

YouthLens

on Reproductive Health and HIV/AIDS

Nonconsensual Sex among Youth

Youth programs need to consider patterns of coerced sex when addressing reproductive health, HIV prevention, and other needs.

Reproductive health and HIV prevention programs for youth rarely address the reality of coercive sex that many youth face. Recent evidence suggests that a significant proportion of young women and, to a lesser extent, young men experience nonconsensual sex. Such coercion is a violation of a person's rights and can have severe physical, mental, and reproductive health consequences, including the risk of unintended pregnancy and HIV and other sexually transmitted infections.

Recent research on this topic was presented and discussed at a global consultative meeting held in New Delhi, India, in September 2003 (see box inside). Among the key issues that emerged were the range of sexual coercion that young people experience, the impact of gender norms on coercion, the consequences of coercion, and program approaches to reduce the problem.

Nature and extent of coercion

Sexual coercion among young people encompasses a range of experiences, ranging from noncontact forms such as verbal sexual abuse and forced viewing of pornography, as well as unwanted contact in the form of touch or fondling, to attempted rape, forced penetrative sex (vaginal, oral, or anal), trafficking, and forced prostitution. It also includes sex obtained as a result of physical force, intimidation, pressure, blackmail, deception, forced alcohol and drug use, and threats of abandonment or of withholding economic support. Transactional

sex through money, gifts, or other economic incentives (especially in the context of extreme poverty) often has a coercive aspect as well.

Sexual abuse can occur in premarital, extramarital, and marital situations. Perpetrators are usually people with whom the victim is familiar, including intimate partners, peers, family members, teachers, and other youth and adult acquaintances. Coercion often occurs in the course of routine activities in the home, neighborhood, community, and school, according to youth in Africa, Asia, and Latin America/Caribbean.¹

Studies have used various methodologies to measure the prevalence of sexual coercion. Surveys have typically asked such questions as, "Have you ever been forced to engage in sex?" Some surveys have probed in greater depth by asking youth if their first sexual experience was something that they wanted at the time, something they agreed to but did not want, or something they were forced to do against their will. For example, a study in Thailand, part of a World Health Organization multicountry study, used these more discriminating questions and found that while only 4 percent of women reported forced first sex, another 19 percent reported unwanted sex.² In contrast to surveys, qualitative studies often reveal greater detail through workshops using personal narratives, in-depth interviews, and focus group discussions.





Sexual coercion in childhood and adolescence has multiple consequences, with links to adverse reproductive health and HIV-related outcomes, subsequent experience of violence at the hands of intimate partners, and mental health problems.

Data on sexual coercion among youth in developing countries are limited; most studies are small with findings that may not be representative. A review of the 13 available studies found that between 2 percent and 20 percent of girls and fewer than 15 percent of boys reported ever experiencing sexual coercion. The youth surveyed were generally ages 15 to 19; of these 13 studies, six included males. In a review of 14 studies that asked about forced first sexual experience, about 15 percent to 30 percent of sexually active girls reported coercion; fewer than 10 percent of boys reported forced first sex. Of these 14 studies, five included males.³

Gender norms play crucial role

Deeply rooted gender norms can contribute to sexual coercion. Many cultures condone sex for boys while girls face social sanctions if they appear to be sexually active or get pregnant. In some regions, girls are often forced into marriage at young ages, facing demands for sex for which they are ill prepared.

Social norms contribute to a perception that controlling women is a sign of masculinity. A study in South Africa suggests that this issue of control has contributed to extremely high rates of rape or attempted rape (2 percent of women in three provinces).⁴ Young men report a feeling of entitlement to sex, and women sometimes agree. In a Nigeria study, 57 percent of male students and 74 percent of out-of-school male apprentices agreed with the statement, “A man has the right to have sex with a woman on whom he has spent a lot of money.” Also agreeing were 37 percent of female students and 43 percent of female apprentices.⁵

In areas where girls continue to marry at a young age, such as South Asia and West Africa, lack of decision-making authority, lack of familiarity with the husband-to-be, and a lack of information on sexual matters can contribute to forced sex in marriage. “At night, I asked her to take off her

clothes,” a 19-year-old painter said of his new wife. “She refused. When I asked her two, three times, she started crying. I made her keep quiet, and after that I took her clothes off and did my work.”⁶

At the 2003 consultative meeting, a panel of local youth emphasized how gender roles condoned coercion of young females. One described teachers who touched girls, but when complaints were made, no action was taken against the teacher. Another described the sexual harassment girls encountered walking to school. Gender norms appeared so entrenched that “many girls were shocked because they realized they have a right to say ‘no,’ that going out with a boy does not give consent for sex,” explained another panelist.

Consequences of sexual coercion

Sexual coercion in childhood and adolescence has multiple consequences, with links to adverse reproductive health and HIV-related outcomes, subsequent experience of violence at the hands of intimate partners, and mental health problems.

Reproductive Health/HIV Outcomes. A review of evidence in Latin America found that young women who had been sexually abused had significantly earlier sexual initiation and more lifetime partners than non-abused women.⁷ A Ugandan study of 575 sexually active women ages 15 to 19 found that those who had experienced sexual coercion, compared to those who had not, were significantly more likely to be nonusers of contraception, to have unintended pregnancies, and not use condoms at last intercourse. The study also found that after controlling for other risk factors, coercive first sex was associated with a 71 percent higher risk of subsequent HIV acquisition.⁸

Violence. Studies have found that women who experience sexual violence are more likely to suffer severe physical violence and violence in pregnancy.⁹ A study in Thailand found that of women who had first sex by force, 65 percent had later experienced

intimate spousal violence, compared to 37 percent of those with a first sex experience where the degree of force was ambiguous, and 25 percent of those who did not have first sex by force.¹⁰

Mental Health Problems. Sexually abused women and men have significantly higher risks for suicidal ideation and behavior than those who were not abused.¹¹ A qualitative study in India among 33 female survivors of incest, which occurred between the ages of 10 and 24, found that these women experienced a wide range of mental health issues that needed to be addressed in order to help them overcome their fear of intimacy and sexuality, and their isolation. Many of the women reported mutilating themselves or contemplating suicide to cope with the memories of the abuse.¹²

Emerging program approaches

At the 2003 consultative meeting, several programmatic lessons stood out. First, reproductive health and HIV prevention programs need to understand and address the full context of young people's lives, including social and economic factors leading to coercion. By emphasizing abstinence, partner reduction, and condom promotion, programs may overlook the reality of the lives of many youth, including factors underlying their ability to choose whether or not to engage in sex. A more holistic and realistic approach would include preventing sexual coercion, providing support to victims, strengthening the legal and advocacy environment, and training providers.¹³

Second, programs need to help improve provider attitudes about, and clinical services for, youth who may have experienced sexual coercion. In a two-year intervention, the International Planned Parenthood Federation (IPPF)/Western Hemisphere Region, in coordination with IPPF affiliates in the Dominican Republic, Peru, and Venezuela, trained all staff on the sensitivity of this issue and how to provide appropriate services. Staff learned to recognize how sexual coercion

affects clients and the importance of maintaining confidentiality and privacy. The initiative introduced new clinical history forms, policies and procedures, and in-house services and referrals. The project resulted in a significant increase in providers who reported confidence in their ability to identify cases of physical and sexual violence and increased sensitivity to gender issues in general and sexual violence among youth in particular.¹⁴

Third, programs must focus on supporting young people's rights, changing gender norms, and improving communication and negotiation skills. Programs have workshops to address gender norms, including associations of sexual violence with masculinity, and to offer alternative models for male behavior. Opportunities to change gender norms arise in other program areas as well. For example, in a Nigeria research project using a narrative workshop, young people reported feeling empowered by gaining skills to prevent coercive behaviors and question traditional norms.¹⁵

GLOBAL MEETING HIGHLIGHTS NEED FOR ACTION

In September 2003, a global consultative meeting on nonconsensual sex among young people in developing countries was held in New Delhi, India. The Population Council/India organized the meeting, in collaboration with the World Health Organization/Department of Reproductive Health and Research, and Family Health International/YouthNet.

The meeting included 35 invited papers and presentations developed by some 50 experts in this field from throughout the world. The gathering of about 100 experts included researchers as well as legal analysts, advocates, policymakers, and young people themselves.

Sessions examined nonconsensual sex in terms of:

- experiences of young females and males: prevalence, forms, and contexts
- youth perspectives, through a panel of seven youth
- patterns of transactional sex
- roles of the legal system
- outcomes of coercion at the individual and community levels
- interventions to prevent, support, and treat
- research design and methods

For more information,
please contact:

YouthNet

2101 Wilson Boulevard
Suite 700
Arlington, VA 22201 USA

telephone
(703) 516-9779

fax
(703) 516-9781

e-mail
youthnet@fhi.org

web site
www.fhi.org/youthnet



**Deloitte
Touche
Tohmatsu**



Fourth, actions at the community, institutional, and policy levels need to sensitize policymakers, religious leaders, and other gatekeepers to the reality and impact of sexual coercion and the need to provide a supportive and nonjudgmental environment. Programs need to work more closely with police, the media, and other authorities to enforce existing laws and to develop community-based councils and other approaches that can help instill a safe environment for young people.

Significant numbers of young people experience sexual coercion, and physical and mental health consequences are profound in the short- and long-term. As shown above, actions can address this problem. More research and innovative interventions are needed to guide programs to help prevent coercion, support youth in making safe and appropriate sexual decisions, and provide counseling and treatment to those who are victims of coercion.

REFERENCE

References to presentations from *Nonconsensual Sexual Experiences of Young People in Developing Countries: A Consultative Meeting*, New Delhi, India, September 22-25, 2003, are noted as "New Delhi Meeting."

1. Ajuwon AJ, Akin-Jimoh I, Olley BO, et al. Sexual coercion: learning from the perspectives of adolescents in Ibadan, Nigeria. *Reprod Health Matters* 2001;9(17):128-36; Wood K, Jewkes R. "Dangerous" love: reflections on violence among Xhosa township youth. In Morrell R, ed. *Changing Men in South Africa*. (Pietermaritzburg, South Africa: University of Natal Press, 2001)317-36; Brown AD, Jejeebhoy SJ, Brown A, et al. *Sexual Relations among Young People in Developing Countries: Evidence from WHO Case Studies. Occasional Paper No. 4*. Geneva: World Health Organization, Department of Reproductive Health and Research, 2001.
2. Im-em W. Sexual coercion among women in Thailand: results from the WHO multi-country study on women's health and life experiences. New Delhi Meeting.
3. Jejeebhoy SJ, Bott S. *Non-consensual Sexual Experiences of Young People: A Review of the Evidence from Developing Countries*. New Delhi, India: Population Council, 2003.
4. Jewkes R. Non-consensual sex of South African youth: prevalence of coerced sex and discourses of control and desire. New Delhi Meeting.
5. Ajuwon A. Research in sexual coercion in young persons: the experiences and lessons learnt from Ibadan, Nigeria. New Delhi Meeting.
6. Sodhi G, Verma M. Sexual coercion among unmarried adolescents of an urban slum in India. In Jejeebhoy S, Bott S, Shah I, et al., eds. *Towards Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia*. (Geneva: World Health Organization, 2003) 91-94.
7. Ellsberg M. Coerced sex among adolescents in Latin America and the Caribbean. New Delhi Meeting.
8. Koenig M, Lutalo T, Zablotska I, et al. The sequelae of adolescent coercive sex: evidence from Rakai, Uganda. New Delhi Meeting.
9. Ellsberg.
10. Im-em.
11. Ellsberg.
12. Gupta A, Ailawadi A. Incest in Indian families: learnings from a support centre for women survivors. New Delhi Meeting.
13. Erulkar AS. Sexual and reproductive health research and programming for youth. New Delhi Meeting.
14. Bott S, Guedes A, Guezmes A. The health service response to sexual coercion/violence: lessons from IPPF/WHR associations in Latin America. New Delhi Meeting.
15. Ajuwon, New Delhi Meeting.



World Health Organization

William Finger of YouthNet, in collaboration with Shyam Thapa (FHI/YouthNet); Deepika Ganju (consultant), Shireen J. Jejeebhoy, and Vijaya Nidadavolu (Population Council); and Iqbal Shah and Ina Warriner (World Health Organization/Reproductive Health and Research).

YouthLens is an activity of YouthNet, a five-year program funded by the U.S. Agency for International Development to improve reproductive health and prevent HIV among young people. The YouthNet team is led by Family Health International and includes CARE USA, Deloitte Touche Tohmatsu Emerging Markets, Ltd., Margaret Sanger Center International, and RTI International.