woman is not being protected from sexual violence.

The significance of this study is that it revealed factors which made women adopt a negative attitude towards their sexual rights allowing men to take advantage of them. The study will reach those women who are silent and through focus groups assist them to air their views. The results of the study exposed the magnitude of sexual violence and types of effects sexual violence is having on the women’s health. To the community, Ministry of Health and Child Welfare and non-governmental organization seeking to help women achieve reproductive and sexual health, the findings and recommendations of the study may help them to come up with campaign strategies to improve sexual health. As a result, women will be empowered by knowledge provided by this study through its findings and recommendations.

1.9 Delimitation

The study focused on women between the ages of 15 to 35 years as these are the women in their reproductive period. The study also focused on those women who were sexually violated from Msasa project and Gweru District Hospital to investigate the effects of sexual violence. The area of study was limited to Gweru urban focusing on Gweru District Hospital and Msasa Project as these institutions are where some of the sexually violated women are found.
1.10 Limitations of the study

Some of the women sexually violated may not be accessible as they do not report or seek help. The researcher therefore focused on those who reported and used counselors at Msasa Project and Gweru District Hospital to access them. It was not easy to engage some of the women in conversation since sex issues are taboo in most cultures in Zimbabwe. However, the researcher combined previous experience as a nurse and counselor with good interview techniques to obtain this sensitive information.

1.12 Definition of terms

Within the contest of this study, the researcher adopted the meaning of key words as follows:

**Health**

According to World Health Organization (2001), health is a state of physical, psychological, social and spiritual well being and not only the absence of a disease or infirmity. In this study health refers to the state of physical, psychological, reproductive and sexual wellbeing.

**The reproductive rights**

As stated by the International Planned Parent Federation (IPPF) (1997), reproductive rights are the rights of couples and individuals to decide freely and responsibly the number and spacing of their children, to have the information, education and means to do so, attain the highest standards of sexual and reproductive health and, make
decisions about reproduction free of discrimination, coercion and violence. This study however views the reproductive rights as the rights of women to decide freely without coercion or force all the matters relating to their reproduction.

**Sexual health**

The International Conference on Population Development (1994) defines sexual health as healthy sexual development, equitable and responsible relationships and sexual fulfillment with freedom from illness, disease, disability, violence and other harmful practices related to sexuality. This is the same definition adopted for this study.

**Sexual rights**

These are the rights of all people to decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual health, be free from discrimination, coercion or violence in their sexual lives and in all sexual decisions, expect and demand equality, full consent, and mutual respect and shared responsibility in sexual relationships. Women also have the right to say no to sex if they do not want it (International Conference on Population Development 1994). These are the rights which the women in this study are expected to be practicing.

**Sexual violence**

Sexual violence is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a
person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. ([Wishart, 2003]

1.13. Organisation of the study

The study report is organized in five chapters. Chapter one is the introductory chapter which brought into focus the background to the study and highlights the research problem. The research questions, objectives, rationale and justification are also included in this chapter. Chapter two dealt with review of related literature where the theories related to sexual violence were analysed to form the theoretical framework. Books and other peoples’ works were also reviewed in order to focus the problem.

Chapter three is the methodology chapter in which the methodology, design, sampling procedures, research instruments, validity and reliability as well as methods of analyzing data were discussed. Chapter four is dealt with data analysis and interpretation and discussion of the findings. Chapter five is the final chapter in which the research is summarized, conclusions and recommendations are made.
CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Introduction

In an order to provide a comprehensive perspective of the effects of sexual violence, related literature was reviewed. This was done to provide an in-depth picture of how women are sexually violated the effects of sexual violence on the health of women and how the women react to the violence so as to assess where the Zimbabwean women fit. The theories of sexual violence and those of health were reviewed to give the study a theoretical framework. The influence of culture on sexual violence was also analysed to understand its influence on the behavior of men and women towards sexual violence. The effects which have been identified by other researchers were reviewed so as to compare with the results of this study.

2.1 Theoretical/conceptual framework

Different theories have been advanced to explain sexual violence and rape in an effort to try and understand what makes men behave in such a manner. By analysing the socio-biological theories of rape, health belief model and the theory of reasoned action the researcher hopes to gain some insight into the behavior of men which make them abuse women as well as understand the reaction of women to the violence.
2.1.1 Socio-biological theories

Thornhill and Palmer (2000) developed the Socio-biological theories of rape which explore the degree, to which evolutionary adaptations influence the psychology of rapists. The socio-biological theories include the animal coercive sex theory and the natural behaviorist theory.

Animal coercive sex theory

Thornhill and Palmer (2000), noted that the behavior resembling rape in humans is widespread in other animals and such behaviors, referred to as ‘forced copulations’, involve an animal being approached and sexually penetrated whilst it struggles or attempts to escape. This is supported by Johnson (1992) who explains that if a woman resists sexual advances, she can be physically forced or coerced into submission. If men’s behavior is like that of an animal, as postulated by Thornhill and Palmer (2000), then it is not surprising that they abuse women and when they do, they do not think of the effects of these actions on the health of a women.

On the same note Thornhill and Palmer (2000) believe that rape appears not as an aberration but as an alternative gene-promotion strategy that is most likely to be adopted by the ‘losers’ in the competitive, harem-building struggle. Thornhill and Palmer (2000) argue that, “if the means of access to legitimate, consenting sex is not available, then a male may be faced with the choice between force and genetic extinction.” This explains the results of a study by Nikojima (2002), which showed that one-third of adolescent girls, report their first sexual experience as being forced. In such cases, the
abusers use force that is necessary to subdue their victims because physically injuring the victims would reduce the chance of reproduction harem-building (Thornhill and Palmer; 2000). In other words the theory implies that when a man fails to access legitimate and consenting sex, they force themselves on the woman sometimes with the intention of making the woman pregnant against her wish. However the theory does not explain why married men who have access to legitimate sex with their wives still rape other women.

This is explained by the findings of a study by Hagen (2002) which describes four conditions where the reproductive gains from sexual violence may outweigh the cost of such behavior. These are: status males who do not fear reprisal, low status women who can do anything for money or a meal, war where armed soldiers can get away with anything and men who are of low status with few opportunities of investing in kin.

On the other hand, McKibbin, Shackelford, Goetz and Starrat (2008) argue that there may be several different types of rapists or rape strategies. One is rape by disadvantaged men who cannot get sex otherwise. Another is "specialized rapists" who are more sexually aroused from rape than from consensual sex. A third type is an opportunistic rapist who switches between forced and consensual sex depending on circumstances. A fourth type is psychopathic rapists who rapes because he is not mentally stable and these are usually victims of childhood abuse. In their research, MacKibbin et al. (2008) found that at least one-third of males admit they would rape under specific conditions. In other words they propose that rape is a conditional strategy
that may potentially be deployed by any man. With this scenario, women are not sexually safe where men are concerned.

**The learned behavior theory**

Jones, (1999) looks at sexual assault as a learned behavior. The basis of this theory is that, "social conditions, such as cultural norms, rules, and prevailing attitudes about sex, mold and structure the behavior of the rapists, foster rape-prone environment and, in effect, teach men to rape." Jones claims that sexual violence was linked to larger patterns of violence within a society, an ideology that encourages male aggressiveness and this encourages them to be sexually aggressive. Such cultural norms devalue women but value male dominance and aggressiveness thus create a subculture that sanctions sexual violence. World Health Organization reports that there is a high correlation between sexual assault and cultures. The report goes on to say that cultural norms, such as male honor, masculinity, and men's sexual entitlement foster societal acceptance of sexual assault. The societal ideology of male superiority emphasizes dominance, physical strength and male honour which encourage rape. In many societies, for example, women, as well as men, regard marriage as entailing the obligation on women to be sexually available virtually without limit (World Health Organization, 2002).

On the other hand, Malamuth and Heilmann (2005), has a psychological development models, which link learned behavior theories. They claim that men who rape often come from harsh developmental backgrounds involving impersonal and short-term social relationships, and backgrounds in which manipulation, coercion, and violence are valid
ways of conducting social relationships. A man with such a background has no whims about sexual violence neither does he care about its outcome.

2.1.2. The Health Belief Model

This model attempts to explain and predict a given health-related behavior from certain patterns of belief about the recommended health behavior and the health problems that the behavior was intended to prevent or control. The model was designed by public health researchers in the 1950’s and was modified by Becker in 1998. The Health Belief Model relates largely to the cognitive factors predisposing a person to a health behavior. The question is, what is the health behavior of sexually violated women and what makes them to behave that way?

To answer this question, the model postulates that there are four conditions which explain and predict a health-related behavior and these are. “The belief in susceptibility, the potential seriousness, perceived or anticipated benefits and the cue to action”

The belief in susceptibility

According to Becker (1998) the belief in susceptibility occurs when a person believes that his or her health is in jeopardy then action will be taken. So in the case of sexual violence the woman has to perceive that her health is in jeopardy, and then she will either report the case or seek medical help. This will then depend on whether the woman was socialised to view sexual violence as an offence or violation of her sexual rights.
The potential seriousness

For a person to seek help, the person should have perceived a potential seriousness of the condition in terms of pain or discomfort, time lost from work, economic difficulties, or other outcomes (Rosenstock, Hochbaum, Kegeles and Levethal, 2001). According to this model, a woman will only seek help if she experiences pain or discomfort otherwise she will not report the sexual violence.

Perceived or anticipated benefits

On assessing the circumstances, the person has to believe that benefits stemming from the recommended behavior outweigh the costs and inconvenience and that they are indeed possible and within grasp (Becker, 1998 cited in Campbell; 2001). After sexual violence the woman will only seek help if she believes in the benefits of reporting and health care to outweigh the inconveniences and the embarrassment of reporting sexual violence. This appears to be suggesting that women will only report violence if there are benefits which come with the reporting.

The cue to action

Campbell (2001) explains cues to action as internal or external forces which activate a person’s ‘readiness to act’. The external forces can be from educational materials or counseling sessions (Campbell, 2001). So if a woman receives a cue to action after sexual violence, she will seek medical care otherwise she remains quiet about the violence and suffers in silence.
Women, therefore, will take action only if they believe that they are susceptible, consider potential seriousness of the problem, anticipate benefits or receives a cue to action. Thus women need information on the effects of sexual violence for them to acknowledge its potential seriousness as well as their susceptibility to health problem.

2.1.3. The theory of reasoned action

This theory was designed to explain volitional behaviors and is based on the assumption that most behaviors of social relevance are under volitional (willful) control (Fishbein and Ajzen, 2003.) According to this theory a person’s intention to perform a specific behavior is controlled by two factors; the attitude (negative or positive) towards the behavior and the influence of the social environment (general subjective norm) on that behavior. The person’s attitude is determined by the person’s belief that a given outcome will occur if the behavior is performed. (Fishbein and Ajzen 2003.) This concurs with the health belief model which says that a person will perform a certain behavior if the person perceives or anticipates benefits from the action. This means that the attitudes engrained in the woman will determine how that woman will react to sexual abuse. If she believes that the outcomes will be positive then she will take positive action.

On the other hand the general subjective norms are determined by the person’s normative belief about what the important or significant people think should be done and also by the individual’s motivation to comply with those other people’s wishes or desires.
(Fishbein and Ajzen 2003). So the behavior of women towards sexual violence is determined by the important people in the woman's life and her reaction towards it is influenced by the perceptions of these people. She will react in a way that those people will expect her to. If she believes that most of the people in this social group will expect her to keep quiet then she will do so depending on her motivation to comply with them. In other words the cue to action as in the health belief model is based on the opinion of the significant people in her life. If she is of low status and the abuser is of high status, the chances of her reporting the violence are very small. If the partner or father, who is an important person in the woman’s life (head of the family), is the perpetrator then the woman will not be expected to report. Thus she will keep quiet as she was socialized to be submissive to the men in her life whilst sexual violence continues unabated. But is this good for the woman’s health?

2.1.4. Summary of the theoretical framework

Although Thornhill and Palmer (2000) view the behavior of sexual violence as resembling that of other animals, it can also be influenced by the theory of reasoned action which claims that, the person’s attitude and the person’s environment influence willful behavior as stated by Fishbein and Ajzen (2003). If the man’s attitude towards the woman is negative, and he believes that by raping the woman, he will enjoy sex (positive outcome) then the animal behavior can be applied. This is also supported by Becker’s (1998) Health Belief Model which claims that a behavior can be done if the person anticipates benefits from such behavior. These three theories can therefore explain the behavior of sexual violence.
The same principles also influence the reaction of women towards sexual violence. The woman can report sexual violence if she has a positive attitude towards self, views sexual violence as wrong and anticipates benefits from reporting. Whilst the behavior of both men and women can be explained by the Health Belief Model and the theory of reasoned action, it has a bearing on the socialisation and culture of the individual.

2.2. Role of Culture in sexual violence

A human being is a product of his/her environment and this environment is shaped by society. In order to understand the reaction of women to sexual violence, we need to understand the women’s culture which governs her behavior. In many societies women are treated as the property of men who keeps them under subjectivity and to do as told without any question (Ncube 1998). In the African culture, married women are expected to be sexually passive and submissive to their husbands, whereas men are expected to be the initiators of sex and also set the conditions for the sexual encounter (Kambarami, 2007). On the same note, Messer (2004) states that women are expected to satisfy the sexual desires of their husbands. As a result, when a husband wants sex, the wife should comply because that is part of the marriage contract (Madlala, 2000). Furthermore, even if women suspect their husbands of infidelity they cannot insist on safe sex because men control the sexual encounter (Meursing and Sibindi, 1995). This scenario has seen HIV and AIDS spreading like veld fire because women cannot insist on safer sex measures as men control the sexual encounter.
In addition, “The changing family in Zambia” journal (1997), explains that women have no choice when it comes to sex. They cannot even say “no” as they are brought up for the comfort and enjoyment of men. The African culture frowns upon a woman who is not submissive to her husband in matters of sex. This goes on to say that women are socialized not to decline their husband’s sexual advances. Thus, culturally women have no sexual rights; as a result men can use them as a sexual toy with nobody worrying about the effects of forced sex on them as long as the man is satisfied (Kambarami, 2007). The man can have sex whenever he wants and the woman will agree because that’s the way she was socialized. Since the man is the head of the family the woman will tolerate the violence irrespective of the effects on her health.

Another aspect of the African culture is the power of the father over the girl child’s sexuality and marriage. Under the customary law, the father should consent to the marriage of their child irrespective of the girl’s age and with the same principle can pledge the girl in marriage (Ncube, 1998). Pledging a girl child in marriage is a form of sexual violence hence concurs with Jones (1999) who claims that social conditions such as cultural norms and rules mould and structure the behavior of sexual violence.

In Zambia as well, the payment of lobola entitles a man to his wife’s reproductive system and earns him conjugal rights as reported in the, changing family in Zambia, (1997). Therefore, the African woman culturally has no sexual rights. However, women are being empowered to stand for their sexual rights, but will this empowerment change the beliefs and the socialisation of an African woman to the point of realising that sexual violence can affect their health?
Sexual violence is based on gender hierarchy and sexual entitlement in the African man since their culture implies that man has a right or even duty to force himself onto a woman (Jewles, 2006). This is supported by Madlala (2002), who states that sexual violence makes the African man more powerful and virile. As a result sex in marriage is just a marriage ‘deal’ which should be fulfilled whenever the husband demands it. The woman however just puts up with it as they were socialized to do the husband’s biding and should not complain about sexual assault (Nkosi, 2006). In other words, in the African culture, sexual violence does not exist within the context of marriage. The culture actually promotes sexual violence without the slightest consideration to its effects on the health of the women. This is supported by Jones (1999) who explains that the societal ideology of male superiority emphasizes dominance, physical strength and male honour which encourage sexual violence. In many societies, for example, women, as well as men, regard marriage as entailing the obligation on women to be sexually available virtually without limit (World Health Organization, 2002). This means that women can be violated in the name of culture and society accepts it without a whim. But what does the same society say about the effects of such violence on the woman? One wonders!

In many cultural settings it is held that men are unable to control their sexual urges and that women are responsible for provoking sexual desire in men (Ariffin, 1997). Here the victim takes the blame for the violent acts performed on her body whilst the perpetrator is justified. How families and communities react to acts of rape in such settings is governed by prevailing ideas about sexuality and the status of women. In some societies, the cultural “solution” to rape is that the woman should marry the rapist,
thereby preserving the integrity of the woman and her family by legitimizing the union (Heise, 1994). Such a “solution” is reflected in the laws of some countries, which allow a man who commits rape to be excused his crime if he marries the victim (UNICEF 2001). Apart from marriage, families may put pressure on the woman not to report or pursue a case (Heise, 1994). Many men thus simply exclude the possibility that their sexual advances towards a woman might be rejected or that a woman has the right to make an autonomous decision about participating in sex. However, societal norms around the use of violence as a means to achieve sexual objectives have been strongly associated with the prevalence of rape especially in societies where the ideology of male superiority is strong – emphasizing dominance, physical strength and male honour (Sanday, 1981). Countries with a culture of violence, or where violent conflict is taking place, experience an increase in almost all forms of violence, including sexual violence (Briggs and Cutright, 1994).

On the other hand, the Shona culture views any sexual relationship with an unmarried girl as unlawful unless sanctioned by marriage and authorized by the parents (Holleman, 1997). In a way this is directed at protecting the unmarried woman from sexual abuse or harassment. However should a man have sexual intercourse with an unmarried woman, seduction charges are paid to the girl’s parents irrespective of whether the girl gave consent or not (GoldGin and Gelfand, 1995). Furthermore, the parents of the woman, in the Shona culture, as stated by Ncube (1998), retain power over their daughter’s sexuality even after attaining 18 years which is the legal age of majority or 16 years which is the legal age of consent, until the girl is married. After marriage the power is then ceded to the husband upon payment of lobola. This means that culturally women
have no power over their sexuality. Sexual decisions are made for her by the man in her life; her father initially then later her husband. This social environment, which makes men significant people in a woman’s life, makes it difficult for the woman to report sexual violence.

At the same time the Shona, like any other patriarchal society, views males as heads of the families who play the role of ‘protecting’ and ‘supervising’ the family units. They exercise their power by employing the ‘male gaze’ and use the socialisation processes to enhance male dominance and retain the females in subservient positions (Madlala, 2000). The insistence on the ‘male gaze’ to which women have to respond by modifying their behaviour ‘appropriately’ or risk the consequences (including rape and other forms of assault) highlights how women are constantly in danger, and how men are easily exonerated from rape crimes (Madlala, 2000).

Socialisation of the boy child can lay a foundation for sexual violence in the Shona culture. The boy pursues a girl proposing and the girl is expected to play hard to get otherwise she is labelled as sexually weak and promiscuous. It is for this reason that when a boy makes sexual advances to his girlfriend, he does not take seriously her attempts to say “no” because he anticipates them anyway, and this adds to his aggression and use of force (Mungwini and Matereke, 2009). Thus men are always faced with the problem to determine the amount of force they have to use on a woman. If it is too much it becomes rape and if it is too little it achieves nothing (Musarurwa, 1988). Mungwini and Matereke (2009) supports this when they claim that the success in getting a girl to bed depends in part on the amount of force that a man uses relative to
her resistance. The foundation laid by society makes it difficult to define sexual violence in the Shona culture.

The fact that sexual aggression is culturally sanctioned is reflected in the figurative language that Shona men use to recount their sexual exploits to their peers. Below are a few, *umburudza (make one roll)*, *kudhonora (beating)* and *kurikita (beat hard)* which paint a picture of a hapless female who has been subdued by the man and taken through the whole sexual ordeal like some kind of sex slave. The whole act is true punishment to the woman whilst to the man it is an achievement which the man enjoys to administer (Musarurwa, 1988). The male organ as well, is figuratively portrayed as a *sjambok (whip)* used to mete out deserved punishment on the female. How this organ is used as a whip is therefore through rape. Musarurwa (1988) goes on to explain that the stated shona derogative terms capture a situation that is characterised by severe struggle typical of a wrestling match that culminates in the woman or girl submitting or lying helplessly. It is from such kind of language that one can discern the roots of sexual violence in the Shona culture.

The sexual violence, sexual politics and the construction of manhood among the Shona of Zimbabwe depicts the crying and groaning of a woman from pain to signify male superiority, and is consistent with the idea of thrashing, submission and conquest. (Mungwini & Materenke, 2009). In support of this, Chimhundu (1995) noted that, among the Shona, sexual relations involve victory and conquest on the part of the male, and defeat and surrender on the part of the female. The orientation one gets as an adolescent in talking to one’s peers about the subject of sex is one where the male
figure has to be merciless when it comes to sexual encounter. Therefore the way the Shona use language to capture sexual encounters is in itself, an incubator for sexual aggression which promotes and instigates sexual violence (Mungwini and Matereke, 2009). Because the female organ is culturally portrayed as a delicacy like honey, it heightens men’s drive for it, and one cannot rule out rape for those who cannot properly negotiate for sex. Indeed, many a man has been reported to have told a woman that he would not mind going to jail because of rape, as he was dying to ‘have a taste’ of her! (Chimhundu, 1995). The portrayal of female bodies as commodities to be enjoyed or feasted on by men as well as the socialisation of the boy child in the Shona culture promotes sexual violence.

2.3. Types of sexual violence

Sexual violence occurs in different forms. McMahon, Warren, Douglas and Brener, (2006) describes the types of violence as; coercion, rape, harassment, trafficking, forced marriage or cohabitation and violent acts against sexual integrity.

2.3.1 Coercion

Sexual coercion covers a whole spectrum of degrees of force to include using physical force to obtain sex. It may involve psychological intimidation, blackmail or other threats - for instance, the threat of physical harm, of being dismissed from a job or of not obtaining a job that is sought. Such type of force is used by men with power, money or authority and may also occur when the person aggressed is unable to give consent – for
instance, while drunk, drugged, asleep or mentally incapable of understanding the situation (Hagen, 2002).

2.3.2. Rape

Rape is defined as physically forced or otherwise coerced penetration of the vulva or anus using a penis, other body parts or an object. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape (Hagen, 2002). This sexually violent act can take place in different circumstances and settings. These include rape by strangers, rape within marriage or dating relations and systematic "war rape" during armed conflict. Gang rape involving at least two or more perpetrators is widely reported to occur in many parts of the world. Systematic information on the extent of the problem, however, is scant. In Johannesburg, South Africa, surveillance studies of women attending medico-legal clinics following a rape found that one-third of the cases had been gang rapes (Swart, Richter, Burns and Mogale, 2000). National data on rape and sexual assault in the United States reveal that about 1 out of 10 sexual assaults involve multiple perpetrators. Most of these assaults are committed by people unknown to their victims (Greenfeld, 2001). This pattern, though, differs from that in South Africa where boyfriends are often involved in gang rapes (Swart et al. 2000).

2.3.3. Sexual harassment

Sexual harassment which is demanding sex in return for favors is more common in work places. The legal definition of sexual harassment is “unwelcome verbal, visual, or
physical conduct of a sexual nature that is severe or pervasive and affects working conditions or creates a hostile work environment.” (Omaar de Waal, 1994)

Omaar de Waal (1994) goes on to explain that the conduct of the harasser must either be severe or it must be pervasive to be sexual harassment. A single incident is probably not sexual harassment unless it is severe. For example, a single incident of rape or attempted rape would be sexual harassment. The conduct is also not sexual harassment if it is welcome as a result it is important to communicate (verbally, in writing, or by your own actions) to the harasser that the conduct makes you uncomfortable and that you want it to stop. If the conduct is continued, then it becomes sexual harassment. However this definition might not work in the shona culture where a boy pursues a girl, and her no is expected (Mungwini and Matereke, 2009), hence will not deter him. Nevertheless, sexual harassment can be verbal or written, physical, nonverbal or visual (Heise, 1993).

Heise (1993) gives examples of sexual harassment as to include; verbal or written comments about clothing, personal behaviour, or a person’s body; sexual or sex-based jokes, requesting sexual favours or repeatedly asking a person out. It could be sexual innuendoes like telling rumours about a person’s personal or sexual life, threatening a person. The harassment can become physical like assault, blocking movement, inappropriate touching of a person or a person’s clothing, kissing, hugging, patting, or stroking. The nonverbal harassment involves looking up and down a person’s body, derogatory gestures or facial expressions of a sexual nature, following a person.
Harassment can be visual as in posters, drawings, pictures, screensavers or emails of a sexual nature. (HEISE, 1993)

2.3.4. Forced marriage or cohabitation

Forced marriage or cohabitation involves parents pledging their daughters in marriage. A forced marriage is a marriage that takes place without the full and free consent of both parties. Force can include physical force, as well as being pressurised emotionally, being threatened or being a victim of psychological abuse (Forum on Marriage and the Rights of Women and Girls, 2000). An example of forced marriage is pledging a girl child to appease an avenging spirit where the girl will be given to a male member of the family. Here the girl’s wishes or feelings are irrelevant therefore it becomes sexual violence.

2.3.5 Sexual trafficking

This is trafficking of people for the purpose of sexual exploitation. Each year hundreds of thousands of women and girls throughout the world are bought and sold into prostitution or sexual slavery (Chauzy and Kyrgyz, 2001, Dinan and Owed, 2000).

Research in Kyrgyzstan has estimated that around 4000 people were trafficked from the country in 1999, with the principal destinations being China, Germany, Kazakhstan, the Russia Federation, Turkey and the United Arab Emirates. Of those trafficked, 62% reported being forced to work without pay, while over 50% reported being physically abused or tortured by their employers (Chauzy & Kyrgyz, 2001). A World Organization
against Torture (OMCT) report suggested that more than 200,000 Bangladeshi women had been trafficked between 1990 and 1997. (Benninger-Budel et al; 1999).

2.3.6. Other forms of sexual violence

Other forms of sexual violence include denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases or pregnancy, violent acts against sexual integrity, including genital mutilation. Among some of our ethnic groups, female genital mutilation is practiced but, like the circumcision of the boys, it is kept so secretive, only a few elders of the tribe know about it or can speak authoritatively of what goes on in the remote camps set up for it (Forum on Marriage and the Rights of Women and Girls, 2000).

2.4 Impact of sexual violence on Reproductive Health

The World Health Organisation has declared violence against women as a major public health and of particular violence by an intimate partner (WHO; 2000). It is said sexual violence has multiple reproductive health problems as cited by Campbell, Garcia-Moreno and Sharps (2009). These include gynaecological health problems, obstetric and sexually transmitted infection such as AIDS. In Victoria, the cumulative effects of intimate partner violence (of which sexual assault is a part) makes it the leading risk factor contributing to death infections including of women between the ages of 15 and 44 years, outweighing smoking, obesity, alcohol and drug use (VicHealth, 2004).
2.4.1 Sexual Violence and Gynecological Problems

Sexual violence appears to increase women's risk for many common gynecological disorders, some of which can be debilitating (Coker, Smith, Bethea, King, and McKeown, 2000). An example cited by Kehler (2006) is chronic pelvic pain, which accounts for as many as 10% of all gynecological visits and one-quarter of all hysterectomies in the USA. In addition, sexual abuse in childhood has been linked to increased sexual risk-taking and thus to STIs, which can lead to chronic pelvic pain, often due to pelvic inflammatory disease (Letourneau, Holmes & Chasendunn-Roark, 2000).

The other gynaecological problems are decreased sexual desire, genital irritation, pain during intercourse, chronic pelvic pain, urinary tract infections and vaginal bleeding or infection (Coker et al, 2000). Kehler (2006) also outlines other gynecological disorders associated with sexual violence as to include irregular vaginal bleeding, vaginal discharge, painful menstruation, pelvic inflammatory disease and sexual dysfunction (difficulty in orgasms or lack of desire) and conflicts over frequency of sex. Sexual assault also increases risk for premenstrual distress, a condition that affects 8% to 10% of menstruating women and causes physical, mood, and behavioral disruptions (Eby et al.; 1995). Gynecologic symptoms for example, dysmenorrhea (severe pain or cramps in the lower abdomen during menstruation), menorrhagia (abnormally heavy or prolonged bleeding during menstruation) can also occur (Golding, Wilsnack & Learmen, 1998). These studies done in America and Australia makes it clear that sexual violence makes it increasingly difficult for women to become reproductively health, but how are the sexually violated women in Gweru affected by these gynaecological disorders?
2.4.2. Sexually transmitted diseases including HIV/AIDS

HIV infection and other sexually transmitted diseases are recognized consequences of rape in New England (Jenny, Hooton and Bowers, 1990). Naker and Michau (2004) also points out that forced prostitution and marital rape puts the woman at a high risk of sexually transmitted infections (STI) and HIV/ AIDS. This fact is supported by Jenny et al (1990) who noted a particularly high risk of HIV and other sexually transmitted diseases in women who had been trafficked into sex work.

The risk of HIV infection is also increased in sexual coercion by spouse into unprotected sex when the man knows that he is unfaithful. Research on women in shelters has shown that women who experience both sexual and physical abuse from intimate partners are significantly more likely to have had sexually transmitted diseases (Wingood, DiClemente & Raj, 2000). Studies conducted in the United States show that women in violent and abusive relationship are less likely to use condoms, let alone request them, hence are more likely to contract STI including HIV than other women (Kalichman, 1998). The association between sexual violence and the risk for HIV/STI has also been observed in Southern Africa in a study by Adjuon (2002). The study identified that culturally-sanctioned gender roles foster power imbalances that facilitate women’s risk for sexual violence and STI/HIV. Because of sexual violence women are at a very high risk of STI and HIV as revealed by this evidence. However, what is the scenario in zimbabwe and in particular Gweru? Violent or forced sex can increase the risk of transmitting HIV. (Hakimi, Johnson, Keown and Ghirlando, 2001).The same author goes on to explain that, in forced vaginal penetration, abrasions and cuts
commonly occur, thus facilitating the entry of the virus - when it is present -through the vaginal mucosa. On the other hand, adolescent girls are particularly susceptible to HIV infection through forced sex because their vaginal mucous membrane has not yet matured. (Matasha, Dowd and Korda, 1998) Those who suffer anal rape are more susceptible to HIV than would be the case if the sex were not forced, since anal tissues can be easily damaged, again allowing the virus an easier entry into the body. (Hakimi et al; 2001). If one third of adolescent girls are sexually violated as pointed out by Nikojima (2002), then WHO’s idea of sexual health is still far from being a reality, but what is the prevalence of HIV in sexually violated women in Gweru?

According to Buga, Amoko and Ncayiyana (1996), being a victim of sexual violence and being susceptible to HIV share a number of risk behaviours, for instance, forced sex in childhood or adolescence, can increases the likelihood of engaging in unprotected sex, having multiple partners, participating in sex work and substance abuse. This can result in infection of the victim by HIV and other STIs. Sexual coercion among adolescents and adults is also associated with low self-esteem and depression, factors that are associated with many of the risk behaviours for HIV infection (Campbell & Soeken, 1999). On the same note, women who experience forced sex in intimate relationships often find it difficult to negotiate condom use either because using a condom could be interpreted as mistrust of their partner or as an admission of promiscuity, or else because they fear experiencing violence from their partner (Buga, 1996). Apart from getting HIV from the sexual assault itself, the woman can also get HIV from the risk behavior resulting from sexual violence. Thus the risk of getting HIV from sexual violence is doubled.
2.4.3. Obstetric effects of sexual violence

Among the more common consequences of sexual violence are those related to reproductive health. Pregnancy may result from rape, though the rate varies between settings and depends particularly on the extent to which non-barrier contraceptives are being used (Boyer & Fine, 1992). Campbell (2009) explains that sexual violence strips the sexual autonomy of the woman and can result in unwanted pregnancy. Experience of coerced sex at an early age reduces a woman’s ability to see her sexuality as something over which she has control. As a result, it is less likely that an adolescent girl who has been forced into sex will use condoms or other forms of contraception, increasing the likelihood of her becoming pregnant (Holmes, 1996). The study by McFarlane (2005) in Texas indicated that 20% of the women who were sexually violated became pregnant. In another study by Holmes (1996) 5% of the victims of sexual violence became pregnant, although 32.4% of them did not realise it until in the second trimester. Not only do the women get pregnant but they also suffer frequent complications of pregnancy like pregnancy induced hypertension (PIH) or eclampsia (Satin, Ramin and Stone, 2002).

On the same note, incest often results in pregnancy which is covered by abortion, often initiated by the abuser (Aterbet, 2002). In addition, Boyer, (1998), claims that two thirds of sexually violated adolescent girls get pregnant with 80% of them opting for abortion irrespective of whether it is safe or not. In India, a study of married men revealed that men who admitted forcing sex on their wives were 2.6 times more likely to have caused an unintended pregnancy than those who did not admit to such behaviour (Martin,
Silverman, Decker, and Kapur, 1999). Now, imagine what will happen in a country like Zimbabwe where abortion is not easily accessible even though it is legal where rape is proved. It is therefore apparent that sexual violence can increase maternal morbidity and mortality, but how bad is it in Gweru?

A study of adolescents in Ethiopia by Mulugeta, Kassaye, & Berhane (1998) found that among those who reported being raped, 17% became pregnant after the rape, a figure which is similar to the 15–18% reported by rape crisis centres in Mexico. A study in the United States of over 4000 women followed for 3 years found that the national rape-related pregnancy rate was 5.0% per rape among victims aged 16–45 years, producing over 32,000 pregnancies nationally among women from rape each year (Holmes, 1996). In many countries, women who have been raped are forced to bear the child or else put their lives at risk with back-street abortions (Holmes, 1996).

2.5. Psychological effects of sexual violence

Sexual violence has been associated with a number of mental health and behavioural problems in adolescence and adulthood (Briggs & Joyce; 1997). In a population-based study in California, the prevalence of symptoms or signs suggestive of a psychiatric disorder was 33% in women with a history of sexual abuse as adults, (Mullen, Pathe and Purcell, 1988). Abused women reporting experiences of forced sex are at significantly greater risk of depression and post-traumatic stress disorder than non-abused women (Creamer, Burgess & McFarlane, 2001). In another study of adolescents in France, a relationship between having been raped and current sleep difficulties, depressive symptoms, somatic complaints, or aggressive behaviour was
found (Ellsberg, Heise and, Gottemoeller, 1999). In the absence of trauma counselling, negative psychological effects have been known to persist for at least a year following a rape but even with counselling, up to 50% of women retain symptoms of stress (Foa, 1999; 195) This evidence elsewhere, is enough to conclude that sexual violence can cause mental disorders but is it the same with the Zimbabwean woman who was socialised to tolerate violence.

2.5.1. Self blame

Self-blame is among the most common of both short- and long-term effects of sexual violence and functions as an avoidance coping skill that inhibits the healing process. The victims will often internally blame themselves because of the violation of boundaries, broken trust, and the feeling of personal danger which occurs with rape (Tangney and Dearing, 2002). They also claim that there are two main types of self blame: behavioral self blame (undeserved blame based on actions) and characterological self blame (undeserved blame based on character). Victims who experience behavioral self blame feel that they should have done something differently, and therefore feel at fault. Basing on the ‘male gaze’ as stated by Madlala (2000), the woman may blame herself because of the way she was dressed or the place she was despite the fact that she is a victim. Victims who experience characterological self blame feel there is something inherently wrong with them which have caused them to deserve to be assaulted. As a result the victim will look for support from the husband, boyfriend, or spouse who may be unwilling to accept reality and leave or blame the victim.(Tangney and Dearing, 2002).
2.5.2. Shame

Shame is another psychological disorder which is directly linked with sexual abuse (Watkins and Bentovim 1992). Tangney and Dearing (2002), lists five ways shame can be destructive and these are lack of motivation to seek care, lack of empathy, cutting themselves off from other people, anger and aggression. Shame has a special link to anger for example, when people are shamed and angry they tend to be motivated to get back at a person and get revenge. (Tangney and Dearing, 2002). In addition, shame is connected to psychological problems – such as eating disorders, substance abuse, anxiety, depression, and other mental disorders as well as problematic moral behavior such as suicidal tendencies.

2.5.3. Suicidal behaviour

Women who experience sexual assaults in childhood or adulthood are more likely to attempt or commit suicide than other women (Davidson, Wiedeman, Sansone and Sansone, 1996). The experience of being raped can lead to suicidal behavior as early as adolescence. In Ethiopia, 6% of raped schoolgirls reported having attempted suicide. They also feel embarrassed to talk about what had happened to them (Davidson et al1996). A study of adolescents in Brazil found prior sexual abuse to be a leading factor predisposing to several health risk behaviors, including suicidal thoughts and attempts. (Anteghini, 2001). Experiences of severe sexual harassment can also result in emotional disturbances and suicidal behaviour. A study of female adolescents in Canada found that 15% of those experiencing frequent, unwanted sexual contact had exhibited
suicidal behaviour in the previous 6 months, compared with 2% of those who had not had such harassment (Bagley, Bolitho & Bertrand 1997). From these studies, sexual violence is capable of making a woman mentally crippled.

2.5.4. Physical effects of sexual violence

Holcomb (2010) outlines that there are immediate physical effects of sexual violence such as pain and bodily injuries, especially if the perpetrator used force. Specific physical effects may include: bruises, cuts, bleeding and broken bones. An unnamed victim of sexual violence wrote, ‘The on-going violence throughout my years of marriage was mental and sexual. My urethra was so battered I became incontinent; my psyche was so battered I became a mental cripple. I finally got out and changed my name and city, and found myself again’ (Unnamed victim/survivor in Easteal, 1994). Damage to the urethra, vagina and anus can occur for some victims of penetrative sexual assault. Physical effects are listed on short term as it is presumed that the person will heal from the physical harm of abuse, although the scarring that may remain will always be a constant reminder of the violence.

2.6. Reactions of women to sexual violence

According to the ABS Women’s Safety Survey (1996), women’ responses to sexual violence are varied and are determined by their culture and their health beliefs. The most common action taken was to discuss it with friends (58%) and family (53%). 19% of women who experienced physical violence contacted the police. 15% of women who experienced violence from a stranger were most likely to report to police whereas those
assaulted by a current partner were least likely to report to the police. This evidence concurs with (Schwartz, 1997) who said that sexual assault is one of the most under-reported crimes where 'there are numerous "hidden" victims who do not report their victimisation to the police or to health officials, making them invisible in official statistics'. However, the reactions of women are a result of the beliefs that are engrained in the woman as explained by the health belief model and the theory of reasoned action. In addition, the culture of the woman has a major influence on her reaction to sexual violence.

2.7. Summary

The socio-biological theories of rape explains that men are sexual violent because they resemble other animals. However this behavior is willful hence can also be explained by the health belief model and the theory of reasoned action. The socialization process and the culture of an individual governs the reactions of an individual, be it violence or the reaction to the violent act. There are different types of sexual violence to include rape, coercion, and harassment among many others. Related studies on the effects of sexual violence were reviewed and show a negative effect on the health of the women. If women in other countries are affected, is it the same in the Zimbabwean context with reference to Gweru. The next chapter, which is chapter three, addresses the research methodology.
3.1 Introduction

Straus and Corbin (2008) view methodology, as a way of thinking about and a way of studying social realities. There are basically three types of research methodology that is qualitative, quantitative and mixed. The methodology discussed in this chapter addresses a way of thinking and studying the behavior of sexual violence. This chapter addresses the research methodology, research design, data collection methods and procedures, sampling methods and ways of analysing the data collected.

3.2. Qualitative methodology

Qualitative research methodology, according to Denzin and Lincoln (2000), is a method used to study human behavior and their habits. It is all about exploring issues, understanding phenomena and answering questions where it seeks to answer the why, how and what of the topic (Patton, 1990). The designs used in qualitative research methodology include surveys, case studies and experiments and the approaches for data collection are focus groups, interviews and document analysis (Buchanan and Bryman, 2009).
3.3 Quantitative methodology

Quantitative methodology is all about quantifying relationship between variables and this relationship is measured using statistics such as relative frequency, correlation and others (www.sport.sc.org). Qualitative methods are good at verifying problems and they yield discrete evidence (Polit and Hungler, 2003). The quantitative methodology places emphasis on precise measurement and controlling extraneous sources of error where this is achieved by isolating a variable of interest and manipulate it to observe the impact of manipulation (Rudestam and Newton, 2007). By controlling variables, the researcher can make inferences of a casual relationship of two or more variables. The control is accompanied by randomisation during sampling which gives every subject a probability of being selected hence it can be generalized (Rudestam and Newton, 2007). However controlling variables is not practical when dealing with subjects like human beings and in such cases quasi experimental designs can be used since they can maintain the argument and logic of experimental research (Creswell, 2003). Such kind of a research can be called ex post facto - a systematic empirical approach in which the investigator does not employ experimental manipulation because the events have already occurred or they cannot be manipulated (Kerlinger and Lee, 1999). However a quantitative research does not seek to understand behavior. Therefore in this study a mixed method was best in order to understand the behavior of sexual violence as well as assess its effects on the health of women.
3.4 Mixed research methodology

The mixed methodology is a method which brings together qualitative and quantitative research methods so that they complement each other and this enhances validity of the research findings (Buchanan and Bryman, 2009). The mixed methodology can strengthen the outcomes of the study because the advantages of one approach may compensate for the weakness of the other (Tashakkori and Teddlie, 1998). Since both qualitative and quantitative studies are designed “to understand and explain behaviour and events” (Dzurec & Abraham, 1993; 76), they can therefore be blended to bring the best representation of both worldviews by providing breadth and depth which is required in research (Wilson & Hutchinson, 1991, Lincoln & Guba, 2000). By using triangulation, the bias inherent in any particular data source and or a particular method will be cancelled out when used in conjunction with other data sources and methods, thus enabling the researcher to be more confident of the results (Denzin, 1978) The mixed methodology utilizes structured interviews which can be mixed with observation or other traditional qualitative methods of data collection and this triangulation of methods expands the meaningfulness of the findings (Grix, 2010). This is supported by Jick (1979) who propounds that conducting a mixed research stimulates the development of creative ways of collecting data making the data thicker and richer.

This method helps in dealing with different levels of analysis as the analysis will involve quantitative analysis of questionnaire or interviews and qualitative analysis on focus group discussions or documentary analysis (Creswell, 2003). Morse (1991) considers this as an advantage of mixed methods during the data analysis stage, as the
quantitative data can facilitate generalisation of the qualitative data and shed new light on qualitative findings and alternatively, qualitative data can play an important role by interpreting, clarifying, describing, and validating quantitative results (Sieber, 1973).

The researcher chose a mixed methodology (qualitative and quantitative) research method to seek answers to the effects of sexual violence on the health of women. The qualitative method was used to answer two of the research questions: how are women sexually abused and how do women react to sexual violence? Qualitative method is ideal because it is effective in the study of behavior and behavior changes. It aims to gather an in-depth understanding of human behaviuor and the reasons that govern such behavior (Denzin, & Lincoln, 2000). The qualitative method was chosen in this study because it was used to explore the reasons why men sexually abuse women and what happen after the abuse in relation to the women’s health. The qualitative method can be used to gain insight into people’s attitudes, concerns, culture and lifestyle so it was the best method to use to explore the behavior of sexual violence and how women responded to it. Qualitative research yields correlations and explanations into the cause and effect relationships (http://symptomresearch.Nih.gov.htm.) hence its use in this study to expose and explain the effects of sexual violence on the health of women.

The research was qualitative with quantitative embedded to supplement the qualitative method. The quantitative method was used to answer the research question: how is the health of the women affected by sexual violence? The numerical data collection enabled the researcher to establish the percentage of women affected by sexual violence. The researcher’s intention was to yield discrete evidence of the extent to which sexual
violence affects women’s health and the prevalence of HIV resulting from sexual violence hence a quantitative approach.

By combining methods and empirical materials, the researcher overcame the weakness or intrinsic biases and the problems that come from a single method. The purpose of the researcher in triangulation was to obtain confirmation of findings through convergence of different perspectives. And the point at which the perspectives converge, represent reality. In carrying out this study, the researcher was guided by the pragmatic paradigm. The mixed methodology uses the pragmatism approach which entails both qualitative and quantitative methods for guiding the investigation (Patton, 1990).

3.5 Research paradigm

Research paradigm is described as the underlying assumptions and intellectual structure upon which research and development in a field of inquiry is based (Kuhns, 1970). On the other hand, Patton (1990), views a paradigm as a world view, a general perspective, a way of breaking down the complexity of the real world. However, Cuba (1990), views a paradigm as an interpretative framework, which is guided by "a set of beliefs and feelings about the world and how it should be understood and studied." In this research therefore, the researcher was guided by the pragmatic paradigm.

The pragmatic paradigm places "the research problem" as central and applies all approaches to understanding the problem (Creswell, 2003, 11). Pragmatism emphasizes on workability of the method hence its approach to research is practical (Little, 2001). With the research question 'central' in pragmatism, data collection and
analysis methods are chosen as those most likely to provide insights into the question with no philosophical loyalty to any paradigm. Kuhn’s (1970) adds that, pragmatists are concerned about which questions are most important to the study and which methods are most appropriate for conducting the study. Creswell further argues that, instead of methods being important, the research problem is the most important issue and individual researchers have freedom of choice regarding the methods, techniques and procedures of research that best meet their needs and purposes.

The pragmatic approach in research is therefore different from the more traditional paradigms such as (post)positivist research approaches in that it is applicable in all kinds of research and is suitable in a mixed research. As Tashakkori and Teddlie (1998) argue, pragmatism rejects the either-or dichotomy of the incompatibility thesis as it embraces both points of view and is more oriented towards using both qualitative and quantitative methods. The idea which is central of pragmatists is that knowledge claims arise out of actions, situations and consequences rather than antecedent conditions as in positivism (Creswell, 2003). As a result, the pragmatic paradigm was ideal in a real-life situation as in this study of sexual behavior where independent variables cannot be minimized nor completely accounted for (Collins, Joseph, and Bielaczuc, 2004).

The pragmatic approach was chosen because it allows anything relevant to be used in studying the effects of sexual violence on women’s health. It accommodates positivism, post positivism and even interpretivism as long as it is relevant to the study. The flexibility of the pragmatic paradigm and its applicability in a mixed research makes it the research paradigm of choice.
3.6 Research design

According to Borg and Gall (1989), a research design refers to the procedures selected by the researcher for studying a particular set of questions. In this study, the casual comparative design was used. Comparative research looks at two or more similar groups, individuals, or conditions by comparing them and this comparison often focuses on a few specific characteristics (Patton, 1990). This method provides an explanation about the extent of relationship between two or more variables and examines the relationships including similarities or differences among several variables (Polit and Hungler, 2003). This design can employ both qualitative and quantitative methods in discovering the possible cause and effects of a behavior or personal characteristic by comparing subjects in which the behavior is present to those in which it is absent. This design is ideal in a study that does not easily permit experimental manipulation in order to establish the cause and effect relationship (Patton; 1990). It was relevant in this study as it is extremely difficult to manipulate human beings (Creswell, 2003). It is not practical to make some men sexually violent therefore an experimental design is not possible. According to (Polit and Hungler, 2003), the design, allows many relationships to be studied in a single research. This made it the design of choice as the researcher sought to find the reproductive, psychological and physical health effects of sexual violence.

3.7 Sample Procedures

A purposive sampling method was used to obtain a sample of 30 women who have been sexually violated. Patton (1990) defines purposive sampling as a method of selecting subjects based on a common characteristic. The common characteristic in this
case was that records show that they were sexually violated. The snow balling method was used at Msasa project and Gweru District Hospitals to obtain women who have been sexually violated. In this study, the researcher used the counselors at Msasa project and Gweru District Hospital to identify women who were sexually violated. Because of the sensitive nature of the study, it would have been difficult to get to the subjects unless they trusted you, hence the use of the counselors who have already gained the trust of the subjects.

The convenient sampling was used to obtain women who say that they were never sexually violated. Questionnaires with questions about different forms of abuse were given to women between the ages of 15 to 35 who visited Gweru Provincial Hospital to identify those who say were never sexually abused. Convenient purposive sampling was used because it was not easy to identify those who were not sexually abused as some women were abused but kept quiet about it so the questionnaire eliminated those.

For focus groups, churches and schools/colleges were used in order to vary the age groups. A systematic random sampling method was used. A random sampling method was used to select women who participated in the focus group. This method was used in order to give every woman a chance to participate in the focus group (Polit and Hungler, 2003). A systematic sampling was done to select 3 groups of 20 women for the focus group. A systematic sampling involves the selection of every $k^{th}$ case from the group until the required sample is obtained (Polit and Hungler, 2003)
3.7 Data collection methods

The instruments used to collect data in this study were structured interviews. Face to face interview, according to Brunt (1997) were the best instrument available because it allowed collection of in depth data. It allowed flexibility and clarification of questions as the interviewer could modify the line of inquiry to enable the interviewee to understand (Borg and Gall, 1997). The interview allowed probing of interesting responses and observation of the non verbal responses (Polit and Hungler; 2004). Since the information in this study is sensitive, observation of body language was very important and called for probing, to bring out sensitive information. In addition the interview allowed the researcher to explain the purpose of the interview so as to gain cooperation which was essential in order to get the effects sexual violence is having on the women.

However, Merrian and Simpson (2000) explain that an interview can create fear, anxiety and suspicion or even humility depending on how it is carried out. This was rectified by the use of communication skills which show understanding and empathy to enable the interviewee to relax (Buchanan and Bryman; 2009). The researcher being a nurse has experience in eliciting confidential information from clients hence did not have problems in this area. The use of open ended question allowed the interviewee to express feelings thus giving the researcher leads which were followed up and more data obtained (Borg and Gall; 1997). In this study it was very important to elicit feelings of the respondents as they gave a clue to psychological effects which the victim may not have been aware of.
3.8 Data collection procedures

Using the counselors at the institutions to gain trust of the sexually violated, interviews were done at the institutions (Msasa Project and Gweru District Hospital). The interview was recorded (after consent was given) to allow capturing of all the details so that no information would be missed during analysis. Interviews of the control group were done at Gweru Provincial Hospital.

Focus group

A focus group is an organised discussion of 6 to 12 participants lasting 1 to 2 hours. The discussion was structured in a flexible way to provide an opportunity for respondents to participate. The focus group technique involves a moderator facilitating discussion on a particular topic. (Straus and Corbin, 2008) This was a way of drawing out information even from the shy ones and also from those who were violated but did not report. The advantage of a focus group was that an idea developed by an individual was developed and explained more thus a lot of information was obtained in a short time. Focus groups are also a tool of gaining information on participants’ views, attitudes and beliefs on a topic (Buchanan and Bryman; 2009). The focus group discussion provided answers on the types of sexual violence women encounter, their attitude towards sexual violence and the type of health problems women encounter after sexual violence. This discussion was also recorded so that no data would be missed during analysis but consent was sought first.
Analysis of documents

Document analysis was done to answer the research question: how is the health of women affected by sexual violence? This is a formal and systematic qualitative method of obtaining data. It involved selection of relevant documents to analyse in depth. (Denzin and Lincoln; 2000). In this study, analysis of victims’ documents from the hospital was done to identify the effects of the violence from a professional’s point of view.

3.9 Data presentation and data analysis

Data obtained was presented using statistical methods for easy interpretation and analysis according to the objectives. Descriptive data was computed for each comparison group that is psychological effects, reproductive effects and physical effects to allow comparison and quantification. Descriptive Statistics included Mean and the Standard Deviation of all the dependent variables. Inferential Statistics was done using the ANOVA method to analyse the results so as to determine the effect of the independent (non manipulated) variable on the dependent variable. The ANOVA allowed the researcher to determine the interaction between the independent variable and the dependent variable. The paired t-test was also used to analyse quantitative data to augment the ANOVA. Whilst the ANOVA analyses the variance between and within group, the t-test measured the significance level using the average means. At significant level 0.05 or less, the null hypothesis was rejected. To avoid the type 1 error of rejecting the null hypothesis when it is correct, the Chi Square was also used to analyse
the data. The chi square assesses the difference between the frequencies of occurrence of the dependent measure.

The dependent variables in the study were the health effects on the women. These were the reproductive, psychological and physical health problems and HIV and STI. The dependent variable was sexual violence. Data obtained by document analysis and from focus groups was analysed qualitatively. The data was coded, categorized and classified before comparisons and conclusions are drawn.

3.10 Validity and Reliability

Treece and Treece (2000) define validity as the ability of the instrument to answer the research problem which in this case was to identify the effects of sexual violence on the health of women. However the problem of validity with a causal-comparative research was that it was impossible to randomly assign subjects to the various groups and that extraneous variables could not be controlled or eliminated (Fraenkel & Wallen, 2000). Never the less, this could be reduced by pair matching, comparing homogeneous groups, and analysis of covariance (Polit and Hungler; 2004). In this study the researcher compared homogenous subgroups and analysed covariance in an effort to improve validity. The researcher divided each group into subgroups according to age and marital status and then compared the subgroups.

The researcher used the triangulation method to obtain data in an effort to improve validity. The data collection methods that were used in this study are interviews, questionnaires, focus groups and document analysis. Methodological triangulation
involves the use of multiple qualitative and/or quantitative methods to study the problem. For example, results from interviews, focus groups, and documentary analysis were compared to see if similar results are being found. If the conclusions from each of the methods are the same, then validity is established (Patton, 2002). Thus, using triangulation adds a depth to the results that would not have been possible using a single-strategy.

### 3.11 Ethical considerations

Matters of sex are private and not easy to talk about to strangers, therefore respondents need to be strongly reassured of confidentiality and anonymity. They were reassured that no name would appear anywhere such that even the researcher would not even know who said what. The respondents' were also assured that the information obtained would only be used for the purpose of the study. Informed consent was also sought from the subject who entered into the study willingly. They were asked to sign the consent forms whose contents were explained to them before signing. The subjects were reassured that they would retain the right to withdraw from the study whenever they felt the need. Permission to carry out the research was sought from the institutions involved and the Medical Research Board.

### 3.12. Summary

The research methodology used for this study was a mixed methodology which was mainly qualitative with quantitative embedded. The pragmatic paradigm was chosen to guide the research since it allows triangulation of methods. The casual comparative
design was used to compare the sample and control groups to find the effects of sexual violence. A sample of 30 women who were sexually violated was obtained from Msasa Project and Gweru Hospital using the purposive sampling method where the snowballing technique was applied. The convenient sampling method was used to obtain a control group of 30 women who were not sexually violated according to the responses of the questionnaire. Data was obtained using face to face interviews of the sample and control group, documentary analysis of case files of sexually violated women and focus group discussions. Data was analysed using both quantitative and qualitative methods. Ethical issues were observe before and during data was collection
4.0. Introduction

In order to find out the effects of sexual violence on the health of women, data was collected through interviews, questionnaires, focus groups and documentary analysis. The triangulation method was used to improve validity of the results. The results were presented in tables, charts and graphs for easy comparison of the sample and the control group. The statistical presentation of data also makes analysis easy. The data is presented under the headings; biographic data, assessment of sexual violence, types of sexual violence, effects of sexual violence and attitudes of women towards sexual violence.

4.1 Biographic data

Data was collected from the sample group, control group and hospital documents of reported cases of sexual violence and from focus groups. The biographic data is the data pertaining to age, marital status and level of education.

4.1.1 Age

The age group of the women in this study is 16 years to 35 years and these are the women who are sexually active and are still in their reproductive age. The focus groups were determined by the ages of women so that they could interact easily. The ages of
the high school girls ranged from 16 - 19 years, whilst those of the college girls ranged from 19 – 26 years. The ages of the church women focus group ranged from 20 – 35 years.

The ages of the women who were interviewed were divided into 4 age groups of 5 year interval. For interviews, the women were also divided into two groups, the sample which comprised of sexually violated women and the control which comprised of none sexually violated women. Each group had a total of 30 women who were matched for age so as to improve on validity. A documentary analysis of sexually violated women who had been attended at Gweru Hospital was also done and a total of 30 records were randomly selected. Table 4.1 shows the distribution of sexual violence women according to their age group.

**Table 4.1 Distribution of women according to age**

**N = 30**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Sample</th>
<th>Control</th>
<th>Documentary analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
<td>Number</td>
</tr>
<tr>
<td>16 - 20</td>
<td>8</td>
<td>27</td>
<td>8</td>
</tr>
<tr>
<td>21 - 25</td>
<td>7</td>
<td>23</td>
<td>7</td>
</tr>
<tr>
<td>26 - 30</td>
<td>7</td>
<td>23</td>
<td>7</td>
</tr>
<tr>
<td>31 - 35</td>
<td>8</td>
<td>27</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
<td>30</td>
</tr>
</tbody>
</table>
The 16 - 20 years age group had 8 women (27%) for the sample and control group whilst from the documentary analysis, this age group constituted 43% of the women who were sexually violated. The 21 -25 years age group had 7(23%) women. On the other hand, 8 (27%) of the documents analyzed were in the 21 – 25 age group. The 26 – 30 years age group had 7 women comprising of 23% whereas there were 4 (13%) documents for this age group. Finally there was the 31 – 35 years age group which had 8 women which comprised of 27% of the women and 5 (17%) documents for this age group.

Findings from the interviews show that the mostly abused age group is the 16 – 20 with a 27%. In the same vein, documentary analysis revealed that the most vulnerable age group is 16 -20 which accounted for 43% of the documents randomly selected for analysis. This age group consists mainly of adolescence and this supports the claims of the World Sexual Violence Report (2011) that most adolescents are initiated into sex by force. The findings also support Watts & Zimmerman (2002) who report that up to one-third of adolescent girls reported their first sexual experience as being forced. They also concur with the findings of a study by Caceres et al (2000) which showed that 40% of young women reported that their sexual initiation was forced. In addition to this, Halco’n et al (2000) also found that 50% of women in a European multi country study reported that their first sexual intercourse was forced. These findings are supported by a number of studies, from sub-Saharan Africa, indicating that the first sexual experience of girls is often unwanted and forced (World Sexual Violence Report, 2011). Considering the research findings and the supporting literature, the researcher therefore links this high percentage of sexual violence to adolescents as forced initiation supported by the
culture which encourages men to use force since the girl is expected to be submissive but initially refuses.

Another 27% of the interviewed women fell into the 31-35 age groups. However, from document analysis 17% of the women in this age group had been sexually violated. Although there is a difference in the percentages, the figures were significant to raise concern from the researcher that this age group is still violated despite their advanced ages. Since they were already initiated into sex, the violence could be because of intimate partner violence. The percentage is lower in those women who were attended at the hospital for sexual violence maybe because the women find it difficult to report their partners for sexual violence. This is in accordance with the WHO report which says that sexual assault by an intimate partner is neither rare nor unique to any particular region of the world (WHO; 2000). The report goes on to list percentages of women who were sexually violated by their intimate partners, for instance, 23% of women in North London, England, reported having been the victim of either an attempted or completed rape by a partner in their lifetime. Similar figures have been reported for Guadalajara, Mexico (23.0%), Leo´n, Nicaragua (21.7%), Lima, Peru (22.5%), Canada 8.0%, England, Wales and Scotland(combined) 14.2%, Finland 5.9%, Switzerland11.6% and the United States 7.7%),(WHO;2000). With this evidence the researcher feels that intimate partner violence is occurring but the women are bound by culture such that few women will report the men who paid lobola for her for sexual violence.
4.1.2 Marital status

The marital status of the women was assessed in relation to sexual violence to note if there is a relationship. Figure 4.1 shows the distribution of sexual violence in relation to marital status.

![Pie chart showing marital status distribution](image)

**Fig 4.1  Marital Status**

The women who were married constituted 76%, the divorced 12%, widowed 10% and the single 2%. The majority (76%) of the respondents were married. Since 76% of the sexually violated women are married, then the perpetrators of the sexual violence are their intimate partners. These findings are in consensus with Statistics from the Royal Women’s Hospital Journal which revealed that 23% of women who had been married or in a de facto relationship experienced violence by a partner at some time during the relationship. The high percentage of sexual violence in married women could be that the
marriage was a cover up by sexual violence by a boyfriend as stated by Heise (1994), that in some societies, the cultural “solution” to rape is that the woman should marry the rapist, thereby preserving the integrity of the woman and her family by legitimizing the union. This practice is common in the Shona culture which views any sexual relationship with an unmarried girl as unlawful unless sanctioned by marriage (Holleman, 1997). Thus the researcher attributes the high prevalence of sexual violence in married women to intimate partner violence and to marriages occurring as a result of sexual violence. These findings support the findings of a survey conducted by WHO in the Midlands Province of Zimbabwe on intimate violence which revealed that 25% of the 966 women interviewed, reported sexual violence by a husband or a boyfriend.

4.1.3 Level of Education

The other biographic data assessed in relation to sexual violence is the level of education of the women. The researcher wanted to find out if there was any relationship between level of education and sexual violence. Table 4.2 shows the level of education of the women who were violated.
Table 4.2 Level of Education

N=30

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Number of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Secondary</td>
<td>18</td>
<td>60</td>
</tr>
<tr>
<td>Tertiary</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

The violated women with primary education were 2 which is 7%. Those with secondary education were 18 (60%) with the remaining 10 (33%) of the women having tertiary education. One would assume that the women who are sexually violated are illiterate and do not know about human rights. However all the women who were sexually violated are literate so they can understand their sexual rights but they are still violated. This could be that they are not empowered or it could be because of their culture. The culture aspect is supported by Chimhundu (1995) who depicts sexual relations to involve victory and conquest on the part of the male, and defeat and surrender on the part of the female. Even if the majority (60%) of the women has attained secondary education and 33% attaining tertiary education, they are still violated sexually. The
assumption is that sexual violence has nothing to do with the level of education or knowing one’s rights but maybe linked to the culture of the individual.

In addition, the theory of reasoned action explains the action taken by the women after being sexually violated as the person’s reaction is governed by the beliefs about what the important or significant people think should be done and also by the individual’s motivation to comply with those other people’s wishes. So if the significant person in the woman’s life is the boyfriend or spouse and she believes in him, then she will be violated despite her level of education.

4.2 Assessment of sexual violence

In order to obtain the control group, the researcher gave the women who were attending Ante Natal Clinic (ANC) or Post Natal Clinic (PNC) at Gweru Hospital questionnaires to assess sexual violence. The women were asked questions on whether they had been raped, coerced into sex, sexually harassed, involved in forced commercial sex or forced into marriage. A woman who answered yes to any of these question means she would have been sexually violated. The women who answered no to all the questions means she had never been violated and these are the women who formed the control group. The results are tabulated in table 4.3
Table 4.3 Results of sexual violence assessment

N=50

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexually violated women</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>None sexually violated</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

A total of 50 women were given the questionnaire and 30 women (60%) were not sexually violated whilst 20 women (40%) were sexually violated. The 30 women (60%) who were not sexually violated formed the control group. However the findings show that sexual violence is rampant and is under reported as stated by Sadik (2002) who points out that sexual violence occurs throughout the world, although in most countries, due to its private nature, estimating the extent of the problem is difficult. This is also supported by Schwartz (1997) who suggested that sexual assault is one of the most under-reported crimes where ‘there are numerous “hidden” victims who do not report their victimisation to the police or to health officials, making them invisible in official statistics’. The 40% of the women who responded to the questionnaire to assess sexual violence were sexually violated but did not report to the police or health official hence are the ‘hidden victims.’ These findings also support Putt & Higgins, (1997) who claim that crime victimisation survey data continue to underestimate the extent of violence
against women. The fact that 40% of the women who responded to the questionnaire had been violated but did nothing about shows that it is not easy for the woman to report sexual violence. Some of the women indicated that they had been violated by their husbands or boyfriends with some having been violated by relatives hence this made it difficult to report. This supports the theory of reasoned action because the perpetrators mentioned were significant people in the woman’s life so they could not report.

4.3 Types of sexual violence

The types of sexual violence that the women encountered were assessed in order to find out how women are sexually violated as well as to assess if women are aware of the types of sexual violence. This data was collected from questionnaires, interviews as well as from focus group discussions. The data from the assessment of sexual violence revealed that 40% of the respondents had been violated but the cases were not reported. Table 4.4 shows the types of sexual violence that these women encountered whilst Figure 4.2 compares the types of sexual violence known by the sample and control groups.
Table 4.4  Types of sexual violence encountered by women

N=20

<table>
<thead>
<tr>
<th>Type of sexual violence</th>
<th>Number of respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coercion</td>
<td>18</td>
<td>90</td>
</tr>
<tr>
<td>Rape</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>Forced prostitution</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Forced marriage</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

The types of sexual violence encountered by the women who were sexually violated are coercion, rape and forced marriage. Coercion had a frequency of 90% which was followed by rape with a frequency of 40%. Forced marriages had a frequency of 10% whilst forced prostitution had none. These results echo the sentiments of Johnson (1992) who explains that if a woman resists sexual advances, she can be physically forced or coerced into submission. In many societies, according to Ncube (1998), women are treated as the property of men who keep them under subjectivity and to do as told without any question thus subjecting them to sexual violence. In addition, Kambarami (2007) concludes that culturally, women have no sexual rights as a result men can use them as a sexual toy as long as the man is satisfied.
The results shown in table 4.4 reveals the types of sexual violence that the women encountered but what are the types of sexual violence known to women. These are shown in Figure 4.2 which compares the types of sexual violence known by the sample group to those known by the control group.

![Figure 4.2 Types of Sexual Violence Known to Women](image)

Seventy percent (70%), of the sample group knew about rape compared to 53% in the control group. Maybe more women in the sample group knew about rape than those in the control group because they physically experienced it. The knowledge on sexual coercion was almost the same in the two groups and that is 37% for the sample group and 40 % for the control group. Sexual harassment as a type of sexual violence was known by 7% of the sample and 10% of the control group. The women had knowledge on the types of sexual violence although none of them were aware that sexual
trafficking and forced marriage are forms of sexual violence. Since the women in the two groups are not aware that forced marriage is a form of sexual violence, they may be easily be forced into marriage and may not do anything about it. On the same note they may be involved in commercial sex as a form of employment.

On the other hand, focus group discussions of high school girls and college girls revealed that they were knowledgeable on types of sexual violence. The girls brought up sexual trafficking as a form of sexual violence and also talked about parents forcing their daughters into marriage by chasing them away from home when they get pregnant or when they come home late. The scenario was however different with the church women who argued that the bible is very clear on what should be done if a man sleeps with a girl outside marriage. “The Bible says that these two should marry to preserve the honour of the girl and that of her parents so they are not forced into marriage but they decided to get married when they slept together,” argued one of the church women and the other women seemed to agree on this. This argument supports Heise (1994) who claims that in some societies, the cultural “solution” to rape is that the woman should marry the rapist, thereby preserving the integrity of the woman and her family by legitimizing the union.

From these findings, it can be observed that young women like high school girls and college girls are knowledgeable on the types of sexual violence. This may be because of the introduction of gender courses at all levels of education. However, the argument brought up by the focus group church women makes it apparent that what others term
sexual violence may not be violence to other sectors of society and this makes it difficult to have a clear cut definition of sexual violence.

4.4.1 Effects of sexual violence on health

In order to effectively assess the effects of sexual violence, five variables were used namely reproductive, psychological, physical, HIV and STI. Since there are two groups (sample and control), the variables are represented as rep1 and 2, psych 1 and 2, physical 1 and 2, hiv 1 and 2 and sti 1 and 2. The results from the control group (not violated) were coded 1 and that from sample (sexually violated) were coded 2. These variables were measured against the independent variable, sexual violence, to assess if the independent variable has any effect on the reproductive, psychological and physical health of the women. The results from the sample and the control group were then compared to find out if the health of the women who were sexually violated (sample group) was affected in relation to those not sexually violated (the control group). The data was analysed using the ANOVA and the t-test to test the hypothesis below.

$H_0$: There is no difference in reproductive, psychological and physical health between sexually violated and none sexually violated woman

$H_1$: There is a difference in the reproductive, psychological and physical health between sexually violated and none sexually violated women.

At a significance level of 0.05 or less we reject the null hypothesis. The SPSS was used to analyse data
Table 4.5  ANOVA test results

<table>
<thead>
<tr>
<th></th>
<th>sum of squares</th>
<th>df</th>
<th>mean square</th>
<th>f</th>
<th>sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>reproductive effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>between groups</td>
<td>2.400</td>
<td>1</td>
<td>2.400</td>
<td>11.60</td>
<td>.001</td>
</tr>
<tr>
<td>within groups</td>
<td>12.000</td>
<td>58</td>
<td>.207</td>
<td></td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>14.400</td>
<td>59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>psychological effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>between groups</td>
<td>3.267</td>
<td>1</td>
<td>3.267</td>
<td>16.14</td>
<td>.000</td>
</tr>
<tr>
<td>within groups</td>
<td>11.733</td>
<td>58</td>
<td>.202</td>
<td></td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>15.000</td>
<td>59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>physical effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>between groups</td>
<td>4.267</td>
<td>1</td>
<td>4.267</td>
<td>29.69</td>
<td>.000</td>
</tr>
<tr>
<td>within groups</td>
<td>8.333</td>
<td>58</td>
<td>.144</td>
<td></td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>12.600</td>
<td>59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>between groups</td>
<td>1.067</td>
<td>1</td>
<td>1.067</td>
<td>6.40</td>
<td>.014</td>
</tr>
<tr>
<td>within groups</td>
<td>9.667</td>
<td>58</td>
<td>.167</td>
<td></td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>10.733</td>
<td>59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>between groups</td>
<td>1.350</td>
<td>1</td>
<td>1.350</td>
<td>10.25</td>
<td>.002</td>
</tr>
<tr>
<td>within groups</td>
<td>7.633</td>
<td>58</td>
<td>.132</td>
<td></td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>8.983</td>
<td>59</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The variance between and within groups was analysed using the ANOVA. The results of the ANOVA show that the variance between and within groups for reproductive health are significant at 0.01 so we reject the null hypothesis since the significance is less than 0.05. So there is a difference in the reproductive health between sexually violated and
none sexually violated women. This difference could be attributed to sexual violence. However there may be other causes but Campbell et al (2009) link sexual violence to a multiple of reproductive health problems with both immediate and long-term consequences. The multiple reproductive health problems as cited by Campbell et al (2009) include gynaecological, obstetrics and sexually transmitted infections including HIV/AIDS.

HIV and STI are reproductive health problems which can separately be linked to sexual violence. However the variances are at a significant level 0.014 and 0.02 respectively. Since they are less than 0.05, we then reject the null hypothesis. Thus the infections of HIV and STI are different in the sample and control group. The difference may be due to sexual violence as supported by Jenny et al (2004) who postulate that HIV and STI are recognised consequences of rape.

The variance within and between group for psychological effects was at 0.00, hence the null hypothesis is rejected. This means that there is a difference in psychological health for women who are sexually violated and those not violated. The difference may be attributed to sexual violence and is supported by the findings of Mullen at al (1998) that there is a prevalence of psychological disorder in 33% of sexually violated women.

The variance within and between groups for physical health was at significant level of 0.00 so we reject the null hypothesis. This shows that there are differences in physical health between sexually violated and none violated women. Whilst the researcher cannot rule out other causes other than sexual violence, the results are supported by
Holcomb (2010), who claims that there are immediate physical effects of sexual violence such as body injuries and pain.

To validate the ANOVA, the hypothesis was also tested using the t-test which tests significance levels using the average means. The paired t-test was used since the data was in two groups. The variables were labeled 1 for those not sexually violated and 2 for those who were violated. The results of the t-test are shown in Table 4.6

**Table 4.6 T-test results**

<table>
<thead>
<tr>
<th></th>
<th>Paired difference</th>
<th>T</th>
<th>Df</th>
<th>Sig (2tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>Std deviation</td>
<td>Std Error mean</td>
<td>95%conf. int. of difference</td>
<td>Lower</td>
</tr>
<tr>
<td>Sexual violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pair 1 Pys1,2</td>
<td>-4666 .6288</td>
<td>.1148</td>
<td>-7014</td>
<td>-2318</td>
</tr>
<tr>
<td>Pair 2 Rep1,2</td>
<td>-4000 .5632</td>
<td>.1028</td>
<td>-6103</td>
<td>-1896</td>
</tr>
<tr>
<td>Pair 3 Phys1,2</td>
<td>-5333 .5074</td>
<td>.0926</td>
<td>-7228</td>
<td>-3438</td>
</tr>
<tr>
<td>Pair 4 Hiv1,2</td>
<td>-2333 .6260</td>
<td>.1143</td>
<td>-7671</td>
<td>-0004</td>
</tr>
<tr>
<td>Pair 5 Sti1,2</td>
<td>-3000 .5349</td>
<td>.0976</td>
<td>-4993</td>
<td>-1002</td>
</tr>
</tbody>
</table>

*Group 1-not sexually violated; Psy-psychological effects*
Group 2: sexually violated;  

Phys-physical effects

Reproductive effects

The mean of psychological effects had a significance of 0.00 which is less than 0.05 so we reject the null hypothesis which says there is no difference in psychological health between sexually violated and none sexually violated women. These results are similar to those of the ANOVA. Therefore sexual violence can affect the psychological health of women.

In reproductive health the significant level was at 0.001 which is also the same with the ANOVA. Again we reject the null hypothesis and say that sexual violence can affect the reproductive health of women.

The level of significance for the physical health was at 0.00 which is still the same with that of the ANOVA. The null hypothesis is therefore rejected meaning that there is a difference in physical health between the sexually violated and the none sexually violated women.

STI had a significant level of 0.005 which is also less than 0.05 so the null hypothesis is rejected. The significant level from ANOVA was 0.02 which is also less than 0.05 so this means that sexual violence can result in sexually transmitted infections. HIV had a significant level of 0.05 which is equal to 0.05 so we accept the null hypothesis that there is no difference in HIV in sexually violated and none sexually violated women. This may mean that HIV infection is not only acquired through sexual violence. However, these results are in contrast with the ANOVA results which show that there is a significant difference in HIV between the sexually violated and those not violated.
However, Jenny et al (1990) noted a particularly high risk of HIV and other sexually transmitted diseases in women who had been trafficked into sex work.

To avoid type 1 error where we can reject $H_0$ when it is true, the chi square was used to test the hypothesis. The chi square was also used to analyse the relationship between sexual violence and the health of women. The results of the analysis of data using the chi square are shown in Table 4.7.

**Table 4.7 Results of chi square test**

<table>
<thead>
<tr>
<th>sexual violence</th>
<th>reproductive effects</th>
<th>psychological effects</th>
<th>physical effects</th>
<th>HIV</th>
<th>STI</th>
</tr>
</thead>
<tbody>
<tr>
<td>violated</td>
<td>chi-square(a)</td>
<td>10.800</td>
<td>6.533</td>
<td>26.133</td>
<td>16.133</td>
</tr>
<tr>
<td>df</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>asymp. sig.</td>
<td>.001</td>
<td>.011</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>not violated</td>
<td>chi-square(a)</td>
<td>1.200</td>
<td>6.533</td>
<td>.533</td>
<td>2.133</td>
</tr>
<tr>
<td>df</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>asymp. sig.</td>
<td>.273</td>
<td>.011</td>
<td>.465</td>
<td>.144</td>
<td>.068</td>
</tr>
</tbody>
</table>
There is a significance level of 0.001 in reproductive health for the sexually violated women (sample group). So for the sample group, the null hypothesis is rejected. For the control group (those not violated), the significant level is 0.273 which is more than 0.05 so the null hypothesis is accepted. What this means therefore is that sexual violence can affect the reproductive health of the women as shown by the chi-square, ANOVA and t-test which all rejected the null hypothesis.

For the psychological effects, there was a significance level of 0.01 for both the violated group and the non violated group. The null hypothesis is rejected in both groups. This means that psychological problems do occur but not necessarily because of sexual violence only. However, this is contrary to Briggs & Joyce (1997) who found sexual violence to be associated with a number of mental health and behavioural problems in adolescence and adulthood. However, the ANOVA and the t-test reject the hypothesis.

The association of physical health effects and sexual violence had a significance level of 0.00 for the sexually violated women so we reject the null hypothesis. This means that there is a relationship between sexual violence and physical health. On the other hand, there was a significance level of 0.46 in the control group, so the null hypothesis is accepted meaning there is no relationship. From these results, the ANOVA and t-test, sexual violence can lead to physical health problems.

The association of HIV and STI to sexual violence had a significance level of 0.00 in the sexually violated group so for both cases the null hypothesis is rejected. The situation is different for none sexually violated group whose significance levels were 0.14 for HIV and 0.68 for STI. The significant levels are more than 0.5 so the null hypothesis is
accepted. These results show that there is a relationship between sexual violence and STI and HIV. In the t-test the null hypothesis was accepted for HIV but because of these results and ANOVA, there may be a relationship between sexual violence and HIV.

The results of the hypothesis tests were then compared with descriptive analysis of the interview results and evaluated against the findings of the documentary analysis and focus group discussions.

Documentary analysis was done to find out the effects of sexual violence on the health of women from the professional perspective. This was done to validate the data obtained from the interviews. Figure 4.3 depicts the health problems identified on the victims’ case files.

Figure 4.3  Effects of Sexual Violence
The effects on health which the sexually violated women encountered were pregnancy (20%), STI (10%), HIV (28%) and physical injuries (12%). If the woman reports within 72 hours, pre-test on HIV, pregnancy test and STI are done then they are given a review date to repeat the tests. This is done to determine whether the effect was a result of the violence or it was pre-existing before the violence. The results shown in Figure 4.10 were a result of violence since they manifested on the repeat test. These findings and the results of the statistical test indicate that sexual violence has an effect on the health of women. Three of the effects which resulted from sexual violence, that is, pregnancy, STI and HIV are all reproductive health problems so the researcher assumes that the common health problem occurring as a result of sexual violence in women is the reproductive health. If we compare these results to the ANOVA, t test and chi square, which all rejected the null hypothesis that there is no difference in reproductive health between sexually violated and non sexually violated women it is therefore observed that reproductive problems can result from sexual violence.

Injuries are a physical health problem and have 12% prevalence to the victims. The ANNOVA and t-test also rejected the null hypothesis that there is no difference in the physical health of sexually violated and non sexually violated women. This implies that sexual violence has effects on the physical health of women. Therefore findings of the documentary analysis compliment the statistical analysis of the effects of sexual violence on the health of the women when they seem to agree that sexual violence can affect the health of women.
The effects encountered by the victims as documented in their case files were analysed in relation to age in an effort to evaluate the age group which is mostly affected. The results are shown in Figure 4.4.

**Figure 4.4  Distributions of Effects According to Age Groups**

In Figure 4.4, 20% of the violated women ended up pregnant. The pregnancies however were restricted to younger women with 80% of the pregnancies affecting the 16-20 age group and remaining 20% affecting the 21-25 age group. Sexual violence according to Boyer & Fine (1992) may result in pregnancy, but the rate varies depending on the extent to which non barrier contraceptive are being used. The researcher therefore assumes that the older women (25-35 years) may have been using some form of non barrier contraception resulting in them not getting pregnant.

Of the sexually violated, 24% contracted HIV. This shows that HIV is prevalent in sexually violated women. The findings appear to support Hakimi et al (2001), who say that the risk of HIV increases with forced sex due to the forced penetration and
abrasions which occur. The risk is higher in the younger women with a 50% in the 16-20 age group and 33% in the 21-25 age group. The findings concur with Matasha et al (1998) who claim that adolescent girls are particularly susceptible to HIV infection through forced sex because their vaginal mucosa has not yet matured. Thus this age group could have been affected more because of their immature vaginal mucosa which can tear or bruise easily increasing the chances of getting infected.

The results show that 12% of the sexually violated suffered some form of physical injury. 83% of the injuries were genital and occurred in the 16-25 age group while 17% of the injuries were non genital and occurred to the 31-35 age group. Genital injuries occurred to the younger age group maybe because their mucosa is not yet mature as claimed by Matasha et al (1998). The 16-25 age group could have been affected more due to tearing and bruising of the genital mucosa as it is still immature. It may also have been due to forced initiation which can be very traumatic resulting in genital injury.

4.4.2. Reproductive effects

The women in the sample and control group were assessed to identify the prevalence of reproductive health problems and the results were compared between the two groups. The findings are tabulated in Table 4.8
Table 4.8  Prevalence of reproductive health effects in sexual violence

N=30

<table>
<thead>
<tr>
<th>Effect</th>
<th>Sample</th>
<th></th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
</tr>
<tr>
<td>Reproductive effects</td>
<td>Yes</td>
<td>17</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>13</td>
<td>43</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

The women who were violated had a 57% frequency of reproductive health problems against a 30% in the control group. Forty three percent (43%) of the sample did not experience any reproductive health problem against 70% of the control group. From these figures the prevalence rate was 0.57 for reproductive health problems in sexual violence. This rate is quite high meaning that sexual violence can actually lead to reproductive health problems. The findings are the same as those from the ANOVA, t-test and chi square. The results strongly support Campbell (2009), who noted that sexual violence has an increased risk of a range of reproductive health problem, with both immediate and long-term consequences. The range of the reproductive health problems which were encountered by the sexually violated and none violated women are shown in Figure 4.5 where they are compared.
Figure 4.5 Reproductive Health Effects.

From Figure 4.5, it is apparent that the women in the sample group, that is the sexually violated women, had more reproductive health problems as compared to the control group - those not sexually violated. This therefore validates the results of the statistical analysis which rejected the null hypothesis that there is no difference in the reproductive health of women between the sexually violated and the none sexually violated.

Sexual dysfunction in violated women had 70% against 7% in the control group. The sexual dysfunction mentioned in the interviews was lack of libibo and dyspareaunia which is pain during intercourse. In the sexually violated women, Coker et al (2000) points out that decreased sexual desire can occur as a result of genital irritation, pain
during intercourse, chronic pelvic pain, urinary tract infections and vaginal bleeding or infection. The lack of sexual desire in the violated women could be due to the pain experienced during forced penetration when the woman was not ready. Kehler (2006) also outlines other gynecological disorders associated with sexual violence as to include sexual dysfunction which involves difficulty in orgasms or lack of desire. The author goes on to say this will result in conflicts over the frequency of sex which may exacerbate the sexual violence. In other words, this means that the woman will refuse sex due to the pain and the partner will force himself on her causing more pain until the woman loses interest in sex completely. This will then foster continuous cycle of sexual violence.

Chronic pelvic pain had 10% in the sample group against 0% in the control group. This identifies with the findings of Kehler (2006) in which chronic pelvic pain accounts for as many as 10% of all gynecological visits and one-quarter of all hysterectomies in the USA. In addition, sexual abuse in childhood has been linked to increased sexual risk-taking and thus to STIs, which can lead to chronic pelvic pain, often due to pelvic inflammatory disease (Holmes et al, 2000). The chronic pelvic pain leads to loss of libido and dyspareunia which can result in sexual violence and thus create a vicious cycle.

The women who got pregnant constituted 43% of the sample whilst in the control group, the frequency was 13 %. This supports observations by Boyer & Fine (1992) who noted that pregnancy may result from rape, though the rate varies between settings and depends particularly on the extent to which non-barrier contraceptives are being used.
Campbell (2009) goes on to explain that sexual violence strips the sexual autonomy of the woman and can result in unwanted pregnancy. If a woman is stripped of her sexual autonomy, she cannot make decisions about contraceptive hence according to Boyer & Fine (1992), she can easily fall pregnant because of the sexual violence. The findings of this study are similar to the findings of a study by McFarlane (2005) in Texas which indicated that 20% of the women who were sexually violated became pregnant.

As for abortion, the sample group had a frequency of 17% whilst the control group had 7%. This appears to support Boyer, (1998) who claims that two thirds of sexually violated adolescent girls get pregnant with 80% of them opting for abortion irrespective of whether it is safe or not. In addition, Aterbet, (2002) argues that incest often results in pregnancy which is covered by abortion, often initiated by the abuser. From the interviews, some of the women verbalized that the abortions were initiated by their mothers or boyfriend’s. So the decision to abort was decided by another person. This behavior is explained by the theory of reasoned action where the decision is made to please the significant person in the woman’s life. However, there is an alternative to abortion which is marriage. Holmes (1996) observed that, in many countries, women who have been raped are forced to bear the child or else put their lives at risk with back-street abortions.

STI and HIV are also reproductive health problems but they were analysed separately in order to come up with their prevalence in sexual violence. The prevalence of STI is shown in Table 4.9 where the frequencies in the sample and control group are
compared. That of HIV is depicted in Table 4.10 where the two groups are also compared.

Table 4.9 Prevalence of STI

N=30

<table>
<thead>
<tr>
<th>Effect</th>
<th>Sample</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>percentage</td>
</tr>
<tr>
<td>STI</td>
<td>Yes</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>30</td>
</tr>
</tbody>
</table>

The women who were sexually violated had a frequency of 33% in STI against a 3% in the control group. Thus the prevalent rate for STI in sexually violated women is 0.33 which is very high. As for HIV, the prevalence is shown in Table 4.10.
Table 4.10  Prevalence of HIV

N=30

<table>
<thead>
<tr>
<th>Effect</th>
<th>Sample</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>HIV</td>
<td>Yes</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

HIV infection in the sexually violated women had a frequency of 37% against a 6% in the control group. Thus the prevalent rate of HIV in the sexually violated women was 0.37 which is very high, especially when compared with the ministry of health’s advocacy of 0 prevalence of HIV. The high prevalence rates of STI including HIV/AIDS are backed by the results of the statistical analysis from the ANOVA and the chi-square which seem to suggest that these infections are linked to sexual violence. In support of this, Naker and Michau (2004) points out that forced prostitution and marital rape puts the woman at a high risk of sexually transmitted infections (STI) and HIV/AIDS. these findings are also supported by Jenny et al (1990) who noted a particularly high risk of HIV and other sexually transmitted diseases in women who had been trafficked into sex work.
The risk of STI and HIV infection according to Winghood et al (2000) is increased in sexual coercion and it is the most frequent type of sexual violence accounting for 90% of the types of sexual violence in this study. Coercion by a spouse into unprotected sex, when the man knows that he has been unfaithful results in the woman contracting the infection. Studies conducted in the United States by Kalishman(1998) show that women in violent and abusive relationship are less likely to use condoms, let alone request them, hence are more likely to contract STI including HIV than other women (Kalichman,1998). The association between sexual violence and risk for HIV/STI has also been observed in Southern Africa in a study by Adjuon (2002). On the same note, Buga (1996) observed that women who experience forced sex in intimate relationships often find it difficult to negotiate condom use either because using a condom could be interpreted as mistrust of their partner or as an admission of promiscuity. In some cases the women fear experiencing violence from their partners by advocating for a condom hence risk the infection.

4.4.3. Psychological Effects of Sexual Violence

The women in the sample and control groups were interviewed to assess if there is an association between sexual violence and psychological health problems. The results of the two groups are shown in Table 4.11 where they are compared.
Table 4.11 Prevalence of Psychological Effects

N=30

<table>
<thead>
<tr>
<th>Effect</th>
<th>Sample</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>percentage</td>
</tr>
<tr>
<td>Psychological effects yes</td>
<td>20</td>
<td>67</td>
</tr>
<tr>
<td>Psychological effects no</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

The percentage of psychological problems in sexually violated women was found to be 67% against a 6% in the control group. This high prevalence compares favourably with the results of the ANOVA and t-test which showed that there is a difference in the psychological health of violated and none violated women. The findings concur with the study by Briggs & Joyce (1997) who found sexual violence to be associated with a number of mental health and behavioural problems in adolescence and adulthood with a prevalence of 33%. The different types of psychological problems which were encountered by women in this study are shown in Figure 4.6.
Figure 4.6  Psychological Effects of Sexual Violence

From Figure 4.6, it is evident that women who were sexually violated had a higher percentage of psychological effects as compared to none violated women. Insomnia with 12%, shame 42% and suicidal tendencies 33% were found in the sample group only. The women who were violated tended to suffer more from stress which had a 43% compared to 8% in the control group. As for self blame, it was experienced by 62% of sample compared to 2% of the control group. These findings show that women who were sexually violated are the ones who experienced psychological problems compared to those not violated so sexual violence can affect the psychological health of women.

The psychological disorder of self blame had a frequency of 62% which is very high. Tangney and Dearing, (2002) claim that self-blame is among the most common of both short- and long-term effects of sexual violence and functions as an avoidance coping
skill that inhibits the healing process. The victims will often internally blame themselves because of the violation of boundaries, broken trust, and the feeling of personal danger which occurs with rape. Tangney and Dearing (2002), go on to say that women who experience characterological self blame feel that there is something inherently wrong with them which have caused them to deserve to be assaulted. Madlala (2000), states that the woman may blame herself because of the way she was dressed or the place she was despite the fact that she is a victim. The findings also support Ariffin, (1997) who states that many cultural settings claim that men are unable to control their sexual urges and that women are responsible for provoking sexual desire in men. The victim takes the blame for the violent acts performed on her body whilst the perpetrator is justified. As if this is not enough, the victim also blames herself and this delays the healing process leading to stress.

The results of this study show that 43% of the violated women had stress compared to 7% in the control group. The results support the findings of a study by Ellsberg et al (1999), who found that there was a relationship between having been raped and stress. Stress manifest as sleep difficulties, depressive symptoms, somatic complaints, or aggressive behaviour. Most of the women interviewed had sleep problems indicating that they had some form of stress. The stress can be worse in the absence of trauma counseling where negative psychological effects have been known to be persistent (Foa,1999).

There was a 43% frequency rate of women who experienced shame following sexual violence and a 0% for those who were not violated. This supports claims by Watkins
and Bentovim (1992) that shame is another psychological disorder which is directly linked with sexual abuse. Some of the interviewed women would mention that they felt naked after the abuse and would be ashamed of themselves such that they find it difficult to tell someone about it. If this shame is not addressed it could lead to suicidal thoughts.

From the findings, 33% of the women who were sexually violated thought of attempting suicide compared to 0% in none sexually violated group. This could mean that the trauma of sexual violence could be so severe in some women to make them think of taking their lives. Some women interviewed said that they feel dirty and not worthy living. These feelings could result in one thinking of suicide. According to the findings of a study by Davidson et al (1996), the experience of being raped can lead to suicide. The results of this study are also similar to those of a study by Bagley et al (1997) who established that 15% of those experiencing frequent, unwanted sexual contact had exhibited suicidal behaviour compared with 2% of those who had not been sexually violated. For one to harbor suicidal tendencies, it means that the woman will have been severely traumatised psychologically. Thus sexual violence is capable of affecting the psychological health of women.

4.4.4. Physical effects of sexual violence

The women were assessed for physical health problems and the rate of occurrence is shown in Table 4.12. The purpose of the assessment was to find out if sexual violence affect the physical health of the women by comparing the findings of the sample and control group
Table 4.12 the physical effects encountered by women

<table>
<thead>
<tr>
<th>Effect</th>
<th>Sample</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Physical effects</td>
<td>Yes</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>no</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4.12 shows that 16 (53%) of the violated women were physically harmed compared to 2 (6%) from those not violated. From the sample group, 14 (47%) were not physically harmed compared to 28 (94%) from the control group. The prevalence of physical health problems in the sexually violated group was found to be 0.53 against 0.6 in the control group so this shows that sexual violence can result in physical health problems. These findings appear to agree with the results of the statistical analysis of the ANOVA and t-test which showed that there is a difference in the physical health of violated and none violated women. In addition the result of chi-square test also showed that there is a relationship between sexual violence and physical health of women. This evidence appears to support Holcomb (2010) who outlines that there are immediate physical effects of sexual violence such as pain and bodily injuries, especially if the perpetrator used force. Figure 4.7 show the comparison of physical effects between sexually violated and none sexually violated women.
Figure 4.7  Physical Effects of Sexual Violence

The findings show that 40% of the women who were sexually violated were also physically violated against 4% for those who were not sexually violated. Genital injuries were experienced in the sexually violated group with a 17% against none in the control group. Research on women in shelters has also shown that women who experience sexual abuse also experience physical abuse from intimate partners (Wingood et al 2000). These findings show that women are battered in addition to sexual violence so their physical health may be affected.

4.5. Attitudes of Women towards Sexual Violence

The attitudes of women were assessed so as to find out their beliefs and feelings towards sexual violence. These beliefs and feelings, according to the theory of reasoned action, govern the women’s behavior towards sexual violence. Data to assess
the women’s attitudes were obtained from interviews and focus group discussions. The data from the interviews was collected from the two groups, that is, the sample and control. The results were compared to find out if sexual violence had affected the beliefs and feelings of those who were violated. Data from the focus group was used to augment the findings from the interviews. Four (4) questions were asked to assess the attitudes of the women. These are; why do men sexually abuse women? How women should react to violence? How should women react? And, what can be done about sexual violence?

4.5.1 What women think makes men sexually violent

The women were assessed on what they believe to be the causes for sexual abuse. The purpose of this was to bring out the perceptions of women on the social problem of sexual violence. The responses of the interviews from the sample and control groups were categorised and are shown in Figure 4.8.
Figure 4.8 What Women Think Makes Men Sexually Violent

The responses from figure 4.8 show that the perceived causes of sexual violence are the same in those women who were violated and those who were not. What this means is that the perceptions of women on sexual violence is not affected by sexual violence. The most common perceived causes of sexual violence were culture with 57% from the sample and 53% from the control group and the personality of men with a 50% from sample and 43% from the control group. Fifty percent (50%) of the women from both the sample and the control group perceived woman factor as a cause for sexual violence. Women factor includes dressing, suggestive behaviour and denying the husband his conjugal rights. Thirteen percent (13%) of the sample and 10% of the control group thought that sexual violence occurs as a result of men’s lust and is gender related. Other factors which were highlighted by 20% of the sample and 13% of the control group were poverty, political power and raping for fun. Responses from the focus groups
revealed that the perceived causes of sexual violence were culture, women factors, lust, psychological problems, power, gender inequality and love. Responses from the interviews and focus groups seem to agree on culture, lust, personality, power as well as women themselves to be the perceived causes of sexual violence by the women.

Culture seems to be the central reason why men sexually abuse women. Sentiments like 'society allows men to do whatever they want with women because of this lobola thing', were common in all the focus groups. It appears as if the women feel that the issue of lobola is at the bottom of sexual violence and yet some women are abused outside marriage. The perceived cause of culture supports what is explained in "The changing family in Zambia" journal (1997), that women have no choice when it comes to sex. They cannot even say "no" as they are brought up for the comfort and enjoyment of men. The arguments brought up by this literature seem to suggest that women are meant to be enjoyed by men irrespective of paying lobola hence the raping, harassment and so forth. However, the African culture frowns upon a woman who is not submissive to her husband in matters of sex (Ncube, 1998). This seems to imply that the man can have sex whenever he wants and the woman will agree because sex in marriage is just a marriage ‘deal’ which should be fulfilled whenever the husband demands it. Thus culturally women have no sexual rights; as a result men can use them as a sexual toy with nobody worrying about the effects of forced sex on them as long as the man is satisfied (Kambarami, 2007). The woman however just puts up with it as they were socialized to do the husband’s biding and should not complain about sexual assault (Nkosi, 2006). The woman was socialized to respect men and that culture implies that a husband has a right or even duty to force himself onto a woman (Jewles, 2006). This is
supported by Madlala (2002), who states that sexual violence makes the African man more powerful and virile. This scenario makes it difficult to give sexual violence a definition which suits all cultures.

Even though Jones (1999) says that the societal ideology of male superiority emphasizes dominance, physical strength and male honour, which encourage sexual violence, some women argued that the women put themselves in a position to be raped. In the focus group of high school girls, some girls were very strong about women inviting sexual violence. One girl pointed out that, ‘girls go out to secluded area with a guy, wearing seductive dresses then they claim to have been raped’. The seductive behavior of the women may stimulate sexual feelings in the men who may become violent if turned down. Ariffin (1997) seem to agree with this when he says that in many cultural settings, it is held that men are unable to control their sexual urges and that women are responsible for provoking sexual desire in men. So besides the cultural connotations that culture allow men to be sexually violent; the women may invite it as well in the way they dress and look at a guy.

The women thought that personality and the characteristics of an individual man can result in him violating women sexually. “There are some men who want to test what they see on pornographic movies,” said one college girl. A high school girl pointed out that some men are cruel and enjoy sex whilst the woman is screaming or is in pain. This is in support of the animal coercive theory by Thornhill and Palmer (2000), who noted that the behavior resembling rape in humans is widespread in other animals and such behaviors, referred to as ‘forced copulations’, involve an animal being approached and
sexually penetrated whilst it struggles or attempts to escape.

Another personality problem which was a common response during interviews was lust. Comments like, ‘men cannot be satisfied with one woman’ and ‘they cannot leave beautiful girls alone’ or ‘they behave like animals’ were common during the focus group discussions. This appears to support Johnson (1992) who explains that if a woman resists sexual advances, she can be physically forced or coerced into submission. However some girls in the focus group argued that, ‘it may not be lust but the guy will be in love or wanting to marry but the girl will be reluctant so the guy will resort to rape in order to win the girl as she will be left with no choice but to marry him’. This argument can be supported by Heise (1994), who claims that in some societies, the cultural “solution” to rape is that the woman should marry the rapist, thereby preserving the integrity of the woman and her family by legitimizing the union. On the same note Thornhill and Palmer (2000) believe that rape appears not as an aberration but as an alternative gene-promotion strategy that is most likely to be adopted by the ‘losers’ in the competitive, harem-building struggle. It seems as if the women believe that sexual violence could be a personality problem inherent in the men where a man is not able to convince a woman to marry him and resorts to rape or he is just full lustful and enjoys inflicting pain.

Some women, especially the church group, thought that psychological problems can be the cause of sexual violence since the bible instructs men to love their wives. The other groups echoed this point alluding use of violence to abuse during childhood. This point is postulated in the theories of rape where McKibbin et al., (2008) argue that there may
be several different types of rapists or rape strategies of which one of them is *psychopathic rapists*. It appears as if the women are aware that psychological problems can alter the behavior of men and it can be altered towards sexual violence. From the findings, it appears as if women believe that men in authority, with power and money take advantage of the poor and vulnerable women. One college student laments, "some men use blackmail to force themselves on a woman and if you refuse, you will fail." This seems to suggest that some college girls are awarded pass marks in return of sexual favours. This is sexual harassment which is a type of sexual violence. In support of this, Hagen (2002) describes some of the conditions where the gains from sexual violence may outweigh the cost of such behavior to be; high status males who do not fear reprisal and low status women who can do anything for money or a meal. In the case of the college girls who want to pass, they may do anything for a pass mark. This may mean that the lecturers, who are high status males, maybe taking advantage of the college girls who want to pass an examination.

4.5.2 The Reactions of Women to Sexual Violence

In trying to find out the attitudes of women towards sexual violence, the researcher asked women through focus groups and interviews on how women should react to sexual violence. The interview results which compare the two groups (the sample and the control group) are shown in Table 4.9.
From the interviews, 60% of the women in the sample group and 53% of the control group suggested that the men be reported. Twenty three percent (23%) of violated woman and 27% of the non violated women thought that the couple should negotiate and that the woman should be firm during the negotiation. Counseling was another way of dealing with the violence which was suggested by 17% of the sample group and 13% of the control group. Seven percent (7%) of the violated group against 13% of the control group said that they would rather tolerate or accept the man’s demands without
question. The other options brought up by the women were ending the relationship or fighting back. This accounted for 3% of the violated women and 6% of the control group.

From the focus groups, women felt that the men should be reported and the women counseled. However some felt that a woman cannot report a man she is married to but should just accept her fate and pray for God’s intervention. The results from the interviews and focus groups concur on reporting, seeking counseling, and acceptance.

The women felt that the abused woman should report to the police, woman organisation or to a professional health worker. However some women argued that one cannot report her husband or the men she loves because that will be the end of the relationship. Sentiments like, ‘report a men who paid lobola for you’ and ‘report the man you love’ were brought up from the focus groups. It seems that the women were reluctant to report sexual violence and that they felt that it was not the right thing to do. This way of behaviour is explained by the theory of the health belief model which says that action is only taken if one expects to benefit from the outcome. However, by reporting one’s partner, the woman could end up losing a lover who could also be the bread winner, so she may opt to keep quiet about it. The sentiments of the women seem to be in support of Kambarami (2007) who said that culturally, women have no sexual rights, as a result men can use them as a sexual toy with nobody worrying about the effects of forced sex on them as long as the man is satisfied. In addition, “The changing family in Zambia” journal (1997), explains that women have no choice when it comes to sex. They cannot even say “no” as they are brought up for the comfort and enjoyment of men. Therefore those women who are against reporting but opting to get along with the
abuse are only following their culture. This may be the reason why 40% of the women who responded to the questionnaire to assess sexual violence did not report the sexual violence they encountered.

The reluctance to report can be attributed to cultural practices and beliefs. The beliefs that man has a right or even duty to force himself onto a woman appeared to influence how such women reacted to sexual violence (Jewles, 2006). This is supported by Madlala (2002) and Nkosi (2006), who state that sexual violence makes the African man more powerful and virile and that the woman should just put up with it as they were socialized to do the husband’s biding and should not complain about sexual assault.

From both the interviews and the focus groups, women suggested counseling as a remedy to sexual violence. Counseling would be beneficial according to Foa (1999), who claims that in the absence of trauma counseling, negative psychological effects have been known to persist following rape. However most of the high school and college girls in the focus groups opted to talk to a nurse or counselor to get advice rather than to their parents as they believed that a parent can become emotional or judgmental. A professional counselor should not be judgmental or emotional or else the victim would close down and will not get the help required.

These responses from the women showed that the woman had various methods of dealing with sexual violence. These included reporting, negotiating, counseling, accepting the situation and others such as ending the relationship or fighting back. However, according to the theory of reasoned action, specific behavior is controlled by two factors; the attitude (negative or positive) towards the behavior and the influence of
the social environment (general subjective norm) on that behavior. This means that the option that is going to be chosen by an individual woman will be governed by her attitude towards sexual violence as well as her social environment hence the responses of the women to sexual violence may never be the same.

4.5.3. Controlling sexual violence

In response to the question; what can be done about sexual violence? The women from the focus groups and those interviewed had suggestions for ending or reducing sexual violence. The suggestions of the sample group and the control group are compared in Figure 4.10

![Fig 4.10 Ways of Reducing Sexual Violence](image-url)
In order to reduce sexual violence, 57% of the control group and 47% of the sample group believe that if men are given stiffer penalties, they will not violate women. Thirty three percent (33%) of the sample and 17% of the control group believed that educating men on the rights of women will decrease the cases of sexual violence since they will be involved. The sexually violated group had higher frequencies than the none sexually violated group maybe because these women have lived the violence and have seen some of the options not working for them. Similar responses (33%) occurred in both groups pertaining to the empowerment of women. The women thought that if they are all informed about their rights and what steps to take when violated, they will have been empowered. Those who opted for counseling had a frequency of 23% from those sexually violated against 7% from those not sexually violated. There is a higher percentage (23%) in the violated women maybe because they were helped by counseling.

From the focus groups, it also came out that women need to be empowered. The girls felt they need life skills to defend themselves and they also need to have negotiating skills. They also lamented on the jail term given to rapists that it is not prohibitive hence stiffer penalties should be introduced. "Men need to be castrated or amputated then no one will rape again", said one of the participants. Some were more rational and suggested that there be organisations which will educate men on the rights of women and that women are people with feelings and their rights are human rights too.

‘Girls should also not tempt men and should be careful who they date ’said one participant. The girls also advised each other to be wary of overseas scholarships for
girls. This could be a trap for trafficking of girls into prostitution because once the girl is stranded out of the country; the so called sponsors can use her for prostitution. Peer pressure should be avoided especially when going for parties as one maybe having an agenda not known to you.

Both the interviewees and the focus groups agreed that counseling can be done to the victims to help them deal with the trauma of sexual violence. They also noted that improved communication can help solve pending problems which may lead to sexual violence. However some women felt that if communication fails, it would be better to end the relationship through divorce or separation.

4.5 4 Women’s perceptions on the effects of sexual violence on the health of women

The researcher wanted to find out the perceptions of women on how sexual violence affects their health. Table 4.13 shows the compares the responses of the sample and control groups of women who were interviewed.
Table 4.13 sexual violence and the health of women

N=30

<table>
<thead>
<tr>
<th>Does sexual violence affect the health of women?</th>
<th>Sample</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Yes</td>
<td>28</td>
<td>93</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Totals</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

In response to the question, 93% of the sample and 97% of the control believed that sexual violence can affect the health of women whilst 7% of the sample and 3% of the control believe that the health of the women is not affected by sexual violence. From all the focus groups, it appears that the women believe that sexual violence can affect the health of the women. However some participants argued that there is no effect after having sex with or without consent but after discussing the effects, they too were convinced that sexual violence can affect the health of a woman. The results of both the interviews and focus group seem to agree that sexual violence affect the health of the women. The effects brought up by the women who were interviewed are shown in Figure 4.11
Fig 4.11 Effects of Sexual Violence as Perceived by Women

The most prevalent health problems related to sexual violence as perceived by the women from the two groups were STI, HIV, pregnancy and psychological problems. STI had 47% from the sample and 37% from the control group. This was followed by HIV which had 37% from the sample and 30% from the control group. Pregnancy had 30% from the sample and 17% from the control group whilst Psychological problems had 20% from the sample and 37% from the control group. The less common health problems that were obtained from the women were abortion with 7% from the sample and 3% from the control group, injuries with 7% from the sample and 13% from the control group and high blood pressure with 3% from the sample and 7% from the control group.
The health problems that were highlighted by the focus groups were mainly psychological and reproductive health problems. The psychological problems included stress, depression, self blame and suicidal tendencies. The reproductive health problems mentioned were pregnancy, lack of interest in sex, criminal abortion, HIV and STI. From the results of the interviews and focus group, the women believe that their psychological health and reproductive health can be affected by sexual violence. The health problems identified from the documentary analysis were pregnancy, STI, HIV and abortion are the same reproductive health problems identified from the interviews and focus group. This may therefore mean that sexual violence can actually affect the women’s reproductive health and that the women seem to be aware of it.

The women believed that sexual violence can affect them psychologically and 67% of the sexually violated women (sample group) were affected psychologically against 6% of those not violated (control group). This may mean that sexual violence could be a cause of psychological health problems in women and the women suspect it. Thus it may be necessary to empower the women if they are to resist sexual violence and or to seek medical care if they are abused. The responses appear to support the results of a study by Briggs & Joyce (1997) whose findings show that sexual violence was associated with mental health and behavioral problems in adolescence and adulthood with a prevalence of 33%.

The women also felt that reproductive health can be affected by sexual violence. In the same vein, 57% of the violated women encountered reproductive health problems against 30 % in the control group. This is an indication that sexual violence can affect
the reproductive health of women. The findings support Campbell et al (2009) who claim that sexual violence has multiple reproductive health problems. From the documentary analysis 20% of the victims became pregnant. In addition, the interview revealed that 43% of the sexually violated had unplanned pregnancies against 13% from the control group. Those who had unplanned pregnancies from the control group claim that they forgot to take their family planning pills or were not aware of family planning methods. In contrast to this, those who had unwanted pregnancies in the sample group were raped or coerced into unprotected sex or the partners deny them the right to use family planning methods. These sentiments from the interviews seem to be similar to the sentiments from the focus groups. ‘An abusive husband finds ways of making you cling to him so that you cannot think of divorce or get work, so he makes sure you are either pregnant or breast feeding,’ said one of the participants.

Lack of interest in sex (loss of libido) was common to sexually violated women. One woman said, ‘how can you enjoy or think of sex after the trauma of rape.’ Another woman said, ‘I am so scared of sex, I don’t think I will ever enjoy it.’ The sentiments pertaining to loss of libido were so strong and women really got emotional with some saying, ‘dying would be better if a divorce is not possible.’ From the interview of violated women, sexual dysfunction was the most prevalent reproductive health problem with a 70% frequency. From these results it is evident that sexual violence can contribute to sexual dysfunction.

The women also believed that HIV and STI can result from sexual violence. They argued that during a rape, there is no time for wearing a condom. The women lamented
that abusive men do not use protection even if they know that they are infected. ‘The man will infect you willingly so that he will have an excuse of beating you,’ said one woman from the focus group discussion. It can be assumed that some men violate women because of their cruel personality as brought up by the women when they answered the question on why men abuse women. The sentiments seem to support the claims of Wingood et al (2000) that the risk of HIV infection is increased in sexual coercion by spouse into unprotected sex when they know that they are unfaithful. The evidence support the results of the studies conducted in the United States by Kalichman (1998) which revealed that women in violent and abusive relationship are less likely to use condoms, let alone request them, hence are more likely to contract STI including HIV than other women. In addition to these findings, there is a prevalence of 33% and 37% for STI and HIV respectively in the sexually violated group so it may be deduced that sexual violence can lead to STI and HIV infection to abused women.

4.6 Summary

The data was presented in tables and graphs for easy analysis. Data from the two groups (sample and control) was presented together for comparison purposes. The hypothesis was tested using three tests (ANOVA, t-test and chi-square) and the null hypothesis which says there is no difference in reproductive, psychological and physical health between sexually violated and none sexually violated women was rejected. So there is a difference in the reproductive, psychological and physical health between sexually violated and none sexually violated women. Data from interviews was analysed using descriptive statistics and showed that there is a difference in the reproductive,
psychological and physical health between sexually violated and none sexually violated women. The percentage of reproductive effects was 57%, psychological effects 67%, and physical effects 53% in the sexually violated women. The prevalence of HIV and STI was found to be 0.33 and 0.37 respectively. Documentary analysis of 30 documents was done and the results were similar to those from the interviews and focus groups.

The attitudes of women towards sexual violence were assessed through focus groups and interviews and the results were the same. The women’s attitudes are grounded in culture which empowers men and makes women subjects to men. In order to reduce or end sexual violence, the women felt that they needed to be empowered. The women also felt that the men needed to be educated on sexual rights in order to break the chains of culture.
CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.0. Introduction

The researcher set out to find the effects of sexual violence on the health of women. The data was collected and in chapter four the data was presented and analysed in relation to the literature and theoretical framework in chapter two. In this chapter, the study is summarised and conclusions are made with reference to the questions and objectives raised in chapter one. Recommendations and further researches are also suggested in this final chapter of the study.

5.1. Summary

The research sought to investigate the effects of sexual violence on the health of women. The background highlighted that women are sexually violated throughout the world and that in Zimbabwe; sexual violence is on the increase. This is evidenced by an average increase of 78% over 2 years (2009 -2010) from three institutions which deal with sexual violence in Gweru that is, Msasa project, MSF and Gweru Hospital. This was the problem that prompted the researcher to investigate how the women are affected by sexual violence. Review of related literature included the theories of rape and behavioral theories, role of culture, types of sexual violence and effects of sexual violence on health.
A mixed methodology was used to carry out the research. The qualitative methodology was used to answer two of the research questions; *how are women sexually abused? and how do women react to sexual violence?* The quantitative methodology was used to answer the research question; *how is the health of women affected by sexual violence?* A casual comparative design was used to carry out the investigation as it allowed comparison of two groups (the sexually abused and those not sexually abused) in order to identify the effects.

Purposive sampling was used to obtain the sample group (those sexually abused). The snowballing method was used at Msasa Project and Gweru Hospital to obtain a sample of 30 who were sexually violated. For the control group (those not sexually violated) a convenient sampling was done at Gweru hospital maternity department where the women were issued with a questionnaire to identify the women who were not sexually violated. The first 30 women to meet the criteria formed the control group. Data was collected using structured interviews, questionnaires, documentary analysis and focus group discussions from church women, high school girls and college girls. The data was analysed using the SPSS for quantitative data. Descriptive statistics were also used to analyse data.

**2.2 Conclusions**

The study shows that sexual violence has effects on the reproductive health of women. The null hypothesis, that is; there is no difference in reproductive, psychological and physical health between sexually violated and none sexually violated women was rejected by the ANOVA, t-test and chi-square. In addition to the rejection of the null
hypothesis, 57% of the sexually violated women against 30% of none sexually violated had reproductive health problems. The most frequent effects noted from the study were sexual dysfunction and pregnancy whilst some women had abortions and chronic pelvic pain.

It was also evident from the research that psychological problem could arise from sexual violence with 67% against 6% in the control group. In addition the null hypothesis that is; there is no difference in reproductive, psychological and physical health between sexually violated and none sexually violated women was also rejected by the ANOVA and the t-test. Self blame was the major psychological problem. There were also stress, shame and suicidal tendencies.

The research findings also show that sexual violence also affects the physical health of women. They show that 53% of the sample group suffered physical violence against 0% of the control group. The null hypothesis; there is no difference in reproductive, psychological and physical health between sexually violated and none sexually violated women was rejected by the ANOVA, t-test and chi-square. Physical assault was the major physical effect with a few women having genital injuries.

The prevalence of STI in sexually violated women was 0.33 and that of HIV was 0.37. These figures are significantly high especially when the ministry is calling for 0 new infections of STI including HIV.

The study revealed that women are sexually violated though some of them will not report the violence to either the police or health centre. This is shown by the 40% of the
respondents of the questionnaire to assess sexual violence that were violated but did not report. The major reason for the reluctance to report was that they are married to the men and it is not cultural to report your husband.

The type of sexual violence which the women mostly encounter is rape and sexual coercion. The study also revealed that the women are not aware of forced marriage and sexual trafficking as types of sexual violence.

The study revealed that women believe that culture contributes significantly to sexual violence as it is seems to be permissive to men forcing themselves on women. However, some men violate women because of their personality i.e. cruelty. The attitude of woman towards sexual violence is influenced by their culture. Because of their culture the women find it difficult to report sexual violence.

The findings show that women feel that men need to be educated on the rights and feelings of women. In addition to this, women felt that stiffer penalties which are deterrent should be given to perpetrators of sexual violence.

Sexual violence is a reality and the women are violated in and outside their homes. This act is a result of the socialisation process which has socialised women to be submissive whist men are socialised to rule women. This means that even if women are aware of the violation of their sexual rights they are bound by the chains of culture which are difficult to break in spite of being educated. Their behavior is therefore explained by the theory of reasoned action which explained that a willful behavior is influenced by the environment and attitude of the individual. An attitude of submissiveness does not
encourage the women to take action so they need to be empowered. The health belief model can also be used to explain this behavior through ‘perceived benefits’. There are no benefits from reporting abuse from a husband as one is bound to lose the breadwinner and be a laughing stock of the community so the woman will prefer to keep quiet about it. Not only that, another problem which was noted is the case of cultures at conflict.

What the western culture may define as abuse maybe seen as normal in the Shona culture. For example, it is normal within the Shona culture for a woman to kneel down when giving a husband food, but an outsider may define this as abuse. In that respect, defining abuse can be problematic as there are cultural connotations involved. From this study it is clear that a married woman is bound by cultural expectations to provide for his husband at his ‘demands’ including sex. This makes it therefore difficult for the woman to define this as sexual violence and report his husband.

The women’s health is being affected by sexual violence but she suffers alone as the issue is not easy to discuss. She suffers psychological trauma caused by having sex against her wish which deprives her of her confidence and or trust in the opposite sex. Her reproductive health is affected as she goes through an unwanted pregnancy and or subject herself to an abortion in unsafe environment which will subject her to more health problems. The pregnancy and its outcome compound the woman’s psychological trauma. In addition, being infected by HIV or a sexually transmitted infection from rape is the worst. Whilst physical injuries may heal, the problems associated with HIV, abortion and caring for an unwanted baby will be a constant reminder of the traumatic
effect for the rest of her life. Therefore even if the Shona culture is permissive to sexual violence, the woman’ health is affected.

The reality is that the health of a Zimbabwean woman is also affected by sexual violence like in other countries where research has been done. However the culture seems to be permissive to sexual violence. The woman therefore needs to be empowered and protected if she is to be healthy in the broad concept of health.

5.4. Recommendations

After carrying out this research and analysing the results, the researcher therefore makes the following recommendations which if taken by the stakeholders, may save the health of the women, families, communities and the nation;

- There is need to introduce organisations which target men, educating and counseling them on sexual rights and the effects of violence on the health of women as it will also affect the men. The assumption here is that if men are knowledgeable and understand the feelings of women, they may change the behavior of rape.

- Whilst there are organisations which help women, they need to go out to the people to explain their mandate as the women are not aware of the services they offer. This is one way of empowering women.

- The literature from the Ministry of Health and Child Welfare and other non-governmental organisation should depict sexual violence as a major concern and should also highlight its consequences.
➢ The victim friendly section of the police is a noble idea but women are not comfortable to discuss sexual issues with men so it is highly recommended that it be manned by women.

➢ Most of the victims of sexual violence are affected psychologically but are not assessed for this at the health institutions. Therefore the assessment tool of victims used by the hospitals should also assess the psychological aspect so that the woman is helped holistically to avoid post traumatic syndrome.

➢ The government should introduce stiffer penalties which are deterrent to sexual violence. The idea is to scare men from violating women sexually.

➢ Legal abortion should be made accessible and the bureaucracy involved be removed so as to help women who would rather not keep the child. The medical superintended or the provincial medical director should sign the abortion form once it is legalised instead of the permanent secretary of health. This will reduce the backstreet abortions which the women are forced to encounter.

➢ Children born out of rape should automatically be taken into child care or be considered for adoption or fostering unless the mother is willing to keep the child. This may assist the healing process and reduce the psychological health problems of the woman.

5.6 Suggestions for further research

In order to end the problem of sexual violence more research need to be done. Here are suggestions for further research;
The research used the casual comparative research design which has its limitations. It also focused on Gweru urban only. There may be need to conduct a similar research study on a wider scale in Zimbabwe so as to be able to generalize the research findings.

The perceptions of men towards sexual violence

The effectiveness of counseling in Post Traumatic Stress Disorders related to sexual abuse

The cultural connotations of sexual abuse
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APPENDIX A

INFORMED CONSENT
INFORMED CONSENT

PROJECT TITLE: AN INVESTIGATION INTO THE EFFECTS OF SEXUAL VIOLENCE ON THE HEALTH OF WOMEN IN GWERU URBAN

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NB. I give you this consent so that you may read about the purpose, risks, and benefits of this research study. I cannot promise that this research will benefit you. However, your participation is voluntary and you have the right to refuse to take part, or agree to take part now and change your mind later. Whatever you decide, it will not affect your regular care so please review this consent form carefully and ask any questions before you make a decision.

Purpose

You are being asked to participate in a research study of the effects of sexual violence on the health of women. The purpose of the study is to identify how the health of women is being affected by sexual violence. You were selected as a possible participant in this study because you are a woman between 16 and 35yrs and has been sexually/ not sexually violated so you will be one of the 30 sample or control group.
Procedures and Duration

If you decide to participate, you will undergo a 20 minute interview to find out if you experienced any reproductive, mental or injuries related to sexual violence or be part of a focus group to discuss the attitudes of women to sexual violence for about an hour or two.

Risks, Discomforts and Benefits

There are no risks involved but the discomfort you may encounter is discussing personal information. There are no benefits from this study.

Procedures and Duration

If you decide to participate, you will undergo a 20 minute interview to find out if you experienced any reproductive, mental or injuries related to sexual violence or be part of a focus group to discuss the attitudes of women to sexual violence for about an hour or two.

Risks, Discomforts and Benefits

There are no risks involved but the discomfort you may encounter is discussing personal information. There are no any benefits from this study.

Confidentiality

If you indicate your willingness to participate in this study by signing this document, I assure you that any information obtained from you will remain strictly confidential but maybe revealed (with your permission) to the ministry of Health and Child Welfare and Non Governmental organisation so that they can improve the health of women. Under some circumstances, the MRCZ may need to review patient records for compliance audits.

Voluntary Participation

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the Ministry of Health or Msasa Project or its personnel. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty. Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

Authorization

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.
The study may involves audio recording to enable the researcher to capture all the data but the recordings will only be used for the purpose of the study.

I understand that audio recordings will be taken during the study. (Mark either “Yes” or “No”)

I agree to be audio recorded

Yes

No
APPENDIX B

QUESTIONNAIRE TO ASSESS SEXUAL VIOLENCE
QUESTIONNAIRE TO ASSESS SEXUAL VIOLENCE

SECTION A-

Biographic data

Tick in the appropriate box

1. Age
   - 15-20
   - 21-25
   - 26-30
   - 31-35

2. Marital status
   - single
   - Married
   - Divorced
   - Widowed
3. Level of education
   primary ☐
   Secondary ☐
   Tertiary ☐
   None ☐

4. Religion
   Christian ☐
   Moslem ☐
   Traditional ☐

**SECTION B**

**History of sexual violence**

1. Have you ever had sex?  YES ☐  NO ☐

2. If yes, was it with your consent
   All the time....................................................... ☐
Sometimes……………………………………………….. ☐

Never…………………………………………………….. ☐

3. Have you, at any given time, been…

…coerced *(talked)* into having sex when you did not want to YES ☐ NO ☐

Used by someone for commercial sex……………………..YES ☐ NO ☐

Raped……………………………………………………….. YES ☐ NO ☐

If raped, by whom?

Spouse/husband/partner…………………………………….. ☐

Boyfriend…………………………………………………….. ☐

Relative……………………………………………………… ☐

Stranger……………………………………………………… ☐

If married, did you consent to the marriage…….. ☐
APPENDIX B

STRUCTURED INTERVIEW SCHEDULE
STRUCTURED INTERVIEW SCHEDULE

SECTION A-

Biographic data

1. Age;  
   - 15-20
   - 21-25
   - 26-30
   - 31-35

1. Marital status;  
   - single
   - Married
   - Divorced
   - Widowed

2. Level of education;  
   - Primary
3. Religion;  
   - Christian
   - Moslem
   - Traditional
   - Other; Specify

B. Sexual violence assessment

1. Have you ever been sexually violated?
   If yes, how?
2. How do you feel about it?
3. Did you report the incident? Why?

C. Reproductive health assessment

1. Do you enjoy sex? Explain your answer
2. Have you ever experienced pain during intercourse?
If yes what had happened

3. Have you ever had more than 1 sexual partner?

4. Did you plan all your pregnancies? If no, what happened?

4. Have you had any abortion? IF yes, explain the circumstances

5. Do you have a history of sexually transmitted infection? How about your partner?
   - When was it?
   - How did you get it?

6. What is your HIV status?
   - If positive, how do you think you got it?

7. Do you have any other reproductive health problem?

D. Psychological health

1. Do you have any sleep difficulties?

2. Have you ever suffered from stress? If yes, Why?

3. In relation to your sex life, have you at any given time;
   i. Blamed yourself? Why?
   ii. Felt ashamed of yourself? Why?
   iii. Felt like committing suicide? Why?

E. Physical effects

Have you ever been assaulted because of sex? Explain

Have you had genital injuries? Explain the cause?

F. Women’s views on sexual violence

In your opinion,
1. What makes men abuse women sexually?

2. How should women react?

3. What can be done about sexual violence?

4. How do men sexually abuse women?

Do you think sexual violence affect the health of women? How?
APPENDIX D

PERMISSION TO CARRY OUT RESEARCH