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"HE FORCED ME TO LOVE HIM": PUTTING VIOLENCE ON ADOLESCENT SEXUAL HEALTH AGENDAS

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Abstract—Violence against women within sexual relationships is a neglected area in public health despite the fact that, in partially defining women's capacity to protect themselves against STDs, pregnancy and unwanted sexual intercourse, it directly affects female reproductive health. This paper presents the findings of a qualitative study conducted among Xhosa-speaking adolescent women in South Africa which revealed male violent and coercive practices to dominate their sexual relationships. Conditions and timing of sex were defined by their male partners through the use of violence and through the circulation of certain constructions of love, intercourse and entitlement to which the teenage girls were expected to submit. The legitimacy of these coercive sexual experiences was reinforced by female peers who indicated that silence and submission was the appropriate response. Being beaten was such a common experience that some peers were said to perceive it to be an expression of love. Informants indicated that they did not terminate the relationships for several reasons: beyond peer pressure and the probability of being subjected to added abuse for trying to end a relationship, teenagers said that they perceived that their partners loved them because they gave them gifts of clothing and money. The authors argue that violence has been particularly neglected in adolescent sexuality arenas, and propose new avenues for sexuality research which could inform the development of much-needed adolescent sexual health interventions. © 1998 Elsevier Science Ltd. All rights reserved

Key words—violence against women, South Africa, adolescence, sexual health, health promotion, gender

INTRODUCTION

Adolescent sexual and reproductive health has been identified as among the most important health and development problems facing South Africa (ANC, 1994; Department of Health, 1995). Nationally the adolescent pregnancy rate is estimated to be 330 per 1000 women under 19 years of age (RSA, 1995) (no reliable data disaggregated by ethnicity or region are available). While this is undoubtedly very high, the significance of this rate reveals itself more fully if it is regarded as both a determinant and an indicator of poor sexual and reproductive health, and of broader social problems among this group. Other indicators reveal the extent of sexual ill-health among teenagers; the most up-to-date national HIV survey conducted among women attending public ante-natal clinics found the prevalence of HIV-positivity among pregnant teenagers to be 9.5% (Swanavelder, 1996). Improving the sexual health of adolescents in South Africa is a major challenge for all those involved in health promotion, policy-making and research.

In South Africa research on adolescent sexuality has been predominantly characterised by Knowledge–Attitudes–Practices (KAP) surveys (see for example Craig and Richter-Strydom, 1983; Ncayiyana and Ter Haar, 1989; Kau, 1988, 1991; Flisher *et al.*, 1993; NPPHCN, 1995; Buga *et al.*, 1996), which have enabled a general understanding of some aspects of adolescent sexuality to be acquired. Usually covering similar fields of enquiry, they have revealed that adolescents here, as elsewhere in the world, have a propensity to engage in a set of sexual practices characterised as "high risk", and have demonstrated gaps in adolescents' reproductive knowledge and poor intergenerational communication on sexual matters. Among adolescents a "KAP-gap", or failure to use knowledge to modify practices, is commonly observed in this research. Factors such as pressure from female peers and male partners have been suggested as contributing to early (and unprotected) sexual intercourse. Other research conducted in South Africa among African adolescents has revealed pressure to engage in early and unprotected intercourse, and in many contexts to have a child in order to prove love, fidelity and womanhood (Preston-Whyte and Zondi, 1992; Varga and Makubalo, 1996). Other authors, however, have pointed to adolescents' shame, fear of social retribution, and abuse from healthcare providers (Kau, 1988; Boult and Cunningham, 1991; Abdool-Karim *et al.*, 1992; Walker, 1995) for both seeking out contraception and becoming pregnant at an early age.

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Internationally, recent social scientific research on sexuality, in partnership with HIV/AIDS lobbies, has brought about changes in the ways individuals' behaviour is analysed. In particular there have been moves away from biomedical and epidemiological constructions of individuals as members of groups designated as high risk (homosexual, intravenous drug-user) or low risk (heterosexual), towards understanding individuals as situated agents engaging in (high or low risk) practices with others. Understanding sexual encounters as sets of practices which are negotiated and enacted by the individuals concerned creates a space for considering how inequities determine and are played out during sexual intercourse, thereby affecting individuals' capacity to control it on their own terms (Worth, 1989; Holland *et al*., 1990; Wilton and Aggleton, 1991; McGrath, 1993; Orubuloye *et al*., 1993; Lear, 1995). These new understandings have revealed the need to put violence on health research agendas.

This paper presents the findings of an exploratory qualitative study conducted among Xhosa adolescent women which revealed pervasive male control over almost every aspect of their early sexual experiences, and the male enactment of this in part through violent and coercive practices during sexual encounters. In discussing the findings we argue that violence has been widely neglected in health research and intervention development, and more especially so in adolescent sexuality arenas. There is an urgent need to open up new avenues for research and intervention in the area of adolescent sexuality, in particular focusing on violence, if it is to be possible to create a space in which young women can empower themselves to control their sexuality, sexual experiences and reproductive health.

BACKGROUND: RECENT SEXUALITY RESEARCH

Methods used in sexuality research have undergone a shift in the last decade, with emphasis increasingly being placed on the individual as a social and interactive agent. Most notably for example, recent innovative quantitative studies (for example Laumann *et al*., 1994) have developed new survey instruments in order to investigate previously unexamined issues such as sexual networks and gender power, constituting a shift away from the documentation of sexual behaviour towards an understanding of the dynamics of sexual interaction within specific settings (AIDS and Reproductive Health Network in Brazil, 1995). In qualitative research there has been increased interest in communication and decision-making (Worth, 1989; Holland *et al*., 1990; Kline *et al*., 1992; Browne and Minichiello, 1994; Lear, 1995) within sexual relationships, while its methods have continued to be used to explore the complexity of sexuality from the perspectives of individuals (Moore and Rosenthal, 1992; Tolman, 1994; NPPHCN, 1995).

Adoption of this more social and dynamic perspective has led to power being increasingly written into analysis, and forces micro-level sexual decision-making onto the agenda: how, why and when are decisions made by individuals to have sex, and to engage in specific sexual practices? How are inequities played out and resisted? To give examples, how far are practices such as condom use and female sexual refusal negotiable and negotiated between individuals in different settings? How is individual control asserted when there is conflict?

The sex act itself is the site of multiple power differentials, which include ethnicity, social status and age, but which in heterosexual encounters are dominated by gender (Holland *et al*., 1990; Wilton and Aggleton, 1991). Gendered power relations acted out in heterosexual encounters directly affect female sexual and reproductive health outcomes, in that they partially define women's capacity to protect themselves against sexually transmitted disease, pregnancy and unwanted sexual acts. This understanding has motivated a body of literature whose concern is the extent to which women are able to control their sexual encounters with men.

Worth (1989) for example found that her informants, inner-city New York women who used drugs or who had partners who used drugs, described the type of sexual encounters they experienced as constrained by multiple factors which differed situationally and included: the poverty of the communities in which they lived which caused sex to become an economic commodity; the shortage of men (lost through death and imprisonment) which can lead to women sharing sexual partners; the kinds of drugs used which influenced how the sexual act was performed and experienced. Similarly, Bagandan women in the research of McGrath (1993) explained that poverty forced them to engage in extra-marital sex for food or money, where capacity for negotiation, including condom use, was limited.

Reading the literature demonstrates, however, that women's capacity to influence the course of a sexual encounter differs between individuals, groups and location. The data from Kline *et al*. (1992) for example leads her to doubt "the generality of models linking low condom use to women's lack of power in relationships". Her paper concludes that sexual decision-making among her "high-risk" research participants, black and Hispanic women who were HIV-positive, used drugs intravenously or had partners who used them, was actually characterised by a high degree of control. Women described the following strategies as successful in imposing condom use: withholding sex; reasoning with male partners; and postponing their demand for condom use until men were so sexually aroused that they would accept sex under any condition named by the woman. Orubuloye *et al*. (1993) write that Yoruba women were in fact able to refuse sex