

**"When you carry a condoms all the boys think you want it":
Negotiating competing discourses about safe sex.**

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Abstract

With the advent of HIV, sexual health campaigns and formal sex education in schools have worked to instil the concept of safe sex into the collective minds of Australia's youth. However the concept in its present guise is a fairly limited one. We argue in this paper that the predominant emphasis on safe sex as condom use in education programs, may be counter-productive for some young heterosexuals for two reasons. First, this strategy is male focused and may not extrapolate well to young women who face special risks around pregnancy and rigid societal gender norms which govern sexual behaviour. Second, health promotion strategies aimed at young heterosexuals are based on an assumption of rational decision-making in sexual encounters and obscure the non-rational nature of arousal and desire, and the unequal power relations that exist between young men and women engaging in sex. Five hundred and twelve senior rural students participated in the study which included group discussions about sexuality and survey items which focussed on the meanings of safe sex and the accessibility and use of condoms. The results showed that though most students identified condoms with safe sex, many were ambivalent about using them. Reasons given related to problems of negotiation, difficulties of access, and the risks which condoms gave no protection from, such as a sullied reputation. Perhaps, partly because of this, some students were looking to less secure methods of protection such as informal history-taking and monogamy. It is argued that successful sexual health promotion strategies must address the broad spectrum of concerns facing young men and women when they become sexually active and that consideration be given to the social context in which young people conduct their sexual lives.

Introduction

Simon Watney has argued that "...gay men invented safe sex" (Watney, 1994, p. 137). In a contemporary western sense, the term "safe sex" originally encapsulated the educational response of the gay community to the HIV pandemic, and described a number of eroticised practices which gave protection from HIV. In spite of recent discussion about overexposure to safe sex messages (Watney, 1994), the campaigns have been remarkably successful in the gay community. Consequently, concerns about the spread of the HIV virus into the wider community in the late 1980's lead to the appropriation of the concept of "safe sex" in campaigns which targeted heterosexuals.

With the advent of HIV, adolescent sexual activity, historically regarded by the adult community as problematic (Hudson, 1987; Lees, 1993), has become the focus of further interrogation, speculation, manipulation and fear. In particular there has been the concern that teaching young people how to have sex safely might encourage an increase in, and an earlier onset of, sexual activity (Fineberg, 1988; Frankham, 1993). In spite of this anxiety, educational authorities in most Australian states have taken on a mandate to incorporate the concept of safe sex into sexual health programs. For various reasons, however, the substance and underlying philosophy of safe sex in schools (Harrison, Hillier & Walsh, 1996; McWilliam, 1995) is a vastly changed product from the one which has proved so successful among gay men. The "safe sex" message which is promoted in Australian school sexual health programs has been simplified and sanitised to the extent that often the only remaining message appears to be "safe sex equals condom use". This focus on sexual intercourse to the exclusion of other ways of being sexual, privileges a risky practice, while leaving unnamed other ways of being sexual which are potentially available to young people. Underpinning this message is the promotion of "reproductive sex" as natural and functional and the silencing of non-reproductive sex, regardless of the inherent safety (or lack of safety) of any of these practices. This may have restricted the range of safe sex possibilities available to young people in any sexual encounter (Abramson & Pinkerton, 1995).

Given that the "safe sex" concept has been developed from a model designed for gay men, it is possible that there may be issues around sexual activity, specific to women, in addition to HIV prevention, which have not been adequately addressed by current safe sex messages. The "safe sex" phenomenon, Singer (1993) has argued, has directed attention to the risks of sexually transmissible diseases, in particular HIV, to the exclusion of any of the other risks of heterosexual intercourse. Singer, noting this, observed that:

"For men, sexual safety may simply be a matter of wearing a condom. For women, however, sexual safety is not so easily achieved because the risks for women who engage in sex ... outstrips the risks of contracting a sexually transmitted disease"

(Singer, 1993, p. 67).

Sexual intercourse has never been safe for some women, and despite improvements in medical technology and changing attitudes, young women often face many of the risks in having sex that their mothers and grandmothers faced, long before the AIDS epidemic began. The dangers inherent in certain methods of contraception and in unwanted pregnancy continue to have serious implications for women. Where sex education programs have existed in schools, and safe sex has been incorporated into them, issues around reproduction have been dealt with alongside the risks of contracting HIV. However, an exclusive focus on condoms as protection from STDs and pregnancy, overlooks the more proximal risk of a sullied reputation, which may be exacerbated through the process of obtaining condoms and, by association, planning for sex (Holland, Ramazanoglu, Scott, Sharpe & Thompson, 1990).

These problems are likely to be more salient in rural and remote areas where populations are small. These communities present special problems for young people who have great difficulty ensuring confidentiality and privacy even in the most intimate aspects of their lives and who can suffer considerable social sanctions if they are seen to be crossing forbidden lines which delineate acceptable from unacceptable behaviour. Knowledge that a girl is

sexually active, particularly if she is unable to sustain a committed relationship (Kitzinger, 1995) can sour the townsfolk's feelings and behaviours towards her, including, if she stays in the town, limiting the types of relationships available to her in the future.

This leads us to ask whether safe sex campaigns which privilege protection from STDs (and in sex education courses, pregnancy), at the expense of other dangers of sex, while at the same time promoting only reproductive sex, may be counter-productive for young people. Safe sex in the context of HIV risk does not necessarily mean safety in terms of other risks. Discourses around the meaning of safe sex and current safe sex campaigns which privilege HIV prevention run the risk of being perceived as irrelevant if they do not acknowledge other, perhaps more immediate, concerns in the lives of young heterosexuals.

Furthermore, researchers have noted that the promotion of a rational choice model of condom use may not be entirely appropriate, partly because it does not adequately account for the double standards and power relations which are most often a part of heterosexual sex (Holland, et al, 1990; Wyn, 1994). According to Ward (1993), risk-taking implies autonomy, and sexual autonomy is a state which young women rarely achieve. Girls, for example may find it extremely difficult to negotiate the use of a condom, especially when, at the same time they are expected to be naive in sexual matters. The sexual relationship is a site in which the exercise of power and resistance is played out, and the underlying assumption that young people are acting out their sexual fantasies on a level playing field is considered by many to be naive (Bloor, 1993; Lees, 1993; Tolman, 1994).

Ten years after the beginning of safe sex campaigns, it is important to know how the condom and other strategies fare in young people's constructions of safe sex methods. McIntyre and West (1993), for example, found in their Glaswegian study that 84% of 18 year olds mentioned condoms when defining safe sex. It is important also to know how useful these strategies are in ensuring that sexual encounters are safe. Our aim in this paper is to explore

the meanings of safe sex to senior rural students and to ascertain the usefulness of, and contradictions inherent in, the safe sex strategies used by young people in small rural communities.

Research Methodology

The research reported here was part of a larger study with school attending rural youth in eight towns across Tasmania, Victoria and Queensland. Rural was defined as 'living in stable towns with populations of under 10,000'. The data for this paper were from the responses of senior student in years 10 (year 11 in Queensland) to a number of survey items listed below which concerned safe sex and condoms.

Survey Items

What does safe sex mean to you? - open ended question

How likely do you think you are to get an STD(HIV)?

I could get a condom without anyone I know seeing me (5 point scale)

How difficult is it for you to get condoms?

If you want to get condoms, how comfortable are you at getting them?

For those young people who use condoms when having sex, who do you think mostly suggests using them?

The last time you had sex did you and your partner talk about condom use?

The last time you had sex did you or your partner have a condom with you?

Was a condom used?

The quantitative data were coded and entered into SPSS Mac for descriptive and comparative analyses. Data were also drawn from a series of 14 single sex focus groups held with senior students in seven of the eight towns visited. These discussion groups had approximately six to eight students in each and lasted for one hour. A semi-structured theme list was used as a guide for the same sex facilitator in each group. The focus group discussions and the meaning of safe sex responses were transcribed and read in depth by the researchers in the project. Using content and theme analysis, broad categories were identified and cross-verified by other project members. Because the results reported here are mainly descriptive and

qualitative, for ease of reporting, the results and discussion have been dealt with simultaneously.

Results and Discussion

Five hundred and twelve senior students, 203 [40%] boys, 308 [60%] girls and one, no sex given, completed the surveys. The students had an average age of 15.8 years with ages ranging from 15 to 19. Ninety-seven percent were born in Australia with English being the main language spoken in 99% of homes. Sixty-one percent were raised in nominally Christian households, two percent Buddhist, Hebrew or Muslim and 37% no religion. Religion was regarded as unimportant by 51% of the participants. One hundred and ninety-five [38%] of these young people had experienced sexual intercourse, 379 [74%] had experienced sexual touching and 430 (84%), passionate kissing.

insert Table 1 here

Meanings of safe sex

Three hundred and one girls and 191 boys responded to the question *what does safe sex mean to you* and 20 left the item unanswered. Understandings around safe sex dealt with two broad themes. The first concerned the methods of protection which these young people believed would ensure safety in sexual encounters and the second, the risks and dangers which these methods were designed to address.

A. Safe Sex Methods

Method 1: Safe sex means condom use

The largest category of response to the meaning of safe sex item described safe sex as using a condom (180 [54%] of the girls 109 [48%] of the boys). The following examples were representative of this discourse:

"The use of a condom during sexual intercourse" (boy 0264)

"Condom use" (girl 0122)

"The male using a condom when having sex" (girl 0135)

"It means being prepared e.g. condom" (boy 0739).

"Using a condom or some other barrier to prevent the transfer of bodily fluids" (boy 0098).

"It means having sex with protection - a condom and spermicide to prevent spreading STDs" (girl 0495).

The dominance of the "safe sex = condom use" responses is an indication of the success of AIDS prevention education which has in many ways concentrated on penetration and socialising the condom (e.g. the "Tell him if it's not on it's not on" campaign) to the exclusion of other modes of safe sexual expression. Condoms were the most mentioned safe sex strategy, but it was clear from the data that when it came to putting this knowledge into practice, these young people perceived and encountered many problems with obtaining, carrying, using and supplying them.

a) Obtaining the condom. Condoms were rarely available in anonymous ways in these small rural towns and so they had to be procured publicly from the chemist or the supermarket or from other larger towns. Girls were at a disadvantage here in several ways. First, significantly more boys (49% boys 35% girls) ($t_{505} = -5.56$ $p < .001$) were likely to agree with the statement: *I can get a condom without anyone seeing me.* Compounding this perception was the girls' belief that if she bought a condom she, more than the boys, would be automatically regarded as planning to have sex. As one girl noted:

"Well if a guy goes in and buys condoms it's just like they're just checking it out or maybe they're just being curious, just being boys. But if a girl goes in then they're having sex"

(girls' discussion group, Queensland)

Boys were thought to often fool around with condoms and use them as toys so that buying them did not necessarily indicate sexual activity. Examples such as that of Shane below were given throughout the discussion groups:

"Do like Shane did. Fill them up with piss and throw them in the movies"

(boys' discussion group, Queensland)

Moreover, we asked in the survey about the difficulty of, and comfort with, obtaining condoms. In each case there was a significant gender difference with girls perceiving themselves to be at more of a disadvantage than boys. Of the 25% of the sample, significantly more girls (18% boys 30% girls), ($t_{492} = -3.38, p < .001$), found it difficult or very difficult to obtain condoms. Similarly, of the 48% who expressed discomfort at obtaining condoms, 52% were girls ($t_{490} = -2.63, p = .009$). The reasons given had to do with embarrassment, lack of anonymity, and parental disapproval. Boys, more than girls were likely to be refused service, but the general difficulty and discomfort girls felt was stronger.

b) Carrying a condom was not perceived as harmful for boys in general. One girl said that the boys wore it like a badge, that they often flipped open their wallets to expose the condom carried in it. But carrying condoms did endanger the good reputation of girls who could be seen to be planning to have sex. Thus, the condom which was designed to give protection from one danger of having sex, served to increase the risk of another. According to the participants in the discussion group below, carrying a condom for a girl could also bring on unwanted advances from boys because she could be thought to be promiscuous.

"There's a lot of girls carry them [condoms] because they don't want, there's no way they're getting pregnant"

"But when you carry a condom all the boys think you want it"

(girls' discussion group, Queensland)

Condoms were also evidence at home (as was the pill) that the girls were sexually active.

c) Negotiating the use of a condom. Our data showed that at the last sexual intercourse, 69%

of the students (boys 76%, girls 64%, $\chi^2[1] = 3.1, p < .07$) used a condom, leaving 31% who had unprotected sexual intercourse. Moreover, we learned from more general questions about condom use that 45% (no sex difference) didn't always use a condom with casual partners and 37% (no sex difference) didn't always use a condom with regular partners. Lees (1993) has argued that using a condom for a girl involves actively talking about it rather than just letting it happen, and to do this she must express her intention to have sex. Boys also had particular concerns about a girl's reaction when they introduced a condom into a sexual encounter because this act signalled his intention to have intercourse.

Sixty-eight percent of our sample (no sex difference) said that they did talk about condoms the last time they had sex and a chi square analysis showed that those who talked about condom use before sex were significantly more likely to use one ($\chi^2[1] = 37.34, p < .0001$). However, of those who talked about using a condom, 17% still did not use one, and of those who did not talk about it, 37% still used one. We can only speculate that some condom use occurred without negotiation, for example, an established practice in a relationship or a boy using as a matter of course, but that in other cases, negotiation was attempted and it failed. Whatever the explanation, it is clear that with 31% of these young people not using a condom at the last sexual encounter, and 45% not always using a condom, many of these young people had no fail-safe way of putting the safe sex equals condom strategy into practice.

d) Supplying condoms.

insert Table 2 here

Given the problems discussed so far that these young people, especially the girls, encountered in obtaining, carrying and using condoms, and given also that the condom is a male tool, one might expect that the norm would dictate that boys supply the condom. Our research data (see Table 2) however, showed a different expectation with more than ten times the number of senior students (32% vs 3%) believing that girls, rather than boys supplied the condoms in

sexual encounters. Though 48% of the sample thought that both partners supplied the condom for sex, there was the expectation by many, that it was girls who took care of these things. A chi square analysis showed gender differences in peer norms ($\chi^2[3] = 15.6, p < .001$) with more boys than girls believing both partners suggested condoms and more girls than boys believing that girls did. The following excerpt from a girls' discussion group reflected this result and many of the other discussions:

Who do you think suggests using condoms?

"The girls".

"Because they care about the protection.

They won't just do it....They are worried about the outcomes".

Girls can get pregnant or anything"

(senior girls discussion group)

Interpretation of this result should be tempered by the knowledge that 60% of the respondents were not sexually active. However, it does reflect an illogical or counter-productive norm for safe sex behaviour which is set against a cultural backdrop of gendered expectations in which the group which has most difficulty dealing with condoms is the one which is nevertheless expected be responsible for ensuring their use.

When we asked the participants who had had sexual intercourse ($n = 195$) whether at last intercourse, they or their partner had a condom with them, the results differed markedly from the peer expectations with more boys (72%) than girls (52%) ($\chi^2[1] = 7.9, p = < .004$) having a condom with them at the last sexual encounter. We suspect that this is an example of education working change in spite of entrenched cultural norms and this data could be used as an intervention, by presenting evidence of peer norms to further increase the numbers of condom carriers among young people.

Method 2: Safe Sex means unspecified prevention/precaution/protection

A large number of the responses (60 girls [20%] and 30 boys [15%] mentioned terms such as

protection, prevention and precaution without being specific about what this might mean. For example:

"Having sex with protection to stop yourself from catching an STD and also using protection to stop pregnancy" (boy 1125)

"When both partners are using protection" (boy 0109)

"Taking the right precautions when having sex" (girl 0476)

"Preventing STDs and pregnancy" (girl 0107)

We offer two possible explanations for this non-specificity. Firstly, the discourse of safe sex is so 'normalised' that it is presumed that a reader will know that protection, precaution and prevention are equated with condom use which equals safe sex (similar to "it" or "the real thing" signifying sexual intercourse). In this case our figures would be more similar to the 84% who mentioned condoms in MacIntyre and West's (1993) study. The second, less palatable explanation is that students know they need to protect themselves and their partners from STDs and pregnancy, but they are not at all sure what this means. Even when the responses were more specific, providing lists of barrier methods of contraception, it is not clear that students knew how to operationalise their knowledge. They are particularly problematic where there appears to be a naive view of power relations and the difficulties around negotiating safe sex.

Method 3: Safe Sex means trusting your partner

Some students emphasised trust between partners as an important element of safe sex. Twenty-two girls (11%) and 5 boys (3%) wrote that having trust in their sexual partner would protect them from STDs. Included in this was the understanding that there was emotional safety in the relationship when the sexual partner was *the right person*. The following responses were typical of this belief.

"Using a contraceptive and trusting the person you're with" (girl 0009)

"Having sex with a long term trusted partner" (girl 0014)

"Trusting your partner, maybe girl on the pill, knowing beforehand if either of

you have STDs" (boy 0746).

Though many who mentioned trust as a safety precaution also included other forms of protection such as contraception, it was quite clear that putting faith in and trusting one's partner were regarded by some, especially girls, as reliable methods of protection from disease. This reliance on trust is consistent with findings from other studies of young people's constructions of safe sex (Holland *et al*, 1990; Lees, 1993). As Holland *et al* state: 'If love is assumed to be the greatest prophylactic, then trust comes a close second' (1990, p. 17).

Trust, as part of the discourse of love and romance sits in competition with the scientific, decontextualised safe sex message in sex education programs, in which trust and love are not part of the safe sex equation. Trusting one's partner may have many meanings, including trusting him/her to not have sex outside the relationship. However, relationships in this age group are generally precarious and trust may not be an appropriate way to guard against infection. This is true of all relationships but may be particularly problematic with this age group. We know that many of the partnerships these young people were referring to were short term (average of two months). As a consequence, a series of chaste and trustworthy partners, may provide little protection from STDs.

From the opposite perspective to trust in one's partner's as a safe sex method were the 11 boys [5%] and 16 girls [5%] who wrote that they could protect themselves by limiting the number of people with whom they had sex. In particular, staying with one person and not sleeping around could, according to these young people afford protection from STDs.

"Using protection. I also think it means staying with one person, not going around to a different guy every weekend" (girl 0127)

"It also means no one night stands" (girl 0491)

"Using a condom and having one steady partner" (girl 1134)

"Practise sex with one partner. No gang bangs" (boy 0730)

However, as with trusting to love, the temporary nature of these relationships means that in one year, a person could have several steady monogamous relationships, never sleep around, yet still be unprotected.

Method 4: Safe Sex means knowing informally your partner's sexual history

Another theme (11 [5%] boys and 3 [1%] girls) was an explicit or implicit emphasis on sexual history taking. Many of these responses reflected the belief that one could know, in an informal way, whether one's partner was likely to have an STD. This may be because of his/her appearances, for example whether s/he looks clean and healthy. Alternatively, it may mean depending on local or intuitive knowledge about the person's sexual behaviours:

"To me it means knowing the person you're with closely, using a condom, knowing s/he doesn't have STDs" (girl 0356)

Using a condom etc. Girls use the pill. Don't root sluts" (boy 1140)

"Make sure your partner doesn't sleep around so you know he isn't likely to have diseases" (girl 0032)

"Knowing your partner's sexual activities and wearing a condom" (boy 0758).

The common aspect of these informal ways of knowing a person's disease status, is that they are likely to be based on conjecture or gossip, rather than direct communication with the person concerned, especially given one third of the last sexual encounters of these young people were with first time sexual partners. We suspect that a belief in informal methods of knowing one's partner would be particularly compelling in small towns where anonymity and confidentiality were perceived to be almost impossible to achieve. However, as a safe sex method, dependence on gossip for knowledge of one's partners sexual history is likely to be an unreliable alternative.

Method 5: Safe Sex means knowing your partner's disease status through tests

A more formal safe sex procedure advocated by some of the students, particularly the girls

(13 girls [4%] and 3 boys [1%]) involved having tests to find out the partner's disease status.

"Regular checkups from your doctor" (girl 0736)

"Safe sex means using contraceptives and only having sex with people who you know, through tests, don't have STDs" (boy 0005).

"It means sex using some form of contraception, and making sure that your partner doesn't have an STD" (girl 0231).

This strategy falls into the category of a rational medical discourse that views safe sex as a choice made by autonomous individuals and obscures the problems that may be faced in negotiating tests. Many of the group, particularly the girls reported difficulty negotiating the use of condoms. For many of the same reasons, negotiating tests for STDs in small towns and ensuring partner cooperation in this endeavour, would be most impractical and possibly unachievable. Moreover, given these young people's tendency to engage in serial monogamy, even if one set of tests were carried out (notwithstanding window periods), protection could only be assured until the next sexual partner.

Method 6: Safe Sex is non-penetrative sex or no sex

A very small number of the participants (3 boys (1%) and 3 girls (1%)) listed non-penetrative sexual activities as safe sex strategies. They are all recorded below:

*"Use of condoms or sex with out penetration" (*boy 0740)*

"Non-penetrative sex" (boy 0876)

"Safe sex is having sex without sticking it in" (boy 1164)

*"Safe sex means no sex (penetration) (*girl 0355)*

*"Playing around without having intercourse" (*girl 0508)*

"Safe sex means to have safe sex, example if you were really worried about getting pregnant you could just play around. There are many more things you can do" (girl 0872)

*students who had had sexual

intercourse

These examples are interesting because they make references to ways of having sex which the majority of the students failed to mention. We do not know whether this omission was definitional, that is, sex meant intercourse, and therefore safe sex was protection from intercourse, or whether non-penetrative sex was thought to be unsafe. Girl 0355 prefaced non penetrative sex as no sex while the other five defined non-penetrative sexual behaviours as sex and as safe. Four out of the eight had experienced sexual intercourse. Given that 77% of the senior students who responded to this item had experienced sexual touching at some point without intercourse, it is surprising that more of them did not categorise these behaviours within their meanings of safe sex.

Allied to the previous category of response which saw safe sex as non-penetrative, some students saw abstinence as an alternative safe sex practice. The numbers in this clusters were small (8 girls (3%) and 2 boys (1%) and this was not always seen as exclusive of other practices.

"Having protected sex or not having sex at all" (girl 0260)

"No sex or using a condom" (girl 0513)

"No sex" (boy 0497)

It is possible that to these students, no sex meant no sexual contact at all. Prohibition and taboo are rarely successful preventative strategies, though some educational interventions, particularly in North America, have aimed at delaying sex until marriage (Ames, 1992; Klein, 1994). Alternatively, no sex, may, in the minds of these students, have included non-penetrative sex. Given that many of these non-penetrative behaviours could be described as safe in terms of STDs, pregnancy and reputation, it may be possible to place the erotic spotlight on non-penetrative alternatives which these young people already know about, by redefining them as positive, safe and enjoyable alternatives in the sexual repertoire.

The safe sex methods named by the students in this study, are clear evidence of the success of

the safe sex equals condom message. However, in practice, condom use presented many problems for these young people which were exacerbated by the peculiarities of life in a small rural town. Many of the young people found it difficult to access condoms privately, and the ramifications of carrying and negotiating their use presented special dangers which could be avoided by depending on other less reliable protective methods. As will be seen from the following section on the perceived risks of having sex, the safe sex methods mentioned above are at best piecemeal in terms of all-round risk protection and at worst, because there are competing risks, give no protection at all.

B. The Risks of Having Sex

The participants in this study were aware of a number of risks of having sexual intercourse, many of which were perceived to be greater for the young women.

Risks 1 & 2: Safe Sex means protection from STDs and from Pregnancy

Though the aim of most safe sex education is to raise people's awareness to the risks of STDs, (and for sexual health education, the risks of pregnancy) we learned from the survey data that many rural young people believed the problem had little relevance to them. Eighty-five percent of our sample believed themselves to be invulnerable to STDs (no sex difference) and this is not dissimilar to urban groups in Australia (Dunne et al, 1993) and overseas (Bloor, 1995). Given this sense of invulnerability to STDs, the promotion of protection from pregnancy in sex education classes, and the perceived risks of pregnancy, it is not surprising that fears of unwanted pregnancy (46 boys [23%] and 107 girls [35%]) were mentioned at least as often as STDs (51 boys [25%] and 100 girls, [32%]) in the safe sex responses. This concern was particularly evident in the girls' responses and boys often alluded to it as well. Rarely were STDs mentioned without pregnancy being included also:

"Using contraceptives definitely condoms, the pill for prevention of pregnancy, condoms stop most STDs" (girl 0232).

"Using a condom to stop getting pregnant or getting AIDS/STDs. Using the pill to

prevent falling pregnant" (girl 0246).

Some of the responses reflected confusion over the protection afforded by condoms as opposed to other contraceptives. Contraceptives, such as the pill and the diaphragm, which the girls were able to control because they required no negotiation for their use, but which afford little or no protection from STDs, were often mentioned interchangeably with the condom.

"Using a condom or diaphragm while having sex with a partner" (girl 0822).

"Safe sex means that both the boy and girl are protected in some way. Either by the pill or a condom" (girl 0519).

Others in the group, referred to the risks of pregnancy exclusively and unspecified contraception as the only safe sex procedure:

To have sex with a contraceptive" (boy 0030).

"It just means that you can have sex with a small chance of getting the girl pregnant" (boy 0116).

"To me safe sex means contraception"(girl 0267)

"Using contraception" (girl 0360)

In the focus groups the risk of pregnancy was perceived by many to be far greater than the risk of contracting STDs. In these towns few knew of anyone with AIDS or other STDs but they all knew of young mothers, their disrupted lifestyles and the negative treatment afforded them by their townsfolk. The following interchange between a group of Tasmanian girls was typical of the discussion in many of the focus groups and reflected rationalising, rather than rational decision making about safe sex:

"I don't think AIDS is an issue here though. I don't"

"Being in -----it doesn't feel like an issue"

"It's only getting pregnant"

(girls' discussion group, Tasmania)

The boys were generally well aware of the girls' greater concerns with pregnancy and the tendency to use the contraceptive pill as protection.

Interviewer: Do people of your age who have sex use condoms?

"Yeah"

"No"

"Some do"

"But like girls are on the pill so they don't use condoms"

"I'd use it anyway, just to be safe"

(boys' discussion group, Queensland)

For those who perceive pregnancy to be the major danger of intercourse, and given the problems of negotiation involved in condom use (Albury, 1990), it may be a small step to ignore the risks of STDs and to think of safe sex only in terms of pregnancy. We are not suggesting here that young women always consciously weigh up their options, rather that there are limited ways in which they can position themselves in regard to sexual safety.

Risk 3: The risk of a "sullied reputation"

An added risk, alluded to in every focus group by the young women, concerned reputation. It was clear from our discussions that the loss of a good reputation was a danger which confronted every young woman in the town. However, this risk was never mentioned in the "meaning of safe sex" responses. It may be that this is because "safe sex" campaigning has rendered the word "safe" inaccessible as a descriptor of culturally and socially based, as opposed to biologically based dangers of having sex.

Loss of reputation was an all pervasive concern which meant being labelled as a tart, a moll or a slut. It was easy to gather a bad reputation in a small town where everyone was known and confidentiality and privacy were never assured. A bad reputation meant sexual harassment, loss of friends, feeling dirty, and general alienation. One girl talked about a

friend with a "bad reputation" who had a song made up about her by the boys at her school which they would sing whenever she came by. Several girls said that they got bad reputations from mixing with other girls who had bad reputations so that in effect, the gaining of a bad reputation meant alienation from girlfriends as well as harassment from boys. The effects of this type of harassment on those who had lost their good reputations, as well as the regulating effects on the remainder of the girls who were trying to keep theirs, cannot be underestimated. And this discrimination was directed only at girls. As one young woman in a focus group said:

"They [boys] have a one night stand and nothing happens. We're more in fear of getting labelled like a tart or a slut or something. Whereas the boys if they have it they don't get labelled...and we're more ashamed of it if we do".

(girls' discussion group, Queensland)

The boys were also well aware of the sexual double standard and the risk that girls took when they had sex. However, they were apathetic about it. The risk of a bad reputation was seen to apply only to girls in the same way that pregnancy was perceived to be a danger only for girls. Indeed many boys felt that their reputations would be enhanced by people knowing they were having sex.

"You do it for the feeling and to brag about it afterwards"

(boys' discussion group, Tasmania)

Young women in these small towns were placed in danger of losing friends, family and the opportunity of further relationships when they had sexual intercourse or when it appeared as though they did. The use of a condom gave no protection here and indeed was likely to exacerbate the problem. Young women who had sexual intercourse were forced to choose between a number of competing dangers while at the same time being unequally positioned with their sexual partners in terms of the power to negotiate multiple safeties.

Conclusion

The message of safe sex was learned well by the rural adolescents in this study, and they delivered it, as we might assume it was presented to them, in a fairly impersonal mechanical manner. Condom use was the most often mentioned safe sex strategy, and these young people were aware of the risks of HIV and other STDs which the condom was designed to address. However, the young women in particular, were also faced with other dangers inherent in them having sexual intercourse and the idiosyncratic difficulties involved in attempting to supply and negotiate the use of a condom in a sexual encounter.

Pregnancy, at least as much as STDs, seemed to present a major concern. Many of the group had witnessed the fate of young pregnant women in small country towns, not only in terms of having a child to care for and the life-style changes that involved, but also the strong statement this made in terms of sexual behaviour. Related to this was the pervasive concern, expressed in every discussion group, about the risks facing young women, of people knowing about their sexual activity, the consequential loss of reputation and the harassment and alienation which were likely to accompany this public knowledge. Those who were sexually active ran this risk, unless they were able to keep their activities away from the town gaze. Buying condoms in small towns is a public activity and these young women expressed concern about other people's reactions when they attempted to follow the dominant safe sex prescriptions.

Moreover, there was never an assurance of partner co-operation in condom use. The rational approach to safe sex, which regards safe sex as a choice, overlooks the importance of the context of sexual encounters, and the possibility that what happens in a sexual encounter may not involve two autonomous individuals. Safe sex may in many cases not be a matter of choice. Research on the barriers to safe sex for young Australians living in urban areas of Sydney (Kippax, Crawford, Waldby & Benton, 1990) and Melbourne (Wyn, 1993) has

highlighted the ways in which young people are positioned within relationships, and how this will impinge on their ability to negotiate sexual encounters safely.

The levels of condom use of these rural adolescents compared well with their urban peers (Dunne, et al, 1993). However, it remains true that many (31% at last sexual encounter and 45% sometimes) were not consistently protecting themselves from STDs. It is an argument of this paper that when the condom is construed as the only safe sex option, girls (and some boys for different reasons), given the perceived difficulties of condom use and the multiple perceived dangers of sexual intercourse, may have no obvious ways to position themselves as safe from all risks. This may have contributed to these rural adolescents producing pseudo safe sex methods which they believed would protect them from STDs.

Most of our participants felt secure in their perceptions that they were not personally at risk of contracting HIV and other STDs. They often based this sense of invulnerability on a range of protective beliefs, such as trusting in reputation, appearances, or the quality of the relationship, which were either inappropriate, risky, or, sound in theory but difficult to negotiate in practice. For the same reason that privacy and confidentiality were perceived as difficult for the young people to maintain in small rural towns (Warr & Hillier, 1997), safe sex methods based on informal sexual history taking (facilitated through gossip) were regarded as providing reliable protection from STDs. Just as these young people believed that their behaviours were public knowledge, so they believed that knowledge of the behaviours of others was public and available to them.

Though the official original safe sex campaigns promoted a number of reliable safe sex practices, the range of protective measures has been restricted for young heterosexuals by educational authorities and school communities to that which reflects sexual practices which are regarded as morally acceptable. It was recognised early in safe sex campaigning in the gay community that rather than being seen as restrictive and coercive, safe sex needed to be

seen as an erotic, positive alternative (Watney, 1994). This is in line with Taylor and Lourea (1992) who argued that it is far easier to increase sexual options than to extinguish them. However, this has not happened in safe sex education with young heterosexuals, many of whom find condom use a restrictive and difficult practice.

We are not arguing here that condom use with intercourse should be discouraged as a safe sex strategy, rather, that for young heterosexuals, the strategies should take in a range of ways of being sexual which would address the myriad of dangers which concern them. The contemporary concept of safe sex may have emerged from the gay community, however, the risks and the context of sex are also different for heterosexual youth. Adolescents are faced with the real dangers of contracting STDs, but they also perceive other dangers, which, if not addressed in the total safe sex package, may result in practices which are STD risky, but pregnancy and reputation safe.

A more holistic approach which recognises all the perceived risks, promotes a range of safe sex practices and situates safe sex within the context of these young people's lives is needed. This may mean, as Singer (1993) has suggested, redefining other types of sexual activity as sex (and safe or not safe) in the same way that the six adolescents in the study did. Sex for pleasure may need to sit alongside sex for reproduction as a valid reason for engaging in sex for we suspect that the number of the young people in our sample who were having sex in order to reproduce may have been negligible.

In conclusion, there are many reasons why safe sex promotion for young heterosexuals has evolved in the way that it has. Some of these relate to its contemporary origins in the gay community, while others relate to educational communities and their concerns about what is appropriate subject matter for teaching in schools. Teaching safe sex is a risky enterprise, and even the *safe sex equals condom* message has been criticised by some in the community as inappropriate subject matter for the school curriculum. Though the participants in our study

knew the message well, up to forty-five percent of the sexually active group were, for whatever reason, unable to adequately protect themselves with condoms and this left them at risk of contracting STDs. From our data, we have suggested many reasons for this, including the special difficulties of using condoms, the added risks of sexual intercourse facing young heterosexuals and inappropriate methods of protection against STDs. Safe sex education must address the range of concerns which motivate young people in their sexual activities, and it must also provide them with more ways of being safe. This may be part of the challenge for safe sex education for the future.

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Tables

Table 1. Number, percentage, average age in years and months, and gender of students.

	<i>seniors</i>	<i>age in yrs & mths</i>
<i>males</i>	203 40%	15yrs 7mths
<i>females</i>	308 60%	15yrs 7mths
<i>total /average</i>	511	15yrs 7mths

Table 2. Responses, by gender, to the question *For those young people who use condoms when having sex, who do you think mostly suggests using them?*

	<i>boys do</i>	<i>girls do</i>	<i>both do</i>	<i>don't know</i>
<i>males</i>	7 3.6%	45 23%	112 57%	32 16%
<i>females</i>	7 2.3%	118 38.6%	128 41%	53 17.3%
<i>total \bar{n} and %</i>	14 2.8%	163 32.5%	240 47.8%	85 16.9%