REVIEW ARTICLE

Review of Sexuality Studies in Africa: Setting a New Post-2015 Research Agenda

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ABSTRACT

At the nexus between reproductive health, population and development is the subject of sexuality which has generated extensive discourse in the past two decades. In this paper, we review Africa sexuality studies published between 1994 and 2015 with the aim of synthesizing the available evidence and suggesting a new research agenda for post-2015. Review findings showed that previous studies covered the five components of sexuality – practices, partners, pleasure/pressure/pain, procreation and power to different extents. Risky sexual behaviour was prevalent from adolescence till older ages. Literature on pleasure, pain, procreation and power reflect the complex diversity driven by traditional norms, gender roles and attitudes across the continent. Knowledge gaps were highlighted and new agenda suggested for sexuality research. *(Afr. J Reprod Health 2016; 20[1]: 21-28).*

Keywords: sexual behaviour, sexual violence, sexual pleasure/satisfaction, gender roles, socio-cultural norms, sub-Saharan Africa.

Résumé

Au centre du lien entre la santé de la reproduction, la population et le développement est le sujet de la sexualité qui a suscité un grand discours au cours des deux dernières décennies. Dans cet article, nous passons en revue les études sur la sexualité en Afrique qui ont été publiées entre 1994 et 2015 dans le but de synthétiser les éléments de preuve disponibles et de proposer un nouveau programme de recherche pour l'après-2015. Les résultats de cet examen ont montré que les études précédentes ont porté sur les cinq composantes de la sexualité – des pratiques, des partenaires, le plaisir / la pression / la douleur, la procréation et la puissance à des degrés divers. Le comportement sexuel à risque était très répandu dès l'adolescence jusqu'à un âge plus avancé. La documentation sur le plaisir, la douleur, la procréation et la puissance reflète la diversité complexe soutenue par les normes traditionnelles, les rôles des sexes et les attitudes à travers le continent. Des lacunes dans les connaissances ont été mises en évidence et un nouvel ordre du jour a été proposé pour la recherche sur la sexualité. *(Afr. J Reprod Health 2016; 20[1]: 21-28).*

Mots-clés: comportement sexuel, violence sexuelle, plaisir sexuel/ satisfaction, rôles des sexes, normes socio-culturelles, Afrique sub-saharienne.

Introduction

Since the introduction of the Millennium Development Goals (MDGs), the challenges facing sexual and reproductive health have been at the forefront. Five out of the eight MDGs were related in some ways to sexual and reproductive health. These were eradication of poverty and hunger, promotion of gender equality and women empowerment, reduction of child mortality, improvement of maternal health, combating HIV/AIDS, malaria and other diseases[1]. The key to addressing the challenges and goals related to sexual and reproductive health is a better understanding of sexuality. Research has addressed aspects of sexuality including its definition, components and associated factors in African contexts[2-4]. While research has assisted in the partial acheivement of the MDGs, many African countries were unable to meet the goals. This failure is indicative of the additional work that research, policy and practice needs to do to further development on the continent. As the international community set a new agenda for post-2015, it is necessary to appraise the knowledge gained from research in the past two decades and make suggestions for sustaining or improving the progress made so far.

Apart from a book on review of sexual behaviour in sub-Sahara Africa published in the

late 1980s[4], previous reviews of sexuality studies in sub-Saharan Africa focused on sexual behaviour of in-school adolescents and youths[5], school-based sexual health interventions to prevent STI/HIV[6], parent-child communication about sexuality and HIV/AIDS[7]. While these past reviews have contributed in no small measure to shaping the search for possible solutions to sexuality challenges, however, an inclusive examination of literature related to aspects of sexuality such as sexual practices, partners and pleasure, pressure and pain is necessary. This review covers this broader context and therefore aims to synthesize existing research on sexuality in Sub-Saharan Africa over the past two decades, identify knowledge gaps and subsequently suggest a research agenda for post-2015.

Methods

Literature Search strategy

Pubmed, Medline, African Journals Online (AJOL), Bioline international and POPLINE databases were searched for original articles published in English Language between 1994 and 2015. Different combination of the following search terms were used: sexuality, sexual behaviour, sex practices, sexual pleasure, sexual satisfaction, sexual enjoyment, sexual assault, sexual coercion, forced intercourse, unwanted sex, gender roles, gender norms, and sub-Saharan Africa. Table of contents of major journals publishing articles in the subject area were also searched. These include: African Population Studies, African Journal of Reproductive Health, Reproductive Health Matters among others.

Results

Findings from the review are described in a systematic manner under sub-headings that capture the five components of sexuality as articulated by Gupta[8]. These are: practices, partners, pleasure/pressure/pain, procreation and power.

Sexual practices

At least one of three indices were commonly used to describe sexual behaviour. These indices were: condom use at last sex, multiple sexual partnership and sex with casual or commercial partner. Age at sexual debut/initation was also reported in some studies. In this regard, the topical issues can be grouped under the following sub themes: adolescents and youth sexual behaviour, adult male and female sexual behaviour, sexual behaviour in special groups (such as older adults and persons living with HIV).

Sexual behaviour among adolescents and youths

Though there were variations in the age range for most of the studies on adolescents, many of them were among respondents aged 10–24 years. Male-female differences in condom use, age of sexual debut and multiple partnership were commonly reported. There were a few multi-country studies on adolescent sexual behaviour based on nationally repsentative data such as the demographic and health surveys (DHS) and AIDS indicator surveys[9,10]. About a quarter have initiated sex before age 15 years, though the proportion declined over time. Female sex and low level of education were associated with early sex debut. Multiple sexual partnerships though decreased over time, was more common among males and urban residents.

Madise et al contributed evidence on the link between poverty and risky sexual behaviour among adolescents using nationally representative data from Burkina Faso, Ghana, Malawi and Uganda[11]. Girls in the wealthiest wealth quintile in Burkina Faso, Ghana and Malawi had later sex debuts compared to those in the poorest quintile. Among boys, wealth was not significant except in Malawi where those in middle quintile had earlier sexual debut. There was no association between wealth status and multiple sex partnership.

The surge in the interest of researchers in adolescent sexual behaviour is related to the HIV/AIDS and STIs prevention programmes. As a follow up to this, studies were conducted to assess the extent to which correct knowledge of HIV/AIDS has resulted in behaviour change. Unfortunately, evidence from Nigeria[12], Botswana[13] and Uganda[14] showed that being knowledgable about HIV/AIDS do not necessarily translate into safe sex practices by adolescents.

Though migration is the least researched component of population change in sub-Saharan Africa, evidence emerging from an urban health and demographic surveillance system in a slum area of Nairobi suggests that there was no significant difference in risky sexual behaviour between migrant and non-migrant youths[15]. Further studies would be required to ascertain the generalizability of this observation. Out of school youths constitute a special group whose sexual behaviour have also been studied. Kunnuji found that food deprivation was a significant predictor of early sex debut and multiple partnerships among youths in a slum area of Lagos State, Nigeria[16]. Other factors that predisposes out-of-school youths to risky sexual behavior include alcohol consumption and influence of peer pressure[17].

Uchudi et al conducted a multilevel analysis of the determinants of multiple sexual partnerships in 20 SSA countries using DHS data collected in 2003-2008[18]. The results showed that individual factors (early sexual initiation, young age, education, media exposure and working for cash away from home) and cultural context (permissive sexual norms) are the main determinants of multiple sexual partnerships. These patterns of results point to the need for life course perspectives on the determinants of sexual behavior.

The advent of the internet and other information technology platforms seems to have increased the complexity of the dynamics of sexual behaviour among youths. These technological tools have resulted in a new phenomenon known as cybersex–involvement in online sexual activities. A study among youths and adolescents in Lagos, Nigeria revealed that about 50% were involved in online sexual activities such as visiting pornographic sites, sex chats, cybering and satisfaction of sexual urge via the internet[19]. Intensity and time of internet use were the strongest predictors among other factors.

While sexual behaviour among adult females has received greater attention from researchers, the experiences of males has more or less being neglected, aside from few studies in which gender differences are reported. A qualitative study among sexually active men and women in Mozambique revealed that traditional norms and beliefs about masculinity played strong roles in forming male sexual behaviour[20]. These community norms and beliefs about male sexual behaviour are not limited to Southern Africa alone. Orubuloye et al in a large community-based mixed method study in Nigeria found that most of the men and women believed that though sexual activity are permitted only in a marriage, men are by nature sexually polygynous[21]. This was corroborated by Mitsuga et al who reported that about 1 out of 10 sexually active Nigerian men were involved in extra-marital affairs[22].

Sexual behaviour among other groups

Due to its connection to reproductive health, studies on sexual behaviour were most often conducted among men aged 15-59 years and women aged 15-49 years. Evidence shows that sexual activity is common among older persons. This was demonstrated by results from Malawi which indicated that 26.7% of women and 73.8% of men aged 65 years above were sexually active[23]. Findings from a qualitative study among older adults (age 50-75 years) in southwestern Nigeria also showed that sexual activity is viewed as important in old age and there were gender differences in sexual desire/pleasure[24]. How older adults go about satisfying their sexual desire is therefore an important research question deserving further investigation especially in high HIV prevalence settings.

Among sex workers, unsafe sex practices were associated with alcohol consumption as revealed by a recent study in Uganda[25]. Also, there are speculations that initiation of antiretroviral treatment promotes risky sexual behaviour in HIV positive persons[26]. The evidence is not consistent given the different findings from diverse contexts[27,28].

Sexual partnership

Studies on different forms of sexual partnership seems to be scarce in Sub-Saharan Africa. This may not be unconnected with the perceived stigma and unfavourable environment for these type of sexual relationships. For instance, South Africa is the only country in the sub-region that has decriminalize same-sex relationships. Rabie et al

investigated the construction of sexuality among young gay men in semi-rural South Africa and found that the respondents constructed their sexuality as "being like a woman"[29]. Another South African study explored condom use experiences and reported on factors that inhibit and facilitate usage[30]. Factors found to aid condom use include alternative sexual strategies while reduced sexual pleasure was reported as discouraging condom use. Even though, global evidence suggest that this group have higher risks of HIV, it is however very difficult to conduct studies among them[31,32].

Pleasure, Pressure and Pain

The quest for sexual pleasure and enjoyment/satisfaction is a major factor determining how men and women engaged in sexual acts. The literature on this aspect of sexuality appeared to be skewed towards certain issues. This review showed that sexual satisfaction/pleasure has most often been investigated in regard to contraceptive use[33], male/female circumcision[34] and sexual functioning among survivors of non-communicable diseases such as diabetes[35] and stroke[36]. In addition, sexual pleasure was found to be studied while investigating different sex practices especially among women. For example, Bagnol et al reported on two sex practices among Mozambiquan women–elongation of the labio minora and insertion of natural or synthetic products into the vagina (dry sex)[37]. These practices were usually undertaken for female identity and enhancement of sexual pleasure. Another study among women in Uganda and Tanzania revealed that intravaginal practices were driven by cultural norms and social expectation on hygiene, sexual pleasure, and relationship security among others[38]. Though these practices varied from culture to culture, the motivations were very similar with sexual pleasure featuring repeatedly[39,40].

The promotion of male circumcision as a strategy for HIV prevention has also attracted the interest of researchers to investigate the effect of male circumcision on male sexual functioning and satisfaction[34]. Evidence is however mixed. Results from Kenya suggest that male circumcision does not have any negative effect on sexual satisfaction or functionning[41]. A study in Malawi found that female partners of circumcised men had greater sexual satisfaction[42] while another study in KwaZulu-Natal, South Africa found that voluntary medical male circumcision was associated with better perception of masculinity, male identity, sexual performance and pleasure[43]. Concerning female circumcision, it is widely condemned in the reproductive health circle. Though the evidence on its effect on sexual functioning is inconclusive, however, a study in Lagos, Nigeria showed that female genital cutting adversely affect their sexual functioning[44].

The search for interventions to control or eradicate pressure/pain in sexuality must have contributed to the quantity of research in this area. Terms used to connote pains and pressures include: sexual coercion, unwanted sex, non-consensual sex, forced intercourse, sexual assault, sexual abuse, sexual harrassment, and sexual violence. While prevalence varied widely depending on the context and definition of the term used, the summary is that these negative experiences are quite common in Sub-Saharan Africa. While evidence on causes are sparse, there is overwhelming facts to show that male intimate partners are the greatest perpetrators and female partners are the victims[45,46]. There were evidence to show that females also inflict pains/pressures on their male counterparts[47,48]. Findings also suggest that the main driving force behind these attitude is traditional norms and cultural beliefs that portray men as being superior to women and therefore can use every means to get whatever they want including sexual intercourse[49-51]. A common denominator for most of the pain/pressure experiences is alcohol use by either partners. In addition, males with multiple partners were very likely to inflict pain/pressure in form of coercion, forced sex, unwanted sex etc[52,53]. Sexually transmitted infections, HIV/AIDS, depression, low self-esteem and post-traumatic stress disorder are common consequences of these acts[50,54,55]. In the light of these, programmes on protection of women reproductive health and rights need to be sustained. Research efforts on innovative and effective interventions have also become imperative.

Power and procreation

Power is the most important component of sexuality because it influences how all the other components are expressed and experienced[8]. For instance, power determines whose interest superseed in procreation (number of children), contraceptive use (sex practices), and sexual pleasure/pain. Power as a sexuality component have been operationalised in terms of gender-imbalance in decisionmaking on sexual relationships. Specifically, power is viewed as ability to make choices[56]. The distribution of this ability between men and women makes the concept of power and gender to be intertwined. This complex relationship underscore the relevance of the third millenium development goal that focussed on gender and women empowerment. The extant evidence is that unequal power balance in favour of men is driven largely by hegemonic masculinity and the predominant patriachal beliefs and structure in sub-Saharan Africa[21,57,58]. Caldwell et al argued based on evidence from several countries that while constructs/definition of adolescence was driven by international, economic and social forces, in sub-Saharan Africa, contemporary adolescence was been shaped by the traditional culture with implications for sexuality and reproduction[59]. This notion is supported by several empirical studies especially those that investigated gender-based violence, condom use, and HIV. Even though, females are on the receiving end of males domination, they also believed it is right because that is what the traditional norms dictates[58,60]. Evidence from Post-apartheid South Africa showed that change is possible but challenging. A qualitative study among undergraduates showed that though there have been dramatic changes in gender norms and recognition of women rights, women were still restrained by traditional construction of gender roles[61]. Gender power imbalance is one area that need urgent intervention in sexual and reprodcutive health.

Conclusion

Knowledge gap and research agenda

In view of the available evidence, some knowledge gap which could form the fulcrum of a new research agenda are highlighted. Majority of the existing studies do not provide useful information on the characteristics of sex partners apart from the type (regular, casual or commercial). It is necessary to collect richer data on the identity of sex partners, circumstances leading to formation and dissolution or concurrency of sexual relationships. Since sexuality is partly driven by cultural norms and beliefs, qualitative studies exploring the roles/influence of contextual characteristics are needed. Definitely, such studies would need to go beyond the conventional cross-sectional designs. This should be with a view to explore how sexual identity, orientation, practices and other behaviour evolve especially in adolescence and younger ages.

Further evidence are needed on determinants of specific sexual behaviour. This becomes important given the point that knowledge of HIV/AIDS do not result in safe sexual practices. A relevant question is why do men/women adopt certain practices/ behaviour? Has traditional/cultural norms about sex and sexuality changed over time and how do such changes affect sexual and reproductive health? Since family setting also affect adolescent sexual behaviour and family changes is one of the consequences of population dynamics; the consequences of family change for adolescent sexuality need to be better described. With the onset of phenomenon such as cybersex, design of prevention programmes would benefit from an in-depth knowledge of the aspect of sexuality most affected by technological advancement. For instance, does involvement in cybersex have any implication for safe sex practices?

More work need to be done in the area of data collection methodologies. Many of the existing studies are based on the conventional cross-sectional designs which is obviously deficient for causal inference. Mixed method designs that use qualitative techniques can be deployed to provide deeper understanding about sexual behaviour. Besides, health and demographic surveillance systems represent a fertile source of longitudinal data with which

cause-effect relationships can be appropriately studied.

Since gender imbalance in power is related to all other components of sexuality and power is deeply entrenched in socio-cultural norms that seems to be difficult to change. Thus, to fulfill the WHO's definition of sexual health, there is need for innovative approaches to achieve changes in socio-cultural norms and gender role attitudes. Programmes on gender equality and women empowerment therefore need to look beyond the current approaches which are centered around education.

Contribution of authors

JOA- design of the study, literature search, and writing of the first draft of the manuscript; ND – participated in drafting the introduction and review of manuscript for important intellectual content; COO- Conception/ design of the study and review of manuscript for important intellectual content; BLS- review of manuscript for important intellectual content. All authors read and approved the final manuscript.

References

1. UN Millennium Project. Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals 2006.
2. Dixon-Mueller R. The sexuality connection in reproductive health. Studies in Family Planning. 1993;24(5):269-282.
3. Oomman N. Sexuality: Not just a reproductive health matter. Reprod Health Matters. 1998;6(12):10-12.
4. Standing H, Kisekka MN. Sexual Behaviour in Sub-Saharan Africa: A Review and Annotated Bibliography1989. 250 p.
5. Kaaya SF, Flisher AJ, Mbwambo JK, Schaalma H, Aaro LE, Klepp KI. A review of studies of sexual behaviour of school students in sub-Saharan Africa. Scand J Public Health. 2002;30(2):148-160.
6. Paul-Ebhohimhen VA, Poobalan A, van Teijlingen ER. A systematic review of school-based sexual health interventions to prevent STI/HIV in sub-Saharan Africa. BMC Public Health. 2008;8:4.
7. Bastien S, Kajula LJ, Muhwezi WW. A review of studies of parent-child communication about sexuality and HIV/AIDS in sub-Saharan Africa. Reprod Health. 2011;8(25):1-17.
8. Gupta GR. Gender, sexuality, and HIV/AIDS: The what, the why, and the how. XIIIth International AIDS Conference; Durban, South Africa 2000.
9. Curtis SL, Sutherland EG. Measuring sexual behaviour in the era of HIV/AIDS: the experience of Demographic and Health Surveys and similar enquiries. Sex Transm Infect. 2004;80 Suppl 2:ii22-27.
10. Ferry B, Carael M, Buve A, Auvert B, Laourou M, Kanhonou L, et al. Comparison of key parameters of sexual behaviour in four African urban populations with different levels of HIV infection. Aids. 2001;15 Suppl 4:S41-50.
11. Madise N, Zulu E, Ciera J. Is poverty a driver for risky sexual behaviour? Evidence from national surveys of adolescents in four African countries. Afr J Reprod Health. 2007;11(3):83-98.
12. Omoyeni S, Akinyemi AI, Fatusi A. Adolescents and HIV-related behaviour in Nigeria: does knowledge of HIV/AIDS promote protective sexual behaviour among sexually active adolescents? African Population Studies. 2014;27(2):331-342.
13. Letamo G. Does correct knowledge about HIV and AIDS lead to safer sexual behaviour? The case of young people in Botswana. African Population Studies. 2011;25(1):46-62.
14. Rutaremwa G, Ntozi JP, Diana N. Has high knowledge of HIV/AIDS among the youth translated into positive sexual behavior in Northern Uganda? African Population Studies. 2011;25(1):95-114.
15. Munindia K, Mudege N, Beguy D, Mberu BU. Migration and sexual behaviour among youth in Nairobi's slum areas. African Population Studies. 2014;28(3):1297-1309.
16. Kunnuji M. Basic deprivation and involvement in risky sexual behaviour among out-of-school young people in a Lagos slum. Cult Health Sex. 2014;16(7):727-740.
17. Khasakhala AA, Mturi AJ. Factors associated with risky sexual behaviour among out-of-school youth in Kenya. J Biosoc Sci. 2008;40(5):641-653.
18. Uchudi J, Magadi M, Mostazir M. A multilevel analysis of the determinants of high-risk sexual behaviour in sub-Saharan Africa. J Biosoc Sci. 2012;44(3):289-311.
19. Kunnuji M. Prevalence and predictors of unsolicited exposure to and involvement in online sexual activites among young Internet users in Lagos metropolis. African Population Studies. 2013;27(1):1-13.
20. Macia M, Maharaj P, Gresh A. Masculinity and male sexual behaviour in Mozambique. Cult Health Sex. 2011;13(10):1181-1192.
21. Orubuloye IO, Caldwell JC, Caldwell P. Perceived male sexual needs and male sexual behaviour in southwest Nigeria. Soc Sci Med. 1997;44(8):1195-1207.
22. Mitsunga TM, Powell AM, Heard NJ, Larsen UM. Extramarital sex among Nigerian men: polygyny and other risk factors. Journal of Acquired Immune Deficiency Syndromes. 2005;39:478-488.
23. Freeman E, Anglewicz P. HIV prevalence and sexual

behaviour at older ages in rural Malawi. Int J STD AIDS. 2012;23(7):490-496.
24. Agunbiade OM, Ayotunde T. Ageing, sexuality and enhancement among Yoruba people in south western Nigeria. Cult Health Sex. 2012;14(6):705-717.
25. Mbonye M, Rutakumwa R, Weiss H, Seeley J. Alcohol consumption and high risk sexual behaviour among female sex workers in Uganda. Afr J AIDS Res. 2014;13(2):145-151.
26. De Coninck Z. Does access to antiretroviral drugs lead to an increase in high-risk sexual behaviour? Afr J Reprod Health. 2014;18(3):15-16.
27. Osinde MO, Kaye DK, Kakaire O. Sexual behaviour and HIV sero-discordance among HIV patients receiving HAART in rural Uganda. J Obstet Gynaecol. 2011;31(5):436-440.
28. Diabate S, Chamberland A, Zannou DM, Geraldo N, Azon-Kouanou A, Massinga-Loembe M, et al. Sexual behaviour after antiretroviral therapy initiation in female sex workers and HIV-positive patients from the general population, Cotonou, Benin. AIDS Care. 2013;25(11):1426-1432.
29. Rabie F, Lesch E. 'I am like a woman': constructions of sexuality among gay men in a low-income South African community. Cult Health Sex. 2009;11(7):717-729.
30. Siegler AJ, Voux A, Phaswana-Mafuya N, Bekker LG, Sullivan PS, Baral SD, et al. Elements of Condom-Use Decision Making among South African Men Who Have Sex with Men. J Int Assoc Provid AIDS Care. 2014;13(5):414-423.
31. Scheibe A, Kanyemba B, Syvertsen J, Adebajo S, Baral S. Money, Power and HIV: economic influences and HIV among men who have sex with men in Sub-Saharan Africa. Afr J Reprod Health. 2014;18(3):84-92.
32. Muraguri N, Temmerman M, Geibel S. A decade of research involving men who have sex with men in sub-Saharan Africa: current knowledge and future directions. Sahara j. 2012;9(3):137-147.
33. Cox CM, Hindin MJ, Otupiri E, Larsen-Reindorf R. Understanding couples' relationship quality and contraceptive use in Kumasi, Ghana. Int Perspect Sex Reprod Health. 2013;39(4):185-194.
34. Kigozi G, Watya S, Polis CB, Buwembo D, Kiggundu V, Wawer MJ, et al. The effect of male circumcision on sexual satisfaction and function, results from a randomized trial of male circumcision for human immunodeficiency virus prevention, Rakai, Uganda. BJU Int. 2008;101(1):65-70.
35. Olarinoye J, Olarinoye A. Determinants of sexual function among women with type 2 diabetes in a Nigerian population. J Sex Med. 2008;5(4):878-886.
36. Akinpelu AO, Osose AA, Odole AC, Odunaiya NA. \ Sexual dysfunction in Nigerian stroke survivors. Afr Health Sci. 2013;13(3):639-645.
37. Bagnol B, Mariano E. Vaginal practices: eroticism and implications for women's health and condom use in Mozambique. Cult Health Sex. 2008;10(6):573-585.
38. Lees S, Zalwango F, Andrew B, Vandepitte J, Seeley J, Hayes RJ, et al. Understanding motives for intravaginal practices amongst Tanzanian and Ugandan women at high risk of HIV infection: the embodiment of social and cultural norms and well-being. Soc Sci Med. 2014;102:165-173.
39. Martin Hilber A, Hull TH, Preston-Whyte E, Bagnol B, Smit J, Wacharasin C, et al. A cross cultural study of vaginal practices and sexuality: implications for sexual health. Soc Sci Med. 2010;70(3):392-400.
40. Scorgie F, Kunene B, Smit JA, Manzini N, Chersich MF, Preston-Whyte EM. In search of sexual pleasure and fidelity: vaginal practices in KwaZulu-Natal, South Africa. Cult Health Sex. 2009;11(3):267-283.
41. Krieger JN, Mehta SD, Bailey RC, Agot K, Ndinya-Achola JO, Parker C, et al. Adult male circumcision: effects on sexual function and sexual satisfaction in Kisumu, Kenya. J Sex Med. 2008;5(11):2610-2622.
42. Shacham E, Godlonton S, Thornton RL. Perceptions of Male Circumcision among Married Couples in Rural Malawi. J Int Assoc Provid AIDS Care. 2014;13(5):443-449.
43. Humphries H, van Rooyen H, Knight L, Barnabas R, Celum C. 'If you are circumcised, you are the best': understandings and perceptions of voluntary medical male circumcision among men from KwaZulu-Natal, South Africa. Cult Health Sex. 2015;17(7):920-931.
44. Oyefara JL. Female genital mutilation (FGM) and sexual functioning of married women in Oworonshoki Community,Lagos State, Nigeria. African Population Studies.2015;29(1):1526-1540.
45. Bingenheimer JB, Reed E. Risk for coerced sex among female youth in Ghana: roles of family context, school enrollment and relationship experience. Int Perspect Sex Reprod Health. 2014;40(4):184-195.
46. Stern E, Cooper D, Greenbaum B. The relationship between hegemonic norms of masculinity and men's conceptualization of sexually coercive acts by women in South Africa. J Interpers Violence. 2015;30(5):796-817.
47. Haile RT, Kebeta ND, Kassie GM. Prevalence of sexual abuse of male high school students in Addis Ababa, Ethiopia. BMC Int Health Hum Rights. 2013;13:24.
48. Sikweyiya Y, Jewkes R. Force and temptation: contrasting South African men's accounts of coercion into sex by men and women. Cult Health Sex. 2009;11(5):529-541.
49. Conroy AA. Gender, power, and intimate partner violence: a study on couples from rural Malawi. J Interpers Violence. 2014;29(5):866-888.
50. Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntryre JA, Harlow SD. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. Lancet. 2004;363(9419):1415-1421.
51. Erulkar AS. The experience of sexual coercion among

young people in Kenya. Int Fam Plan Perspect. 2004;30(4):182-189.
52. Agardh A, Odberg-Pettersson K, Ostergren PO. Experience of sexual coercion and risky sexual behavior among Ugandan university students. BMC Public Health. 2011;11:527.
53. van der Straten A, King R, Grinstead O, Serufilira A, Allen S. Couple communication, sexual coercion and HIV risk reduction in Kigali, Rwanda. Aids. 1995;9(8):935-944.
54. Conroy AA, Chilungo A. Male victims of sexual violence in rural Malawi: the overlooked association with HIV infection. AIDS Care. 2014;26(12):1576-1580.
55. Hoffman S, O'Sullivan LF, Harrison A, Dolezal C, Monroe-Wise A. HIV risk behaviors and the context of sexual coercion in young adults' sexual interactions: results from a diary study in rural South Africa. Sex Transm Dis. 2006;33(1):52-58.
56. Kabeer N. Gender equality and women's empowerment: A critical analysis of the third millennium development goal. Gender and Development. 2005;13(1):13-24.
57. Jegede AS, Odumosu O. Gender and health analysis of sexual behaviour in south-western Nigeria. Afr J Reprod Health. 2003;7(1):63-70.
58. Rassjo EB, Kiwanuka R. Views on social and cultural influence on sexuality and sexual health in groups of Ugandan adolescents. Sex Reprod Healthc. 2010;1(4):157-162.
59. Caldwell JC, Caldwell P, Caldwell BK, Pieris I. The construction of adolescence in a changing world: implications for sexuality, reproduction, and marriage. Stud Fam Plann. 1998;29(2):137-153.
60. Orubuloye IO, Caldwell JC, Caldwell P. African women's control over their sexuality in an era of AIDS. A study of the Yoruba of Nigeria. Soc Sci Med. 1993;37(7):859-872.
61. Mantell JE, Needham SL, Smit JA, Hoffman S, Cebekhulu Q, Adams-Skinner J, et al. Gender norms in South Africa: implications for HIV and pregnancy prevention among African and Indian women students at a South African tertiary institution. Cult Health Sex. 2009;11(2):139-157.