

‘They think it’s all up to the girls’: gender, risk and responsibility for contraception

Abstract

Much research suggests that attitudes to responsibility for use of contraception amongst young people are strongly gendered. However, decision making, if decisions happen at all, is bound up with notions of hegemonic masculine and feminine roles as well as factors around relationship status. Data from two earlier qualitative studies were re-analysed with an emphasis on findings related to gender and responsibility for use of contraception. The first study investigated unintended conceptions amongst 16-20 year old women. Interviews focussed on knowledge and views about contraception, sex education, and sexual health services. The second study involved focus groups with two groups of 14-18 year old men to explore their views on sex education, sexual health, and contraception. Almost all the young women said that young men viewed contraception as ‘not their job’. In contrast, the young men thought that responsibility should be shared. The key issue, however, related to relationship status, with decision-making being shared in long term relationships. There are some gender differences in accounting for decisions about use of contraception; however the key issue revolves around relationship status.

Key words: gender, young people, contraception, responsibility, risk

Background

There is widespread policy interest in teenage sexual health in many developed countries, which often manifests itself in terms of concerns about teenage pregnancy and the risks associated with sexual activity. Several countries, including the UK, USA, Canada and New Zealand, have tried to reduce teenage pregnancy rates by various means, including different methods of sex education. In the USA, several states promote abstinence education, although evidence suggests this has minimal impact on reducing teenage pregnancy rates (Santelli et al 2007). More recently, attempts to make sex education, including topics such as relationships and consent, compulsory in UK schools failed to be accepted in a parliamentary vote (BBC, 2014). Although sex education is compulsory in maintained schools in the UK as part of the science curriculum, academies and free schools do not have to follow the national curriculum, and parents may withdraw their children from sex education lessons in any school. (Long 2014). As they are part of a science curriculum, lessons may not necessarily address issues such as relationships, focusing more on biology, an emphasis which young people often dislike (Forrest et al 2004). Recent cuts to sexual health services in the UK may make contraception harder to access, particularly for teenagers, despite recommendations by the National Institute for Health and Care Excellence (2014) that contraception should be more easily available to under-25s. Thus, despite or perhaps because of the lack of guaranteed access to high quality, rounded sex and relationships education, how young people navigate and negotiate sexual relationships remains an important topic.

In 2001, UNICEF published a 'league table' of teenage pregnancy rates in rich nations, which showed that in 1998, the UK was second only to the USA, with 30.8

and 52.1 births per 1,000 15-19 year olds respectively. In 1999, the UK Government implemented the Teenage Pregnancy Strategy (Social Exclusion Unit 1999), aiming to halve the under-18 conception rate by 2010, establish a downward trend in the under-16 conception rate, and increase the proportion of teenage parents in education, employment or training in order to reduce the risks of social exclusion. Between 1996 and 2006, teenage pregnancy rates declined in England and Wales, Canada and the USA, although rates in England and Wales and USA remain consistently higher than in Canada (McKay and Barrett 2010). Recent data available for England and Wales (ONS 2013a) indicate that the under-18s conception rate is the lowest it has been since 1969, and has declined by 34% since 1998. Although it is not possible to compare conception rates across Europe, it appears that the UK has one of the highest birth rates in the EU for 15-17 year olds (ONS 2013b). Therefore interest in policies to further reduce teenage pregnancy rates continues.

Although the Coalition Government which came into power in 2010 abolished the Teenage Pregnancy Unit set up by the previous Labour Government to implement the Strategy, reducing teenage pregnancy rates remains a priority in the UK. Similar desires to reduce teenage pregnancy rates exist in many other developed countries including Canada, New Zealand and the USA. In addition, young people appear to be disproportionately affected by sexually transmitted infections (STIs) with one comparative study of 14 developed countries finding that up to 50% of cases of gonorrhoea and over 50% of diagnoses of chlamydia occurred among 15–24 year-olds (Panchaud et al. 2000). Young people continue to be the group most affected by STIs in the UK, with about two thirds of new diagnoses in women and half in men occurring amongst 15-24 year olds (Department of Health 2014).

Research on attitudes to contraception has tended to focus on young women, partly because as Marston and King (2006) point out, women are generally considered to be responsible for prevention of pregnancy. However, there is a certain stigma attached to carrying condoms for women, as this signifies either desire or experience, both often considered to be unacceptable characteristics for women. As Holland et al (1990) have established in their substantial body of work on gender and young people, the imbalances in power relationships mean that it becomes difficult to plan to have safe sex, (i.e. sex where precautions are taken, usually to protect against STIs and pregnancy) as planning to have sex may lead to getting a 'reputation'. This can be critical for young women, as they can very easily become labelled as 'cows', 'sluts', or slags, both by other young women and by young men (Lees 1993, Wight 1994). As Lees discusses, the label can often be attached irrespective of behaviour, and once given is very difficult to lose, with consequent negative effects on identity. This can be critical in communities where everyone is known to each other, such as schools. Hillier et al (1998) point out the threats to reputations of young women carrying condoms, especially where having the skill and confidence to negotiate condom use implies experience, with potentially negative associations. Abel and Fitzgerald (2006) found that for New Zealand teenagers negotiating condom use, risks to reputation were more important than risks associated with non-use of condoms such as pregnancy or STIs. Whilst public health discourses emphasise the need for self esteem, particularly in this realm, they fail to acknowledge the dangers for 'acceptable' female identity and behaviour of assertiveness and self esteem, if it results in women becoming more assertive. As Shoveller and Johnson (2006:54) argue, the focus on self esteem has 'removed us from attending to social contexts and structural forces', and in particular where young people are concerned, it presumes

unrealistic assumptions about ‘the level of agency and control afforded to young people’ (2006:48). Indeed, as Hillier et al (1998:15) argue, health promotion strategies are ‘based on an assumption of rational decision making’ which ignores the ‘non-rational nature of arousal and desire, and the unequal power relations that exist between young men and women,’ with Holland et al (1990) going further to argue that public health campaigns will fail if they address women but do not take unequal power relations into account. Thus dominant cultural ideas of female sexuality and power relationships make it very difficult for women to negotiate safe sex. However, recent studies have shown that whilst hegemonic ideas of masculinities and femininities exist, and lead to gendered expectations of behaviour (Gevers et al 2012), reality for many young people is more complex (Allen 2003a, 2003b, Maxwell 2007, Devries and Free 2010). Young women express sexual desire, which is not always viewed negatively, and young men express desire for emotional closeness and having someone to talk to (Allen 2004, Forrest 2010).

Where research on sexual behaviour has been conducted with both sexes, it suggests that young men have some of the same concerns as young women, such as visibility in accessing services and the need for confidentiality (Stanley 2005, Craig and Stanley 2006), but also that they differ in their views about responsibility for contraception (Hooke et al 2000). Hooke et al’s study amongst 13-15 year olds found that whereas 73% of girls thought that contraception was a joint responsibility, only 46% of boys did. In addition, 21% of boys felt that casual sex was acceptable, compared to 5% of girls. Often, young men leave it up to their girlfriend to decide whether or not to use condoms (Devries and Free 2010), and if women do not insist on use of a condom, safe sex is not practised (East et al 2011). Ekstrand et al (2007)

found that Swedish boys trusted girls to use hormonal or emergency contraception as they were felt to be more responsible for pregnancy prevention than boys.

In terms of negotiating contraceptive use, Buston et al (2007) compared young teenagers who become pregnant with those who do not, in order to understand why only some sexually active teenagers conceive. They found that where both partners were young, they often lacked the skills and confidence to discuss contraception, thus compounding other practical difficulties they had in both obtaining and correctly using contraception. Not only is it necessary to have the ability to discuss contraception, the need to think ahead and plan implies the negotiation of a complex web of choices about relative risks and responsibility.

Flood (2003) found that young Australian men considered the risk of pregnancy to be greater than the risk of STIs, and viewed it as their partner's responsibility to deal with that risk by using the contraceptive pill. Condoms were felt to be difficult to use, and to spoil the spontaneity of sex. Williamson et al (2009) found young Scottish women had similar attitudes, seeing STI prevention as secondary to pregnancy prevention, and also tending to use condoms with casual partners or in the early stages of a relationship, moving onto using other forms of contraception, most commonly the pill, once their relationship became more established and they viewed their partner as a boyfriend. In contrast to other studies, none of the young women in this study felt that carrying condoms had any implications for having a negative reputation. Additionally, they describe condom use becoming 'normalised', with an expectation that condoms would be used in early

stages of relationships or in casual sex. Grunseit (2004) found that contraceptive use was associated with sex with a regular partner or where sex was planned. Perhaps this more recent work is an indication that attitudes to condom use are changing, particularly as far as their implications for female reputations, and planning to have sex, are concerned. Furthermore, as Hoggart and Phillips (2011) point out, much recent work points to the complexity of sexual decision-making for both boys and girls during the period of adolescence when both sexes are exploring their sexuality.

This paper discusses decision making and attitudes towards responsibility for use of contraception, and how those processes may be affected by gender and by relationship status. For the purposes of this paper, casual sex means sex between people not in a relationship, often “one night stands” at parties or nightclubs; “relationship” means that a couple see each other regularly, and intend to stay faithful to each other. Once they refer to each other as “boyfriend” and “girlfriend” the relationship is usually regarded as “established” as opposed to “early stages” where the young people may be deciding whether they want a regular partner.

Methodology

Data from two earlier qualitative studies (Author and A.N. Other 2010, Author 2011) were re-analysed with an emphasis on findings related to gender and responsibility for use of contraception. The first study, which took place in 2007, investigated unintended conceptions, focussing on reasons for non-use of contraception amongst 16-20 year old women soon after or prior to termination of pregnancy. As this study was designed to look at access to and use of sexual health services, interviews focussed on knowledge about sexual health, contraception, access to services and use

or non-use of contraception. Issues of gender and responsibility emerged in early interviews, and were then explored with subsequent interviewees. The second study, which took place in 2010, involved focus groups with two groups of 14-18 year old men to explore their views on sex education, and knowledge of and responsibility for contraception. In both studies, interviews and focus group discussions were conducted by the author, an experienced qualitative researcher who has worked with young people, and carried out research on sensitive topics. In the first study, 24 young women were interviewed, 23 face to face and one by telephone. The second study comprised two focus groups, one with three participants and one where only two participants attended but the decision was taken to continue the meeting; this latter group might better be described as a paired interview with two young men who were school-friends. The original intention with the second study was to hold four focus groups, two with young fathers and two with non-fathers; this was planned as a pilot study to test methods of engagement and discover issues of concern to young men as far as sexual health was concerned. However, despite repeated efforts, aided by local staff who ran a “Young Dads Drop-In” session, no young fathers took part. It was hoped that accessing young fathers via the drop-in service would encourage participation. Unfortunately sessions did not run during the initial recruitment phase, and when they began again, attendance was very low. Despite meeting a number of young fathers at the Drop-in and discussing the project with them informally, they either declined to take part or, when they did agree, did not keep appointments. This may have been because the researcher was an older female, or because they had lost the habit of attending the Drop-in due to it being closed for several months.

Interviews and focus groups were recorded with the consent of the participants, and fully transcribed. Both sets of transcripts were originally analysed

using a grounded theory approach to analysis, initially to build broad categories which were then refined and developed using a constant comparative approach (Strauss 1987, Strauss and Corbin 1990). Secondary analysis of qualitative data can be used to gain insights on sensitive topics or topics concerning hard to reach groups (Fielding and Fielding 2000), both of which applied in this case. It has also been used to generate new findings by looking at existing data from a new perspective (Holland and Thomson 2009). Although the practice of carrying out secondary analysis of qualitative data has been criticised for potentially taking the data out of its original context (Heaton 2008), in this case the analysis was conducted by the researcher who carried out the fieldwork and analysis for both studies originally, so awareness of context was not lost. The secondary analysis process involved re-reading all the transcripts to locate and code any mention of gender, or instances where gender might have played a part in the situation being discussed by participants. Data were then reviewed in order to explore gendered accounts in depth. By carrying out this iterative process between coded data and transcripts through a constant comparative approach, a picture emerged of how and when gender was referred to by participants.

Focus groups and interviews provide “parallel datasets” (Barbour 2007:46) allowing for comparison between data, focussing on “differences and discrepancies” (2007:47). The secondary analytical process carried out with data from the two studies allowed for this exploration of discrepancies in terms of how young men and young women spoke about the influence of gender. Although interviews may be regarded as more private accounts by virtue of being one-to-one compared to the more public nature of a focus group, I would argue that in both studies there was an element of performance, in that both genders were performing what was an acceptable

social role. For example, many of the young women blamed contraceptive failure for their need for a termination, which might be seen as a more acceptable reason than not using contraception at all. Similarly, as discussed below, the young men positioned themselves as responsible and sharing. Thus it may be that when discussing a sensitive topic such as sexual behaviour with young people, particularly with an older female researcher, data from interviews and focus groups are not too far apart in terms of public versus private accounts.

Both studies took place in an urban setting in the north of England, and received ethical approval from the Local NHS Research Ethics Committee (study 1) and the University Research Ethics Committee (study 2). Names of participants have been changed for the purposes of anonymising the data; the age of each participant is given in brackets after their name.

Results and discussion

In terms of non-use of contraception, the most common reasons given in the study with young women were forgetting to take the pill, not thinking about contraception (usually as a result of being 'in the moment' but also in that 'it [pregnancy] won't happen to me'), being under the influence of alcohol, and the influence of young men/partners (Author and A.N. Other 2010). The study with young men explored this final reason in more detail, and the results discussed below focus on this particular aspect of the findings in both studies.

The young women interviewed often said that young men were reluctant or refused to use condoms, mainly because they did not like them, but also because they 'don't think' about contraception:

A lot of boys say they don't like them but I just don't think they think about that sort of thing, I really don't. (Debbie, 18)

As in Flood's study (2003), young men were reported to say that condoms made sex less enjoyable, but both young men and young women said that using condoms took away spontaneity, both in the sense of not wanting to stop to have a discussion about condom use, or getting caught up 'in the moment'.

Most interviewees said that there was an assumption that young women would be on the pill, and that it was up to her to have organised contraception to protect herself from pregnancy:

It's just like, hit puberty go on the pill. That's what they're thinking. Loads of lads I used to hang round with thought that. (Louise, 17)

A lot of boys just assume, 'oh I thought you was on the pill, I thought you would've been.' Well I'm not, (laughs) so... Yeah, a lot of them just assume, don't they? (Sarah, 18)

Although an unspoken assumption exists that most young women will be on the pill, Sarah points out that this is not always the case; several interviewees said

they had used the pill and disliked it, or it did not agree with them, and many young women moved between using different types of contraception and/or no contraception at all; in some cases, the reason they were pregnant was because they had been “caught out” switching between methods.

This need for protection from pregnancy by being on the pill is consistent with studies discussed above suggesting that the danger of pregnancy is perceived as a much higher risk than that of catching an STI, with more serious, and potentially more visible, consequences. Although, as Rob points out in the extract below, there are ways of dealing with unwanted pregnancies, Sam suggests that STIs are seen as a more easily treatable problem:

- Sam (17): Pregnancy would be weighing on people's minds a lot more. STIs you can treat, but pregnancy you can't really treat.*
- Rob (18): You can get abortions, get the morning after pill.*
- Sam: Yeah, but it's not as simple as getting rid of an STI, is it?*

This perceived simplicity about getting rid of STIs may be because pregnancy weighs on people's minds, possibly because of potential moral implications of a termination. STIs may have fewer moral implications because they are diseases to be cured.

Young women were also described as more serious about contraception by participants in both studies, mainly because the potential consequences of unprotected sex were perceived to be worse for them than for young men:

Int: Do you think there's a difference in the way boys and girls think about contraception?

Rosie (16): I think girls take it more seriously. To be honest.

Int: Do you think boys think it's the girls' job to think about it?

Rosie: Yeah. Cos they're not the one who'll have ... they'll just think at the end of the day if they do get a girl pregnant or whatever, at the end of the day it's not really their problem. A lot of boys think that.

Whereas Ekstrand et al (2007) found that young men made assumptions about their girlfriends' use of contraception on the basis of trust (mainly trusting that she did not want to become pregnant), none of the participants in either study discussed here explicitly mentioned trust. Many of the young women talked about assumptions, mainly made by young men about them taking responsibility to protect themselves, but trust in the sense of being a basis for a sexual relationship did not feature in any of the discussions. Rather than this meaning that trust is absent from relationships, perhaps its absence from the data means it is implicit in young people's discussions of assumptions and shared responsibility.

The younger male participants agreed that young women were more serious about contraception, although it is interesting to note that when asked about contraception in general, they assumed that we were discussing condoms:

Int: Do you think boys and girls think differently about contraception?

Mike (16): Yes. No question.

Int: In what way?

Mike: Most boys are prepared not to use them, but girls generally are like, 'no you must use them'.

Joe (15): Yes, girls are very keen to use them.

However, having said that young women were keener on using contraception, or at least condoms, they felt that the responsibility was with the man:

Int: Whose responsibility is it, do you think, if you're in a relationship, to sort out contraception?

Joe: Boys, I think.

Mike: Yeah.

Joe: 'cause they've got to protect their thing.

Mike: 'cause they're doing it, aren't they? It's their fault if anyone gets pregnant.

Here it is interesting to note that each participant gives a different reason for taking responsibility. Whereas Mike mentions pregnancy and allocates fault to the boy for getting a girl pregnant, Joe alludes to STIs when he talks about 'protecting their thing', i.e. their penis. Earlier in the discussion, they had talked about a corridor at school leading to the biology classrooms which had posters depicting STIs, and Joe had described with some relish how horrible the pictures were, and what might happen to 'your thing' if you caught an STI.

However, the older ones felt that responsibility for contraception was shared equally between boys and girls:

Int: Thinking about contraception, do you think there's a difference between girls and boys in terms of who takes responsibility?

Sam (17): In my experience, no. I think it's shared really.

Rob (18): It's shared. You're both going to do it.

This view that responsibility is shared may be because they were both sexually experienced (i.e. had had more than one sexual partner) and currently in relationships, whereas with the younger pair, Mike was a virgin and although Joe was in a sexual relationship, it was with his first and only (to date) girlfriend, with whom he had been involved since they were both 13.

Responsibility is clearly affected by knowledge about the sexual partner, in particular, whether the female is on the pill or using long term reversible contraceptive methods. As Lees (1993) discussed, knowledge comes from many sources and may not be accurate. Young people may know when one of their social group has had a relationship with another, but may make incorrect assumptions based on boasting and gossiping. They also make decisions based on perceptions of appearance, and whether someone is like them, as STIs may be seen as only happening to people not like themselves (Senior et al 2014). Knowledge about whether someone was using contraception might also be different depending on whether it was a 'one night stand' or a regular partner, which Charley describes as being "with somebody":

I think in a couple of cases they probably just think they're on the pill. But that's maybe if they just have one night stands and things but if you're with somebody, they're obviously gonna know whether you're on the pill or not, so you'd both decide to use summat, wouldn't you? (Charley, 19)

As far as the young men were concerned, the responsibility for contraception in a casual encounter was with the young woman; however, even though the onus might be on her, they suggested that the decision would still be mutual:

Int: Does it make a difference if you're in a relationship to if it's a one-night stand?

Sam: It makes it more important to be shared.

Int: In a relationship?

Sam: Yeah.

Int: But say meeting someone in a nightclub...

Sam: I think it's more down to the girl then. It's still shared, though, really.

Rob: It's still shared.

In several interviews and both focus groups, it was said that people (young men and young women) went to parties or nightclubs with the intention of having casual sex. None of the young women discussed carrying condoms, although several mentioned being too nervous or drunk to ask whether their partner had one. Sam and Rob, the older young men, felt that it was unlikely that young women would carry them or ask a partner to use one, but that if she did ask, he probably would. Mike and

Joe, the younger ones, had just agreed that it was sensible for both young men and young women to carry condoms, but immediately after agreeing this, in their discussion of meeting someone at a party who asked them to use a condom, and produced one, Mike declared that he would consider her 'a slag' because she was clearly planning to have sex. Joe agreed that she would be perceived that way, but still felt it would be sensible for her to carry condoms. Sam and Rob talked about how other people used terms such as 'slag' and how young women would be labelled as such, but it was very much something 'other people' said, and not them. Still, the existence of the 'double standard' in terms of regarding sexually active males as 'heroes' but sexually active young women as 'slags' was acknowledged as alive and actively used to label people. It is worth noting the continuing power of labels with regard to sexual behaviour; even where the participants acknowledge labelling as unfair, they still accept that it happens.

Once a relationship was established, it was suggested by some interviewees that the couple would make a joint decision, or at least discuss contraception, before switching from condoms (if they had been using them) to the young woman going on the pill or getting an implant – 'the rod'. As in the study by Williamson et al (2009), there was a sense of progression in terms of choices about which type of contraception to use would change as a relationship progressed, which again raises the issue of trust; a young man has to trust his partner when she says she is on the pill, whereas condoms are a very visible method of contraception, so moving to using the pill indicates that the relationship is a trusting and possibly lasting one.

In both interviews with the young women and the focus groups with the young men, it was suggested that there may be an element of peer pressure to have sex, combined with showing off, both about having sex, and not using condoms. Joe and Mike discussed how young men who had not had sex by the time they were 16 would be called names by others at school. Here, Louise talks about peer pressure being worse from other young women than from young men, and other interviewees said that virginity was regarded as something “to be got rid of” by other young women:

When I first did it, it was to fit in with everyone I was hanging about with ... it was even worse with it being an all girls' school. So you was like, it's full of lasses going 'I've lost my virginity, I've done this', and you was like 'whoa'. Time for you to do it. So you go out and do it. (Louise, 17)

Int: Some people have said there can be pressure on people to have sex at a young age. Do you think there's pressure on boys from other boys?

Sam: Yes, definitely

Rob: Yeah, "I did it, go out and do it", that kind of pressure. Most of them are lying. 80% are lying.

As well as boasting about sex, they may also boast about not using condoms:

But I have heard them talking about it, that they don't want to, big group of lads going 'oh I don't use them,' all this crap, bigging it up. (Katie, 16)

It's things they say to be hard, you know what I mean? 'Oh, I didn't use a condom'. You get people like that in our school. (Joe, 15)

The combination of name calling and boasting, then, leads to peer pressure to have sex, and to have sex in a particular way.

Several female interviewees talked about pressure to have sex without a condom, and in some cases the persuasion had included the fact that they could have unprotected sex, then go to get emergency contraception (EHC) later:

Int Do you think boys put any pressure on girls to have sex without a condom?

Becky (16) Yeah they just tell them to go and get the morning after pill. That's what they all say.

Int So it's fine to do it without a condom ...

Becky - yeah -

Int ... because you can get a pill afterwards?

Becky Yeah. That's what they think.

Int Is that quite a common attitude?

Becky Yeah it is around where I live.

One interviewee talked about termination being presented as an alternative option to using contraception:

I have had my ex-boyfriend saying to me, before, 'it's alright, if anything happens you can just do this', [have a termination] and I'm like, 'well, no it's not as easy as that, it's horrible, it's not a nice thing to do either,' but he's like, 'no, it's alright', you know. I think a lot of lads will be like that, as well, with girls. (Fiona, 16)

However, Fiona was the only one who described this sort of situation, whereas EHC was reported to be viewed much more widely by young men as an acceptable alternative to safe sex. The implications for STIs are clear, particularly if these attitudes are applied in settings where young people are having casual sex with partners whose history they do not know. In almost all the interviews, the 'problem' was seen as unwanted or unintended pregnancy; sexually transmitted infections and the desire to avoid them by using condoms was only mentioned by two interviewees as being part of the decision-making process, but was still discussed as an issue for young women, and not a reason that young men had given for wanting to use condoms. Young men, meanwhile, might not be thinking about STIs at all:

Int: Thinking about STIs, does that play a part in boys' minds?

Joe: I don't think boys actually think about anything when it actually comes to it, if you know what I mean.

Mike: No.

Joe: They think about it when they might actually have got something, but they never think about it before.

Int: So the next day ...

Joe: ...they think 'oh my God, I could have that, and that, and that ...'

Mike: ...if it's with someone they don't know.

Int: But it's not something that would stop them having sex?

Mike: No.

Sam and Rob reported similar views, and this viewpoint seems to show that Debbie's comment earlier, that young men simply 'don't think', is borne out by what the young men say, at least as far as STIs are concerned.

Having said that young men 'don't think', it is clear from the findings discussed above that in fact their thinking can be quite nuanced. Although at times they reported somewhat simplistic and 'macho' notions that they knew other young men held, their thinking about relationship status and responsibility was quite complex. The presentation by the young women of young men being a group who would either assume that young women would take responsibility or would leave it 'all up to the girls' does not appear to be borne out by the second study; however, the young women themselves also presented much more nuanced arguments about responsibility and decision making, and how those would be affected by relationship status. It is clear that the relationship between gender, risk and responsibility is not clear cut, and decision making and responsibility does not neatly fall along gendered lines; relationship status appears to be key for both genders.

Strengths and limitations

The findings of both studies were from small qualitative samples in a particular part of northern England, and therefore may not be transferable to a wider population. In addition, the first study had a very specific remit, looking at reasons for unintended

conceptions amongst young women having a termination, therefore the young women interviewed may not have been typical of the wider population. There may also be an element of post hoc rationalisation amongst the interviewees, in terms of explanations about why that particular young woman became pregnant, and she may not wish to appear to be 'to blame'. Given that the interviewees were unintentionally pregnant, their perceptions of young men's attitudes may have been influenced by bad experiences in some cases: although most of the young women said that their decision to have a termination had been made jointly with their partner, others reported that their pregnancy had resulted in relationship breakdown and that they therefore felt unable to carry on with the pregnancy. Nevertheless, almost all the young women interviewed reported some form of pressure from young men, upon themselves and their friends, and that young men viewed contraception as 'not their job'. It should be noted that the discussions of contraceptives may have been influenced by the fact that the young women had discussed it with their consultant and been advised about future methods of contraception. This may have affected their views on types of contraceptives, and certainly had increased their knowledge of the range available; it may also have influenced their thoughts about responsibility for using contraception.

It should also be noted that interviews with the young women took place at a difficult time in their lives, and thus great care was taken not to cause distress. (Author 2013). Participants were given several opportunities to ask about the study, and to decline to take part, and were told they could end the interview at any point. Interviews which took place prior to the termination were more successful than ones which took place afterwards, as it appeared that young women were happy to talk

about an event that was about to happen, but not about one that had happened, as they regarded the termination as the end of a difficult time.

The second study was primarily a pilot to test methods of engaging with young men, which demonstrated that young fathers were very hard to engage, and it was easier to get involvement from non-fathers. The focus groups were very small and in one case might be better described as a paired interview with friends; all participants were white and in full-time education and it is likely that attitudes may differ from those who are not in education, training or employment. In addition, having a female researcher may have had an impact on what the young men were prepared to say, and whether they were performing what they considered to be acceptable masculine roles, for example by claiming to act responsibly, or talking about how “other” young men, but not them, boasted about not using condoms or called young women insulting names. The paired interview with Joe and Mike, who were classmates, may have been influenced by their friendship; I would argue that in fact the influence, if any, was beneficial, in that they both appeared to discuss quite personal matters very openly, and this may not have been the case if it had been a group of strangers. Nevertheless, given the difficulties of engaging with young men of this age group, the study contributes to making heard the voices of a group who often go unheard in research on this topic.

Despite these limitations, the findings of the two studies provide an insight into the complex and nuanced decision-making processes of young people about their sexual lives and relationships.

Conclusions

There are clear implications of these findings for the sexual health of young people, particularly in the context of government policies resulting in a reduction of provision of sexual health services and in education policies that do not guarantee access to high quality sex and relationships education of the type that young people themselves say they need. Risk is perceived almost entirely as the risk of 'falling pregnant', with the issue of STIs only being discussed when directly introduced into the conversation by the researcher. If unwanted pregnancy is perceived as the only risk of unprotected sex, then hormonal contraceptives such as the pill, long-term reversible contraceptives and EHC are methods which will protect against that risk, but are all methods which firstly require action from the woman, and secondly will afford neither the woman nor the man any protection against STIs. It also places all the responsibility on women for organising and/or taking contraception, which despite the assurances from the young men that responsibility for contraception is shared, does not require much action on their part.

As much of the recent literature, particularly work by Allen (2003a, 2003b, 2004) and Forrest (2010) demonstrates, young people themselves are aware of hegemonic and idealised notions of masculine and feminine roles and can challenge them; at the same time, they operate within the double standard whilst acknowledging that its continued existence is unfair. One interesting conundrum emerging from these studies is that young women who carry condoms, who are therefore assumed by some young men to be planning to have sex, are labelled in a derogative manner, which is consistent with the findings of Hiller et al (1998) amongst others, yet at the same time

there are widely held assumptions that young women will be 'on the pill', which does not bring the same negative label.

It is somewhat simplistic to assume that all the responsibility lies with young women, although clearly many of the young women in this study feel that it does, much of the time, and Marston and King (2006) show that this is a view widely demonstrated in the literature. However, the young men were revealing in the ready acceptance of shared responsibility. Relationship status is significant in terms of young people's decision-making about contraception, with both young men and young women thinking that responsibility is shared in a relationship. However, gendered assumptions about responsibility play a part, particularly in casual encounters where little thought is given to the risk of catching STIs, and it is reported by young women that young men assume they are on the pill in order to protect against unwanted pregnancy. The way young people talk about how responsibility for contraception is allocated or assumed indicates that relationships between gender, risk and responsibility are complex and fluid.

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