ORIGINAL RESEARCH ARTICLE

Gender Based Violence and its Effects on Women's Reproductive Health: The Case of Hatcliffe, Harare, Zimbabwe

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Abstract

Gender based violence (GBV) negatively impacts on women's reproductive health (R.H) and is contrary to human rights and RH statutory instruments. The study triangulates quantitative and qualitative research methods with women in the reproductive age group being the target group. The study noted that 95% of the respondents experienced physical violence, 31% rape by a stranger, 92% spousal rape and 65% forced marriages. Socio-cultural, religious, economic and policy implementation factors underlie a culture of silence that prevails among the victims of GBV. The study recommends economic empowerment of women and information, education, counselling pertaining to the negative effects of GBV to both males and females. There is need for education about grievance procedures and scaling up of policy enforcement in order to curb the gruesome effects of GBV. *(Afr J Reprod Health 2014; 18[1]: 110-122).*

Keywords: physical abuse, sexual violence, forced marriages, Hatcliffe, Zimbabwe

Résumé

La violence basée sur les sexes (VBS) a un impact négatif sur la santé de la reproduction des femmes (SR) et elle est contraire aux droits de l'homme et les textes réglementaires de SR. L'étude fait une triangulation des méthodes de recherche quantitatives et qualitatives avec les femmes dans le groupe en âge de procréer étant le groupe cible. L'étude a noté que 95 % des interrogées ont connu la violence physique, 31 % le viol par un inconnu, 92 % le viol conjugal et 65% les mariages forcés. Les facteurs de mise en œuvre religieuses, économiques et politiques socio- culturel, sous-tendent une culture de silence qui règne parmi les victimes de violence sexiste. L'étude recommande l'autonomisation économique des femmes et de l'information, l'éducation, les conseils concernant les effets négatifs de la violence sexiste pour les mâles et pour les femelles. Il faut l'éducation sur les procédures de règlement des griefs et l'élargissement de l'application de la politique afin de limiter les effets horribles de la violence sexiste. *(Afr J Reprod Health 2014; 18[1]: 110-122).*

Mots-clés : violence physique, violence sexuelle, mariages forcés, de Hatcliffe, Zimbabwe

Introduction

The United Nations Declaration on the Elimination of Violence against Women defined gender based violence (GBV) as:

… any act of violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life[1].

Pursuant to the aforementioned definition of GBV, this study also placed emphasis on the reproductive health impacts of GBV against women. This is partly because traditional gendered power-inequalities make women more vulnerable to GBV[2,3,4]. Evidence has shown that at least 60% of women globally are exposed to reproductive health (R.H) problems related to GBV than their male counter parts[3,5]. Such exposure to R.H problems is contrary to the definition of human rights which stipulates, '….*universal respect for, and observance of human rights and the fundamental freedoms for all without discrimination as to race, sex, language, or religion..*'[6,7]. GBV targeting women is also contrary to the definition of R.H and major components of The International Conference on Population and Development (ICPD) and its Programme of Action. The ICPD defined RH as:

…a complete state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life and no merely the absence of infirmity. Implicitly, reproductive health enables people to have a

satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so[8].

On the other hand, the ICPD Programme of Action, paragraph 7.34 posited that:

Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. Equal relationships between men and women in matters of sexual relationships and reproduction, including full respect for the physical integrity of the human body; require mutual respect and willingness to accept responsibility for the consequences of sexual behavior[3].

Globally, policies have been formulated in a bid to eradicate GBV targeting women. Such policies include: The Convention on Elimination of all Forms of Discrimination against Women of 1979; The UN General Assembly of 1993; Fourth World Conference on Women: Action for Development, Equality and Peace, held in Beijing, China, in 1995; The Declaration on Gender and Development on the Prevention and Eradication of Violence against women and Children of 1997 and The Domestic Violence Bill of 2006. The Government of Zimbabwe has made strides in addressing gender based violence through the enactment of various pieces of legislation like the 1987 Matrimonial Cause Act, the 1989 Maintenance Act, the 1997 Administration of Estates Act, the 2001 Amended Sexual Offences Act, the 2006 Criminal Law (Codification and Reform) Act and the 2007 Domestic Violence Act.

Regardless of all the aforementioned policies and conferences, GBV continues to be a thorn in flesh among women globally, regionally and Zimbabwe in particular. For instance, it has been noted that globally, 65% of women are exposed to GBV[9,10]. More than 50% of women in Bangladesh, Ethiopia, Peru and Tanzania reported that they have been subjected to physical or sexual violence by intimate partners[9], with a prevalence rate of 71% in rural Ethiopia[11]. The prevalence of GBV among women has been attributed to power equalities between men and women[2], a culture of silence among women[10] and also failure to implement crafted policies[12]. Available literature revealed that 30% and 22% of women in the United Kingdom and the United States of America respectively reported that they were once subjected to physical abuse by their marital partners[13]. A study in Zimbabwe for Musasa project revealed that 32% of women reported physical abuse by marital partners since the age of 16 years[2]. Globally, it is also estimated that, one in five women is a victim of rape or attempted rape in her lifetime[10]. It has been noted that 20% of the girls reported that they had experienced at least one incident of sexual abuse[14]. In Peru, Samoa and Tanzania, it was noted that between 10 and 12% of women have ever suffered sexual violence by strangers after the age of 15 with 25% of married women (globally) reported being forced to have sex when they did not want by their marital partners[15]. In Zimbabwe, available literature revealed that 37% of women in Midlands were once victims of sexual harassment perpetrated by their marital partners[2].

Forced marriage is another form of GBV which is prevalent globally, regionally and Zimbabwe in particular. Research has shown that 34% of women are forced into marriage[4], while 57% of girls in Afghanistan were forced into marriage before the age of 16 years[16]. In Sudan and Yemen, it was noted that 34% and 32% respectively were forced into early marriages[17]. Zimbabwe has been as noted one of the countries with the highest child forced marriages in the world with an estimated 55% prevalence rate[18]. While child marriage is common in Zimbabwe, prevalence is highest in Mashonaland Central (50%), followed by Mashonaland West (42%), Masvingo (39%), Mashonaland East (36%), Midlands (31%), Manicaland (30%), Matabeleland North (27%), Harare (19%), Matabeleland South (18%), and Bulawayo (10%)[18]. The needs to ensure a better future for daughters and economic gains have been cited as the underlying factors to forced marriages[4]. It has been reported that on average, one out of three girls in Zimbabwe will be married before 18 years[18].

Regardless of the prevalence of GBV, available statistics indicate that GBV has gross reproductive health effects on women. In global studies (World Bank, 1993; UNFPA, 2006; UNAID, 2010), rape and physical violence rated higher on women's deaths than other deterministic factors such as

cancer, motor vehicle accidents, war and malaria[19,3]. Studies in Brazil[20] and Afghanistan[21] revealed that 13% and 44% of deaths respectively among women aged 15-49 years were a result of physical violence perpetrated by male sexual partners. Regionally, a survey in South Africa showed that women who were sexually abused by their partners were 48% more likely to be infected with HIV than those who were not[22]. Another study conducted in Tanzania in 2001 revealed that HIV positive women were three times more likely to have experienced sexual violence at the hands of their current partner than other women[23]. It was also revealed that forced sexual intercourse results in a higher risk of abrasion and bleeding, providing a ready avenue for transmission of the virus among women[3,20]. In addition, it has been noted that globally, 61% of people living with HIV are in sub-Saharan Africa and the majority (54%) of those infected are women[5,24,25]. It was further posited that Botswana, Lesotho, Swaziland and South Africa carry the bulk of women in the reproductive age group who are HIV and AIDS positive (Ibid). GBV has been singled as a major determinant of HIV and AIDS infections among women in sub-Saharan Africa[24,25]. As a result, international organisations are focusing on the eradication of violence against women in the quest to fight the spread of the epidemic[26].

In Zimbabwe, studies have been conducted about GBV among women[10,27,28]. However, it should be noted highlighted that the studies tend to be similar in nature. They mainly concentrated on the prevalence and determinants of GBV. Having observed the dearth of literature pertaining to R.H impacts of GBV on women, this study will identify the forms of GBV and their R.H impacts to women in the reproductive age in specifically in Hatcliffe area.

Methods

Study design

The study targeted women in the reproductive age group (15-49 years). These women were targeted because they are more vulnerable to GBV and its effects. Hatcliffe area was purposively selected because it had high rates of GBV compared to other nearby suburbs. A triangulation of quantitative and qualitative methods was used in the study. A survey was used to collect quantitative data, whilst focus group discussions, key informant interviews and in-depth interviews were used to collect qualitative data.

Data Collection Methods and Tools

Survey

A survey (using a questionnaire) was undertaken to quantify the magnitude and reproductive health impacts of GBV on women in Hatcliffe.

Sample size determination

The sample size was determined using the formula: $n= (Z^2*p*q)/e^2$. Where n = the desired sample size; p = the proportion of women aged 15-49 years in the entire population who were affected by GBV; q = 1-p (proportion of the total population of Hatcliffe excluding the target population); z = the standard normal deviate set at 1.96 which corresponds to 95% confidence level; e = the margin of error set at 0.05. According to Central Statistical Office's sampling frame of 2002, the total population of Hatcliffe was 23897 and the total number of women in age range 15-49 was 2261. As such, the sample was calculated using the following procedure: $n = (1.96^2*0.09*0.91)/0.05^2 =126$.

Sampling procedures

The sampling procedure was done in three stages. The first stage was the selection of Hatliffe residential area and the two enumeration areas (020 and 030). Probability proportionate to size sampling was then used to determine the following: the number of respondents from each EA; the number of respondents per age-group in all EAs; and the number of respondents per age-group and per EA (Table 1). The Central Statistical Office 2002 Master Plan was then used to identify households in each EA from which participants were to be drawn. The households were selected using the stratified random sampling procedure with an interval of three (3). The first question that was asked to all the selected women after informed consent was whether those women

were once victims of GBV before the collection of socio-demographic characteristics. Those who had not experienced GBV were automatically excluded from participating in the study. Where a household had more than one woman within the age range 15-49 who once became victims of GBV, one woman was randomly chosen.

Table 1: Number of respondents per EA and age groups

Age group	EA 020	EA 030	Total
15-19	6	5	11
20-24	10	9	19
25-29	11	12	23
30-34	12	14	26
35-39	10	11	21
40-44	7	10	17
45-49	5	4	9
Total	61	65	126

Focus Group Discussions

Three FGDs (using a FGD guide) were conducted with women aged 15-24, 25-39 and 40-49 regardless of whether they suffered GBV. Each FGD had ten participants. The selection of the participants was based on availability and willingness to participate. FGDs were conducted in order to get a community perception about the definition of GBV and the reproductive health effects of GBV. All FGDs were conducted in the vernacular Shona. One of the authors of this paper was a moderator whilst the other was a note-taker during FGDs. Sessions for FGDs lasted between one and one and half hours.

Key Informant Interviews

Six key informant interviews (both male and females) were conducted with the Victim Friendly Unit (VFU) police officers, Musasa Project and Ministry of Health and Child Welfare (MoHCW) focal persons. Two officials from each organization were purposively selected. Key informant interviewees were community experts who provided statistics on the prevalence of GBV in Hatcliffe and also its impacts.

In-depth interviews

Six in-depth interviews were conducted with women who volunteered to participate. In-depth interviews were conducted in order to obtain qualitative data that subsequently validated those collected using questionnaires.

Data Management and Analysis

Quantitative Data

Questionnaires were coded after data collection for the purpose of tracking errors during data entry. A dictionary was also created for data entry using Statistical Package for Social Sciences (SPSS) software (IBM). Double entry and data cleaning was done to ensure that there were no errors on data entry. Consistency of responses was checked by comparing two sets of data from the double entry. Frequency distributions were run from the two parallel data sets. The SPSS was employed to analyse quantitative data. Frequency distributions and cross-tabulations were run for the purpose of highlighting the relationship between dependent and independent variables.

Qualitative Data

Qualitative data were captured through extensive note taking and audio-taping. These data were transcribed, translated and typed. The Ethnography Software analysed the data using the thematic approach. Upon entering the data into the software package, themes linked to forms of GBV and the reproductive health impacts of GBV were grouped.

Ethical considerations

Participants had freedom to participate in the study. They were not coerced, deceived and induced when informed consent was sought. There was adherence to principles of research with regards to privacy and confidentiality in the study. Before signing consent forms, participants were told about the following: the purpose and objectives of the research; what was expected of a research participant; expected risks and benefits; the fact that participation was voluntary and that one can withdraw at any time with no negative repercussions; anonymity of the data collected in order to enhance confidentiality; and the name and contact information of the local investigator to be

contacted for questions or problems related to the research (including one's rights as a research participant). All participants aged 18 years and above signed consent forms. In addition, parental consent forms and individual ascent forms were signed for participants under the age of 18 years

Table 2: Percentage Distribution of Socio-Demographic Characteristics of the Respondents

Characteristics	Percentage (%)
Age	
15-19	8.7
20-24	15.9
25-29	24.6
30-34	31.0
35-39	15.1
40-44	4.0
45-49	0.7
Total	**100.0**
Marital status	
Married	38.9
Never married	9.5
Divorced	30.0
Widowed	21.6
Total	**100.0**
Religion	
Mainline Churches	16.6
Pentecostals	32.7
Apostolic	50.7
Total	**100.0**
Employment Status	
Employed (Formal)	20.6
Self Employed (Informal)	27.4
Unemployed	52.0
Total	**100.0**
Educational Level	
Primary	69.8
Secondary	18.3
Higher	11.9
Total	**100.0**

N = 126

Results

Socio-demographic characteristics of the women in the age range 15-49

The majority of the respondents (71%) were young adults (25-39 years), 25% were youthful (15-24 years) and 5% were middle aged (40-49 years) (Table 2). Married women also constituted the preponderance of the respondents. The majority of respondents (39%) were married, 30% divorced, 22% were widows and about 9% never married. The study also revealed that the largest percentage of respondents were in the Apostolic sects as 51% of the respondents were drawn from this religious group. Thirty-three percent were Pentecostals and 17% of them were in the mainline churches. The study also highlighted that the majority of the respondents were unemployed. The unemployed constituted 52% of the respondents compared to 27% and 21% who were in the informal and formal sectors respectively. It was further noted that 70% of the respondents had primary education, 18% had secondary education whilst 12% had higher education.

Forms of GBV

Physical Abuse

The study revealed that physical abuse of women was common in Hatcliffe. Ninety-five percent of the participants reported that they once became victims of such abuse. Analysis by their age groups revealed that the majority (66%) of women who were physically abused were young adults (25-39 years) (Table 3). On the other hand, 20% and 10% of the victims were youths as well as middle aged adults (40-49 years) respectively.

Table 3: Percentage distribution of respondents who were physically abused by age groups

Age	Percentage
15-19	6.5
20-24	13.0
25-29	18.5
30-34	22.0
35-39	25.0
40-44	9.0
45-49	1.0

N = 126

In-depth interviews also buttressed the notion brought out in the survey that physical abuse is most prevalent among women aged 30-39. One woman aged 35 years asserted that:

Many victims of physical abuse are married women in their thirties. As one of them, I say this because by age 30 most women will be in marital

unions and where possible, with children. A woman who has children in a union cannot easily break that union whenever exposed to any form of physical abuse. She will always opt to stay put for the sake of her children. That makes her convenient to her husband who happens to be the abuser.

Analysis by marital status revealed that the majority of women (47%) who were physically abused in Hatcliffe were married. Divorced, widowed and never married women reported 33%, 16% and 5% respectively of physical abuse.

A police officer from the VFU also revealed that most of the physically abused women were married. He had this to say:

The majority of the physically abused women are married according to the police records. They constitute more than 50% of all the reports of GBV that we receive from 2006 to date.

Employment status of a woman proved to have a positive correlation with physical abuse. Results from this survey revealed the majority of women (55%) who tasted physical abuse were unemployed. Thirty percent and 15% of the respondents who suffered the same were in the informal and formal sectors respectively.

One woman aged 34 years in an in-depth interview supported the view that unemployed women are always on the writhe of physical abuse. She asserted that:

Normally unemployed women are mostly subject to physical abuse because of their 100% dependency on the husband. How I wish I was employed. My husband always beat me with clinched fists each time I tell him that we no longer have grocery, and more so at the month-end. He always accuses me of being a parasite, waiting to suck his energy. Surprisingly, he does not allow me to sell even pre-paid cell phone top up cards to earn extra cash so that I cease to be a parasite. I cannot report my case to police because if he is to be locked in cells, that will be a double tragedy to me. I do not have resources to look after myself and children.

Another woman aged 30 years and unemployed in in-depth interviews also supported that physical abuse was common among informally employed women. She posited that:

I am a cross boarder trader. I always agonies from physical abuse from my husband who always think that whenever I go to South Africa for business, I will be having extra affairs with other men. He always beat me regardless of how much income I bring home from my trips. He always assume that whenever I bring more money, I will have had sexual intercourse either with many men or I will have 'caught a big fish' (dating someone with the potential of paying more money). I always find it difficult to report the physical abuse I have been subjected to. This is largely because my husband always tell me that even if I am to report, the police will just treat my case as a mere family matter that requires family members to resolve rather than taking appropriate legal measures.

Key informant interviews with Victim Friendly officers also highlighted the view that unemployed and informally employed women suffer the greatest quandary of physical abuse. One of the officers stipulated that:

More than 60% of women who have ever reported cases of GBV to this station are either unemployed or informally employed. They usually say that poverty is disadvantaging them and it has become the key determinant of GBV. However, it is surprising to note that before the cases are taken to court, the majority of them withdraw the cases, a development that likely perpetuates other cases of GBV.

It was observed that level of education of a woman was inversely related to the woman's vulnerability to physical abuse. The majority of the respondents (77%) who suffered physical abuse had primary education (Table 4). Twenty percent and 3% of the victims of such abuse had secondary and higher education levels respectively.

Table 4: Percentage distribution of respondents who were physically abused by level of education

Level of Education	Percentage
Primary	77.0
Secondary	20.0
Higher	3.0
Total	100.0

N = 126

A representative from Musasa Project supported the aforementioned view as she stipulated that:

Physical abuse is more common among women who are not educated. Their precarious conditions of the poverty trap and ignorance of the grievance procedures might be factors underlying their abuse.

One woman in an in-depth interview supported the aforementioned views as she remarked:

I am always physically abused by my husband because he takes advantage of my low level of education. He knows very well that I do not know the grievance procedures. He always boast saying 'Where do you report with such low levels of education? Even if you are to report, where do you get the money for lawyers? I will always win the case because I am better educated than you. I know how to deal with you accordingly'.

Cultural issues normalising physical abuse have left women exposed to severe reproductive health problems. Participants in all FGDs alluded to the fact that physical abuse has been culturally defined as normal. One woman in a FGD with the support of group discussants asserted that:

Every woman knows that at one point in a marriage you have to be beaten by your husband. We were always told when we grew up that a husband who does not beat you does not love you.

One woman in an in-depth interview supported the aforementioned as she posited that:

I have tried several times to report my plight of physical abuse to my mother. However, she has always said to me that is how men behave. She (my mother) always gave me examples of women (whom I know, some of them very educated including her) who ever suffered physical abuse. Even if I look around, my friends at one point in their marriages suffered from physical abuse perpetrated by their husbands. Remember also that we were socialised to appreciate that a good wife does not reveal what is happening in her marriage to strangers and even to relatives. So I have come to accept that there is nothing peculiar about physical violence, it is part of life for any married woman.

The study showed that physically abused women are most commonly susceptible to experiencing R.H problems. All the respondents reported that they experienced at least one R.H problem as a result of physical abuse with the majority (43%) reporting excessive bleeding. On the other hand, 20%, 14%, 13% and 10% of respondents reported that they experienced miscarriages, premature labour, still births and broken bones and other wounds respectively as a result of physical abuse. (Table 5)

Table 5: Percentage distribution of respondents who suffered RH problems as a result of physical abuse

RH Problem	Percentage
Miscarriages	20.0
Excessive bleeding	43.0
Still birth	13.0
Premature labour	14.0
Broken bones and other wounds	10.0
Total	100.0

N = 126

One of the victims of physical abuse who participated in the in-depth interviews supported the view that physical abuse has serious RH problems to the victims citing her personal experiences. She posited that:

Five years ago I experienced a miscarriage that almost took my life when my husband attacked me with booted feet and clenched fists on my stomach whilst I was pregnant. This was a terrible incident in my life.

Another woman from the 40-49 years FGD buttressed the issue of the negative RH impacts physical abuse has to women when she said:

I have a neighbour who was pronounced dead on arrival to hospital due to excessive bleeding that came as a result of physical abuse whilst she was pregnant.

Sexual violence

Rape by stranger

The study exposed that rape was another form of GBV ubiquitous among women aged 15-49 years. The majority of respondents (31%) confirmed that they once experienced rape by strangers. Key informant interviews with VFU police officers at Borrowdale Police Station also supported the high prevalence of rape by strangers among women in the reproductive age group as she asserted that:

Women who experience rape of this nature in

Hatcliffe constitute about 30% of reports of GBV at Borrowdale Police Station. However, this figure could be an under-estimation of reality because some women are shy to report.

The study noted that the majority (76%) of the victims of rape by strangers were unmarried youths. One victim of this form of rape aged 16 years from an in-depth interview posited that:

I was raped two times before I got married. All the two men who raped me were strangers and they are currently serving their sentences. However, to be honest with you, I was very shy to report my plight. I felt that it was a humiliating experience and would always be stigmatised. It just needs some guts to report otherwise there could be many women out there who have not reported the abuse.

The study noted an inverse relationship between rape by a stranger and the woman's level of education. The majority of respondents (95%) who ever suffered this form of rape had primary education. On the other hand, 4% and 1% of the victims who suffered as such had secondary and tertiary education respectively.

One of the participants who participated in the 30-49 years FGD was in support of the above assertion. He had this to say:

Perpetrators of this form rape (rape by a stranger), take advantage of women who are not educated in most cases. They know that women who are not educated take time to report or they do not even report the abuse as they even do not know the grievance procedures. As such, those women tend to be more vulnerable to rape than any other group.

Spousal rape

The study looked at rape that is perpetrated by the victims' spouses. Ninety-two percent of the participants reported their experience of spousal rape with no variation by age group, level of education, religion and employment status. Surprisingly, the majority of respondents (89%) reported that it is rare for women to report spousal rape. This assertion was also supported by a police officer from the VFU who stipulated that:

Spousal rape is common in Hatcliffe. However, the problem is that many women do not know that it is one of the classified sexual offences in the Domestic Violence Bill of 2006. As a result, it constitutes less than 5% of reported cases.

One married woman in the 25-39 years FGD, concurred that it is very improper to report spousal rape though prevalent among women. She remarked that:

Culturally, women are married or are in affairs in order to satisfy their husbands' sexual desires. To report spousal rape is tantamount to expose your failure in sexual obligations and is against the cultural expectations.

This study also revealed that most of the consequences of reporting a spousal rape case to law enforcement agents will affect the economic welfare of the victim. One in-depth interviewee supported the above assertion as she posited that:

If your husband is convicted of the offense, you will suffer the consequences. There will be no-one to cater for your up keeping including children.

Another participant in the 40-49 years FGD exposed that if a victim of spousal rape brings her case to the courts, she will become a social outcast. She postulated that:

All relatives and friends (from your family of origin and in-laws), and even other men and women in general will be bitter with you. People believe that spousal rape is not an offense at all. The minority who might take it as an offence do believe that it is absurd to report it to law enforcing agents.

On the other hand, FGDs of youths revealed that men are not worried of spousal rape because they perceive sexual intercourse as a man's conjugal right following the payment of the bride price. One discussant with the support of group members asserted that:

Married men claim that they pay bride price as an excuse for solely deciding when and how to have sex with their spouses. That also extends to men's unpreparedness to discuss issues that impact on women's R.H such as inability to use condoms for dual protection even if they are in extra marital relationships.

Lack of knowledge about the criminality of spousal rape was also exposed in this study. One in-depth interviewee remarked that:

Until recently I did not know that my husband is committing a criminal offence when he had forced

sexual intercourse with me. My husband always tells me that he paid bride prize. Thus, I should play my part by providing all the conjugal rights regardless of all odds.

The study revealed that rape (forced or spousal) has far reaching reproductive health impacts. In a multiple response question, the majority of respondents, 89%, 88%, 83%, 82% and 80% suffered psychological trauma, exposure to sexually transmitted infections (including HIV), unwanted pregnancies, loss of libido and illegal abortions respectively as a result of rape. Virginal bleeding, genital irritation and urinary tract infection were also reported by 78%, 76% and 72% of respondents respectively in the multiple responses question.

Diminished libido as a result of rape was supported by one rape victim aged 22 years in an in-depth interview. She asserted that:

I am in marriage for two years. However, my experience of rape has resulted in psychological trauma. In addition, I no longer have the desire for sexual intercourse. Resultantly, I do not enjoy sexual intercourse at all with my current partner.

Illegal abortion was also revealed as a consequence of rape. A police officer from the VFU supported this view as she postulated that:

Many reports of illegal abortion we receive are from the victims of rape who will have succumbed to unwanted pregnancies.

On the other hand, this study showed that illegal abortion has severe negative R.H impacts. KII interviews with a representative from MoHCW supported the aforementioned notion. She posited that:

Illegal abortion results in pueperal sepsis, haemorrhage, which also may result in death. Illegal abortions have also been a cause of concern as they are prevalent among the sexually abused women.

Sexually transmitted infections including HIV are also R.H concerns emanating from rape. A participant aged 22 years who took part in in-depth concurred with the afore stated as she reported that:

I am HIV positive as a result of rape. It pains me to imagine that my immune system has been compromised as a result of rape. In addition, the Anti-Retroviral Therapy (ART) which has become part of my life is a bitter pill to swallow.

Forced marriage

Forced marriage was also another form of GBV common in Hatcliffe. The majority of respondents, 65% were victims of forced marriage. Analysis by religion revealed that the majority of respondents (97%) who were forced into marriages belonged to Apostolic sect. Mainline and Pentecostal churches constituted 2% and 1% respectively.

Key informant interviews with a representative from Musasa Project buttressed the fact that women in the Apostolic sect are most vulnerable to forced marriage. The interviewee asserted that:

Marange Apostles arrange intergenerational marriages for their daughters as signs of status and honour, an economic venture and conforming to religious doctrines. The daughters are socialised as part of the church's doctrines to oblige with any arrangement from elders. This is primarily because such arrangements are interpreted as instructions from God. Thus, for the daughters, forced marriages are not a crime.

Findings from the study also revealed an inverse relationship between age and forced marriages. The majority of respondents, 98%, who were forced into marriage, were adolescents and youths. One woman with the support of group discussants in a FGD supported that aforementioned as she alluded:

The Apostolic sect has a tendency of pledging adolescent girls into forced marriages soon after puberty.

The study also noted an antithetical relationship between forced marriage and the girl's level of education and employment status. The majority of respondents (98%) who were forced into marriages had primary education and not employed in Hatcliffe.

The study revealed that forced marriage has gross reproductive health impacts on women. In a multiple responses question, the majority of respondents (85%) who were into forced marriages reported experience of birth complications. Unwanted pregnancies and

exposure to STIs including HIV and AIDS were also pointed out by 79% and 75% respectively.

One KII from the MoHCW in support of the aforementioned results as she expanded the fact that forced marriage has negative impact on women's RH had this to say:

Women who married early and in the age group 15-19 years are twice at risk of maternal mortality when compared with any other age in the reproductive span. This is because their reproductive system is not yet developed to carry pregnancies to full term. In cases where the pregnancy has been carried to full term, the same age group is more vulnerable to birth complications due to cephalopelvic disproportionate (CPD).

Forced marriages affect women's right to decide on their fertility preference. One woman aged 22 years who was forced into marriage had this to say:

I was forced into marriage at the age of 14. My husband is 61 years old and I am the youngest of his four wives. My wish was to have three children, but currently have 5 children. I do not participate in decision making regarding the spacing and number of children.

The study also noted that the decision to use contraceptives in forced marriages solely depends on the husband. This view was supported by all women in FGDs and in-depth interviews. One woman aged 19 years in an in-depth interview highlighted that:

My husband (and with the influence from his relatives) does not allow me to use contraceptives. He always says that we should have as many children as we can for lineage purposes. Most of the times, he always argue that limiting the number of children is contrary to God's wishes of being fruitful and multiplying as expressed in Genesis1vs 28 or Leviticus 26 vs 9.

Discussion

Three forms of GBV have been noted in this study, namely: physical abuse; rape and forced marriages. These findings are consistent with other GBV studies[19,14,11,10,12,28,29,17]. All forms of GBV noted in this study negatively impact on the reproductive health status of women.

Physical violence was common in Hatcliffe with a prevalence of 95%. This finding is consistent with other research findings which noted that that 60% of women ever experienced physical violence in their studies[10,29,12,28]. The study noted that physical violence was most common among young adults, married and either unemployed or informally employed women. Physical violence also inversely correlated with women's level of education in this study. Besides classifying physical violence as a crime in The Domestic Violence Bill of 2006, this study noted that women are weary of reporting. This was largely because of the following: cultural socialisation of perceiving the abuse as normal; poverty and low economic status of women; ignorance of reporting procedures and a perception that police officers treat the crime as a mere family matter that requires family members to resolve rather than taking stern but appropriate legal procedures. Regardless of the abovementioned factors impeding the reporting of physical abuse, this study noted that physical abuse had far reaching effects to women's reproductive health. Excessive bleeding, broken bones and other wounds were reported as common to all women. However, pregnant women have additional impacts like still births, premature labour and miscarriages. These findings are commensurate with studies which revealed that women who experience physical abuse during pregnancy are likely to run twice the risk of miscarriage and four times the risk of having low-birth-weight babies[10,9].

Rape by a stranger is another form of GBV with a prevalence of 31% in Hatcliffe. The study noted that an inverse relationship between rape by a stranger and a woman's level of education. Ignorance of reporting procedures and fear of stigmatisation have left a culture of silence among some women who suffered this form of GBV. It is also disturbing to note that rape has far reaching R.H impacts, inter alia: psychological trauma; diminished libido; exposure to STI and HIV infection; unwanted pregnancies and illegal abortions and possibilities of maternal mortality. On illegal abortions, studies have shown that globally, 13% of the maternal deaths are due to complications of unsafe abortions such as lower

abdominal cramps and external vaginal bleeding[10,30]. This is largely because illegal abortions are performed under clandestine conditions. In Zimbabwe, illegal abortions besides being contrary to the 1977 Pregnancy Termination Act, they are also a criminal offense according to the Criminal Law Act, 2006.

The prevalence of spousal rape in this study was 92% a higher percentage when compared to 13%[32]. Regardless of the aforementioned prevalence and the definition of spousal rape as a crime according to the Sexual Offenses Act Revised in 2001, The Criminal Law (codification and reform) Act, 2006, Chapter 9.23 and the Domestic Violence Bill of 2006, it is bothersome to note that women in this study were reluctant to report the abuse. Although spousal rape is being prosecuted worldwide[10], it is worrisome to note that the same source asserted that only 104 states worldwide are effecting the prosecution. In this study, payment of the bride price (which entails the transfer of conjugal rights to the spouse) made it a taboo to prohibit marital rape as defined in The Criminal Law (codification and reform) Act, 2006, Chapter 9.23. In addition, ignorance about reporting procedures and poverty have been cited as extenuating factors underlying a culture of silence as far as reporting of spousal rape is concerned. Though women fail to report spousal rape, it should be argued that R.H effects of spousal rape such as exposure to unwanted pregnancies and risks of STIs and HIV infections do not spare the women either.

Forced marriages with a prevalence of 65% were also frequent in this study. Whilst forced marriages were a religious conformity, status and honour and an economic venture, it should be argued that the practice had far reaching implications. Forced marriages, as noted in one study, are a violation of human rights, compromising the development of girls and often resulting in early pregnancy and social isolation, with little education, poor vocational training and lack of improved employment opportunities thereby reinforcing the feminization of poverty[32]. Forced marriages in this study exposed women especially uneducated adolescents to risks of early child bearing and increased fertility. Studies by[32,33,34,35,36,37]. also share the same notion. The aforementioned authors noted that a decrease in the mean age at marriage tends to increase fertility and the reproductive period of a woman. In addition, early child bearing (as a result of a forced marriage) in this study was positively correlated to risks of birth complications, a fact not appreciated by parents of the pledged daughters. Similar findings were also echoed by[9] and[17]. Forced marriages have exposed women to unwanted pregnancies. Findings by[38] also substantiate the aforementioned view. Exposure to risks of STI infection including HIV is also another R.H issue emanating from forced marriages. Studies by[9] revealed that women in forced marriages face the risk of exposure to STIs. This study also noted that early child bearing as a result of forced marriages exposed women to birth complications including CPD and increased risks of maternal mortality. Such a view is supported by[18] and[32] in Zimbabwe, complications leading to maternal mortality are accentuated by the age of the mother, with teenagers more likely to experience adverse pregnancy outcomes. In Zimbabwe, Central Statistical Office (1994; 1999; 2005/6; 2010/11) it has been noted that maternal mortality rates were 283, 695, 555 and 612 deaths per 100 000 among women aged 15-49[39,40,41,42] respectively.

The prevalence of forced marriages among women in Hatcliffe negatively impacted on their reproductive health. The study noted that forced marriages unconstructively impacted on women's ability to exercise reproductive and sexual autonomy. It affected women's ability to decide on fertility preference, timing, spacing and also the use of contraception. All the aforementioned violate the definition of R.H rights as posited in The Proclamation of Tehran of 1968, UN General Assembly Declaration on Social Progress and Development of 1974, (Article 3.9) UN International Women's Year Conference echoed the Proclamation of the Tehran in 1975, The Bucharest Conference of 1974, The Convention of all forms of Discrimination against Women of 1979, The World Population Plan of Action of 1984, The Cairo Programme of Action of 1994, The Fourth World Conference on Women in Beijing of 1995 and The Yogyakarta Principles of 2006. It should be argued that the abovementioned conferences emphasised the basic R.H right where

individuals are supposed to decide freely and responsibly on matters relating to their sexuality, including sexual and reproductive health, the number, timing and spacing of their children free from coercion, discrimination, and violence.

Conclusion

There is widespread GBV in Hatcliffe in form of physical abuse, rape and forced marriages. These forms of violence negatively impact on women's reproductive health, yet a culture of silence (largely precipitated by socio-cultural, economic, religious and policy implementation) encase the subject of GBV. It is high time Zimbabwe work out programmes which aim at economic emancipation of women. In addition, there is the need to break the culture of silence through the provision of information, education and counselling (to both males and females) pertaining to the horrible effects of GBV in all ministries if the reproductive health status of women is to be upheld. Efforts must be made in order to scale up the implementation and enforcement of policies pertaining to GBV which Zimbabwe ratified and even enacted as Acts if reproductive health effects of GBV are to be curbed.

Contribution of Authors

Festus Mukanangana conceived the idea and drafted the topic and objectives of the study. He jointly collected data, prepared the manuscript, analysed data with co-authors. He unconditionally approved the manuscript.

Stanzia Moyo jointly analysed data and prepared the manuscript with the other authors. She formatted the manuscript. She unconditionally approved the manuscript.

Alfred Zvoushe jointly collected data with Festus. He also jointly analysed data and prepared the manuscript with the other authors. He unconditionally approved the manuscript.

Oswell Rusinga. He jointly analysed data and prepared the manuscript with other authors. He unconditionally approved the manuscript.

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