Article

Journal of Interpersonal Violence
Volume 24 Number 12
December 2009 2073-2095

10.1177/0886260508327707
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Experiences of Sexual Coercion Among Adolescent Women

Qualitative Findings From Rakai District, Uganda

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Limited data from low-income countries are available on the continuum of coercive experiences, the contexts in which they occur, and how adolescent women perceive and respond to coercion. This article presents results from focus group discussions and in-depth interviews with pregnant and never pregnant sexually active female adolescents, aged 15 to 17, residing in Rakai District, Uganda, to examine sexual coercion, its context, and the links between coercion and adolescent reproductive health outcomes, including early sexual debut and pregnancy. Informants described multiple forms of sexual coercion, including coerced or forced intercourse, unwanted sexual touching, verbal harassment, and transactional sex. Sexual coercion was perceived to be a

normal part of intimate relationships; in particular, informants felt that a woman's lack of decision-making authority, including choices on sexual encounters, was implicit to marriage. This information may help violence prevention programs develop a range of strategies for addressing sexual coercion among adolescents.

Keywords: *sexual coercion; adolescents; early sexual debut; adolescent pregnancy; Uganda*

Sexual violence has been recognized as a global human rights violation and an important public health problem associated with a broad range of negative outcomes for victims (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Sexual violence includes various typologies of abuse including sexual coercion, which has been defined as the "act of forcing (or attempting to force) another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstance to engage in sexual behavior against his or her will" (Heise, Moore, & Toubia, 1995, Chapter 1, ¶3.). Sexual coercion is, therefore, inclusive of sexual violence such as rape. Evidence is accruing in developing countries of links between coercive sex and other sexual behaviors that place women at increased risk for unwanted pregnancy and HIV/STIs, including early sexual initiation, multiple partnerships, and nonuse of contraceptives (Hof & Richters, 1999; Jewkes, Vundule, Maforah, & Jordaan, 2001; Varga, 1997; Waszak Geary, Wedderburn, McCarraher, Cuthbertson, & Pottinger, 2006; Wood, Maforah, & Jewkes, 1998). An extensive body of literature from developed countries corroborates these findings (Chandy, Blum, & Resnick, 1996; Esperat & Esparza, 1997; Kenney, Reinholtz & Angelini, 1997; Roosa, Tein, Reinsholtz, & Angelini, 1997; Stewart, Sebastiani, Delgado, & Lopez, 1996; Stock Bell, Boyer, & Connell, 1997).

Adolescent women are particularly vulnerable to sexual coercion, and international data suggest that in some settings up to one third of girls report forced sexual initiation (Krug et al., 2002). Adolescent women in Uganda are no exception. National data from the 2006 Uganda Demographic Health Survey show that 21% of all 15- to 19-year-old Ugandan women and 36% of

Authors' Note: Data collection for this study was funded through the United States Agency for International Development (USAID) cooperative agreement with Family Health International (FHI) for YouthNet, number GPH-A-00-01-00013-00. The information and views contained in the publication do not necessarily reflect those of FHI or USAID. The authors gratefully acknowledge the helpful comments of John Santelli and Marie Thoma, and Sylvia Namakula and Olive Nabisuubi's assistance with organization of data.

married 15- to 19-year-old women reported having ever experienced sexual violence (Uganda Bureau of Statistics & Macro International, 2007). Other Ugandan studies found that more than 40% of sexually active adolescents reported lifetime experience of forced sexual intercourse (African Child Policy Forum, 2006; Bagarukayo, Shuey, Babishangire, & Johnson, 1993). In the rural Rakai District of Uganda, research found that young women (younger than 25 years) are significantly more likely to report having ever experienced sex that resulted from physical force or threats of violence compared to the reference group of women 35 years or older (OR = 1.56; Koenig, Lutalo, et al., 2004). Additionally, 14% of sexually experienced 15- to 19-year-old women reported that force had been used to compel them into their first intercourse. Risk of coercive sex was found to increase with younger age at first intercourse (Koenig, Zablotska, et al., 2004). Sexual coercion among adolescents in Rakai has been linked to indicators of risky sexual behavior and a range of adverse reproductive health outcomes. Young women who reported forced first sex were significantly more likely to report at least one genital tract symptom and more likely to report both unwanted and mistimed pregnancies (among women who had ever been pregnant). Furthermore, women who reported forced first sex were less likely to be current users of modern contraception and less likely to have used condoms either at last intercourse or consistently during the preceding 6-month period (Koenig, Zablotska, et al., 2004). Sexual coercion in this population has also been associated with elevated levels of prevalent HIV infection (Paxton, Ssengonzi, Nalugoda, Sewankambo, & Wawer, 1998).

Despite the broad definition put forth by Heise et al. (1995), most research on sexual coercion among young women internationally and in Uganda has focused on intercourse resulting from physical violence or threats of violence. Insufficient attention has been paid to understanding the continuum of coercion from nonpenetrative sexual touching and verbal harassment to physical assault. Lack of data on all types of coercion, including forms of sexual abuse other than penetrative intercourse skews our understanding of how young women experience sexual coercion. Furthermore, it limits researchers' ability to comprehend how Ugandan and other adolescent girls define and perceive sexual coercion, the context in which it occurs, and the impact it has on their lives. To conduct effective violence prevention programs and/or provide comprehensive health and social support services to victims of sexual coercion, it is imperative that researchers fully understand what coercion encompasses. Thus, exploration of all forms of sexual coercion as they occur along an extensive continuum is warranted. This article presents in-depth qualitative data that lessen some of the significant gaps in the current literature on sexual coercion among young women in Uganda.

Method

This study was conducted in Rakai District, a rural region in southwestern Uganda, by researchers from the Rakai Health Sciences Program (RHSP) and Family Health International. In May through October of 2005, qualitative data were collected as part of a larger investigation aimed at identifying risk factors for adolescent pregnancy. Data for this article come from interviews and focus group discussions conducted with 52 female adolescents aged 15 to 17 years. All qualitative research participants were drawn from among a pool of eligible research respondents who had participated in the Rakai Community Cohort Study (RCCS), a longitudinal cohort study conducted by RHSP investigators. Since 1994 the RCCS has employed repeat censuses and surveys at 10- to 12-month intervals of all consenting adults aged 15 to 49 years residing in approximately 50 rural villages in the Rakai district. A census is conducted at the beginning of each round to identify individuals eligible for enrollment. Consenting participants are interviewed confidentially by trained interviewers of the same gender. The survey is comprised of a detailed sociodemographic and behavioral interview with questions on sexual behaviors, sexual partners, and reproductive health. Biological specimens are collected for HIV/STI detection. The methods used for the RCCS have been further described in detail elsewhere (Koenig, Lutalo, et al., 2004; Koenig, Zablotska, et al., 2004; Paxton et al., 1998; Wawer et al., 1999; Zablotska et al., 2006).

The sample for the qualitative study described in this article included sexually active adolescent women who were currently pregnant and who had never been pregnant. Pregnancy history and recent sexual experience (having had intercourse in the past 12 months) was ascertained from the RCCS databases. During the 2004-2005 RCCS survey, 497 female respondents 17 years or younger were interviewed about their current sexual activity. In response to the question "Have you had sexual intercourse with any person in the last 12 months?" 236 young women responded affirmatively. Respondents were also asked "Are you currently pregnant?" and urine samples were taken from all consenting women for pregnancy testing. Through these two methods of assessment, 37 respondents aged 17 years or below were found to be currently pregnant. Finally, the 199 respondents who were not currently pregnant but reported recent (past year) sexual activity were asked "Have you ever been pregnant?" and 64 women responded affirmatively, yielding a total of 135 respondents who had never been pregnant but were sexually active. In summary, these selection criteria yielded a total of 37 currently pregnant and 135 never pregnant but

recently sexually active women aged 17 years or younger. Two lists were compiled including locator information for each of these two groups of eligible respondents for recruitment into our qualitative study. Eligible young women were first approached by one of the RCCS interviewers to seek permission for them to be recontacted (based on their participation as a respondent in RCCS) by another member of the Rakai Program. With their permission, an interviewer from RHSP's department of qualitative research made a subsequent visit to invite them to take part in the qualitative study. Respondents were approached and invited to participate until 26 pregnant and 26 never pregnant women had been recruited. Emancipated participants and parents or guardians of unemancipated participants provided written informed consent; unemancipated minors provided written assent. According to Ugandan law, anyone under age 18 who has been married, has children, or is currently pregnant is legally an emancipated minor and does not require parental consent. Approximately half of the research participants were considered emancipated minors.

Qualitative data collection included focus group discussions and in-depth interviews. All data collection sessions were conducted in the local language of Luganda by female interviewers from RHSP's department of qualitative research. The focus groups provided an overview of cultural perceptions and community norms surrounding coercion and pregnancy and informed the development of the guides for the in-depth interviews. One semistructured guide was used for focus groups that covered several topics, including sexual initiation (defined as first penile–vaginal intercourse), decision making between boys and girls regarding sexual relationships, gender differences in relationship power and sexual communication, contraceptive use, social and gender norms related to sexual violence, sources of help and information on sexual violence, parents' role in sexual violence situations, and education in schools regarding sexual violence and early sexual debut.

In-depth interviews explored personal, individual-level accounts of sexual experiences, adolescent pregnancy, and violence. Each informant participated in three consecutive in-depth interviews spaced over a period of 3 months. Three distinct semistructured interview guides were used with each informant. The first interview focused on getting to know the informant, the second focused on first sexual experiences, and the third focused on sexual risk taking and adolescent pregnancy. Each of the three qualitative interview guides highlighted major topics for discussion and suggested probes having to do with learning more about the informant; their experience of sexual initiation including early sexual debut (defined as first sexual intercourse before the age of 15 years); current intimate partnerships; any

experiences of sexual coercion (defined as a continuum of behaviors including verbal harassment, unwanted sexual touching, nonviolent coerced sex, and forced penetrative sex; Heise et al., 1995); and participants' perceptions of the risks associated with their own sexual behaviors, including unwanted pregnancy and HIV/AIDS.

All field research for this study was conducted by members of the RHSP's department of qualitative research, including the department coordinator, a team field supervisor, a data editor, and three female interviewers. All qualitative staff members are university graduates with 3 to 5 years of prior qualitative research experience. Before initiating this study, the research assistants underwent an intensive 2-week refresher course on qualitative research methods, informed consent with minors, proper interviewing technique, and techniques for eliciting sensitive information. The World Health Organization (2001) guidelines for conducting safe and ethical research on violence against women were followed for this study. As such, fieldworkers were trained to provide short-term support to victims of violence and to refer women requesting assistance to available local services and sources of support. All staff participated in a week-long intensive training facilitated by local violence prevention and counseling experts on how to provide basic psychosocial support to individuals experiencing physical and/or sexual partner violence and make referrals to counselors and health personnel when needed. A domestic violence referral network has been established by RHSP and includes professionals such as HIV counselors, health care workers, social welfare officers, and the police. Members of the network are located throughout the district and are skilled to provide counseling, social welfare services, health care, legal advice, and protective services to victims of domestic abuse.

The research protocol, field guides, and consent forms were reviewed and approved by Family Health International's Protection of Human Subjects Committee, the Uganda Virus Research Institute's Science and Ethics Committee, and the Uganda National Council of Science and Technology. Our study used an iterative data collection approach, which allowed the research team to refine and redefine the questions central to understanding the interplay between early sexual experiences, sexual coercion, and other types of partner violence; adolescent pregnancy; reproductive health; and gender norms and dynamics in these young women's lives. The research assistants who conducted the focus groups and interviews were trained to use all of the qualitative instruments as guides rather than as standardized survey instruments. The guides encouraged research

participants, through effective probing, to expand on the topics on which they indicated more knowledge and experience. Thus, although efforts were made to get as much information as possible about each of the research domains, not all questions on the field guides were asked of all participants. Before official data collection began, focus group discussion, and interview guides were pilot tested to ensure consistent use of the tools across data collectors and to verify clarity of the items.

Focus group discussions and interviews lasted about 60 to 90 minutes and were tape recorded after acquiring all participants' consent. The audiotapes were transcribed and translated from Luganda into English and entered into a word processing program. The data were then imported into the NVivo v.2 (QSR International, 2002) for coding and were analyzed using NVivo v.7 (QSR International, 2006). Interrater reliability was assessed by using NVivo's inbuilt merge function, which allows for comparison of transcript coding done by different researchers. Matrices of the interconnections of the areas of interest were constructed to condense and organize the data and to facilitate cross-informant analysis.

Results

In total, 52 female adolescents aged 15–17 years participated in our study. The median participant age was 17 years. Four focus groups and 72 in-depth interviews were conducted. Table 1 describes a few key background characteristics of participants.

Sexual Initiation

The median age of sexual initiation (defined as first penile–vaginal intercourse) among in-depth interview informants was 15 years. Of the 24 informants, 9 (37.5%) had an early sexual debut defined as first intercourse before the median age of 15. Participants from both focus groups and interviews had animated discussions about the bodily changes they were experiencing due to puberty and the way in which some of their feelings toward and relationships with young men were transforming. Participants also spoke candidly about burgeoning individual and peer-level curiosity surrounding sexual experimentation and the initiation of intimate partnerships. Nonetheless, all informants said their first sexual experience was initiated by their male partner or husband and all but two reported that they did not

Table 1
Background Characteristics of Currently Pregnant and Never Pregnant but Sexually Active Women Aged 15 to 17 Years, Rakai, Uganda

	Measure	Pregnant	Never Pregnant
Focus group discussion participants ($n = 28$)			
Marital status	Married	13	1
	Single	1	13
Schooling status	In school	0	12
	Out of school	14	2
In-depth interview informants ($n = 24$)			
Marital status	Married	11	0
	Boyfriend	0	11
	Single (no partner)	1	1
Schooling status	In school	0	10
	Out of school	12	2
Highest education	None or primary	11	3
	Secondary	1	9
Daily work[a]	Academic studies or homework	0	9
	Domestic chores	12	11
	Subsistence agriculture	10	6
	Make and sell handicrafts	5	1
	Shopkeeper	0	1

Note: Within each group (focus group and in-depth interview), equal numbers of participants were pregnant and never pregnant.
a. Some participants responded affirmatively to more than one category, so column totals do not add up to 12.

feel it was the right age to begin having sex. Of the 24 interview informants, 22 (91.7%) wished they had waited until they were older because they felt that at the age of their debut they were not mature enough to deal with the implications of sex, namely, pregnancy and the responsibilities of being in a sexual relationship.

> I had spoilt myself by having sex because that was not the age (15 years) at which people should have sex. . . . I think 18 is the right age because then you can differentiate between good and bad and you know the outcomes or repercussions of sex, like pregnancy . . . and all the feelings you will have toward sex. (unmarried 16-year-old)

Half of the 24 informants reported that their first intercourse was characterized by some form of sexual coercion, including three accounts of physical force (12.5%); five reports (20.8%) of verbal threats of abuse from male partner; and four (16.7%) narrations of inducement in the form of promises of money, gifts, or marriage. Several of the informants, including some who reported coercion (as described above) at debut, explained how love for their boyfriend or husband and curiosity about sex piqued their interest in having intercourse and influenced some to accept their partner's initial invitation for sex. "I wanted him because I did not know how it (sex) felt and how it happens so I agreed to have sex with him so that I too would know how sex is done" (unmarried 17-year-old). Most of the women, however, said that despite feeling love for their partner, they did not necessarily want to have their first sex at the time or in the fashion that it occurred. Instead, sexual initiation was commonly described as something that happened as opposed to something that was chosen. For instance, one 17-year-old married informant explained,

> There was no reason [she had her first sex] I don't know why I accepted. I just agreed. . . . Some girls do it (sex) because they want certain things but I didn't want anything. . . . Sometimes people decide to try and do things when they don't actually know what is involved.

Many informants expressed confusion and an inability to distinguish the primary reason for deciding to have sex for the first time, reflecting the complex process most adolescents go through when making life-changing decisions such as initiation of sexual intimacy. Clearly, those informants who were forced into first sex did so against their will. Most other informants, however, expressed ambivalent feelings about their debut. Many young women described internal conflict as to whether they had made a conscious decision to initiate sex or whether the primary basis of their choice stemmed from relational and social pressures. Various factors were discussed that influenced each woman's sexual initiation, including personal, relational, family, and societal issues. For instance, pressure from partners and peers was common, as illustrated in the following quote: "I realized I had to have sex because all my friends had already finished [having sex]. I wanted to be in the same boat" (unmarried 17-year-old). Another strong factor influencing timing of first sex was economic hardship. An unmarried 17-year-old informant said,

> He used to tell me "I love you and I will give you money." [I had my first sex with him] because I wanted snacks very much and didn't have money to buy them and he had told me he was going to give me money—he gave me 1,000 shillings [$0.60].

Continuum, Social Contexts, and Consequences of Sexual Coercion

Beyond first sex, most informants (21 of 24, 87.5%) reported ever experiencing sexual coercion during adolescence. Accounts of sexual coercion were described along a continuum that included verbal harassment, unwanted touching, nonviolent coercive intercourse, and physically forced penetrative sex (i.e., rape). Informants' experiences and narrations are summarized in this section. Table 2 outlines the types of sexually coercive experiences reported by interview informants by pregnancy status.

Forced sex. In our study, *forced sex* was synonymous with *rape* and defined as any form of assault in which a man (including a boyfriend, husband, friend, relative, or other male person) forced the informant to have sexual intercourse against her will. Seven informants (29.2%) reported experiences of forced sex, including the three cases of forced sexual initiation mentioned previously. The most common perpetrator was the girl's husband or boyfriend; only two informants reported rape by nonpartners. Forced sex entailed various types of physical violence before and during intercourse, including pushing, pulling, manipulating the girl into a sexual position, and holding her down during penetration. One girl's sexual debut was described as follows: "He put his leg out and I fell over it and he lay on top of me—he had sex with me by force" (unmarried 16-year-old).

Forced sex with a nonpartner was referred to as *okukwata olwempaka* or *okuwamba*, which directly translates from Luganda as *rape*. Perpetrators included men who are completely unknown to the victim, men who are known but not in an intimate relationship with the victim, and relatives. Forced sex by a husband or boyfriend was referred to as *okukaka okwegatta* or *okukaka omukwano*, terms that do not carry the same connotation of rape but were, nonetheless, described as involving force and being hurtful, degrading, and unfair to the woman. "It [forced sex] makes me feel bad because you don't enjoy it at all" (unmarried 17-year-old). Nonetheless, informants described forced sex by an established intimate partner as a component of male–female relationships. It was felt that forced intercourse within marriage or other permanent and/or consensual partnership could not be deemed rape, an unwanted experience, or even something that could be characterized as "done against the woman's will" because of widespread acceptance that men have unrestricted sexual access to wives or female partners and that it is a woman's duty to unconditionally satisfy her male partner's sexual desires. Several informants who experienced intimate partner

Table 2
Experiences of Sexual Coercion Among Currently Pregnant and Never Pregnant but Sexually Active Women Aged 15 to 17 Years, Rakai, Uganda

Type of Coercion	All ($N = 24$)	Pregnant ($n = 12$)	Never Pregnant ($n = 12$)
Forced sex			
Yes	7 (29.2%)	4	3
No	17 (70.8%)	8	9
Nonviolent coercive sex			
Yes	16 (66.7%)	11	5
No	8 (33.3%)	1	7
Transactional sex			
Yes	10 (41.7%)	7	3
No	14 (58.3%)	5	9
Unwanted (nonpenetrative) Touching			
Yes	11 (45.8%)	5	6
No	13 (54.2%)	7	6
Verbal sexual harassment			
Yes	10 (41.7%)	6	4
No	14 (58.3%)	6	8

rape, particularly those in marriages (in which women have limited autonomy), described strategies for coping. Some feigned sickness to avoid unwanted intercourse but most countered it with passive acceptance. One married 17-year-old informant narrated an example of how submission replaced the trauma of being raped by her husband:

> There is no way I would have refused because if I did he would have raped me so I just agreed. . . . I did not fear him but I feared having sex with him, but at that time I saw that there was nothing I could do, so I accepted.

Deeply embedded ideas about gender norms and roles also served to substantiate sexual violence against women. Participants believed that men held more powerful, financially oriented, decision-making positions in society and the family, whereas women were responsible for domestic responsibilities, reproduction, and child rearing. Because girls and women are not perceived to make significant financial contributions to the household or the community at large, informants were of the opinion that women who committed to long-term relationships consequently held limited (or

no) important decision-making authority in the home or beyond, including choices about sexual encounters.

> It's natural. . . . The man pays taxes and the woman has to cook, it's like that. Moreover because the woman doesn't pay taxes she has to produce and endure the pain of pregnancy. . . . That's how being a girl affects your life. (married 16-year-old)

Perceived causes of forced sex included male dominance and entitlement to sex and the belief that men and women have dramatically different sex drives. Women were said to desire sex less often than men do and to dislike intercourse during menstruation, late stages of pregnancy, and immediately postpartum. Informants felt that most men wanted to have sex at any given time and had a physical need for sex on a routine basis. Likewise, it was felt that men commonly were unable to tolerate requests for temporary abstinence, often leading to forced sex. "When I have stomach cramps or fever or and am very tired, still my husband wants sex. . . . I try to tell him that I am sick/tired but he refuses and forces me to have sex against my wish" (married 17-year-old).

Physically forced sex was said to lead to deterioration in the woman's quality of life and self-confidence, resulting in an unhealthy impact on sexual behaviors and in patterns of revictimization. One adolescent who described chronic sexual coercion in her marriage explained, "I am supposed to have sex because I have a husband" but in her own words she explained the abuse was "damaging" her life. "Whenever he beats me he is reducing the strength (confidence) in my body" (married 17-year-old). Another young woman said her experiences of sexual violence reduced the value she placed on taking care of her outward appearance: She lost interest in personal grooming but also dressed provocatively so as to sexually attract men. A third young woman, who was single and pregnant, had been raped by a stranger at her first sexual encounter when she was 14 years old. She believed this event led to "sexual urges" (*obwagazi*): "[It] caused me to befriend everyone. It made me become promiscuous. . . . I started wanting to be with a man every day." She reported being in two concurrent sexual relationships during her recent pregnancy, explaining that the man who impregnated her was out of town for a few months and she did not want to abstain for that long. A fourth informant was repeatedly forced into sex with the same partner, became pregnant, and married her abuser; the forced sex and physical domestic violence continued during the marriage.

Nonviolent coercive sex. In addition to forced sex, all interview informants were asked to talk about their experiences of unwanted intercourse that resulted from forms of coercion other than physical violence. Sixteen interview informants (66.7%), including six of the seven young women who reported forced sex, reported experiences of nonviolent coercive sex, usually perpetrated by intimate partners and husbands. Such encounters were usually due to pressure (*okuwalirizibwa*), generally through verbal insistence, deception, and threats (or informant's fear) of abandonment or infidelity.

Verbal insistence and overbearing persistence (*okutambulira* or *okulemerako*) occurred when partners would not take "no" for an answer. Informants perceived such pressure to be a normal component of male–female courtship, relationships, and marriage and described badgering that became so stressful and aggravating that the young woman gave in to the sex. One young woman described how she gave in to an age mate in her community:

> He was over frequenting me and I was tired. . . . He used to find me on the way home with my friends and he could tell me only about that [having sex] and I wanted us to do it and finish it so I decided to have sex. (Unmarried 17-year-old)

Deception or conning (*okumatiza* or *okukiyingiza*) referred to promises that the man did not necessarily intend to keep, such as those of marriage or extravagant gifts, in order to have sex. One form (*okusendasenda*) involved sweet talk and flattery often coupled with romantic gifts and/or letters. Deception-induced sex was most frequently reported to result in a single encounter or a casual relationship as opposed to a long-term intimate partnership.

Many informants had sex because their partner threatened or the informant feared abandonment, infidelity, or accusations of unfaithfulness. "There are boys who want you to have sex with them every day. Whenever he meets you he wants [sex]. You might not be able to do it so he'll get other girlfriends who can" (unmarried 17-year-old). Another young woman said she silently endured unwanted marital sex with her husband because she feared he would complain throughout the community and people would take his side and accuse her of being unfaithful. She said people would "make accusations like 'that woman [the informant] found another man—why else would she refuse to have sex with her husband?!'" (married 17-year-old).

Transactional sex. Because economic circumstances can influence young women's sexual behaviors, we explored experiences of transactional sex

involving the exchange of money, gifts, or favors. As described by Jejeebhoy and Bott (2005), transactional sex is nonconsensual "when it involves the exchange of sex for material gain, as a means for economic or social survival, or when acceptance of material goods or favors leads men to expect sex in return" (p. 19). Ten interview informants (41.7%) said they had ever traded sex for material benefit(s) or promises of benefit(s). Although the gifts, money, or favors exchanged for intercourse were rarely the sole motivation for the sexual encounters, they reduced the young women's ability to negotiate condom use and other safe sex practices and enhanced the male sex partner's decision-making power. Transactional sex partners were most commonly boyfriends and husbands but included authority figures such as teachers, older male friends of the family, and relatives.

Informants listed economic hardship, limited access to personal money, and perceptions of women's financial dependence on men as reasons for having sex in exchange for "benefits" (*okufunamu*) such as cash, school books, household items, clothing, and toiletries. Two informants reported having sex with schoolteachers in exchange for higher class marks or exemption from school fees. One 16-year-old married girl described her sexual debut at age 14 thus:

> My grandmother told me she is very old and does not have money so we (orphans) should cater for ourselves. . . . No, I didn't want the first sex—I wanted money to buy books. If I had books, I would not have had sex.

Some informants disclosed participating in transactional sex to gain status or popularity within their peer groups. Focus group participants had spirited discussions about how social pressures contribute to young women's decisions to exchange sex for benefits. "Girls in peer groups talk about having sex and how their boyfriends give them money (for sex) which makes the other girls want to start having sex for money" (participant 1). "Yes, if a girl has friends who have good things like nice shoes she also wants to try her best to fit in the society" (participant 2).

Both married and single women described transactional sex as a mechanism to gain some control in their relationships as well as in their lives. Some said they commonly refused to have sex with their husband or partner until he agreed to compensate her with money or other goods.

> Sometimes my husband may want to have sex when I don't want to. If he tells me that "let us have sex and I will give you money," even though it's only 1,000 shillings [$0.60] and he gives it to me after having sex, I will have sex because I want that money but not because I want to have sex. (married 17-year-old)

Participants worried that community members would perceive transactional sex as unprincipled and/or disgraceful behavior that could result in one being stigmatized as sexually unrestrained, promiscuous, or even a prostitute. From a personal perspective, however, no informant equated receiving such money or gifts as prostitution. Instead, it was regarded as a mode of survival and/or advancement and was not usually reported to be exploitative or difficult.

Unwanted sexual touching and verbal harassment. To establish a more complete understanding of sexually coercive experiences among our research population, we also explored nonpenetrative forms of abuse such as attempted intercourse and unwanted sexual touching and language. Informants referred to this type of coercion as sexual harassment within two distinct categories: unwanted touching (*okwesittaza*) and unwanted verbal communication (*okuwemulwa*).

Okwesittaza referred to unwanted, nonpenetrative sexual touching (i.e., fondling of a girl's breasts or genitals) and attempted rape. Okwesittaza was reported by 11 informants (45.8%) and was most commonly perpetrated by boyfriends in the early stages of sexual intimacy. One informant narrated her experience in a mixed-gender boarding school: "I was in class copying notes and a boy came up, like they always do, and touched me on my breasts—something which did not make me feel good" (unmarried 17-year-old). Okwesittaza also included indecent exposure, which was usually perpetrated against children in domestic settings, almost exclusively by older cohabiting male relatives.

Okuwemulwa referred to verbal sexual harassment or the use of obscene words to degrade or embarrass a girl or woman and was reported by 10 women (41.7%). One 17-year-old married informant described an experience that occurred in her grandfather's shop.

> My grandfather checked my foot and told me your big toe is separated from others, you have a big vagina. I felt very ashamed and left without buying what I had gone to buy and my friends stared at me.

The most common perpetrators were peers and older male relatives, sometimes in groups and in public settings.

Underlying Risk Factors and Responses to Sexual Coercion

Although some of the never pregnant and unmarried informants reported past experiences of forced sex with boyfriends, they overwhelmingly felt

more entitled than pregnant or married women to say "no" to sex and to have their voices heard. Unmarried, nonpregnant informants felt they had more decision-making power on relational factors and could refuse sex with a boyfriend for a variety of reasons including not being in the mood, menstruation, "unsafe days" in the cycle with respect to pregnancy (*ebiseera eby'okufuniramu olubuto*), having chores or studies, the partner's nonuse of condoms or unknown HIV status of the male, or if she suspected him of having another girlfriend.

In contrast, the autonomy and power of married adolescents was felt to be very constrained. "If you are married and living in the man's house you cannot make your own decisions; it's the man who decides for you" (married 17-year-old). Choices about sex or reproduction were perceived as being in the domain of male authority, and sex and pregnancy are implicit to marriage as illustrated by a comment by a married informant: "Could you be married and refuse to do those things (have sex)? Then what are the reasons as to why you came into marriage?!" (married 17-year-old). Acquiescence was seen as the best way to avoid painful sex, preserve stability and faithfulness in marriage, and to prevent physical or sexual violence or abandonment.

Secrecy was the most common response to sexual coercion, regardless of perpetrator or the form of abuse. Married adolescents felt they would receive little support or even be reprimanded for complaining about forced sex from a husband. Sex is "an obligation because you are married" (married 17-year-old). Although victims of nonpartner rape acknowledged that this type of violence was unacceptable under all circumstances, and most recognized it as a crime, they nonetheless felt that there were more disadvantages than benefits in reporting sexual violence or seeking assistance from leaders and/or parents. Respondents reported fear of bringing shame to the family, being accused of "asking for it [sex]" or being stigmatized as spoiled (*omwononefu*). Focus group respondents indicated that families frequently make collective decisions to keep rape a secret because relatives "don't want the whole area to know she was raped. . . . They might have found a man for her to marry but because she has grown up [had sex] they will tell him, 'don't bother, that girl was raped already.'" Consequently, most girls who were raped chose not to tell anyone. Similarly, informants who experienced unwanted touching or verbal harassment saw no point in reporting these incidents because they had no mechanism for proving their veracity and wanted to avoid accusations of dishonesty. Some informants expressed uncertainty whether uninvited sexual fondling or obscene language could even be considered forms of reportable abuse.

Discussion

Previous findings reveal the magnitude of sexual coercion among adolescent women in Rakai District, Uganda, and highlighted its associations with risky sexual behaviors, a range of adverse reproductive health outcomes, and unintended pregnancy (Koenig, Lutalo, et al., 2004; Koenig, Zablotska, et al., 2004). Factors of interest that have been strongly correlated to the risk of coercive sex among Ugandan adolescent women are younger age at first intercourse (Koenig, Zablotska, et al., 2004), lower education levels, and early marriage (Uganda Bureau of Statistics & Macro International, 2007). Other research results indicate widespread acceptance of intimate partner violence against Ugandan women under various circumstances (Koenig et al., 2003; Uganda Bureau of Statistics & Macro International, 2007). Data from this qualitative study build on these previous findings and reveal that sexual coercion is taken as a normal part of intimate relationships within the study population.

Our findings also suggest that, as has been reported elsewhere, sexual coercion in rural Uganda is not limited to forced or threat-induced sexual intercourse but involves a broader array of behaviors including unwanted verbal advances; unsolicited sexual touching; transactional sex in exchange for money, gifts, food, or other benefits; unsuccessful attempts at rape; and sex as the result of threats, intimidation, deception, or emotional manipulation. Although very few studies have explored these multiple forms of sexual coercion, our findings indicate they are common and represent a large component of many early sexual experiences. To understand the full picture of sexual coercion as experienced by adolescent women, it is essential to explore all forms as they exist along this extensive continuum. Focusing only on forced intercourse may underestimate the complexity of girls' experiences and obscure important implications for prevention and policy programming as well as future research. Furthermore, studies that only investigate forced sex may make inferences that are confounded by girls' other nonpenetrative or otherwise defined sexually coercive experiences.

The literature suggests that, as in developed countries, strangers are the least common perpetrators of nonconsensual sex among young people in developing countries (Jejeebhoy & Bott, 2005). Our research corroborates these findings in that most reported encounters of sexual coercion involved men known to the victim. Strangers were rarely involved. Noteworthy is that the profile of perpetrators changed slightly according to the nature of the coercive act. Forced and nonviolent coerced sexual encounters were most commonly perpetrated by a boyfriend or husband, and married

women were thought to be particularly vulnerable to unwanted and forced encounters. The range of transactional sex partners broadened to include peers who were nonintimate partners as well as authority figures and male relatives. The main perpetrators of unwanted touching were boyfriends, peers, and older males; indecent exposure usually involved older male relatives. Unwanted verbal harassment was rarely perpetrated by intimate partners but involved peers, older men, and sometimes strangers. A common dynamic between perpetrator and victim was that females lacked choice about the sexual experience. Transactional sex was the only form of sexual coercion in which informants did not necessarily express powerlessness, but it nonetheless presents a number of concerns. The receipt of money and gifts constrained the negotiation of sexual relations and limited girls' ability to negotiate safe sex in transactional sex partnerships because the money, gift, or favor offered by the boy or man entitled him to dictate the context and dynamic of the sexual encounter.

Coercive sex occurs frequently within marriages as in other developing country settings (Santhya, Haberland, Ram, Sinha, & Mohanty, 2007). Early marriage remains widespread in Rakai, where the majority (56%) of adolescent women wed before age 19 (Koenig, Zablotska, et al., 2004). Our qualitative findings highlight the extent to which sex between husbands and wives is considered obligatory as opposed to something young women willingly choose. Passive acceptance of unwanted intercourse was perceived to be the best mechanism to avoid forced sex or "correctional" physical violence perpetrated as punishment for refusing sex to a husband. Pregnancy was also described as implicit to marriage and a decision under the domain of male authority, suggesting that early marriage decreases young women's negotiating power for safe sex and/or delayed reproduction.

Our research underscores the fact that young women frequently perceive lack of choice and nonconsensual sex, two components of the Heise et al. (1995) definition of *sexual coercion*, to be normal facets of intimate relationships. Furthermore, many informants responded with confusion and inability to separate negative feelings (connected with coercive sexual experiences) from positive aspects such as alleviation of the stress caused by persistent requests for sex or happiness about getting a gift or other reward in exchange for the sex. This further suggests the extent to which sexual coercion and nonconsensual sex are normalized within this rural Ugandan population. It also highlights the internal conflict many young women encounter when faced with significant, often life-changing decisions about sexual relationships and their associated repercussions.

Finally, our results indicate that prevailing social and cultural norms create defined gender roles and promote widespread acceptance of sexual coercion. Most research participants believed that intimate partner violence was acceptable under certain circumstances and that men dominate decision making about sexual matters and female reproduction. Participants believed that men made more important financial contributions to the household and community and thus held more powerful decision-making positions in society, whereas women were responsible for domestic responsibilities, reproduction, and child rearing. Previous findings from Rakai indicate that younger women (15 to 19 years of age) as well as younger men were more likely to believe that wife beating is justified under certain circumstances than were older women (Koenig et al., 2003), suggesting that female adolescents' beliefs about gender roles make them more vulnerable to coercion within relationships. This finding has been evidenced through research among youth in other African settings (Hindin, 2003), which dauntingly implies that very little progress is being made in this region toward the prevention of gender-based violence. Furthermore, secrecy and inaction were the most common responses to all forms of coercion, suggesting a lack of empowerment for self-help, a lack of options or services, a lack of knowledge regarding who should be contacted or confidence in their response, or a combination of all these deficits.

There are limitations to our study that merit recognition. Whereas girls and women are the most common victims of sexual coercion, men known to them are the most common perpetrators. Thus, the context in which this form of violence against women (by familiar males) occurs is essential to fully understanding it. A limitation of our study is that we only conducted research with young women, whereas prevention of sexual coercion will necessarily involve the abusive men and require an understanding of the male perspective on gender norms and gender-based violence. Thus, we recommend that further research be conducted with young men to explore factors that influence male attitudes and behaviors (including violence they may have experienced as children or adolescents) and to determine what services and assistance may help them avoid violence and promote gender equity. Secondly, it may not be possible to generalize our findings to other populations of young women in Uganda and Africa. A final limitation of our study is that we did not investigate the role of substance abuse in the context of sexual coercion. This is an important research domain given the extensive body of literature suggesting an association between alcohol and drug use and sexual assault. Of particular relevance to the Rakai population

is that recent findings indicate that alcohol is commonly consumed before sex (Zablotska et al., 2006) and is significantly associated with sexual coercion (Zablotska et al., 2007). In-depth qualitative research would be extremely useful for better understanding interrelatedness of alcohol consumption and sexual violence. Notwithstanding, the research provides additional new information about the breadth of sexual coercion and the context in which sexual coercion takes place in the lives of adolescent women in Rakai.

Our results have several programmatic and research implications. First, sexual coercion and its acceptance are deeply embedded in the community culture. For attitudes regarding acceptable behavior within intimate relationships to change, young women, young men, and couples need to be presented with alternatives to sexual coercion and other forms of intimate partner violence. Changing cultural norms is a long and difficult process, but programs focusing on issues of gender equality, couple communication, and negotiation skills within sexual relationships can facilitate the process of creating more mutually respectful and healthy intimate partnerships. Primary prevention strategies with young people prior to their sexual debut could teach young people that sex is a shared decision even within marriage. Second and more immediately, culturally appropriate support services that are both confidential and nonjudgmental need to be availed to young women who have experienced sexual coercion and violence. Such services could potentially be integrated into existing adolescent reproductive health programs or youth outreach initiatives. Finally, researchers and programmers need to better understand and address sexual coercion as it exists along a continuum. Future research that aims to explore associations between sexual coercion and health outcomes needs to consider all types of sexual coercion (not only penetrative intercourse that results from force or threats) as well as the cumulative effect of different forms of coercion and the importance of multiple victimizations. It is equally important for violence prevention and adolescent reproductive health programs to holistically address sexual coercion by recognizing that nonpenetrative forms of sexual abuse as well as transactional sex may accompany young people's experiences of rape and attempted rape.

References

African Child Policy Forum. (2006). *Violence against girls in Africa: A retrospective survey in Ethiopia, Kenya and Uganda*. Addis Ababa, Ethiopia: Author.

Bagarukayo, H., Shuey, D., Babishangire, B., & Johnson, K. (1993). *An operational study relating to sexuality and AIDS prevention among primary school students in Kabale*

District of Uganda. Poster presentation at the VIII International Conference on AIDS in Africa, Marrakech, Morocco.

Chandy, J. M., Blum, R. W., & Resnick, M. D. (1996). Female adolescents with a history of sexual abuse: Risk outcome and protective factors. *Journal of Interpersonal Violence*, *11*, 503-518.

Esperat, M. C., & Esparza, D. V. (1997). Minority adolescent mothers who reported childhood sexual abuse and those who did not: Perceptions of themselves and their relationships. *Issues in Mental Health Nursing*, *18*, 229-246.

Heise, L., Moore, K., & Toubia, N. (1995). *Sexual coercion and reproductive health: A focus on research*. Retrieved December 4, 2008, from http://www.popcouncil.org/pdfs/scoer.pdf

Hindin, M. J. (2003). Understanding women's attitudes towards wife beating in Zimbabwe. *Bulletin of the World Health Organization*, *81*, 501-508.

Hof, C., & Richters, A. (1999). Exploring intersections between teenage pregnancy and gender violence: Lessons from Zimbabwe. *African Journal of Reproductive Health*, *3*, 51-65.

Jejeebhoy, S., & Bott, S. (2005). Non-consensual sexual experiences of young people in developing countries: An overview. In S. J. Jejeebhoy, I. Shah, & S. Thapa (Eds.), *Sex without consent: Young people in developing countries* (pp. 3-45). London: Zed Books.

Jewkes, R., Vundule, C., Maforah, F., & Jordaan, E. (2001). Relationship dynamics and teenage pregnancy in South Africa. *Social Science and Medicine*, *52*, 733-744.

Kenney, J. W., Reinholtz, C., & Angelini, P. J. (1997). Ethnic differences in childhood and adolescent sexual abuse and teenage pregnancy. *Journal of Adolescent Health*, *21*, 3-10.

Koenig, M. A., Lutalo, T., Wabwire-Mangen, F., Kiwanuka, N., Wagman, J., & Zhao, F. (2003). Domestic violence in Rakai, Uganda: Evidence from a community-based survey. *Bulletin of the World Health Organization*, *81*, 53-60.

Koenig, M. A., Lutalo, T., Zhao, F., Nalugoda, F., Kiwanuka, N., Wabwire-Mangen, F., et al. (2004). Coercive sex in rural Uganda: Prevalence and associated risk factors. *Social Science and Medicine*, *58*, 787-798.

Koenig, M. A., Zablotska, I., Lutalo, T., Nalugoda, F., Wagman, J., & Gray, R. (2004). Coerced first intercourse and reproductive health outcomes among adolescent women in Rakai, Uganda. *International Family Planning Perspectives*, *30*, 156-163.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (2002). *World report on violence and health*. Geneva, Switzerland: World Health Organization.

Paxton, L., Ssengonzi, R., Nalugoda, F., Sewankambo, N., & Wawer, M. (1998). Sexual coercion and HIV risk perception in rural Uganda. *International Conference on AIDS*, *12*, 411. (Abstract no. 236/23351)

QSR International. (2002). *NVivo qualitative data analysis software* (ver. 2). Cambridge, MA: Author.

QSR International. (2006). *NVivo qualitative data analysis software* (ver. 7). Cambridge, MA: Author.

Roosa, M. W., Tein, J.-Y., Reinsholtz, C., & Angelini, P. J. (1997). The relationship of childhood sexual abuse to teenage pregnancy. *Journal of Marriage and Family*, *59*, 119-130.

Santhya, K. J., Haberland, N., Ram, F., Sinha, R. K., & Mohanty, S. K. (2007). Consent and coercion: Examining unwanted sex among married young women in India. *International Family Planning Perspectives*, *33*, 124-132.

Stewart, L., Sebastiani, A., Delgado, G., & Lopez, G. (1996). Consequences of sexual abuse of adolescents. *Reproductive Health Matters*, *4*, 129-134.

Stock, J. L., Bell, M. A., Boyer, D. K., & Connell, F. A. (1997). Adolescent pregnancy and sexual risk-taking among sexually abused girls. *International Family Planning Perspectives*, *29*, 200-203, 227.

Uganda Bureau of Statistics & Macro International. (2007). *Uganda demographic and health survey 2006.* Calverton, MD: Authors.

Varga, C. A. (1997). Sexual decision-making and negotiation in the midst of AIDS: Youth in KwaZulu Natal, South Africa. *Health Transition Review*, *7*(Suppl. 3), 45-67.

Waszak Geary, C., Wedderburn, M. D., McCarraher, D., Cuthbertson, C., & Pottinger, A. M. (2006). Sexual violence and reproductive health among young people in three communities in Jamaica. *Journal of Interpersonal Violence*, *21*, 1512-1533.

Wawer, M. J., Sewankambo, N. K., Serwadda, D., Quinn, T. C., Paxton, L. A., Kiwanuka, N., et al. (1999). Control of sexually transmitted diseases for AIDS prevention in Uganda: A randomized community trial. *Lancet*, *353*, 525-535.

Wood, K., Maforah, F., & Jewkes, R. (1998). "He forced me to love him": Putting violence on adolescent sexual health agendas. *Social Science and Medicine, 47*, 233-242.

World Health Organization. (2001). *WHO ethical and safety recommendations for research on domestic violence against women*. Geneva, Switzerland: Author.

Zablotska, I. B., Gray, R. H., Koenig, M. A., Serwadda, D., Nalugoda, F., Kizogi, G., et al. (2007). Alcohol use, intimate partner violence, sexual coercion and HIV among women aged 15–24 in Rakai, Uganda. *AIDS Behavior*. (Epub ahead of print)

Zablotska, I. B., Gray, R. H., Serwadda, D., Nalugoda, F., Kigozi, G., Sweankambo, N., et al. (2006). Alcohol use before sex and HIV acquisition: A longitudinal study in Rakai, Uganda. *AIDS*, *20*, 1191-1196.

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