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Lived experiences of survivors of sexual Assault who became pregnant and sought care at Mutare provincial hospital-July 2020 in Zimbabwe

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Abstract

Introduction: Becoming pregnant from sexual assault is a significant concern for survivors of sexual assault and survivors of different ages, social, cultural and religious backgrounds may have varying feelings regarding acceptable treatment options (Safeta, 2019). Pregnancy resulting from sexual assault is a multidisciplinary issue which associates health care practitioners, legal services, community and societal systems. The World Health Organization, (2013) guidelines for sexual gender based violence makes provision for immediate care of rape victims within 72 hours, that is, free medical and psychological care, post exposure prophylaxis, treatment of sexually transmitted infections, contraceptive pills and legal support, but few victims seek care (Resnick,2013) resulting in unwanted pregnancies and their traumatic sequelae. This study explored lived experiences of survivors of sexual assault who became pregnant and sought care at Mutare provincial hospital to identify gaps for possible improvements in delivery of comprehensive care.

Methodology: A phenomenological qualitative approach was employed for an exploration of lived experiences of survivors of sexual assault who become pregnant. Purposive sampling was used to draw a sample of ten survivors of sexual assault who became pregnant. A thematic approach was used to explicate data from the study.

Findings: Five themes emerged from the study findings. The three which are unstable family environment; low socio-economic status; and low education and empowerment as risk factors to sexual assault and pregnancy as well as negative outcomes. Two themes related to decision making and outcomes implicated on existing environments as well as strengths and gaps in service provision.

Conclusion: The overall discussion was occurrence of sexual assault facilitated by unfavorable victim environment, late disclosure and missing emergency medical care resulting in pregnancy and psychological distress connected to inadequate care and unresolved socio-demographic issues. Therefore, the study recommends policy level address of detected risky factors and training of multidisciplinary care teams.

Keywords: Sexual assault, rape, pregnancy

1. Introduction

Sexual assault is a global scourge (Coleman, 2015) [4] and the health outcomes appear poor though it has not been systematically studied. Report by UNAIDS (2010) [15] indicate that young and adult females are overwhelmed by disease and trauma from sexual assault because of their vulnerability to effects of violation of their reproductive health rights such as unwanted pregnancy and unsafe abortions. Statistical estimates of pregnancy following sexual assault vary widely, but 5% was given as an estimated rape related pregnancy rate (Franz, 2015) [6]. Worldwide up to 50% of sexual assaults are committed against girls under 16 years of age (Rutgers, 2018) [13] and 28% of adolescent girls who experience complications of abortion are sexual assault victims (WHO, 2001).

The African Commission of Human and Peoples' Rights (ACHPR, 2019) reported that there is widespread sexual violence against women is most African countries, and the violence consists of forced first sexual act, incest and rape by intimate partner leading to unwanted pregnancies and unsafe abortions with their consequences such as psychological trauma. Recent studies in Africa reveal that pregnancy as a result of sexual assault is more prevalent in adolescents. World vision (2019) undertook research in 7 African countries which revealed increased violence and abuse of children as attributes to pregnancies of young girls and adults including caregivers and school teachers were found to be the main perpetrators.

Sexual assault is also widespread in Zimbabwe especially against girls (WHO, 2017) [17] leading to a shutdown in their opportunities and hindrance of their full potential especially when the sexual assault results in pregnancy and child bearing. One in three females who reported being raped in childhood became pregnant as a result (Zimstat, UNICEF, 2013) [22]. The Victim Friendly System consists of interdisciplinary collaborative interventions which have

been put in place to deal with child sexual abuse in Zimbabwe but a study report by Muridzo *et al*. (2018) [11], indicated that there was limited access to the survivors of sexual assault due to resource limitations thereby rendering the system ineffective. Mutare Provincial Hospital is a referral centre for all sexual assault cases for medical care in Manicaland province of Zimbabwe and receives sexual assault survivors days, weeks and even months down for effective emergency contraception as well as abortion services.

In a bid to manage the problem of sexual assault and the resulting sequelae, (WHO, 2013) [20] called for efforts by health services to contribute both to primary prevention and to follow up care and support of survivors of sexual assault. Survivors of sexual assault who become pregnant are likely to have missed the opportunities or emergency medical treatment for sexual assault victims which include prevention of pregnancy and are left with two options which are termination of pregnancy or child bearing. According to Beck, (2019) [22], these two choices depend on sociocultural factors, what she believes, the gestational age and the surrounding laws, and either option costs years of emotional stress and further exposure to violence and trauma**.**

According to Munro *et al*. (2012) [10], there is dearth of research on the health status of adult and childhood rape survivors as they enter pregnancy. Resnick *et al*., (2012) [12] posit that few survivors of sexual assault access care and factors leading to this low rate of seeking care are not fully known. The effects of trauma of sexual assault need to be explored from the time of assault to the time care is sought as well as after care experiences. WHO (2012) [18] also recommended exploration of each survivor's experience in decision making process from the time of assault and how she responded to pregnancy.

1.2 Implications

The study has identified gaps and strengths for improvement of provision of comprehensive and holistic care for survivors of sexual assault who become pregnant. The findings have implications to midwifery practice, education, research, nursing and midwifery administration as well as policy makers. Inter-professional collaboration, interdisciplinary training of care givers and evaluation of existing protocols and policies for effectiveness are all required in light of new information and trends in dealing with prevention of sexual assault and mitigating its effects.

2. Methodology

A qualitative phenomenological approach was employed to accurately explore the lived experiences of survivors of sexual assault who become pregnant. Husserl's descriptive phenomenology, which aims at revealing transcendences of human experience through description, was identified as the most suitable design for this kind of study. Purposive sampling was used to recruit 10 participants aged between 18 and 25 years. The researcher used unstructured interview guide to obtain data through face to face interviews. Data was captured through audio recording and note writing.

2.1 Data collection procedures

The researcher used records from Mutare Provincial Hospital casualty, gynaecology, maternity and mother and child health departments to identify the potential participants, their addresses and telephone numbers. The participants whom the researcher managed to reach on telephone were contacted and the researcher conveyed important information about the intended research. Those who agreed to participate in the research and were willing to be video- taped as well as having access to transport to and from Mutare Provincial Hospital were enrolled for the study. After obtaining participant consent, interviews were done on one to one basis and as the participants narrated their stories in response to the questions, the researcher was writing notes as well as audio recording. The investigator was also noting non- verbal cues and making observations to note any emotional distress so as to respond accordingly. The central question was, 'What are your experiences with pregnancy as a result of sexual assault?'

2.2 Data management and analysis

Audio recording was done with the permission of the participants and a written consent. Participants were coded as p1 to p10 and the audios were labelled using the participants' code numbers. The researcher recorded the interview as comprehensively as possible as to what happened, who was involved, when, where and how events occurred. A file was used to store informed consent forms, notes during the interview, notes written by some of the participants and all written information during data explication. Data explication was done in this research instead of data analysis so as to avoid loss of the whole phenomenon. The following Hycner (1999) [8] steps were followed as cited by Groenewald (2004) [7]; Bracketing and phenomenological reduction, delineating units of meaning, clustering of units of meaning to form themes, summarising each interview, validating it and if necessary modifying it and finally extracting general and unique themes from all the interviews and making a composite summary. The results were presented using a thematic approach. The themes were presented as experiences around the time of assault; experiences from the time of assault to reporting and seeking care; and experiences regarding decision making.

3. Results: Lived experiences of survivors of sexual assault who became pregnant

3.1 Experiences around the time of assault

As the participants related their life histories it was noted that most of them came from broken families, some being orphans, or stayed with single parents, domestic violence was present at home and experienced some psychological and emotional abuse to include child neglect and sexual harassment. Feelings of guilt, anger, betrayal, suicidal thoughts, feeling cheap, reduced social status and withdrawal were frequently mentioned by the participants. These were worsened by the inability to disclose and keeping it to themselves and failure to get psychological counselling and support. It was difficult for them to share experiences related to sexual issues.

P8,'I stayed with my parents and brothers and had a neighbour, a gardener who was frequently proposing me and at times he would sexually harass me. We were close since we were neighbours but on this day he accused me of destroying his phone charger which I once borrowed and

asked me to come to his room to see it. When I got to his room he locked the door, forcefully grabbed me to the bed and tied my mouth and forced himself on me whilst I was trying to fight him. I felt betrayed for the trust I had for him as a neighbour, I even thought of ending my life. I felt cheap and was angry, I had mixed emotions and even my social life lowered and I talked less than I used to do. I was sexually assaulted."

P9,'I stayed with my uncle, the husband of my mother's young sister together with their 4 year old daughter while my aunt was frequently away from home doing buying and selling business. He used to buy a lot of nice food and goodies and used to joke telling me about what he had been doing with his girlfriends, one day around 12 midnight, he raped me and told me to be quiet and the following day he raped me for the second time and threatened to end my life if I was to tell anyone

P5,"My mother died when I was four years and my father died when I was 11 years, then I was taken by my great grandmother. At first I stayed well but as time went on, she ill- treated me, was always shouting at me accusing me of things I did not do depriving me of educational needs and even rest. I was also being emotionally abused by a male cousin who wanted me to do everything for him including his laundry, sending me to buy cigarettes and at times clapping me. I could not complain to the grandmother because I was told that I would be chased away from home. I endured overworking, being deprived of rest and kept quiet because I had nowhere else to go. My male cousin then started to sexually harass me by kissing me when he was drunk and I pushed him away, I told Gogo (great grandmother) and she said that's what boys do when they are drunk. The other day I was watching TV when he came and pushed me on the sofa and raped me. I called for help but there was no response'

3.2 Experiences from the time of assault to reporting and seeking care

Concerning reporting the sexual assault and seeking care only one of the ten participants reported to her guardian soon after the event, but only to be threatened to be chased away from that home if she would report to the police. One participant disclosed well after 72 hours, which was done after 5days. The other participants only disclosed when their parents or guardians noticed their pregnancies. Four participants were afraid to disclose to their parents for fear of being blamed.

P1, 'After the activity, the perpetrator gave me money for me not to tell anyone. Because of fear, I did not. Mom came back and I was afraid to tell her because she has a temper at times. Mum discovered that something was eating me up and asked if something was wrong but I kept insisting that I was fine. After 5 days I had the courage to share and disclosed to my close friend who advised me to tell mum as quickly as possible and I did so. When I told her we visited a police station to make a report and we were accompanied to hospital for medical examination I was given a pill to prevent pregnancy but was told it might not work because I reported late. Mom discovered that I was pregnant at five weeks and we went to get legal and medical help.'

P4,'I did not tell my mother that I was raped because she was always saying, 'ukarara nemunhu ndiko kwaunobva wanogara'(if you sleep with a person you proceed and go to stay where the person stays), so after the incident I asked my mother that I wanted to go and stay with my uncle because I feared that she might discover that I have slept with someone and send me back to the perpetrator. I stayed with my uncle till his wife discovered that I was pregnant at 20 weeks and that's when I disclosed the issue to her. She called my mother and we went to report to the kraal head who then referred us to the police.'

P6,'After the sexual assault, the perpetrator intimidated me saying 'you know your father, if you tell anyone, you will be chased away from home'. I also thought that if I tell anyone I will be chased from home because my father was strict and I feared that he would blame and victimise my mother as well. So I kept quiet till my mother discovered that my tummy was growing big and she examined me and found out that I was pregnant. I then told her what happened but because she also feared my father she could not tell him so she decided to secretly go with me to the perpetrator's home who had run away out of the country. His mother suggested that we seek abortion secretly from a traditional practitioner but my mother refused and left me there. When mother told my father that I was pregnant and at the perpetrator home who has ran away, he took me back home and reported the case to the police referred us to hospital for medical examinations and care.'

3.3 Experiences regarding decision making

Some decisions were influenced by the family's religious values as well as personal belief of not wanting to shed innocent blood and believing that termination of pregnancy is an act of killing. Counselling and information provided by police from victim friendly unit as well as medical practitioners mapped the decisions on the way forward. Participants received information on available options and were asked to choose. Gestational age also influenced the medical practitioners' decision, whether termination of pregnancy was possible or not

P7, "The nurse said she, referring to me so that I can obtain a letter for termination of pregnancy. I went for a scan and went to court and they said it should be removed. I and my mother told the police that we did not want termination of pregnancy and we were referred back to hospital. The nurse told us that 'Mudumbu Mune Tsvina' (the uterus was contaminated) so the pregnancy should be removed, so I agreed to termination, 'Nekuti Ndozvanga Zvavepo'(that was the obtaining circumstance).

P6,'The police said you need TOP(Termination Of Pregnancy) so that you continue with school but both my parents were not agreeable. My mother said she did not want blood on her hands and my father supported my mother's decision and said he would let her go back to school after delivery. I then chose to keep the pregnancy as well because I considered that it may be the only child that God gave me despite being conceived through rape.'

3.4 Experiences with the pregnancy and its outcome

In this study it is revealed that TOP relieved the survivors of sexual assault who became pregnant and where resources were available they would continue with school and get empowerment. Two of the participants who had TOP regretted later because of spiritual pain associated with

termination of pregnancy that is some feelings of guilt. Loss of educational opportunities, difficulty with parent child bonding and late acceptance of the child were reported by those who continued with pregnancy and child birth.

P1,'I am happy that I continued with school after termination of pregnancy and I am now doing tertiary education. I felt so guilty that I killed an innocent soul and abortion is legal but it's a sin to God. I am satisfied with the outcome though and everything is ok now.

P5,'Termination of pregnancy relieved me because I became pregnant as a result of sexual assault by a cousin. It was done timeously and my going to school was not disturbed. I was helped by another uncle by removing me from the place and facilitated arrest of the perpetrator. I do not have any regrets and I am working hard at school to achieve my dreams.'

P4,'I had a caesarean section because I was too young to have a normal delivery. Though I wanted to have TOP, I reported late when it was not possible for me to have it. I have accepted the situation and I love my baby.'

P10,'I was severely grieved when the doctor told me that I cannot have TOP because my pregnancy was 28 weeks and I should book for delivery of a baby. I was not ready to have baby, I was only a grade 7 pupil and wanted to go to school to start my secondary education the following year. The nurses counselled me and I went home just because there was nothing I could do. I did not want this pregnancy from sexual assault and the entire trauma. I delivered the baby by operation at hospital I breastfed my baby up to 11 months and went to continue with secondary school at a different place while my mother took care of my baby.'

3.5 Experiences with care received

All of the participants went to report to the police soon after disclosure. No barriers were mentioned in accessing the service. Almost all the participants reported being helped fully and with kindness by police officers. Health care providers facilitated other procedures and did the medical examinations. The participants lacked knowledge about what was really happening to them. The study indicated that the survivors last received health care or any supportive care on discharge following TOP or from maternity. There was no follow up care which would help map the way forward for mitigating the post assault effects.

P,5' My other uncle called the police and reported the issue and my uncle who raped me was arrested.' I was accompanied to the local police station by my aunt and they asked me to relate what has happened but I could not say anything. I went back home and the next day the police came and accompanied us to see a social worker who managed to discuss with me then I was able to tell her all what happened. The police officer then went with me to court to get a letter for termination of pregnancy. 'We went to hospital and I was asked to go for scan which showed that I was 16 weeks pregnant. I was referred back to hospital and I was admitted for TOP. My aunt was asked to sign some papers but I dint know what she was signing for. I had termination of pregnancy and I stayed in hospital for 3 days and the perpetrator was given an 18 year jail sentence'

P,1, 'When I tested positive for the pregnancy, we went to the magistrate to be given a letter for TOP.I was then referred to hospital and was admitted for the procedure. The nurse asked some few questions and she was writing down something. The process went on well and I was discharged after 3 days.

P,3, 'I was admitted in gynaecological ward and the process of TOP went on well and I did not encounter any problems and was handled well. I was discharged after 3 days and I was not told about anything to do after discharge.'

P,4, ' The police wrote something and referred me to hospital. At the hospital, I was examined and was told that the pregnancy cannot be terminated because it was more than 4 months and we went back home. When the pregnancy was due, I started having labour pains and I went to hospital. I was examined and they said I should go for Caesar and I had the operation. My mother came and collected me from the hospital when I was discharged. The perpetrator was taken to jail but was released after paying bail. We went to court twice and he was appearing and refusing the case.

4. Discussion

4.1 Theoretical framework

In this study the original 5 level Bronfenbrenner (1977) [3] socio-ecological model was adapted to include the institutional level to the effect of exploring policy and influence change. The five levels of the socio-ecological model were applicable throughout all the stages of experiences of survivors of sexual assault who become pregnant. The study has identified gaps in the social environments which impact the occurrence of sexual violence and pregnancy as a consequence and the principles of the social ecological model can be applied to improve this social environment. The socio ecological model has facilitated explanation of existence of the research problem and implementation of recommendations can be well fitted in the framework. It can be adopted in amending guidelines and protocols at individual, relational, community, institutional and policy levels. The prevention and mitigation of pregnancy resulting from sexual assault need to be planned for, covering all levels in the socio ecological cycle.

4.2 Interpretation of findings

The researcher reviewed related literature that illuminated the study and that was the basis for the discussion. Themes which emerged from addressing research questions as well as demographic data were discussed in detail and in relation to literature review as well as the conceptual model.

4.2.1 Lived experiences of survivors of sexual assault who become pregnant

This study revealed that teenagers and adolescent girls were at high risk of becoming pregnant from sexual assault as reported by WHO (2012) [19] that adolescents have reduced ability to decision making as well as inability to use condoms or any contraception. The study findings concur with WHO (2017) [17] which postulated that widespread sexual assault against girls in Zimbabwe lead to a shutdown in their life opportunities and hindrance to their full potential especially when the sexual assault results in pregnancy and child birth. Fifty per cent of the survivors did not get the opportunity to go back to school. The study also revealed the other side of the story as 50% of the

participants had histories of drooping in and out of school due to lack of school fees and educational resources and are the ones likely not to continue with education after TOP or child birth. Resource availability would ease post- traumatic stress while poverty and lack of resources for a living caused participants to continue grieving over the past events which had worsened their situations.

The occurrence of sexual assault in the family environments has also been identified by a study in Peru which revealed that the pregnancies that occurred in girls of ages 16-22 were as a result of sexual assault mainly committed within the home environment (INEI, 2015) [9]. In this study, survivors of sexual assault who became pregnant were coming from unstable family environments. Loss of one or both parents through death led to exposure to child neglect, emotional abuse, child labour, psychological abuse and lack of confidence and reduced decision making abilities in these survivors.

The findings of this study concurred with several other studies in literature which revealed that delay in reporting and seeking care is prevalent among survivors of sexual assault who become pregnant. Ninety percent (90%) of the survivors never disclosed the assault till they discovered that they were pregnant or a parent or care giver noticed the pregnancy. Results of this study shows a shift from a past study in Zimbabwe by Dube *et al*., (2013) [5] which detected lack of knowledge and awareness about action to take following assault as all the participants in this study had received information at school or through social media about what action to take after sexual assault. The lack of knowledge and awareness was on the existence of support organisations, shelter refuges and assurance of safety if they were to disclose or report.

In this study data from the interviews revealed that decision making as to what action to take with pregnancy conceived through sexual assault was influenced by counselling from police victim friendly unit and health care providers, gestational age at the time of reporting and the survivor and her family's beliefs about the two options available. Results of this study revealed that pregnancy played an important role in exposing sexual assault which is difficult to disclose in young girls and adolescents. Termination of pregnancy also brought relief from incest as well as offering the young girls opportunities to continue with their education. Acceptance of the baby was reported by all survivors though it happened after some time with others facing difficulty with bonding. The results of the study on experiences of care were analysed in light of the WHO (2013) guidelines and revealed how much is being accomplished as well as gaps which need to be addressed.

4.3 Implications of the study

4.3.1 Implications to nursing and midwifery practice

The findings of this study inform the health care system on gaps identified in delivery of comprehensive care, which is lack of client specific and sensitive care as well as interpersonal communication and patient education in the health care system. Nurses and midwives are at the forefront in history taking, planning care and referring to other team members as the clients seek initial medical services, termination of pregnancy, antenatal care, maternity care and postnatal care. Nursing as an art and a science that looks at the clients holistically that is physical, mental, social and spiritual well- being and though they might not address it all themselves they facilitate through co-ordination with police, support organisations and other sectors at all levels of the socio-ecological model.

4.3.2 Implications to nursing and midwifery education

The study revealed gaps in individualised client sensitive and specific care and in interpersonal communication between the nurse, midwives and other team members and therefore it informs nursing and midwifery educators of the importance of emphasizing client specific and sensitive care. The importance of inter-professional collaborative education will also be appreciated in this area which requires interdisciplinary and collaborative efforts in achieving comprehensive care of survivors of sexual assault who become pregnant.

4.3.3 Implications to research

The study has identified low rate of disclosure and in this research disclosure and reporting was facilitated by occurrence of pregnancy. More community studies are likely to reveal more than what is known on prevalence of sexual assaults and its effects. Research findings will facilitate uptake of evidence based practice in nursing and midwifery and encourage nurses and midwives to undertake operational research in their areas of practice.

4.3.4 Implications to nursing and midwifery administration

The study revealed that midwives and nurses performed procedures well for the physical needs of clients indicating that they may fail to get enough time to cater for the psychological and social aspects of patient care. This informs administration on the need to review staff allocation so as to increase staff establishment that would enable attention to psycho-social needs of the clients. The study identified on job training needs for health care workers which managers can appreciate and design training workshops in that regard.

4.3.5 Implications to policy makers

The study revealed the impact of low socio-economic status and unstable family environments in expediting sexual assault and its horrible effects. Low utilisation of existing support organisations, counselling and lack of awareness about their existence and operations was also detected. Means to identify these needy and disadvantaged girls should be availed and community education and awareness need to be addressed by policy makers. An evaluation of existing policies and their effectiveness is required in light of new information and emerging trends in dealing with prevention of sexual assault and mitigating its effects.

4.4. Summary of findings

The summary of findings was presented in light of answers addressing the research questions. It briefly outlines the major findings of the study as reflected in emerging themes.

4.4.1 Unstable family environment: was found to be a significant vulnerability factor in young girls and adolescents who become pregnant as a result of sexual

assault. Death or divorce of parents led to the girls growing in extended families enduring child neglect and other forms of child abuse. Decision making ability and empowerment to resist abuse as well as to seek care was limited as sexual assaults occur within these home environments. The victimisation becomes part of the vicious cycle and if the environment does not change they have worse outcomes and difficulties and remain at risk for further violence.

4.4.2 Low socio-economic status: and poverty, inability of parents or guardian to pay school fees was found to be predisposing factors of sexual assault as well as multiplying their problems when they get pregnant as a result. They failed to get education and empowerment for a living, further exposing them to gender based violence due to dependence and lack of income and employment.

4.4.3 Lack of knowledge and empowerment in reporting and seeking care - to resist threats and fear which impede disclosure and care seeking behaviour, was found to be predominant in occurrence of pregnancy as a result of sexual assault together with lack of awareness about existence of support organisations such as safety homes. The sequelae is late disclosure and missing emergency medical preventive care such as emergency contraception for pregnancy prevention; and post exposure prophylaxis for HIV and STI prophylaxis.

4.4.4 Nonconcrete factors in decision making process

Individuals' choices, circumstances (such as perpetrator being a relative), family beliefs and sentiments about abortion, gestational age influences the decision to either continue with the pregnancy or have TOP. Information received during counselling by care givers also helps one to make a well informed decision.

4.4.5 Pregnancy as the precursor for disclosure of sexual assault

The study revealed that pregnancy from sexual assault, though an adverse event exposes sexual assault and abuse of young girls by adults. It was discovered that if pregnancy did not occur, the sexual assault would not be reported at all and this brought to light high probability of existence of so many undisclosed and unreported sexual crimes against adolescent girls. Stigmatisation, social detachment and identity crisis were causes of psychological stress in those who had TOP. Some, who with pregnancy and child bearing, faced challenges of lack of support in bearing and caring for the child and shattered education opportunities especially those in families with poor economic backgrounds.

4.4.6 Strengths and gaps in care and services

Strengths were found in well trained victim friendly unit police officers in handling the victims satisfactorily. The courts were efficient in timely offering of authority for TOP but some survivors and their family were disgruntled by non -conviction of the perpetrators. The chain of procedures was well done in health care system but communication, psychological care, follow up support, referrals, coordination and collaboration need to be strengthened. There is generally lack of training for comprehensive sexual assault specific and sensitive management in the multidisciplinary team which needs to be put in place by policy makers.

5. Conclusion

Pregnancy resulting from sexual assault was found to be most predominant in adolescent girls with unfavourable and unstable family backgrounds and associated with low socioeconomic status and other forms of abuse occurring in the home environment. The challenges that are faced before the sexual assault were found to make the experiences more horrible and causing further exposure to abuse and these included lack of family support and lack of financial resources and empowerment. As pregnancy was the precursor for disclosure of sexual assault, by reverse argument, it thus would appear that where there is no pregnancy there might not be any disclosure. The decision to terminate or to continue with the pregnancy and outcomes depend on individual circumstances, therefore, counselling and support is needed for either option. Training of care givers in the multidisciplinary team is of paramount importance in providing holistic, client sensitive and specific care to survivors of sexual assault who become pregnant. Evaluation of existing strategies, address of pre-existing individual family and community environmental risk factors is also recommended.

6. Recommendations

The researcher came out with the following recommendations which emerged from major findings of the study.

In-service training of nurses and midwives who are involved in the care of survivors of sexual assault who become pregnant; and health care institutions to have special nurses to be consulted when the clients come and leave the hospital. Care guidelines and protocols should be clearly written down and well displayed and visible in hospital and a checklist to monitor adherence to the guidelines to ensure provision of comprehensive care. Gender based violence and sexual assault to be included in basic nursing and midwifery curriculum and taught by sensitised educators.

Interdisciplinary training of all service providers and care givers who are involved in the care of survivors of sexual assault who become pregnant, so as to bridge the gap of communication breakdown through a strong referral system and information sharing. This will help eliminate errors of omission and improve better health outcomes and client satisfaction. Curriculum based child empowerment lessons for young girls through primary and secondary education so as to increase their decision making power and resist threats and overcome fears that hinder them from disclosing and reporting sexual abuse and violence.

Community awareness on safe disclosure of sexual assault through mass media and Information, Education and Communication material informing communities about available support organisations and improving access even by those in most remote areas. Multisector approach is recommended in identifying unstable families and children who are at risk and in need of financial support so that they are linked to support organisations for interventions. Strengthening and building up of health family environments through religious, cultural and other societal

forums. Large scale research in the community using qualitative and quantitative methods is needed to identify despoiled women and explore their experiences with pregnancy as a result of sexual assault and to include those who did not seek care and those who had back street abortions.

7. References

1. ACPHR. Genaral Comment on No 2 Article 14 of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa.@ Africa union.org 2019.
2. Beck CJ. What are the Options for a Woman who is Raped and becomes Pregnant? 2019. https:// www.medscape.com./view article/918068
3. Bronfenbrenner U. The Ecology of Human Development. Cambridge, Mass: Harvard University Press 1979, 1980-1995.
4. Coleman GD. Pregnancy after rape. Int. J Women's Health Wellness 2015.
5. Dube R. She probably Asked for it: A Preliminary Study in to Zimbabwean Societal Perceptions of Rape. Research and Advocacy Unit 2013.
6. Franz W. The Psychology of Rape. Association for Disciplinary Research in Values and Social Change (A.I.R.V.S.C.) Life isuues.net 2013, 5(2).
7. Groenewald T. A Phenomenological Reearch Design Illustrated. International Journal of Qualitative Methods 2004. https://do.org.1177/16094690400300104
8. Hycner RH. Some Guidelines for the Phenomenological Analysis of Interview Data.in A Bryman & R.G. Burgess (Eds) Qualitative Research London: Sage 1999;3:143-164.
9. INEI, Peru Country Spotlight on Teenage Pregnancy. National Institute of Satistics and Information 2015. https:||dhsprogram.com/pubs/pdf/FR299
10. Munro ML, Rietz MF, Seng JS. Comprehensive Care and Pregnancy: The UnMet Needs of Pregnant Women with a History of Rape. Issues Mental Health Nurse 2012;33(12):882-896.NIH.
11. Muridzo N, Chikadzi V, Kaseke E. Challenges Faced by Professionals Working in Child Sexual Abuse Multi-sectorial Forums: A Case of the Victim-friendly System in Zimbabwe. Social Work 2018;54(4):452-468. https://dx.doi.org/10.15270/54-4-672
12. Resnick HS, Barr C, Danielson CK, Kilpatrick DG. Receipt of Post-Rape Medical Care in a National Sample of Female Victims 2012.
13. Rutgers Sexual Violence Knowledge File 2018. https//.www.rutgers.international
14. Safeta. The Ultimate Source for Sexual Assault Forensic Examination, Technical Assistance 2019. Https:||.www.safeta.org
15. UNIAIDS. Democratic Republic of the Congo 2010.
16. United Nations. In Zimbabwe, UNICEF Goodwill Ambassador Calls for more Protection of Child Victims of Sexual Violence https:// news.un.org.>story>2017
17. WHO. Responding to children and adolescents who have been sexually abused. WHO clinical guidelines. World Health Organization, Geneva. 2017. http://apps.who.int/iris/bitstream/handle/10665/259270/ 9789241550147-eng.pdf;sequence=1
18. WHO. Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines. Geneva*:* World Health Organization, Google Scholar
19. World Health Organization WHO, Safe abortion: technical and policy guidelines for health systems – 2nd ed. 2012. Available from http://apps.who.int/iris/bitstream/10665/70914/1/97892 41548434_eng.pdf
20. World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization. Web of Science®Google Scholar 2013.
21. World Vision. The Violent Truth about Teenage Pregnancy. What Children Say. Report from World Vision 2019. https://relief web.int/organisation/world-vision
22. ZimStat, Unicef. The Multicounty Study on the Drivers of Violence Affecting Children in Zimbabwe: Using a mixed methods, multi-stakeholder approach to discover what drives violence. Journal for Vulnerable Children and Youth, 2013, 13.