The Impact of Sexual Coercion and Violence on Sexual Decision-Making: A Look at Youth in KwaZulu Natal

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As the candidate's supervisor I have / have not approved this dissertation for submission.

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Declaration of Original Work

Except where specific reference is made to the work of others, this work is original and has not been already submitted either wholly or in part to satisfy any degree requirement at this or any other university.

Signed:_____ Date:_____

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Chapter One: Introduction

1.1 Introduction

Achieving higher levels of condom use in KwaZulu Natal, South Africa is particularly important, given the high levels of teen pregnancy and HIV/AIDS in this province. This research analyzes data from the first round of the *Transitions to Adulthood in the Context of AIDS in South Africa (Transitions)* study, based in KwaZulu Natal (KZN), South Africa. Using data collected from interviews with sexually active youth in KZN, this research aims to explore the link between sexual violence and condom use and offer recommendations about how condom use among sexually active youth in South Africa might be increased.

Encouraging condom use is, however, far from simple. Many factors influence youth's condom use, including, it is hypothesized, experiences of violent or coercive sex. Given the high levels of sexual coercion and violence in KwaZulu Natal and South Africa at large, it is important to explore this relationship. This research aims to help explain how youth's experiences of coercive or violent sex affect their condom use, communication and negotiation about condom use. Although the relationships between these variables are complex, it is possible to make some policy recommendations and to suggest avenues for future research.

1.2 Background

1.2.1 HIV/AIDS

Pregnancy and sexually transmitted infections such as HIV/AIDS are the twin risks of unprotected sex. There is little doubt that both of these pose major problems for the adolescents of many Sub-Saharan African countries, including South Africa. According to the World Bank, 8.4% of the adult population in Sub-Saharan Africa was HIV positive in 1999 (World Bank, 2000) and UNAIDS estimates 19.4% of the adult population (age 15-49) in South Africa was HIV positive by the end of that same year (UNAIDS, 2000).

Although HIV in South Africa was originally concentrated in the homosexual and bisexual male population in the late 1980's, the primary mode of HIV transmission is now heterosexual sex, which accounts for 80 percent of HIV cases (with the remaining 5-10 percent via mother-to-child transmission) (UNDP, 1998, cited in Maharaj, 2001). HIV/AIDS is hitting KwaZulu Natal (KZN) particularly hard. According to a recent survey of women attending public antenatal clinics in South Africa, KZN has the highest levels of HIV infection in the country, with estimates of over 36 percent (South Africa Department of Health, 2000). HIV prevalence among youth dropped slightly in 2000 to 16.1%, as compared to 16.5% in 1999. While this is much lower than prevalence rates for women in their twenties (29.1% for women aged 20-24 and 30.6% for women aged 25-29) (South Africa Department of Health, 2000), it is likely that many of the HIV-positive women in their twenties may have been infected in their adolescent years. One recent voluntary testing survey in KwaZulu Natal found that 43 percent of girls aged 15-19 were HIV positive, as compared to approximately 17 percent of boys the same age (Desmond, 2000). The high levels of HIV amongst this age group underscores the importance of exploring what factors influence youth's sexual decision-making.

1.2.2 Pregnancy

In addition, adolescent pregnancy is a major problem in Sub-Saharan Africa at large and in South Africa and KZN in particular. Despite a downward trend in fertility in southern Africa at large (Potts and Marks, 2001: 190), reports show that "early childbirth is most common in Sub-Saharan Africa" with a majority of girls (55% among women aged 20-24) giving birth before the age of 20 (Bongaarts and Cohen, 1998: 101). The long-term consequences of these births can be particularly problematic for young women because many are not within the context of marriage. Recent research suggests that an increasing proportion of women in many

developing countries is initiating sexual activity before marriage (Blanc and Way, 1998). As a result of high levels of adolescent sexual activity and low levels of contraceptive use before the first pregnancy, premarital fertility among adolescent women between ages 15 and 19 in South Africa is high (Garenne *et al*, 2000). According to the 1998 South African Demographic and Health Survey (SADHS), 35 percent of women aged 15-19 had been pregnant or had a child (Department of Health, 1998; Kaufman *et al*, 2001). A recent survey in the Transkei, one of the former African homelands under the apartheid regime, found that 43 percent of women had children by the age of 19, although only 11 percent of these young women were married by that age (Makiwane, 1998). Similarly, *Transitions* report finds that almost a quarter of all females in the sample of adolescents in KwaZulu Natal have been pregnant and about half (50.3%) of those who are sexually active have been pregnant at some point (Rutenberg *et al*, 2001).

The potentially negative consequences of pregnancy for adolescent girls are well documented. Numerous studies document how pregnancies threaten girls' educational success (Singh, 1998: 117; George, 2001a). The *Transitions* study confirms these findings: pregnancy was the most frequently cited reason why girls dropped out of school in (Rutenberg *et al*, 2001). Further, three-quarters of those girls who became pregnant while in school dropped out as a result and the majority (59%) did not resume their schooling (Rutenberg *et al*, 2001). While this indicates that a significant proportion of girls did return to school after their pregnancies, the negative impact of pregnancy on girls' education is clear. Adolescent childbearing can also have significant health risks, including infection and high blood pressure (Zabin and Kiragu, 1998; Singh, 1998). Previous research also suggests that teenage mothers are also likely to have fewer employment options and lower income and are, therefore, more likely to live in poverty (McCauley and Salter, 1995, cited in Mturi and Moerane, 2001).

1.2.3 Contraceptive Use

Despite these risks, a significant proportion (39%) of adolescents in the *Transitions* sample reported using no form of contraception the last time they had sex, with these rates varying widely by race and type of method used (Rutenberg *et al*, 2001: 42). This supports previous research by Garenne *et al* that finds that the high levels of premarital fertility among women aged 12-26 are due to low levels of contraception use before the first birth, particularly among adolescents (Garenne *et al*, 2001). Although use of male condoms or another contraceptive method is only one determinant of pregnancy rates (Bongaarts and Westoff, 2000), it is salient to focus on how violence influences adolescents' condom use because condoms can prevent both pregnancy and sexually transmitted diseases such as HIV.

Although the majority of adolescent women know about contraceptive methods, research in various countries shows that adolescents may be less likely than older women to practice contraception (Blanc and Way, 1998). Recent research in South Africa suggests, however, that contraceptive use is higher among sexually active women in their teens and twenties than among older women (South African Department of Health, 1998). Two-thirds of sexually active adolescents between the age of 15 and 19 report using a modern contraceptive method, although only about one in five teenagers report using a condom at last intercourse (South African Department of Health, 1998). This indicates that although the majority of teens may be using a contraceptive method to prevent pregnancy, the vast majority are not protecting themselves against sexually transmitted diseases such as HIV, despite high levels of awareness of HIV/AIDS (South African Department of Health, 1998). It is particularly relevant, therefore, to explore how factors such as experiences of violence may hinder adolescents' condom use.

1.2.4 Sexual Violence and Coercion

Adolescents experience disturbing levels of sexual violence and coercion in many countries, including South Africa. For example, research in Malawi found that two-thirds of sexually active young women report coercive sex (Rivers and Aggleton, 2001). Previous studies suggests that many adolescents also describe their sexual initiation as forced or coercive (Rwenge, 2000; Jewkes, 1999). Recent research in Zimbabwe found that male pupils and teachers often use gifts and money to coerce adolescent girls into sexual relationships that are exploitative and dependent (Leach and Machakanja, 2001).

Numerous studies suggest that sexual violence and coercion are also common in South Africa (see for example, Richter, 1996, cited in Wood *et al*, 1998; Jewkes, 1999; Wood and Jewkes, 1997). For example, Hunter's recent research in KwaZulu Natal finds that it is "common practice" for men to provide their girlfriends with cash or gifts in what Hunter dubs 'transactional sex'. He posits that such 'transactional sex', which is catalyzed in part by gendered economic differentials, is "central to the spread of HIV" (Hunter, 2001: 1). In addition to coercive sex, rape is also very common in South Africa. Although there is much debate about the number of rapes that occur in South Africa each year, recent research finds that South Africa has the highest per capita rate of reported rape cases in the world (Bollen *et al*, 1999, cited in Adar and Stevens, 2000; Rape Crisis, 2000). The incidence of child rape has also risen substantially in the last decade: between 1994 and 1998 the number of child rapes in South Africa increased by 103 percent (Meyer, 1998, cited in Leclerc-Madlala, 1999). Sadly, numerous studies find that sexual violence is likely to be under-reported (Adar and Stevens, 2000; Heise *et al*, 1994). Although there were almost fifty thousand reported rape cases in 1998, it was estimated in 1997 that only 1 in 36 women who experience sexual violence report their rape (Rape Crisis, 2000). Given that

rape is under-reported in South Africa, the levels of sexual violence in this country are certainly amongst the highest in the world.

Forced sexual initiation is also common in South Africa: Jewkes (1999) reports that one third of adolescent girls in South Africa experience sexual initiation by force. Similarly, several authors report widespread violence and coercion within sexual relationships in South Africa (Wood and Jewkes, 1997; Wood *et al*, 1998; Buga *et al*, 1996, cited in Wood *et al*, 1998), although adolescent girls may not consider forced sex within a relationship as 'rape' (Wood *et al*, 1998). Previous research also suggests that sexual violence and coercion are pervasive in adolescent relationships in KwaZulu Natal (Varga and Makubalo, 1996). In fact, violence may be so common in sexual relations in South Africa that sexually active adolescents accept violence as inevitable (Wood *et al*, 1998).

Recent research based on the *Transitions* study in South Africa supports these findings, reporting that over a third of all females (34%) stated that they were "persuaded", "tricked", "forced or raped" the first time they had sexual intercourse (Manzini, 2001). Similarly, 29 percent of girls report non-consensual sex and 12 percent have been physically forced, hurt or threatened to have sex (Rutenberg *et al*, 2001). These findings echo other recent warnings about the extent of sexual harassment and violence experienced by South African adolescents, often in the context of school, at the hands of male students and teachers (George, 2001a; George, 2001b; Potts and Marks, 2001).

Leclerc-Madlala posits that the high levels of rape and sexual violence in South Africa may be exacerbated by the growing levels of HIV: as young men learn or suspect that they are HIV-positive, they may respond by raping women (Leclerc-Madlala, 1997). Irrespective of the myriad of reasons why the incidence of rape and other forms of sexual violence are increasing in South Africa, an increasing number of women and young girls are undoubtedly affected. It is important, therefore, to understand how these

experiences of sexual violence influence youth's sexual decision-making and subsequent condom use.

1.3 Data and Variables

This research analyzes the *Transitions* data set from the first round of this study. The *Transitions* study focuses on adolescent sexual health and the effectiveness of the *Life Skills and HIV/AIDS Education* program implemented by the South African government in 1998 in response to the HIV/AIDS epidemic. The study is based in KwaZulu Natal, with the sample selected from the Durban Metropolitan area and the Mtunzini Magisterial District using a multi-stage cluster sample approach. Approximately two thousand (n=2007) households with adolescents between 14 and 22 years old were Interviewed between 16 September to 7 November, 1999. In addition to interviews conducted with the head of each household, interviewers questioned the youth themselves about topics such as education history, work experience, Life Skills programs in schools, sexual relationships and contraceptive use and knowledge. Of the 3,770 youth identified in these households, individual interviews were completed with 3,096 respondents. Response rates between race groups differed, but the overall response rate for youth was 82.2 percent (Rutenberg et al, 2001). Data from the individual interviews with the adolescent respondents was used for this research. Although the *Report of Wave I* on the *Transitions* study has recently been released, much of this data set has yet to be analyzed in any depth. Thus, this work will help elucidate one link between adolescent sexual health and experiences of violent or coercive sex.

To explore this link, this research evaluates whether personal experiences of sexual violence impact adolescents' ability to negotiate and practice safe sex and considers whether violence and harassment in adolescents' school and community environment impacts their sexual negotiation skills, condom use and incidence of pregnancy. Because only youth who reported that they had had sexual intercourse (defined as full

penetration) were asked questions about their sexual experience, condom use and availability, pregnancy history and knowledge about reproductive health issues such as HIV/AIDS, most of these analyses considered a sub-set of the 3,096 youth interviewed. The data set was cleaned by deleting all respondents who refused to give the number of sexual partners they had in the previous twelve months (n=76), who had no sexual partners during this time (n=48), or who did not know (n=3) because they were not asked any of the questions about condom use or experiences of sexual violence. In addition, married respondents (n=25), those who refused to give their relationship status (n=1) and respondents over age 24 (n=2) were excluded. Lastly, remaining cases with missing information to the key variables were deleted (n=57). The sub-sample used for analysis included the remaining 1,264 youth who were single and who reported at least one sexual partner in the twelve months prior to the interview.

The dependent variables in this research measure youth's condom use, sexual communication and confidence in their ability to negotiate protected sex. The survey question asking sexually active youth whether they used a condom with their most recent sexual partner was used to gauge youth's condom use. To measure youth's sexual communication, they were asked whether they had discussed condom use with their most recent sexual partner. Lastly, confidence in sexual negotiation was gauged by how confident youth reported feeling in their ability to convince their partner to use a condom. The reliability of respondents' recall about events that occurred long before the survey is questionable; however, these questions asked youth about condom use with their most recent sexual partner and, thus, their responses are likely more reliable.

Independent variables considered include race, gender, age, rural or urban residence and education attained. In addition, youth's responses about their experience with sexual coercion and violence were used. Questions asking youth about sexual harassment and violence at schools

and violence in their communities were used in the bivariate analysis, but were not included in the later regression models, as will be discussed.

These results should be interpreted with caution for several reasons. It is important to note that although the *Transitions* sample is representative for the Durban and Mtunzini areas in KZN province, it is not representative for South Africa at large. First, KZN is plagued by the highest rates of HIV-infection of all South African provinces. Secondly, the demographics of KZN, including a large Indian population, differ from other areas of South Africa. Lastly, as the *Transitions* report points out, KZN experienced periods of political violence in the mid-1980s and early 1990s (Rutenberg et al, 2001). For these reasons, it is important not to generalize these findings and recommendations to the national level. Finally, these results must be interpreted in light of questions about the reliability of adolescents' self-reporting of their sexual activities. Several authors caution that youth often report their sexual experiences inconsistently (see, for example, Eggleston *et al*, 2000; Lauritsen and Swicegood, 1997).

1.4 Methodology

The descriptive analysis is given in the form of frequencies and crosstabs. The multivariate analysis used binary and multinomial logistic regression to determine how each independent variable in the model affects the dependent variable, controlling for all other independent variables in the model. Because the dependent variables were neither normally distributed nor continuous, binary and multinomial logistic regression were used in place of linear regression. For the first two models, with condom use and communication about condom use as the dependent variables, binary logistic regression was used because there were only two outcomes for the dependent variable ('yes' and 'no'). For the third model gauging youth's confidence in their ability to convince their partner to use a condom, multivariate logistic regression was used because the dependent variable had three outcomes ('very confident', 'fairly confident' and 'not confident').

Based on the relevant literature reviewed, variables related to condom use, sexual negotiation and communication, pregnancy, experiences of violent and coercive sex and school and community violence were selected for bivariate analysis. The results of bivariate analysis were used to identify variables to include in three regression models: condom use, communication about condom use and confidence in sexual negotiation about condom use. From the thirteen variables used in modeling, a parsimonious model of the variables influencing each of the dependent variables was developed. Chapters three through six present the variables included in each model and a discussion of the results.

Chapter Two: Conceptual Framework and Literature Review

2.1 Sexual Decision-Making and Negotiation

Sexual decision-making, including the decision about whether to use condoms, is a complex process, influenced by many factors. Sexual decision-making is defined as:

> decisions, preferences and resolutions made by an individual regarding the conditions, such as timing of intercourse or contraceptive use, under which sexual relations occur (Varga, 1997: 52).

While sexual decision-making centers on the individual, sexual negotiation focuses on interactions between partners and is defined as:

> verbal communication between potential sex partners regarding when intercourse will take place and the terms (such as contraceptive use) under which it will occur (Varga and Makubalo, 1996).

Varga points out that sexual negotiation also includes the "non-verbal interaction and dynamic between partners in deciding how and when intercourse will take place" (Varga, 1997: 52). It is essential to understand the processes of sexual negotiation and communication to inform the design of effective sexual health programs (Lear, 1995).

Both sexual decision-making and negotiation are influenced by numerous factors, including perceptions of risk, family and peer pressures, knowledge and belief in self-efficacy (Gage, 1998). Sexual negotiation may be limited because talking about sex is often difficult and because in many cultures, girls "are not supposed to be knowledgeable about sex [and] are expected to be passive in sexual matters" (Blanc, 2001: 194). Adolescents' decisions to practice safe sex, defined in this context as sexual intercourse using a male condom, are shaped by many factors, including feelings that condoms "implied a lack of trust", questions about condoms' effectiveness and partner resistance (Maharaj, 2001: 252-254). Further, condom use may be curtailed because of limited communication: females in KwaZulu Natal

reported avoiding discussing or requesting that their partners use a condom for "fear of physical abuse, rejection or lack of intimacy" (Varga, 1997: 57). Previous studies also find that adolescent girls in South Africa face significant obstacles in accessing modern contraceptive methods (Garenne et al, 2001; Harrison and Montgomery, 2001). Given the particularly high levels of HIV infection in KwaZulu Natal, it is perhaps unsurprising that prior research suggests that youth's fatalism about AIDS, their acceptance of AIDS as "an almost inevitable consequence of being an adult", led many Zulu youth to neglect protected sex (Leclerc-Madlala, 1997: 368).

A myriad of factors other than adolescents' knowledge about protected sex influences their sexual decision-making. Numerous studies suggest that knowledge of family planning practices "does not necessarily translate into practice" (Bauni and Jarabi, 2000: 76; see also Gage, 1998; Rwenge, 2000; Magnani *et al*, 2001). Recent research in KwaZulu Natal suggests that although males recognize condoms as a method to prevent both STDs and unwanted pregnancy, "[k]nowledge of condoms as a contraceptive method does not necessarily translate into correct use" (Maharaj, 2001: 253). Wood *et al* (1998) also challenge the "Knowledge-Attitudes-Practices" model that contends that knowledge leads to action, arguing that such a model tends to "render invisible the realities of power dynamics" within heterosexual relationships (Wood *et al*, 1998: 235).

It is essential, therefore, to understand the context of adolescent sexual decision-making to design successful interventions, rather than merely focusing on sexual education (Rosenthal and Lewis, 1996). Several studies suggest that economic and social barriers, rather than lack of knowledge, impede safe sex behavior (Hulton *et al*, 2000; Magnani *et al*, 2001; Wood and Jewkes, 1997; Rosenthal and Lewis, 1996). Indeed, sexual intercourse represents the intersection of multiple power differentials, including age, social status and ethnicity (Holland *et al*, 1990 and Wilton and Aggleton, 1991, both cited in Wood *et al*, 1998). These power differentials

are clearly important influences on adolescent reproductive health, as are community and family (Blanc, 2001).

2.2 Gendered Power Differentials

Numerous authors agree, however, that gendered power differentials are perhaps the most crucial factor to consider in sexual negotiation and decision-making (see for example, Kalof, 1995; Wood and Jewkes, 1997; Wood *et al*, 1998; Lear, 1995; Blanc, 2001). Drawing on a definition by Gupta, gender refers to norms and expectations about appropriate female and male roles, characteristics and behavior that are shared within a society (Gupta, GR 2000). Contesting the 'knowledge leads to action' model, Wood and Jewkes emphasize instead that gendered power differentials "structure heterosexual relations" (Wood and Jewkes, 1997: 44") and often render women powerless to negotiate the timing or conditions of sex (Wood *et al*, 1998). Further, Gage points out that gender roles and the resultant power dynamics are proscribed by "cultural values regarding sexuality" and are important factors that influence adolescents' sexual decision-making (Gage, 1998: 154). Similarly, studies in KwaZulu Natal found that culturally-sanctioned gender roles limited girls' ability to negotiate protected sex (Varga, 1997). Unequal power in heterosexual relations is, therefore, clearly an important factor to consider in exploring youth's sexual decision-making.

One way that gender inequities negatively affect sexual behavior is by limiting women and girls' ability to negotiate safer sex. Gendered power differentials can discourage communication about reproductive health, thus limiting sexual negotiation (Blanc, 2001). Women may be less able to negotiate protection from sexually transmitted diseases, to discuss sexual fidelity and to refuse sex in relationships characterized by power imbalances (Gupta and Weiss, 1993, cited in Blanc, 2001). Previous research suggests that the "unequal power relations of gender" (Miles, 1992: 16) compromise women's sexual negotiation, thus impeding contraceptive use (Blanc and

Way, 1998; Harrison and Montgomery, 2001). Lear cautions that "[u]sing or not using a condom is not a simple, practical question about dealing rationally with risk, it is the outcome of negotiation between potentially unequal partners" (Lear, 1995: 1314).

Not only do unequal male-female power relations limit sexual negotiation, but such disparities also inhibit condom use. In Uganda, an analysis of the impact of violence on reproductive decision-making found that women who had past experiences of violence within a relationship were less likely to use contraceptives (Ezeh and Gage, 1998, cited in Blanc, 2001). Similarly, research in KwaZulu Natal found that although the majority of women interviewed knew how to protect themselves from HIV infection, not one woman interviewed had ever used condoms because they were disempowered in their relationships (Preston-Whyte, Abdool-Karim and Zondi, 1991 cited in Leclerc-Madlala, 1997). While condom use is more prevalent over a decade later, unequal gender dynamics continue to influence sexual decision-making. More recent research in KwaZulu Natal suggests that because females often have less power in sexual relationships, "their ability to negotiate when intercourse will take place and whether a condom will be used" is reduced (Bauni and Jarabi, 2000: 76). Similarly, another KwaZulu Natal-based study found that men command "enormous power over sexual decision-making" and see the choice about whether to use a condom as their decision alone (Maharaj, 2001: 256). Girls are also at a disadvantage in these negotiations because they are more biologically susceptible to contracting a sexually transmitted disease and because girls usually bear a disproportionate share of the burden of pregnancy. Although Kline *et al* (1992) caution that individual women's power in sexual relationships and their ability to negotiate condom use cannot be generalized across groups and locations, it is clear that knowledge about safe sex behavior does not necessarily lead to action in the face of unequal power in gender relations.

2.3 Impact of Coercion and Forced Sex

The coercion and forced sex that characterize many adolescent sexual encounters are important factors in understanding sexual decision-making (Gage, 1998; Wood and Jewkes, 1997; Varga and Makubalo, 1996; Wood *et al*, 1998; Coker and Richter, 1998). In the context of this study, coercive sex is defined as sex that involves verbal pressure and/or the exchange (or the promise of exchange) of gifts such as money, jewelry, school fees, food or transport for sex. Sexual violence in this research is defined by the threat or use of violence to force sexual intercourse. Hulton *et al* (2000) highlight such sexual violence and lack of material resources as two major barriers that limit young women's ability to implement safe sex behaviors such as use of a male condom. A recent study in Cameroon suggests that young girls often engage in risky sexual activity for "economic reasons, which negatively influences their power to require use of condoms during sexual intercourse" (Rwenge, 2000: 122). Similarly, Ulin cautions that when women are economically dependent on men, they are more likely to engage in coercive sex, which may leave them vulnerable to sexually transmitted diseases (Ulin, 1992, cited in Blanc, 2001). Previous research on adolescent sexual decision-making in South Africa indicates that violence or the threat of violence can negatively affect adolescent girls' sexual decisions (Jewkes, no date; Varga and Makubalo, 1996). Numerous studies in KwaZulu Natal have also found that gender-based violence and coercion limit adolescents' sexual-decision making, stifling communication about topics such as HIV and condoms (Maharaj, 2001; Varga, 1997; Jewkes *et al*, 1999 cited in Jewkes, 1999; Varga and Makubalo, 1996; Wood *et al*, 1998) and compromising young women's ability to negotiate condom use (Heise *et al*, 1993, cited in Jewkes, 1999; Varga, 1997; Varga and Makubalo, 1996).

The consequences of sexual violence for young women can include pregnancy and disease. Recent research suggests that the contexts of adolescents' sexual initiation are "key indicators of adolescents' potential risk

for unplanned pregnancy, abortion and sexually transmitted diseases" (Singh *et al*, 2000: 21). Previous studies in the U.S. suggest that forced sexual initiation is linked to subsequent sexual risk-taking, including "a higher frequency of subsequent adolescent sexual activity and a greater number of partners" (Koyle *et al*, 1989 and Seidman *et al*,1994 both cited in Abma and Driscoll, 1998). In addition, experiences of sexual abuse can result in increased likelihood of risk factors for teen pregnancy such as the failure to use a contraceptive method, early sexual initiation and multiple sex partners (Stock *et al*, 1997, cited in Abma and Driscoll, 1998; Luster and Small, 1997). Experiences of non-voluntary intercourse may also be associated with a higher incidence of teenage pregnancy (Roosa *et al*, 1997 cited in Abma and Driscoll, 1998). Recent research in South Africa supports these findings, indicating that forced sexual initiation can "increase the risk of teenage pregnancy by 14 times" (Vundule et al, 1999, cited in Jewkes, 1999). Maforah *et al* (1997) also found that forced sexual initiation, unwilling sex and rape were more common among pregnant adolescents. Under violent circumstances, therefore, simply teaching adolescent girls the facts about the risks of pregnancy and sexually transmitted infections may do little to change their behavior without empowering them to act on this knowledge.

This research explores how adolescents' experience with violence and coercion, both in and out of school, affects their subsequent sexual decision-making and negotiation. Because sexual violence and coercion reflect and reinforce ideologies about masculinity and femininity, they can shape power dynamics within a relationship and influence adolescents' sexual decision-making. Gage notes that even the "threat of male violence…can pressure…girls to acquiesce to unsafe sexual practices" (Gage, 1998: 157). Other research also suggests that rather than be subject to immediate physical or sexual violence, women may be compelled by the fear or threat of violence to engage in unprotected sex (World Health Organization, 1998 cited in Blanc, 2001). A school and community environment characterized by sexual violence and harassment constitutes such a threat, albeit indirect, to

adolescent girls and may have the same effect of pressuring them into unsafe sex. A recent study in two townships in South Africa's Eastern Cape suggests that not only is violence common in sexual relationships, but also in adolescents' home and school lives (Wood and Jewkes, 2001). Wood and Jewkes suggest that a school and home environment where violence is the norm may condition adolescents to accept that violence is a "normal strategy for punishment and a way of gaining ascendancy and control" (Wood and Jewkes, 2001: 4). If violence is a common feature in adolescents' relationships at home and at school, they may learn to expect violence in their sexual relationships as well. As "[p]hysical assault, rape, and coercive sex... become the norm" in heterosexual relationships in South Africa (Wood and Jewkes, 2001: 4), it becomes increasingly important to understand the implications of this violence for adolescents' sexual decision-making and negotiation.

2.4 Self-Efficacy and Locus of Control

One way that violent or coercive sex can influence adolescents' sexual decision-making is indirectly, by changing their "perceived ability to influence their situation" and, therefore, their subsequent sexual behavior (Gueye, 2001: 60). The degree of control that an individual feels in a relationship has been shown to be an important factor in sexual decisions (Bandura, 1989 cited in Rosenthal and Lewis, 1996). Wood *et al* (1998) advise that

> [t]he degree to which women are, or feel able, to control various aspects of their sexual lives is clearly a critical question for health promotion and the design and impact of appropriate HIV/AIDS and reproductive health interventions (Wood *et al*, 1998: 235).

Several authors have considered this concept of degree of control in terms of "self-efficacy" or "locus of control" (Gage, 1998; Lester and Cook, 1988, cited in Gueye, 2001; Perkel *et al*, 1991, cited in Gueye, 2001; Gueye, 2001; Blanc and Wolff, forthcoming, cited in Blanc, 2001).

Previous research suggests that "self-efficacy" in making decisions about sex is an important factor in the decision to have sex or use a condom (Gage, 1998). Bandura (1977) cites self-efficacy as the most important prerequisite for behavior change. Drawing on definitions used by Soler *et al* (2000) and Bandura (1997), in the context of this research "self-efficacy" refers to a youth's level of confidence that (s)he can successfully negotiate condom use with his or her partner (Soler *et al*, 2000). If youth do not feel that they can refuse sex or convince their partners to use a condom, they may be less likely to practice safe sex. Violence and harassment may condition adolescent girls to "accept male dominance in sexual encounters" (Gage, 1998: 163). Gage notes that adolescent girls in the U.S. who reported feeling "little control over their sexual behavior" were less likely to consistently use condoms and more likely to engage in "risky" sexual behavior (Gage, 1998: 158). Recent research in the U.S. suggests that women's confidence in their ability to negotiate condom use with their partners and their condom-related self-efficacy were important factors influencing consistent condom use (Soler *et al* 2000). In fact, women who were very confident in their ability to negotiate condom use were six times more likely to consistently use condoms (Soler *et al* 2000). Similarly, research in Sierra Leone indicates that adolescents who are more comfortable with sexual negotiation are more likely to use a condom (Lahai-Momoh and Ross, 1997). Because adolescents who experience sexual violence or coercion may feel they are not in control of their sexuality, they may be more likely to cede control in subsequent sexual relationships.

Other authors describe this feeling of control in terms of a 'locus of control', defined as "the extent to which individuals believe that their behavior will have an impact on their situation" (Gueye, 2001: 37). Previous research in South Africa suggests that individuals' locus of control affects contraceptive use and safe sex behaviors. Individuals with an external local of control, who feel as if they have "little or no influence on what happens to them" (Gueye, 2001: 57), are more likely to engage in risky sexual behaviors

such as unprotected sex with multiple partners (Perkel et al, 1991, cited in Gueye, 2001). Conversely, having an internal locus of control can enable people to negotiate safer sex practices, such as condom use (Gueye, 2001). Similarly, Blanc and Wolff (forthcoming), using the concept of "locus of control", found that the more empowered women felt relative to their sexual partner, the more likely they were to discuss sex and to use a condom. Because in situations of forced sex or rape, "the young woman has little control over the situation and her ability to negotiate contraceptive use is negated" (Manzini, 2001: 44), unwanted sexual experiences may negatively affect adolescents' locus of control. Students who experience such violence and coercion may, therefore, be less confident in their ability to negotiate condom use and be less likely to practice safe sex in the future.

Because of the link between violence and individuals' sense of control it is essential to explore how experiences of violence influence youth's sexual decision-making. As Wood *et al* conclude, "the degree to which women are, or feel able, to control various aspects of their sexual lives is clearly a critical questions for health promotion and the design and impact of appropriate HIV/AIDS and reproductive health interventions" (Wood *et al*, 1998: 235). Okubuloye *et al* (1993) also caution that in order to develop effective HIV and STD prevention programs, it is important to understand the implications of women's control over their sexual relations. Wood *et al* (1998) further suggest that failing to consider gender violence and coercion can limit the design and effectiveness of sexual health programs. Thus, it is clearly important to understand how experiences of violent and coercive sex shape youth's sexual decision-making and negotiation about condom use. The following chapters begin to explore this link.

Chapter Three: Sexual Experience, Pregnancy and Violent and Coercive Sex

3.1 Incidence of Sexually Experienced Youth

Table 3.1 indicates that approximately half of youth respondents reported they had experienced sexual intercourse (defined as 'full penetration') in the previous 12 months. A greater percentage of rural youth (51.4%) than urban youth (46.0%) have experienced sexual intercourse. There is also a relationship between population group and sexual experience: a much higher percentage of African youth (54.6%) have had sexual intercourse as compared to any other population group. Boys interviewed were also more likely (51.2%) than girls (44.9%) to report that they were sexually experienced, a difference perhaps because having multiple sex partners may be a "status symbol" for boys (Varga, 1997: 55).

Table 3.1 Percentage of sexually active youth (n=3096)

Characteristic	Percent ever had sexual intercourse
Residence	
Urban	46
Rural	51.4
Population Group	
African	54.6
Colored	34.5
Asian	21.9
White	34.9
Gender	
Male	51.2
Female	44.9
Total	**47.7**

3.2 Incidence of Pregnancy

Figure 3.1 below illustrates that approximately half (50.3%) of female youth surveyed who have been sexually active in the preceding 12 months have been pregnant at some point. Although almost three-quarters (69.3%) of these girls report that their pregnancy was unwanted, very few (2.1%)

have tried to end a pregnancy. As Table 3.2 below shows, there are striking differences between population groups and rural/urban residents in incidence of pregnancy. Rural youth are more likely to have experienced pregnancy, as are women of color. The difference between pregnancy incidence among white youth and African and Asian youth is stark, with the majority of Africans (52.3%) reporting a pregnancy, compared to less than one tenth of whites (6.5%). This may be due, in part, to lower level of condom use among African youth, as discussed in the following chapter. Although this 50.3 percent incidence of pregnancy seems high, it may be because the *Transitions* study includes all youth between the ages of 14 and 22, rather than the more narrow age ranges used in other work. For example, the 1998 South African Demographic and Health Survey (SADHS) found that 35 percent of women aged 15-19 had been pregnant or had a child (Department of Health, 1998). Similarly, a recent survey in the Transkei, one of the former African homelands under the apartheid regime, found that 43 percent of women had children by the age of 19 (Makiwane, 1998).

Figure 3.1: Sexually active females who have been pregnant (n=758)

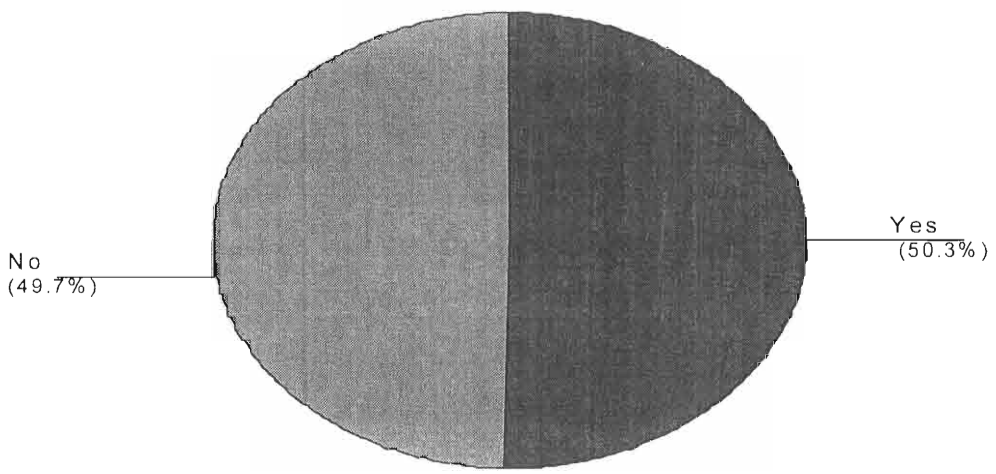


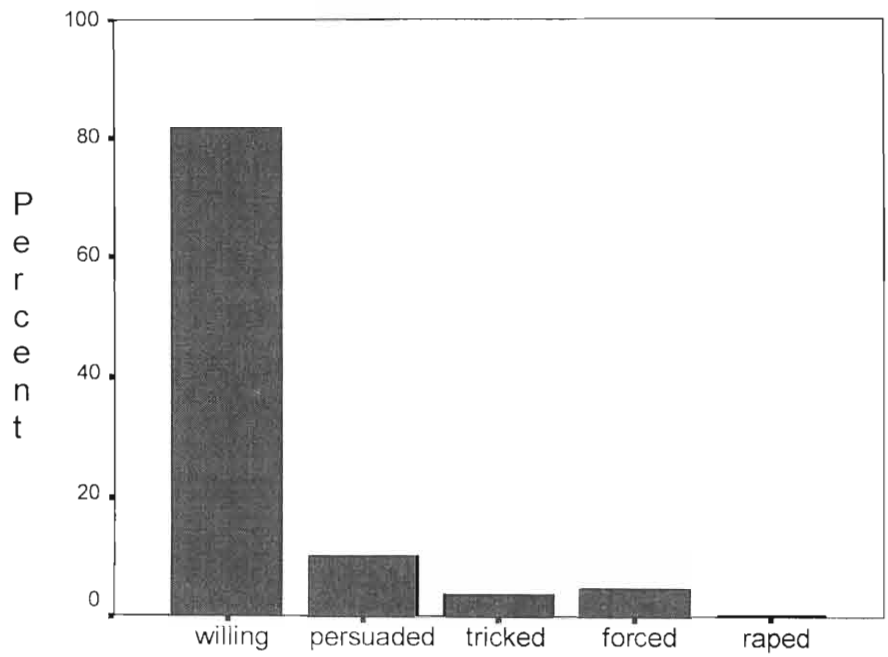
Table 3.2 Incidence of Pregnancy by Population Group and Residence

Characteristics	Ever pregnant (%)
Population group	**(n=758)**
African	52.3
Colored	85.7
Asian	43.9
White	6.5
Residence	**(n=756)**
Urban	47.1
Rural	54.9
Total	**50.3**

3.3 Incidence of Sexual Violence and Coercion

Youth in KwaZulu Natal report substantial levels of sexual violence and coercion. As Figure 3.2 illustrates below, almost twenty percent of sexually experienced youth did not describe their first sexual experience as "willing". Although a very small number of respondents described their first sexual experience as "rape" (0.4%), an additional 4.6 percent claimed their sexual initiation was "forced", indicating that sexual violence is a significant threat facing youth in KwaZulu Natal.

Figure 3.2 How youth describe first time they had sexual intercourse (n=1476)



There are important differences between gender, population groups and rural and urban residents in how they describe their first sexual experience (Table 3.3). Unsurprisingly, females report much higher levels of violence or coercion. While almost all males (96.5%) report that their first sexual experience was "willing", only two-thirds of females (67.6%) describe their experience this way. Although less than one percent (0.8%) of young women claim to have been "raped" the first time they had sex, a much higher percent (8.8%) describe this experience as "forced". Thus, although youth may not use the word "rape" to describe their sexual initiation, violence does play an important role for many girls. In stark contrast, only one boy reported that his sexual initiation was by force.

The differences between population groups' description of their first sexual experience are also noteworthy. Africans are the least likely to describe their sexual initiation as "willing" and over five percent (5.4%) describe the experience as "forced" or "raped". In contrast, almost all Asian youth describe their first experience as "willing" (94.5%), with very few respondents "forced" (2.8%) and none claiming to have been raped. Similarly, coloured respondents also report very high levels of "willing" first sexual experience (95.0%), with no youth describing their experience as "forced" or "raped". It is interesting to note, however, that 5.0 percent of coloured respondents described their experience as "tricked". Whites also report high levels of "willing" sexual initiation, but these youth were also the most likely to describe their first sexual experience as "rape".

There are also interesting differences between how rural and urban residents describe their sexual initiation. Only 73.1 percent of rural youth describe their first sexual experience as "willing"; thus, over one quarter of rural respondents feel they were coerced or threatened (including the categories "persuaded", "tricked", "forced" and "raped"). Urban residents were much more likely to describe their first experience as "willing" (86.5%). However, substantial levels of sexual violence characterized urban residents'

sexual initiation: over four percent described their first sexual experience as "forced" or "raped".

Table 3.3 Description of first sexual experience by background characteristics

		Description of first sexual experience (n=1476)				
Characteristic		**Willing**	**Persuaded**	**Tricked**	**Forced**	**Raped**
Gender	Male	96.5	1.7	1.7	0.1	0.0
	Female	67.6	17.5	5.3	8.8	0.8
Population Group	African	80.0	10.7	3.9	5.0	0.4
	Coloured	95.0	0.0	5.0	0.0	0.0
	Asian	94.5	2.8	0.0	2.8	0.0
	White	87.9	6.06	0.0	0.0	1.5
Residence	Rural	73.1	16.3	4.3	5.8	0.6
	Urban	86.5	6.2	3.1	3.9	0.3
Total		**81.6**	**9.8**	**3.5**	**4.6**	**0.4**

Coercion, molestation and sexual violence also characterize youth's sexual experiences in KwaZulu Natal (Table 3.4). Although a small percentage (3.9%) of sexually experienced youth report having given something for sex, a larger percentage (7.7%) claim to have received something for sex. This may indicate that either a small number of youth are having coercive sex with multiple partners or that youth are receiving things from older partners to have sex. Previous research suggests that over a quarter of young women who engaged in coercive sex did so with partners who were at least 10 years older than they were (Castle and Konaté, 1999, cited in Gueye *et al*, 2001).

Table 3.4 Experiences of Sexual Violence and Coercion among Sexually-Active Youth (n=1476)

Experience	Percent
Ever received anything for sex	7.7
Ever given anything for sex	3.9
Ever touched sexually when unwanted	23.2
Ever had physically forced sex	7.7
Ever unsuccessfully refused sex (n=1361)	14.0

There are some differences between population groups, gender and rural and urban residents in experiences of coercive sex, but the results are mixed (not shown). For example, urban residents are more likely to have given something for sex, but rural residents are more likely to have received something for sex. Females are almost three times as likely to have received something for sex (11.3 percent of girls as compared to 3.9 percent of boys). However, a slightly higher percentage of boys report having given something for sex. There are also differences in the incidence of coercive sex among population groups, with African and coloured youth being the most likely to have both received and given something for sex.

Table 3.5 illustrates that experiences of molestation also differ significantly between males and females, with females more likely to report having been touched sexually when unwanted (25.7 percent compared to 20.5 percent for males). It is perhaps surprising, however, that one fifth of males report experiences of molestation. There is only a small difference between rural and urban residents' experiences of molestation. However, there are stark differences between population groups (see Table 3.5). Africans are the most likely to report that they have been touched in an unwanted sexual way (24.9%), followed by whites (19.7%). Asian and coloured youth were significantly less likely to report unwanted sexual touch, with only 8.3 percent and 5.0 percent respectively.

Unsurprisingly, male and female youth experience very different levels of physically forced sex and unsuccessfully refused sex (Table 3.5). Female youth are much more likely to report experiences of physically forced sex (13.3 percent compared to 1.7 percent of males) and unsuccessfully refused sex (22.4 percent compared to 6.1 percent for males). There are also differences between population groups in experiences of physically forced sex: 9.1 percent of whites and 7.9 percent of Africans report physically forced sex (Table 3.5). It is interesting to note, however, that when the question was rephrased and youth were asked about experiences when they tried unsuccessfully to refuse sex, youth from all population groups were more

likely to report such experiences. Although there were very few coloured respondents, a high proportion of these youth did report incidences of unsuccessfully refused sex (20.0%). Similarly, 15.1 percent of Africans report experiences of unsuccessfully refused sex, while Asian and white youth were less likely to report such experiences. Urban residents were slightly more likely to report physically forced sex, but rural residents were much more likely to report unsuccessfully refused sex (19.0 percent compared to 11.1 percent of urban youth).

Table 3.5 Experiences of molestation and sexual violence by background characteristics

Characteristics	Percent Who Have Experienced Molestation	Percent Who Have unsuccessfully Refused Sex	Percent who have had Physically Forced Sex
Gender			
Male	20.5	6.1	1.7
Female	25.7	22.4	13.3
Population Group			
African	29.4	15.1	7.5
Coloured	5	20	0
Asian	8.3	2.9	5.5
White	19.7	11.5	9.1
Residence			
Rural	24.1	19	7.1
Urban	22.6	11.1	8
Total	**23.2**	**14**	**7.7**

3.4 Unwanted Sexual Experiences and Pregnancy

Experiences of coercive sex do not seem to be related to incidence of pregnancy in youth. Youth who have received something for sex are no more likely to report a pregnancy. Adolescents who have given something for sex were, however, less likely to have experienced an unwanted pregnancy (not shown). This is surprising, given that youth who have given something for sex were less likely to report consistent condom use than

those youth who had not had such experiences (discussed in the following chapter).

Experiences of molestation, or being touched in an unwanted sexual way, do not seem to be related to incidence of pregnancy or unwanted pregnancy in youth. Although youth who have been molested are marginally less likely to report a pregnancy, they are minimally more likely to report an unwanted pregnancy (not shown).

The nature of sexual initiation, forced or willing, does seem to be related to youths' incidence of pregnancy. Those youth who described their sexual initiation as 'forced' were more likely to report a pregnancy than youth who said their first sexual experience was 'willing' (59.7% and 48.8% respectively). Table 3.6 below illustrates that those youth who did not describe their sexual initiation as 'willing' were more likely to report an unwanted pregnancy. This may indicate that the pregnancy resulted from their first sexual experience which, because it was non-willing, may not have been protected sex. Alternatively, this may suggest that youths whose sexual initiation is non-willing are more likely to experience subsequent unwanted pregnancies. Inconsistent condom use may leave these youth vulnerable to subsequent unwanted pregnancies. This finding supports previous research in South Africa which indicated that forced sexual initiation can "increase the risk of teenage pregnancy by 14 times" (Vundule et al, 1999, cited in Jewkes, 1999).

Table 3.6 Relationship between nature of sexual initiation and pregnancy (n=381)

How youth describe first sexual experience	Percent who report unwanted pregnancy
Willing	64.1
Persuaded	76.1
Tricked	90.0
Forced	77.5
Raped	100.0
Total	**69.3**

Unwanted sexual intercourse – forced or unsuccessfully refused sex – is also related to incidence of pregnancy. Youths who have unsuccessfully refused sex were no more likely to have been pregnant, but were more likely to report an unwanted pregnancy (Table 3.7). However, those youths who experienced physically forced sex were much more likely to have also experienced pregnancy: 59.4 percent of those who experienced forced sex had been pregnant, as compared to only 48.8 percent of youth who had not experienced physically forced sex (Table 3.7). It is unclear whether these youths' pregnancies were a direct result of their experiences of forced sex, or whether the link between experiences of forced sex and pregnancy is through condom use. As discussed in the subsequent chapter, nearly two-thirds (63.2%) of those who have experienced forced sex did not use a condom during last sex and the majority of those who have experienced forced sex or who have unsuccessfully refused sex report using condoms "rarely" or "never" with their most recent partner. Similarly, Maforah *et al* found that forced, unwilling sex and rape were more common among pregnant adolescents (Maforah *et al*, 1997). Experiences of physically forced sex were not, however, significantly related to *unwanted* pregnancy; thus, the relationship between violent sex and pregnancy may be explained in part by desired pregnancy among these adolescents.

Table 3.7 Relationship between sexual violence and pregnancy

Characteristics	Percent who have been pregnant	Percent who have had unwanted pregnancy
	(n=321)	(n=222)*
Have unsuccessfully refused sex		
Yes	48.0	80.0
No	48.7	65.3
Have had physically forced sex		
Yes	59.4	68.3
No	48.8	69.6
Total	**50.3**	**69.2**

*Only females who reported a pregnancy were asked whether this pregnancy was unwanted.

3.5 School and Community Violence and Pregnancy

Levels of violence in adolescents' school and community environments were gauged through a series of questions about the youth's perceptions of their surroundings. To measure school violence, students were asked whether there was a lot of fighting and violence among students at their school, whether they felt safe at school and whether sexual harassment was a problem at their school. For levels of violence in the community, adolescents were asked whether they felt safe in their community, whether there was a lot of crime in their community and whether there was a lot of violence among young people in their neighborhood.

The relationship between violence in schools and adolescent pregnancy is complicated. Although youth who felt that there was a lot of violence among students at their school were less likely to report having been pregnant, they were more likely to report an *unwanted* pregnancy, as were youth who did not feel safe at school. Surprisingly, students who reported that sexual harassment was a problem at their school were no more likely to have been pregnant and were actually less likely to report an unwanted pregnancy. Given the high levels of sexual harassment of students by teachers documented in South African schools (George, 2001a), this finding is unexpected.

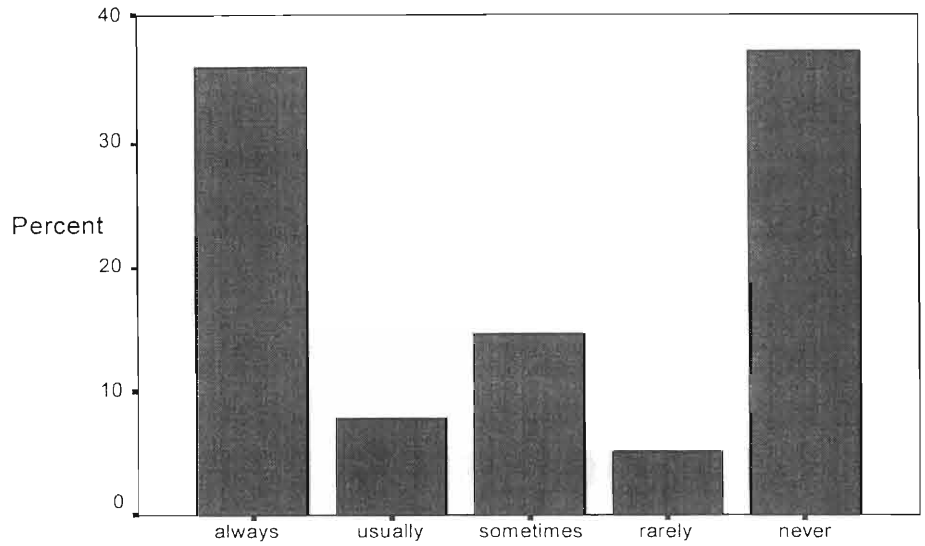
The relationship between a community characterized by the threat of violence and the incidence of pregnancy among youth is unexpected. Youth who reported feeling unsafe in their communities were less likely to have been pregnant and less likely to report an unwanted pregnancy (not shown). In contrast, youth who felt that there was a lot of crime in their communities were more likely to have been pregnant, although these youths were *less* likely to report an unwanted pregnancy (not shown). Surprisingly, levels of violence among youth in a community did not seem to be related to incidence of pregnancy or unwanted pregnancy of youth from these communities. These findings suggest that we should reject the hypothesis that youth living in environments characterized by violence are more vulnerable to pregnancy.

Chapter Four: Condom Use

4.1 Frequency of Condom Use

Figure 4.1 illustrates that a large proportion of youth report consistent condom use with their last partner (35.8%). In addition, over 20 percent of youths surveyed report either using condoms "usually" (7.7%) or "sometimes" (14.5%) with this partner. Of concern, however, is the substantial proportion of youths who "rarely" or "never" used condoms with their last partner. Almost 40 percent of youth claim to have "never" used condoms with their most recent partners, which leaves them vulnerable to the twin risks of pregnancy and disease. It is interesting to note that the majority of youths either use condoms all of the time ("always") or not at all ("never"), with a small proportion in between.

Figure 4.1: Frequency of condom use with last partner (n=1346)



There were also some interesting differences in frequency of condom use by residence (rural/urban), gender and population group (below in Table 4.1). Males were much more likely to report 'always' using condoms with their last partner (46.4% compared to only 26.4% of females), while females were more likely to report 'never' using condoms (42% as compared to

31.4% of males). There were also striking differences in frequency of condom use between population groups. Whites were most likely to report 'always' using a condom (54.4%) and least likely to 'never' use a condom with their last partner (10.5%). African youth were the least likely to 'always' use a condom with their most recent partner, with a larger percentage of African youth reporting 'never' using a condom (39.6%) than those who reported 'always' using a condom (33.7%).

Table 4.1 Frequency of condom use by background characteristics

	Frequency of condom use with last partner				
Characteristics	**Always**	**Usually**	**Sometimes**	**Rarely**	**Never**
Gender					
Male	46.4	6.3	12.2	3.6	31.4
Female	26.4	9.0	16.5	6.2	42.0
Population Group					
African	33.7	7.3	15.0	4.4	39.6
Coloured	42.1	21.1	5.3	10.5	21.1
Asian	49.5	9.5	12.6	4.2	24.2
White	54.4	8.8	10.5	15.8	10.5
Residence					
Rural	46.4	67.6	62.9	65.0	51.5
Urban	28.3	6.1	12.2	6.5	46.8
TOTAL	**35.8**	**7.7**	**14.5**	**5.0**	**37.0**

4.2 Condom Use with Most Recent Partner

Of those youths who have had sexual intercourse in the last 12 months, there is variation in condom use between groups. Table 4.2 (below) indicates that there are striking differences in condom use during most recent sexual intercourse between gender, population groups and rural and urban residents. Males were significantly more likely to have used a condom during their last sexual experience: 55.0 percent as compared to 43.9 percent of females. Africans were least likely to have used a condom, with less than half of African respondents reporting using a condom during their most recent sexual intercourse. The clear majority of whites (68.4%) report using a condom as compared to approximately 60 percent of both Asian and coloured youth. Condom use at last intercourse also differed significantly

between urban and rural residents. While the majority (53.9%) of urban residents report condom use, only 40.4 percent of rural youth used a condom during their most recent sexual experience. It is noteworthy that almost half of all youth who had been sexually active in the last 12 months report using a condom during their most recent sexual intercourse. The South African Department of Health 1998) found that although two-thirds of sexually active adolescents between the age of 15 and 19 report using a modern contraceptive method, only about one in five teenagers report using a condom at last intercourse. It is unclear, however, whether the fact that half of sexually active youth reported using a condom during their most recent sexual intercourse in this research represents a shift in behavior or whether these youth have inaccurately reported on their experience. Previous research found that 37 percent of adolescent respondents reported their sexual experience inconsistently, with boys being nearly 14 times as likely as girls to respond inconsistently (Eggleston *et al*, 2000).

Table 4.2 Condom use during most recent sexual intercourse

Characteristics	Used condom during last sexual intercourse (%)
Gender	
Male	55
Female	43.9
Population Group	
African	47.1
Coloured	57.9
Asian	60
White	68.4
Residence	
Rural	40.4
Urban	53.9
Total	**49**

4.3 Unwanted Sexual Experiences and Condom Use

The relationship between youths' experience with coercive sex, molestation and sexual violence and their subsequent use of condoms is also complex. Youth who have received something for sex are much less likely to have used a condom during last sexual intercourse. While 43.9 percent of youth who have received something for sex used a condom, only 49.6 percent of those who have never received anything for sex did so (Table 4.3). Receiving something for sex is also related to the frequency of condom use. Table 4.3 illustrates that youth who reported having received something for sex were more likely to report 'never' using a condom and less likely to report 'always' using a condom with their last partner. The difference in condom use during last sexual intercourse between youth who reported giving something for sex and those who did not was marginal (Table 4.3). Although youth who have given something for sex were likely to report 'always' using a condom than those youth who had not had such experiences, these youth were also less likely to report 'never' using a condom than youth who had never given something for sex (Table 4.3).

Table 4.3 Relationship between Coercive Sex and Condom Use

Experiences of Coercive Sex	Frequency of Condom Use					Percent who Used a Condom During Most Recent Sex
Received Anything for Sex	Always	Usually	Sometimes	Rarely	Never	
yes	28.9	7.0	17.5	3.5	43.0	43.9
no	36.5	7.8	14.2	5.1	36.4	49.6
Given Anything for Sex						
yes	31.6	12.3	21.1	3.5	31.6	47.4
no	36.0	7.5	14.2	5.1	37.2	49.2
Total	**35.8**	**7.7**	**14.5**	**5.0**	**37.0**	**49.1**

Unwanted sexual experiences are also related to condom use during most recent intercourse and the consistency of condom use. Youth who

have been molested were less likely to report using a condom during their most recent sexual intercourse and less likely to report 'always' using a condom (not shown).

Table 4.4 Relationship between sexual initiation and condom use

	Percent used condom during last sex	How often used condom with last sexual partner				
Describe first sexual experience	yes	always	usually	some-times	rarely	never
Willing	51.2	38.2	8.0	14.1	4.5	35.2
Persuaded	41.1	27.7	6.4	17.0	5.0	44.0
Tricked	38.6	22.7	4.5	13.6	9.1	50.0
Forced	39.7	24.2	6.5	16.1	9.7	43.5
Raped	20.0	0.0	20.0	20.0	20.0	40.0
TOTAL	49.1	35.8	7.7	14.5	5.0	37.0

The relationship between the nature of sexual initiation and subsequent condom use is no less ambiguous. Those who described their sexual initiation as non-willing were less likely to report using a condom during last sexual intercourse (not shown). Youths who described their first sexual experience as "willing" were most likely to report "always" using a condom, although over one-third of these youth also claim to "never" use a condom with their most recent partner (Table 4.4). A much higher percentage of those youth who did not describe their sexual initiation as 'willing' report 'never' using a condom with their most recent partner. Thus, it appears that the nature of youths' sexual initiation is related to their subsequent condom use. This echoes recent research in Mali by Gueye *et al* (2001) which found that young women who described their sexual initiation as 'too early' were less likely to use modern contraceptives such as condoms in part because "having had sex before they wanted to lowered their self-esteem and left them feeling that they could not control what happened to them" (Gueye *et al*, 2001: 59).

The relationship between youths' experience with sexual violence and subsequent condom use is striking (Table 4.5). Although the majority (50.2%) of youth who have not experienced physically forced sex report using a condom during last sexual intercourse, nearly two-thirds (63.2%) of those who have experienced forced sex failed to use a condom during last sex. Youth who experience violent sex are also significantly less likely to use condoms consistently. The majority of those who have experienced forced sex or who have unsuccessfully refused sex report using condoms "rarely" or "never" with their most recent partner. This finding supports previous studies in South Africa which have also found that gender-based violence and coercion stifle communication about topics such as HIV and condoms and compromise young women's ability to negotiate condom use (see, for example, Varga, 1997; Jewkes *et al*, 1999 cited in Jewkes, 1999; Varga and Makubalo, 1996; Wood *et al*, 1998 and Heise et al, 1993, cited in Jewkes, 1999).

Table 4.5 Experiences of sexual violence and condom use

	Percent used condom during last sex	How often used condom with last sexual partner				
		Always	Usually	Some-times	Rarely	Never
Ever had physically forced sex						
Yes	36.8	24.8	6.7	15.2	9.5	43.8
No	50.2	36.8	7.8	14.5	4.6	36.3
Ever unsuccessfully refused sex						
Yes	40.2	27.9	6.7	14	6.7	44.7
No	51.6	38.2	7.9	14.6	4.3	34.9
TOTAL	**49.9**	**36.6**	**7.7**	**14.4**	**4.6**	**36.6**

4.4 School and Community Violence and Condom Use

As discussed in the previous chapter, levels of violence in youth's school environments were measured through questions about whether there was a lot of fighting and violence among students at their school, whether they felt safe at school and whether sexual harassment was a problem at their school. For levels of violence in the community, youth were asked whether they felt safe in their community, whether there was a lot of crime in their community and whether there was a lot of violence among young people in their neighborhood.

The relationship between violence at schools and condom use is complex. Youth who report sexual harassment at their schools were less likely to report having used a condom during their most recent sexual intercourse (Table 4.6). These youth also report less consistent condom use: fewer youth who report sexual harassment at their school claim to 'always' use condoms and more report that they 'never' use condoms. Similarly, a larger percentage of youth who do not feel safe at school report 'never' using a condom (42.8 percent as compared to 35.0 percent of youth who do feel safe at school). Students who report violence among other students at their school were also marginally less likely to report having used a condom during their most recent sexual intercourse and less likely to report 'always' using a condom with their last sexual partner (not shown).

Table 4.6 Sexual Harassment and Condom Use

Sexual Harassment Occurs at Respondent's School	Percent who Used a Condom During Most Recent Sex
yes	43.1
no	50.5

Notably, respondents who reported high levels of violence among youth in their communities were more likely to report consistent condom use and more likely to be confident in their ability to convince their partner to use a condom (not shown). Given that there may be high levels of violence

within sexual relationships as well in these communities, this finding is surprising. Youths' perception of safety and crime in the community were not, however, related to their condom use (not shown).

Thus, bivariate analysis suggests that there is a relationship between experiences of sexual violence and coercion and subsequent condom use. To explore this link further, logistic regression was used. Table 4.7 in the next section presents the categorical variables used in the condom use modeling. The variables gauging youth's perception of violence in their schools and communities were eventually excluded from the modeling because these questions seemed to be a weak measure of the intended variables. Rather than asking youth whether they experienced violence themselves, these questions simply asked youth whether such violence occurred. Thus, these variables were excluded from the multivariate analysis. In addition to the variables listed in Table 4.7 below, two continuous variables were used: current age and age at first sexual intercourse.

4.5 Results of Multivariate Logistic Regression

The dependent variable in this "condom use" model is based on youth's response to a question about whether they used a condom with their most recent sexual partner the last time they had sex with him or her. Because this question asked about respondents' most recent sexual partner and their most recent sexual experience, recall problems should be minimized. As is true of all surveys that ask adolescents to self-report about sexual behavior, however, respondents may not reply accurately. Another potential shortcoming of this variable is that it does not capture information about the consistency of condom use.

Table 4.7 Variables Used in Condom Use Modeling

Variable	Frequencies	Percent
Gender		
Male	594	47.0
Female	670	53.0
Population Group		
African	1115	88.2
White	56	4.4
Other	93	7.3
Residence		
Urban Formal	568	44.9
Urban Informal	219	17.3
Rural	477	37.7
Current Status in School		
Currently schooling	677	53.6
Not schooling without matric	440	34.8
Not schooling with matric	147	11.6
Highest Education Level Attained		
Primary/none	131	10.4
Secondary	1026	81.2
Post-secondary	107	8.5
Have experience of molestation		
Yes	310	24.5
No	954	75.5
Describe first sexual experience		
Willing	1027	81.3
Persuaded or tricked	172	13.6
Forced or raped	65	5.1
Coercive sex		
Have given something for sex		
Yes	53	4.2
No	1211	95.8
Have received something for sex		
Yes	106	8.4
No	1158	91.6
Unsuccessfully refused sex		
Yes	268	21.2
No	996	78.8
Experience of physically forced sex		
Yes	101	8.0
No	1163	92.0
Total	**1264**	**100.0**

Table 4.8 below illustrates the results of a logistic regression showing the variables that influence youth's condom use during their most recent sexual intercourse. Girls were 33 percent less likely than boys to have used a condom during last sex. This may reflect that girls are often powerless to convince their partner to use a condom because of gendered power differentials (see Kalof, 1995; Wood and Jewkes, 1997; Wood *et al*, 1998; Lear, 1995; Blanc, 2001). However, this result may also be explained by the fact that boys' tend to report their sexual behavior more inconsistently than girls (Eggleston *et al*, 2000: 79) and, thus, may exaggerate their own condom use.

As expected, as the age of respondents increases, they become more likely to have used a condom during their most recent sexual intercourse. Older youth are more likely to have been sexually active for a longer period of time, so it makes sense that they were more likely to use condoms.

Table 4.8 Parsimonious Model of Variables Influencing Condom Use

Variable (n=1264)	**Odds Ratio**
Gender	
Male (r)	1.0
Female	0.6676**
Current age	1.083*
Residence	
Urban formal housing (r)	1.0
Urban informal housing	0.5577**
Rural	1.0619
Highest education level attained/attending	
Primary/no schooling (r)	1.0
Secondary	3.6613**
Tertiary	2.5978**
Age at first sex	0.8905**
Have unsuccessfully refused sex	
Yes (r)	1.0
No	1.4122*
Note: ** significant at 0.01 level; * significant at 0.05 level; (r)=reference category	

There are interesting differences in condom use between youth living in formal and informal housing in urban areas. Youth living in informal settlements in urban areas were 44 percent less likely to have used a condom during their most recent sexual intercourse, after controlling for all other variables in the model. This may be because youth living in urban informal settlements are almost twice as likely to have received something for sex as youth living in formal housing in urban areas (11.9 percent and 6.3 percent respectively, not shown). In addition, 9.6 percent of youth living in informal urban settlements reported giving something for sex, as compared to only 4.4 percent of youth living in formal urban housing. As previous research (such as Hunter, 2001) suggests, youth who engage in coercive sex may be less likely to use condoms because material gifts and/or violence are often used to negotiate the terms and timing of intercourse, including unprotected sex. Also, youth living in informal, urban settlements are generally poorer than those living in formal housing and previous research in Peru suggests that higher socioeconomic status may be associated with a higher likelihood of condom use at last intercourse (Magnani *et al.*, 2001).

In addition, differences in condom use between youth living in formal housing and informal settlements in urban areas may be explained in part by attitudes towards condoms. Although bivariate analysis suggests that the majority of youth living in both formal and informal housing felt that condoms were easily accessible (not shown), youth living in informal settlements were almost twice as likely as those living in formal, urban housing to agree that using a condom is a sign of not trusting one's partner (37.4 percent of youth living in informal settlements, compared to 20.4 percent of those living in formal urban housing). Similarly, youth living in informal urban settlements were more likely to agree that it is not necessary to use condoms in a serious relationship (not shown). These differences in attitudes towards condoms may account in part for the differences in condom use between youth living in formal and informal urban housing. There was, however, no significant

difference in most recent condom use between youth living in rural areas and youth living in formal, urban housing.

There are also interesting differences between recent condom use by youth who have attained different levels of education. Compared to youth with either primary level schooling or no formal schooling, youth with secondary or tertiary schooling were significantly more likely to have used a condom during their most recent sexual intercourse. Increased education may lead to greater wisdom and understanding of why condom use is necessary. This may be due in part to the fact that youth with less education are likely to have had less exposure to sexual health education in school. In addition, the casual relationship may actually be in the other direction: youth with less education may have dropped out precisely because they did not use condoms and experienced a pregnancy or had to work to support a child. As noted earlier, the *Transitions* study suggests that pregnancy was the most frequently cited reason why girls dropped out of school (Rutenberg et al, 2001).

The older youth were when they first had sex, the less likely they were to have used a condom during their most recent sexual intercourse. Earlier research in Ghana suggests that sexual initiation at an earlier age is likely to lead to a lower probability of using modern contraceptives (Adih and Alexander, 1999, cited in Gueye *et al*, 2001) such as condoms. However, those youth who had sex for the first time at an older age also have been sexually active for a shorter period of time than youth whose sexual initiation occurred at an earlier age. This may explain, in part, why youth with a later sexual initiation were less likely to report recent condom use.

As hypothesized, youth who have had experiences of unwilling sex were less likely to have used a condom during their most recent sexual intercourse. Table 4.8 suggests that youth who have not unsuccessfully refused sex were over 40 percent more likely to report having used a condom. This may be because youth who experience sexual violence may not feel in control of their sexuality. Previous research in the U.S. found that

adolescents who reported feeling "little control over their sexual behavior" were less likely to consistently use condoms (Gage, 1998: 158). This finding supports earlier studies suggesting that sexual violence may negatively effect youth's self-efficacy and/or locus of control which, in turn, can make them less likely to use condoms and practice protected sex (Blanc and Wolff, forthcoming; Gueye, 2001; Gage, 1998).

The variable "experience of physically forced sex" is not included in the parsimonious model. Although youth who have not had physically forced sex were 1.76 times as likely to have used a condom as those who have had physically forced sex when this was the only independent variable in the model, this variable was no longer significant when other variables were added. Thus, experiences of physically forced sex do not significantly influence youth's recent condom use, even though physically forced sex is likely to have been more violent than experiences of unsuccessfully refused sex. Based on the relevant literature (such as Roosa *et al*, 1997 and Stock *et al*, 1997 cited in Abma, Driscoll and Moore, 1998), this finding was unexpected.

Experiences of coercive sex also did not significantly influence youth's recent condom use, which does not support previous research suggesting that youth involved in coercive sex may be less likely to use condoms (see, for example, Hunter, 2001). Although earlier work suggests that whether sexual initiation is willing or not influences youth's later sexual behavior (Coker and Richter, 1998), including contraceptive use, this analysis showed that whether youth described their sexual initiation as willing, persuaded/tricked or forced/raped did not significantly effect their recent condom use.

Thus, there are many variables that influence youth's recent condom use to varying degrees. Some of these findings are unsurprising; for example, that girls were less likely to report having used a condom. However, the discrepancy in condom use between youth living in formal, urban housing and those living in informal settlements is striking. Similarly,

that youth with higher levels of education were more likely to report using a condom is also important and signals an additional benefit of increasing school attendance and reducing drop-out rates. Lastly, as hypothesized, there is a link between experiences of sexual violence and subsequent condom use. Although not all variables measuring experiences of violent or coercive sex were included in the parsimonious model, it is significant that youth who have unsuccessfully refused sex are less likely to report having used a condom.

Chapter Five: Communication about Condoms

5.1 Sexual Communication

There are interesting differences between the likelihood of various groups of youth to communicate about various sexual topics. While the majority of youth who have had a sexual partner in the last 12 months communicated about sexual topics with their partners, this masks differences between population groups, males and females and rural and urban residents about the topics discussed. Rural residents were less likely than urban dwellers to discuss any of the topics mentioned (Table 5.1). Out of the five topics, all population groups were least likely to discuss avoiding sex. In particular, there is great variation with coloured respondents, with only 42.1 percent discussing avoiding sex and almost all coloured respondents (94.7%) reporting discussing condom use. African youth were the least likely to discuss avoiding HIV/AIDS and other STDs and the least likely to discuss condom use. This lack of communication about condom use is clearly linked to lower rates of condom use and lack of confidence in their ability to convince partners to use a condom, as discussed in the following chapter. A larger proportion of females than males reported discussing most of the sexual health topics mentioned. However, approximately equal percentages of males and females report discussing condom use.

Table 5.1 Sexual Communication Topics Discussed by Background Characteristics

Percent who discussed sexual communication topics (n=1352)					
Characteristics	**Avoiding sex**	**Avoiding pregnancy**	**Condom use**	**Avoiding HIV/AIDS**	**Avoiding STDs**
Gender					
Male	43.8	65.5	69.9	68.2	59.5
Female	64.4	77.1	69.7	73.8	63.2
Population Group					
African	56.3	71.2	67.8	70.7	60.8
Coloured	42.1	63.2	94.7	73.7	68.4
Asian	36.8	70.5	81.1	71.6	64.2
White	57.6	84.7	84.7	78	67.8
Residence					
Rural	48.6	65.4	62.6	65.2	53.0
Urban	58.3	75.1	73.9	74.4	66.2
TOTAL	**54.8**	**71.7**	**69.8**	**71.2**	**61.5**

5.2 Unwanted Sexual Experiences and Sexual Communication

The relationship between experiences of coercion, molestation and sexual violence and communication about various sexual topics is complex. For example, although there are only minor differences in sexual communication between youth who have and have not given something for sex, there is a relationship between receiving something for sex and communication about various sexual topics (not shown). While youth who report having received something for sex were more likely to discuss avoiding sex, pregnancy and HIV, there were only slight differences in the likelihood of these youth discussing condom use and avoiding STDs.

Youth who have been touched in an unwanted sexual way are only marginally more likely to discuss avoiding sex, avoiding pregnancy and condom use and marginally less likely to discuss avoiding HIV and STDs (not shown). However, how youth describe their sexual initiation is related to the likelihood of communication about various sexual topics (Table 5.2). Notably, youth who describe their first sexual experience as "forced" or "raped" were significantly less likely to discuss condom use or avoiding pregnancy with their last sexual partner. Youth whose sexual initiation was "forced" were also the least likely to discuss avoiding sex and avoiding

HIV/AIDS. It is interesting to note, however, that youth who describe their first experience of sexual intercourse as "willing" were the least likely to discuss avoiding sex and avoiding STDs with their most recent sexual partner. Thus, the nature of sexual initiation seems to influence sexual communication in different, and often contradictory, ways. For the purpose of this research, however, the relationship between the nature of sexual initiation and the likelihood of discussing condom use in subsequent sexual relationships is most important.

Table 5.2 Relationship between sexual initiation and communication about sexual topics

	Sexual Communication Topics Discussed (n=1352)				
How youth describe first sexual experience	**avoiding Sex (%)**	**avoiding pregnancy (%)**	**condom use (%)**	**avoiding HIV/AIDS (%)**	**avoiding STDs (%)**
Willing	52.8	71.3	70.1	71.0	61.4
Persuaded	66.7	75.2	72.3	76.6	66.0
Tricked	61.4	79.5	70.5	72.7	63.6
Forced	57.1	65.1	60.3	60.3	49.2
Raped	80.0	60.0	60.0	80.0	80.0
TOTAL	**54.8**	**71.7**	**69.8**	**71.2**	**62.4**

Experiences of rape, including physically forced or unsuccessfully refused sex, were related to sexual communication (Table 5.3). Notably, youth who have been physically forced to have sex are less likely to discuss condom use with their partners, as were those who have unsuccessfully refused sex. Youth who have unsuccessfully refused sex were, in fact, less likely to communicate about most of the sexual topics included in the questionnaire. In addition, youth who have had physically forced sex were also less likely to communicate about avoiding STDs and HIV. However, youth who have had physically forced sex or who have unsuccessfully refused sex were more likely to discuss avoiding sex with their partners. It might be that youth for whom sex has been violent and traumatic may be hesitant to have sex again and, thus, are more likely to discuss avoiding sex.

Table 5.3 Relationship between sexual violence and communication

Percent who discussed sexual communication topics					
Experiences of sexual violence	Avoiding sex	Avoiding pregnancy	Condom use	Avoiding HIV/AIDS	Avoiding STDs
Physically Forced Sex					
Yes	64.2	70.8	64.2	67.0	53.8
No	54.1	71.8	70.4	71.6	62.2
Unsuccessfully Refused Sex					
Yes	58.9	70.6	67.8	65.6	59.4
No	52.9	71.9	70.7	72.5	62.4
TOTAL	**54.0**	**71.7**	**70.2**	**71.5**	**61.9**

5.3 School and Community Violence and Sexual Communication

These results suggest that a school environment characterized by the threat of violence and sexual harassment is not strongly linked to the likelihood of youth discussing various sexual topics with their partners. Youth who reported sexual harassment at their schools were, however, marginally less likely to discuss condom use with their partners and marginally more likely to discuss avoiding sex (not shown). Youth who reported feeling safe at school were more likely to discuss HIV/AIDS and avoiding pregnancy with their partner (not shown). Youth who felt that there was a lot of violence among students in their school were less likely to discuss avoiding STDs, HIV/AIDS, pregnancy and avoiding sex with their partners (not shown).

The relationship between levels of community violence and adolescents' sexual communication is complex. Youth who did not feel safe in their neighborhood were less likely to discuss avoiding sex and avoiding STDs with their sexual partner and marginally more likely to discuss condom use and avoiding pregnancy (not shown). Crime and violence among youth in respondents' neighborhoods were not strongly related to communication about any of the sexual topics mentioned. Surprisingly, the one exception is that those who reported violence among youth in their communities were more likely to report discussing condom use with their most recent partner (not shown).

Table 5.4 Sexual Communication and Violence in Youth's Schools and Communities

	Percent who Discussed Sexual Communication Topics				
	Avoiding sex	Avoiding pregnancy	Condom use	Avoiding HIV/AIDS	Avoiding STDs
Sexual harassment at school (n=864)					
yes	58.3	70.1	65.3	70.8	59.0
no	52.1	69.0	69.5	69.3	59.7
Violence among students (n=863)					
yes	47.7	63.3	67.2	65.5	54.7
no	55.5	71.8	69.4	71.3	61.6
Feel safe at school (n=863)					
yes	53.2	70.1	69.1	70.5	59.5
no	53.1	65.6	67.5	65.6	60.0
Violence among youth in community (n=1352)					
yes	52.6	70.6	69.1	69.2	61.7
no	56.6	72.5	70.3	72.6	61.2
Feel safe in community (n=1352)					
yes	53.3	71.2	69.2	71.0	60.9
no	63.4	74.1	73.2	72.2	64.4
TOTAL	**54.8**	**71.7**	**69.8**	**71.2**	**62.4**

Thus, bivariate analysis suggests that there is an ambiguous relationship between experiences of sexual violence and coercion and communication about condom use. Logistic regression was used to explore this relationship further. The following table (Table 5.5) presents the categorical variables used in the communication modeling. As with the first model, two continuous variables were also used: current age and age at first sexual intercourse. Again, the variables related to violence in youth's schools and community were excluded.

Table 5.5 Variables Used in Condom Communication Modeling

Variable	Frequencies	Percent
Gender		
Male	595	47.0
Female	670	53.0
Population Group		
African	1114	88.1
White	58	4.6
Other	93	7.4
Residence		
Urban Formal	570	45.1
Urban Informal	219	17.3
Rural	476	37.6
Current Status in School		
Currently schooling	678	53.6
Not schooling without matric	439	34.7
Not schooling with matric	148	11.7
Highest Education Level Attained		
Primary/none	136	10.8
Secondary	1005	79.4
Post-secondary	124	9.8
Have experience of molestation		
Yes	310	24.5
No	955	75.5
Describe first sexual experience		
Willing	1030	81.4
Persuaded or tricked	171	13.5
Forced or raped	64	5.1
Coercive sex		
Have given something for sex		
Yes	53	4.2
No	1212	95.8
Have received something for sex		
Yes	105	8.3
No	1160	91.7
Unsuccessfully refused sex		
Yes	267	21.1
No	998	78.9
Experience of physically forced sex		
Yes	100	7.9
No	1165	92.1
Total	**1265**	**100.0**

5.4 Results of Multivariate Logistic Regression

The dependent variable in this "communication about condom use" model is based on youth's response to a question about whether they discussed using a condom with their most recent sexual partner the last time they had sex with him or her. Recall problems should be minimal because this question asked about respondents' most recent sexual experience. However, as noted earlier, youth may not report their sexual behavior accurately. Another potential shortcoming of this variable is that youth in longer-term sexual relationships may have discussed contraceptive use when they initiated sexual intercourse with this partner, but may not discuss condom use (or other contraceptive use) in subsequent sexual experiences.

Table 5.6 Parsimonious Model of Variables Influencing Communication About Condom Use

Variable	Odds Ratio
Residence	
urban formal housing (r)	1.0
urban informal housing	0.5365**
rural	1.0451
highest education level attained	
primary/no schooling (r)	1.0
Secondary	4.4994**
Tertiary	2.5377**
age at first sex	0.9148**
Note: ** significant at 0.01 level; * significant at 0.05 level; (r) = reference category	

Table 5.6 illustrates the results of a logistic regression modeling variables that influence youth's communication about condom use with their most recent sexual partner. The results of this model of sexual communication are similar to the results of the first model which suggested that youth living in informal housing in urban areas were less likely than youth living in formal, urban housing to have used a condom with their most recent partner. Youth living in informal settlements were approximately 46 percent less likely to have discussed using a condom with their most recent sexual partner. It is unsurprising that this lack of sexual communication

influences sexual behavior as well, with these youth being less likely to use a condom (see the preceding chapter). As discussed in the previous model, this difference may be explained in part by more negative attitudes towards condoms and more widespread experiences of coercive sex among youth living in informal settlements. There was, however, no significant difference in the likelihood of communicating about condom use between youth living in rural areas and those living in formal, urban housing.

Differences in educational levels attained were also important in explaining youth's communication about condom use. Table 5.6 shows that youth who have attained some secondary or tertiary education were much more likely than youth with no formal schooling or only a primary level education to have discussed using a condom with their most recent sexual partner. Youth with a secondary level education were approximately 4.5 times as likely to have discussed condom use and those with some tertiary education were over two-and-a-half times as likely as those with no formal education or primary-level schooling. There are many ways that education may encourage sexual communication. For example, greater exposure to sexual health education, or life skills programs, may explain some of this difference. In addition, more educated youth may have more knowledge about sexual health and better sexual negotiation skills. Higher education levels may also offer better prospects for future employment and may, therefore, serve as an incentive to minimize sexual risks by having protected sex.

Age at sexual initiation also influences sexual communication about condoms. As Table 5.6 illustrates, the older youth were when they first had sex, the less likely they were to have discussed using a condom with their most recent sexual partner. This may be explained, in part, by the fact that youth who first had sex at a younger age have been sexually active for a longer period of time than youth whose sexual initiation occurred at an older age. Because youth whose sexual initiation occurred later have been

sexually active for a shorter period of time, they may be less experienced in sexual negotiation.

It is striking that none of the variables related to sexual violence or coercion were significant in explaining differences in communication about condom use. This research hypothesized that youth who had experiences of coercive sex, particularly those who have received something for sex, would be less likely to have discussed condom use, based on previous research (such as Hunter, 2001). However, youth who had experiences of giving and receiving something for sex were not significantly less likely to have discussed condoms with their most recent sexual partner. Similarly, experiences of physically forced or unsuccessfully refused sex were not significant in predicting communication about condom use, although previous research suggests that violence can inhibit sexual communication (see, for example, Blanc, 2001 and Leclerc-Madlala, 1997). Youth who reported having been molested were also no less likely to have discussed condom use and willing or non-willing sexual initiation was not shown to influence sexual communication about condoms.

Although the variables gauging youth's experiences with violent or coercive sex did not significantly influence youth's communication about condom use, youth may fail to discuss condom use for different reasons. Some youth may not discuss condoms because they are using other forms of contraception. Other youth may avoid communicating about condoms because of fear of violence or because of the negative connotations that condoms sometimes carry. Nonetheless, it was unexpected and noteworthy that the relationship between experiences of coercive or violent sex and communication about condom use was not significant. This finding is particularly surprising given that the results of the first model suggest that experiences of unwanted sex do negatively impact youth's condom use. Given that there are many reasons why youth fail to communicate about condoms, it is necessary to explore other factors that influence condom use.

Chapter Six: Confidence in Ability to Negotiate Condom Use

6.1 Confidence in Sexual Negotiation

Some of the differences in condom use between groups may be explained by difficulties in sexual negotiation. As illustrated by Table 6.1 below, there are differences in various groups' confidence in their ability to convince their partners to use condoms. Males were more likely to feel confident, with almost three-quarters of respondents reporting they were "very" confident in their ability to convince their partner to use a condom. In contrast, over a quarter (26.5%) of females were not confident in this ability. This is perhaps not surprising, as males must actually wear the condom. The violence that characterizes many sexual relationships in South Africa (see, for example, Wood *et al*, 1998) may also help explain why young women feel less confident in negotiating condom use.

There are also substantial differences between the confidence levels of various racial groups, with coloureds and Africans being the least likely to feel "very" confident in their ability to convince their partner to use a condom. Over one-fifth (21.6%) of Africans and one-fifth of coloured youth (21.1%) reported feeling not confident. In stark contrast, the vast majority of white youth were very confident (86.4%) in their ability, with less than two percent (1.7%) not confident. Asians showed high confidence levels as well, with almost three-fourths of respondents very confident.

There were also differences in confidence levels between rural and urban residents. Youth living in urban areas were more likely to report feeling "very" confident and less likely than rural youth to feel 'not' confident in their ability (18.4 and 24.1 percent, respectively).

Table 6.1 Confidence in Ability to Convince Partner to Use a Condom by Background Characteristics

Characteristics	Percent confident in ability to convince partner to use condom (n=1352)		
Gender	**Very**	**Fairly**	**Not**
Male	73.6	11.6	14.9
Female	59.6	13.3	26.5
Population Group			
African	64.7	12.9	22.2
Coloured	63.2	15.8	21.1
Asian	71.6	9.5	18.9
White	86.4	8.5	1.7
Residence			
Rural	63.5	12.2	24.1
Urban	69.5	11.7	18.4
Total	**66.0**	**12.5**	**21.1**

6.2 Unwanted Sex and Confidence in Sexual Negotiation

The relationship between youths' experience with coercive sex, molestation and sexual violence and their confidence in their ability to negotiate condom use is complex. As illustrated in Table 6.2, youths' experiences with coercive sex (both giving and receiving something for sex) were related to their confidence in their ability to negotiate condom use. Youth who have received something for sex were much more likely to report feeling "not confident" and were less likely to feel "very confident" in their ability to convince a partner to use a condom. Interestingly, youth who have given something for sex were more likely to report feeling "very confident", perhaps because being in the role of 'giving' something for sex puts one more in control of setting the 'terms; of sex than does 'receiving' something for sex. Thus, youths' experiences of coercive sex and their confidence in sexual negotiation skills are linked.

Table 6.2 Coercive Sex and Confidence in Ability to Convince Partner to use Condom (n=1352)

Experiences of Coercive Sex	Confident in ability to convince partner to use condom (%)		
	Very	Fairly	Not
Received Anything for Sex			
yes	62.3	6.1	31.6
no	66.5	13.1	20.0
Given Anything for Sex			
yes	70.2	8.8	21.1
no	66.0	12.7	21.0
Total	**66.1**	**12.5**	**21.1**

Experiences of molestation, or unwanted sexual touch, are related to youths' confidence in their sexual negotiation skills. Youth who have been touched in an unwanted sexual way were more likely to feel "not confident" in their ability to convince their partner to use a condom: 24.7 percent of youth who have been molested felt "not confident", compared to only 19.9 percent of youth who have not had such an experience (not shown).

Table 6.3 Sexual Initiation and Confidence in Ability to Negotiate Condom Use

	Percent confident could convince partner to use condom		
Describe first sexual experience	very	fairly	Not
Willing	68.7	12.0	18.9
Persuaded	56.0	15.6	28.4
Tricked	61.4	13.6	25.0
Forced	49.2	12.7	38.1
Raped	40.0	20.0	40.0
TOTAL	66.1	12.5	21.1

The relationship between the nature of sexual initiation and subsequent confidence in negotiating condom use is also noteworthy. Those youth who did not describe their first sexual experience as 'willing' were less likely to report feeling "very confident" in their ability to convince a partner to use a condom, with less than half of youth who described their sexual initiation as "forced" or "raped" feeling "very confident". Youth who described their sexual initiation as 'forced' or 'raped' were also more likely to report

feeling 'not' confident in their ability to convince their partner to use a condom.

The relationship between youth's experience with sexual violence and subsequent confidence in sexual negotiation skills is striking. Youth who have experienced sexual violence were less likely to be confident in their ability to convince their partner to use a condom (Table 6.4). Almost one-third (33.0%) of youth who had physically forced sex report feeling "not confident" in their sexual negotiation skills as compared to the approximately 20 percent of youth who had not experienced physically forced sex. Similarly, a smaller percentage of youth who have had physically forced sex or who have unsuccessfully refused sex reported feeling "very" confident in their ability to negotiate condom use.

Table 6.4 Experiences of Unwilling Sex and Confidence in Negotiating Condom Use

	Percent confident convince partner to use condom		
Ever had physically forced sex (n=1352)	**very**	**fairly**	**not**
Yes	55.7	11.3	33.0
No	67.2	12.6	19.9
Ever unsuccessfully refused sex (n=1244)			
Yes	65.0	9.4	25.0
No	67.4	13.1	19.3
TOTAL	**66.9**	**12.5**	**20.3**

Bivariate analysis therefore suggests that a strong relationship exists between unwanted sexual experiences and youth's confidence in negotiating condom use. Multivariate logistic regression was used to further explore what variables influence youth's confidence. Table 6.5 presents the categorical variables that were considered in the communication model. As with the first two models, two continuous variables were also used: current age and age at first sexual intercourse.

6.3 Results of Multinomial Logistic Regression

The dependent variable in this model measures confidence in sexual negotiation skills. Based on a question asking youth how confident they felt in their ability to convince their most recent sexual partner to use a condom, this variable reflects the degree of control that youth felt in their sexual relationship. As noted about the dependent variables in the first two models, asking youth about their most recent sexual partner should minimize recall problems. There is, however, still the possibility that youth may inaccurately report their sexual behavior. Because this question asked about youth's feelings, rather than their behavior, the risk of inaccurate reporting should be minimal. Another potential shortcoming of this variable as a measure of sexual negotiation is that sexual negotiation comprises non-verbal interaction as well (Varga, 1997). Although this facet of negotiation about condom use would be difficult to gauge, it is important to note that it is not captured by the dependent variable.

Table 6.5 Variables Used in Confidence in Condom Use Modeling

Variable	Frequencies	
	Male (n=595)	Female (n=672)
Population Group		
African	498	618
White	30	28
Other	67	26
Residence		
Urban Formal	292	279
Urban Informal	106	113
Rural	197	280
Current Status in School		
Currently schooling	369	310
Not schooling without matric	155	285
Not schooling with matric	71	77
Highest Education Level Attained		
Primary/none	56	80
Secondary	478	529
Post-secondary	61	63
Have experience of molestation		
Yes	133	178
No	462	494
Describe sexual initiation		
Willing	576	454
Persuaded/tricked or forced/raped	19	218
Coercive sex		
Have given something for sex		
Yes	29	24
No	566	648
Have received something for sex		
Yes	23	83
No	572	589
Unsuccessfully refused sex		
Yes	49	220
No	546	452
Physically forced sex		
Yes	11	90
No	584	582

Multinomial logistic regression was used to analyze the variables influencing youth's confidence in their ability to convince their partner to use condoms. The dependent variable, "how confident are you in your ability to convince your partner to use a condom", had three outcomes: very confident, fairly confident and not confident. The dependent variable was split into two

variables, each with two outcomes, in order to fit a binary logistic regression in each. The first variable has "very confident" taking value one and "not confident" taking value zero. The second variable has "fairly confident" taking value one and "not confident" taking value zero. The results in these two models are the same as those obtained when performing a multinomial logistic regression with two outcomes. The modelling was done separately for male and female respondents to see how the confidence level of boys and girls about negotiating condom use differs.

Table 6.6 Parsimonious Model of Variables Influencing Confidence in Condom Use: Females

Variable	Fairly Confident (n=271)	Very Confident (n=576)
Residence		
Urban formal housing (r)	1.0	1.0
Urban informal housing	1.8832*	1.7252*
Rural	0.7173	0.6989
Highest education level attained		
Primary/no schooling (r)	1.0	1.0
Secondary	.2442*	.1648**
Tertiary	0.4831	.3906*
Have been touched sexually when unwanted		
Yes (r)	1.0	~
No	.3257*	
Have received something for sex		
Yes (r)	1.0	~
No	.4012**	
Describe first sexual experience		
Willing (r)	~	1.0
Persuaded/tricked		1.8441*
Forced/raped		1.3441
Note: ** significant at 0.01 level; * significant at 0.05 level; (r) = reference category; ~ = not included in model		

Table 6.7 Parsimonious Model of Variables Influencing Confidence in Condom Use: Males

Variable	Fairly Confident (n=157)	Very Confident (n=528)
Residence		
Urban formal housing (r)	1.0	1.0
Urban informal housing	0.664	1.9899*
Rural	.3693*	0.685
Population Group		
African (r)	~	1.0
White		4.9617**
Other (Coloured and Asian)		12.5073*
Highest education level attained		
Primary/no schooling (r)	~	1.0
Secondary		0.2622
Tertiary		.2745*
Status of schooling		
Currently in school (r)	~	1.0
Not schooling without a diploma		0.5733
Not schooling with diploma		.2876*
Have unsuccessfully refused sex		
Yes (r)	1.0	~
No	.2622*	
Note: ** significant at 0.01 level; * significant at 0.05 level; (r) = reference category; ~ = not included in model		

It is noteworthy that different variables influenced the level of confidence boys and girls had about their ability to convince their sexual partner to use a condom. This is logical, given that it is boys who must actually use the condom. In particular, it is striking that variables related to violent or coercive sex were more likely to significantly influence girls' confidence levels than that of boys.

"Residence" was significant for both girls' and boys' models, but there were some interesting differences between the sexes. Both boys and girls living in informal, urban settlements were more likely to report feeling confident in their ability to convince their partner to use a condom than youth living in formal, urban housing. While boys living in rural areas were also approximately 63 percent less likely to report feeling "fairly confident", girls

living in rural areas were just as likely to feel confident in their ability to negotiate condom use as urban-dwelling girls.

The variable "highest education level attained" was significant for girls, but the direction of the influence was unexpected. For example, girls with secondary level education were approximately 75 percent less likely to report feeling "fairly confident" in their ability to convince their partners than were girls with no formal schooling or only a primary level education. Similarly, girls with secondary or tertiary level education were less likely than girls with primary level or no formal schooling to report feeling "very confident' in their ability to convince their partner to use a condom.

The level of education attained also influenced boys' confidence in their ability to negotiate condom use. Interestingly, these findings suggest that boys who are currently not schooling, but who have earned their diploma are over 70 percent less likely to report feeling "very confident" in their ability to convince their partner to use a condom. These findings are surprising; it seems that education would improve boys' and girls' negotiation skills and increase their knowledge about why condom use is important. Given that the results of the first model suggest that youth with secondary or tertiary schooling are significantly more likely to have used a condom during their most recent sexual intercourse, these results are difficult to interpret. It is possible that more educated youth understood the question better and were, therefore, better able to provide correct answers. Further, educated youth may better understand the implications and consequences of negotiating condom use with their partner and, thus, may avoid doing so.

"Population group" was not significant for girls, but did significantly effect boys' confidence about negotiating condom use. White and coloured and Asian boys were approximately five and twelve-and-a-half times (respectively) more likely to report feeling "very confident" in their ability to convince their partner to use a condom than were African boys. More negative attitudes towards condoms amongst African communities may help explain this difference.

The variables related to experiences of coercive or violent sex were generally significant in explaining variations in girls' confidence in their ability to convince their partner to use condoms, but were largely not significant in explaining differences in boys' confidence levels. Surprisingly, girls who reported experiences of molestation and coercive sex (having received something for sex) were actually more likely to report feeling "fairly confident" in their ability to negotiate condom use. Similarly, the relationship between the degree of willingness of sexual initiation and girls' confidence in their ability to negotiate condom use is not as hypothesized. Girls who described their sexual initiation as "persuaded" or "tricked" were approximately 1.8 times as likely to report feeling "very confident" in their ability to negotiate condom use as girls whose first sexual intercourse was "willing". Notably, none of these variables were significant for boys. However, experiences of having unsuccessfully refused sex did significantly influence boys' confidence in their ability to convince their partner to use a condom. Boys who reported no experiences of unwilling sex were approximately 26 percent less likely than those who had unsuccessfully refused sex to report feeling "fairly confident" in their ability to negotiate condom use. Again, this relationship is in the opposite direction than hypothesized.

The variable "experience of physically forced sex" was not included in either of the parsimonious models because this variable was not significant. The parsimonious models also excluded the variable "have given something for sex" because it was not found to significantly influence boys' or girls' confidence in negotiating condom use.

These findings suggest that experiences of violence or coercive sex do influence youth's confidence in their ability to negotiate condom use, but that such experiences may actually increase youth's confidence. This is particularly interesting given that the results for the first model (see Chapter 4) suggest that youth who have unsuccessfully tried to refuse sex were less likely to have used a condom during their most recent sexual intercourse.

Chapter Seven: Discussion and Recommendations

7.1 Discussion of Major Findings

Exploring how experiences of sexual violence and coercion influence youth's sexual decision-making is essential. Given the high levels of HIV/AIDS and adolescent pregnancy in KZN and South Africa at large, a greater understanding of the factors that affect condom use is particularly urgent. This research contributes to this understanding and sheds some light on the relationship between unwanted and coercive sexual experiences and subsequent condom use.

These findings suggest, however, that this relationship is far from straightforward. Although copious amounts of previous research suggest that coercion and forced sex negatively affect youth's sexual decision-making, inhibiting sexual communication and discouraging condom use (for example, Varga, 1997; Jewkes, 1999; Varga and Makubalo, 1996), this is only partially borne out by this work. This research found that youth in KwaZulu Natal experience high levels of sexual violence and coercive sex. Bivariate analysis suggested that experiences of forced or coercive sex were related to subsequent condom use, communication about condoms and confidence in negotiating condom use. However, once multivariate logistic regression was used to further explore these relationships, many of the variables measuring youth's experiences of forced or coercive sex proved to be insignificant.

The relationship between unwanted sex and subsequent condom use is the most compelling. As hypothesized, youth who reported experiences of unwanted sex were less likely to report using a condom during their most recent sexual intercourse. The hypothesis of this research was only partially supported by the findings: the variables gauging experiences of coercive sex, molestation and the nature of sexual initiation were not significant. These findings still suggest, however, that sexual violence is an important factor to consider in youth's sexual decision-making.

The links between experiences of unwanted sex and sexual communication and negotiation were more ambiguous. Bivariate analysis suggested that experiences of forced sex did negatively influence youth's communication about various sexual topics. However, none of the variables measuring youth's experiences of unwanted sex, molestation or coercive sex proved to be significant in the multivariate regression analysis. This finding was unexpected and challenged the hypothesis that youth who had experiences of molestation, unwanted or coercive sex would be less likely to communicate with their partners about sexual topics such as condom use.

The findings of the third model also contested the hypothesis that experiences of molestation, unwanted or coercive sex would negatively affect youth's confidence in their ability to negotiate condom use. The initial bivariate analysis supported the hypothesis, suggesting that experiences of unwanted or coercive sex and lower levels of confidence were linked. However, once the data set was split into male and female respondents, multivariate logistic analysis revealed a very different relationship between unwanted sexual experiences and confidence in negotiating condom use. Several variables measuring unwanted or coercive sex were significant in predicting girls' confidence levels, but only one such variable was significant for boys. In all cases, the relationship between these variables and confidence levels was contrary to the hypothesis. Boys and girls who had experienced unwanted or coercive sex were more likely to report feeling confident in their ability to negotiate condom use. These findings suggest that we should reject the hypothesis that youth who have experienced sexual violence would be less confident in their ability to negotiate condom use.

Another important finding is the importance of educational attainment in predicting condom use, communication and confidence. These findings suggest that youth with higher levels of education were more likely to report using condoms and more likely to have communicated about condom use with their most recent sexual partner. However, girls and boys with higher levels of education were less likely to report feeling confident in negotiating

condom use. Nevertheless, there may be positive, additional benefits to policies that reduce school drop-out levels and facilitate higher educational attainment.

These findings also suggest that residence is an important factor that influences youth's condom use, sexual communication and confidence in sexual negotiation. Youth living in urban, informal settlements were less likely than those living in formal, urban housing to report having used a condom and less likely to report having discussed condom use. The results of the last model suggest, however, that girls and boys living in informal settlements were actually more likely to feel confident than their counterparts in formal, urban housing. Boys living in rural areas were less likely to feel confident in negotiating condom use. These findings still suggest that efforts to encourage condom use should particularly target youth living in informal, urban settlements.

7.2 Policy Recommendations

These findings should be taken into consideration when designing policies and programs to encourage condom use among youth. In particular, policies that increase school enrollment or discourage dropping out may indirectly encourage condom use. As noted earlier, particular attention should be given to designing interventions for youth living in informal settlements in urban areas.

The results also underscore the need to challenge the prevailing gendered power differentials that facilitate the rampant occurrence of sexual violence. According to Blanc (2001) "when the role of gender-based power is made an integral feature of sexual and reproductive health programs, there is a considerable payoff for both women and men". Thus, she recommends paying "particular attention to power dynamics in programs for adolescents" (Blanc, 2001: 208). Challenging gender roles and cultural norms is, of course, much more complicated than merely targeting a program to a

specific segment of the population. However, reducing the sexual violence that characterizes many sexual relationships in South Africa is essential to encouraging condom use, thereby decreasing the spread of HIV/AIDS and reducing teen pregnancy. As Venier *et al* point out "gender-based violence and the fear of violence on the part of teenaged girls...[are] part of a cluster of social barriers to reduction of HIV infection risk that needed to be addressed in AIDS education" (Venier *et al*, 1998, cited in Leclerc-Madlala, 1999: 47). Simply teaching youth about reproductive health issues without empowering them to act on this knowledge is insufficient and will fall short of what is needed to curb the AIDS epidemic in South Africa.

A greater emphasis in life skills programs on gender violence and sexual negotiation skills is essential. Currently, only about half of students report discussing these topics at school. According to the *Transitions* data, only 44.6 percent of the 2,393 youth who had been in secondary school since 1998 reported discussing sexual negotiation and communication. Further, only 55.7 percent of these youth reported discussing sexual violence and coercion and only 51.1 percent discussed self-esteem and decision-making. Youth living in urban, informal settlements, who reported the lowest levels of condom use and sexual communication with their partners, were less likely than youth living in formal, urban housing to report discussing each of these topics at school, as were youth living in rural areas. These imbalances must be remedied. If needed, a greater proportion of funds should be supplied to schools in these areas to ensure that these topics can be discussed.

Echoing recommendations made by Wood and Jewkes (2001), improved life skills education classes must address "issues of gender violence, non-violent conflict resolution and...self-esteem, trust and team building". Gueye advises that health education programs need to focus on increasing young women's "self-esteem and associated perceived control of their sexual relationships" (Gueye, 2001: 57). Thus, life skills programs should also incorporate discussions of gender roles and challenge the

gender stereotypes that influence sexual behavior. In addition, groups such as DramAide and Soul City should tailor their presentations to discuss gendered violence and build negotiation skills (through role-plays, for example). Previous research by Lahai-Momoh and Ross (1997) found that adolescents who are less anxious/more comfortable about sexual negotiation are more likely to use a condom. Thus, equipping youth with concrete negotiation skills is crucial.

To challenge gendered power differentials and the prevalence of sexual violence, it is essential to incorporate men into prevention programs (Maharaj, 2001; Campbell, 1995). Increasing girls' self-esteem and sexual negotiation skills is important, but insufficient. As Campbell warns, prevention programs that focus on teaching women how to convince their partners to use condoms are problematic because they ignore gender power differentials and "reinforce the idea that safer sex is a female concern and responsibility" (Campbell, 1995: 205). Acknowledging the gendered power differentials that structure heterosexual relationships recognizes that men play an important role in sexual decision-making. Only by explicitly involving men in prevention programs will it be possible to challenge these power differentials and the sexual violence that characterizes many sexual relationships in KZN and South Africa at large.

7.3 Conclusions and Future Research

Thus, although these findings only partially support the hypotheses that experiences of violence negatively influence youth's condom use, sexual communication and negotiation, this research does highlight the importance of addressing the role that sexual violence and coercion play in youth's sexual decision-making. Incorporating discussions about sexual violence, sexual negotiation and decision-making into school-based life skills programs is an important first step, as is incorporating men into prevention programs.

However, additional research into the link between sexual violence and sexual decision-making is essential.

There are several possible avenues for future research. One important area to explore is how to best incorporate the teaching of sexual negotiation skills into current prevention efforts. Given that this research suggests important differences in condom use between youth living in formal and informal, urban settlements, future research is needed to explain how residence influences youth's sexual decision-making. Designing prevention programs that incorporate men and adolescent boys is also essential. Given the high levels of sexual violence in South African schools (George, 2001a), future research must consider how experiences of sexual harassment and assault between teachers and learners and among learners influences condom use by youth. Further research into the link between sexual violence and sexual decision-making is the first step in mitigating the harmful impacts of sexual violence. The fundamental objective, though, should be to challenge the gendered imbalances of power that catalyze the sexual violence so common in South Africa.

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