‘When you come to it you feel like a dork asking a guy to put a condom on’: is sex education addressing young people’s understandings of risk?

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Traditionally, school-based sex education has provided information-based programmes, with the assumption that young people make rational decisions with regard to the use of condoms. However, these programmes fail to take into account contextual issues and developing subjectivities. This paper presents the talk of 42 young people from a New Zealand secondary school who were questioned in-depth about the sex education programme they had received. They discussed a programme that concentrated on the ‘dangers’ and ‘risks’ of sexual intercourse and that failed to enhance negotiation skills or take into account the contexts in which sex occurred for many young people. Although participants were well aware of the public health discourses of the importance of condom use, the implications of putting these discourses into practice held the potential for ‘risks’ of a greater magnitude in the reality of their everyday life. The ‘risk’ to reputation and subjectivity overrode any ‘risks’ that may have occurred through non-use of condoms. This highlights the need for sex education programmes to put greater effort into developing skills of assertiveness, communication and empowerment.

Introduction

Sexually transmitted infections (STIs) are a common public health problem with serious health consequences for thousands of children and adults. More than one-half of all young people in western countries aged 15–19 years have had sexual intercourse (Dickson et al., 1993; Moore & Rosenthal, 1993; Grimley & Lee, 1997). Both unplanned pregnancy and STIs occur at increased rates among this age group compared with other age groups because they are the segment of the population most likely to have multiple partners and less likely to prevent or recognise STIs (Helweg-Larsen & Collins, 1994; Grimley & Lee, 1997; Vermillion et al., 2000).

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The only contraceptive option for sexually active young people who also wish to minimise the risk of acquiring an STI is the consistent use of condoms. Unfortunately, however, condoms are not used consistently by young people (Dickson et al., 1993; Moore & Rosenthal, 1993; Coggan et al., 1997).

Increasing knowledge and skills is a function of most school sexual health programmes, yet this has been shown to have little, if any, effect on negative health outcomes (Gevelber & Biro, 1999; Franklin & Corcoran, 2000; DiCenso et al., 2002). Indeed, randomised control trials assessing the effectiveness of primary prevention strategies within schools have found that overall they were not successful in delaying sexual initiation, nor was contraceptive use improved, nor the number of pregnancies reduced (DiCenso et al., 2002; Wight et al., 2002). Safer sexual outcomes are, thus, it seems not enhanced by the provision of information alone (Abraham et al., 1991; Mellanby et al., 1992; Helweg-Larsen & Collins, 1994).

Theoretically, the provision of information in sex education would provide individuals with the means to make a decision as to whether to practise safe sex or not. Social Cognitive Theory (SCT) proposes that people’s actions are informed by their perceptions of social reality and that behavioural intentions will change with changes in social cognitions, which include beliefs, attitudes, self-efficacy and perceptions of social norms (Willig, 1999). Sexual health programmes, which use SCT to inform them, aim to change these cognitions through the provision of information. The model however, has received limited empirical support (Willig, 1999). It is mostly limited by the fact that its comprehensiveness and complexity make it difficult to utilise, with many studies using SCT focusing on one or two constructs, such as self-efficacy, while ignoring others (Perry et al., 1990; Basen-Engquist & Parcel, 1992; University of South Florida, 1998; Shrier et al., 1999).

Another model, the Theory of Reasoned Action (TRA), proposes that the immediate determinant of health-related behaviour is the individual’s intention to perform it (Fishbein et al., 1991). Young people may indeed articulate an intention to use condoms when they have sexual intercourse. However, as one Australian study found, intentions are not always predictive of behaviour, with one-half of participants in that study reporting that intentions to use condoms were not always carried out in practice (Moore et al., 1996). Non-use of condoms, despite good intentions to use, was reportedly due to either substance use, being carried away by passion, trusting that their partner was safe or simply because their partner had not wished to use a condom. In the last case, the authors pointed out that the decision to use a condom was subject to the agreement of both sexual partners at the time of the sexual encounter and thus cannot be fully predetermined.

Rather than the rational, linear decision-making suggested by SCT, TRA and other behavioural change models, the context of the situation and the nature of the relationship plays an important part in the ability of young people to negotiate protected sex (Aggleton et al., 1998). ‘Heat of the moment’ occasions when condoms are not thought of and sex is unexpected are not taken into account by such models (Bosompra, 2001). The unexpected or opportunistic nature of adolescent sexual intercourse is an aspect of their relationships that requires special
attention. Thomson and Holland (1998) argued that if achieving safer sex was merely a process of rational decision-making, negotiating skills would improve with experience. However, their research suggested that the ability of young people to negotiate safer sex was conditional on the individual encounter or relationship, and that successful negotiation on condom use within one relationship did not imply that, within subsequent relationships, negotiations would be successful. Health promotion discourses may be adopted at some times and not others, in a continuing cycle, with discourse taken up and integrated into self-identity that is partially contingent on shifts in individuals’ social circumstances (Lupton, 1997).

Many individuals adopt, or try to adopt, the imperatives of health promotion, yet many others resist advised strategies (Lupton, 1997). How people negotiate the imperatives of public health and health promotion can be understood, as Lupton would argue, through a concept termed ‘subjectivity’, or sense of self. Subjectivities are changeable and context dependent (Lupton, 1997). While many people articulate socially acceptable views on achieving good health according to dominant public health discourses, in reality the practical difficulties of operationalising such ideologies in everyday life is far more complex (Lupton, 1997). Lupton states that resistance to public health imperatives may arise from a conscious will, where adoption of the imperative is seen as not fitting the self; an unconscious or emotional level, where desire, fear and pleasure are suppressed; or at a non-conscious level, where bodily practices are adopted and reproduced as part of the habits of everyday life (p. 156).

Clearly the nature of the link between formal sexuality education and adoption of its messages is complex, and not to be understood by quantitative measures alone. The challenge therefore is to develop a richer conceptualisation and methodology of evaluation that enables examination of the ways the messages of formal sexuality teaching are received, resisted or reworked in adolescent experience. Although there has been considerable growth in the social study of children and young people (Backett-Milburne *et al.*, 2003), there is still a limited research base that focuses on young people as active agents who negotiate health-relevant behaviours in their everyday lives and in the construction of their subjectivities (Mayall, 1994). How relevant is sex education based on linear behavioural change models to young people as they develop subjectivities, a sense of self? This article explores how school-based sexual health education is received by adolescents in one school in New Zealand. It examines what young people find relevant and lacking in their sex education, and how relevant sex education is to their experiences of negotiating sexuality.

**Method**

This study explored young people’s attitude to sex education. Prior to 2001, sex education in New Zealand was provided in schools as set out by the health, physical education and home economic syllabuses. The Health and Physical Education in the New Zealand Curriculum succeeded these syllabuses and is based on the ideals of the Ottawa Charter, which attempts to examine sexuality through a socio-ecological
perspective (Ministry of Education, 1999). The syllabus utilises many aspects of behavioural change models, including the development of knowledge and skills in areas such as communication and decision-making. It is compulsory until year 10 (second year of secondary school) when students are aged 14–15 years. Although this new syllabus had not been implemented in New Zealand when interviewing began in this study, the study school had undertaken to begin early implementation. The curriculum does, however, cover seven key areas of learning, of which sexuality education is only one. The amount of time spent on sex education equates thus to only a few lessons per year. The curriculum also provides only a guideline for teachers with much scope for variation in content taught.

The study was conducted at a Christchurch co-educational secondary school with a decile ranking of eight. Schools in New Zealand are given a decile ranking of between 1 and 10 based on the socio-economic decile ratings of the areas from which the school draws its students. The school decile ratings run opposite to area decile ratings, in that 1 denotes a school catering for young people from low socio-economic areas and a decile rating of 10 is given to a school zoned for predominantly high socio-economic areas. Although the study school had a fairly high decile rating, it drew its students from a zoned area encompassing wide-ranging socio-economic residential areas.

The study used a three-and-a-half-year qualitative cohort, with a small quantitative component consisting of a short questionnaire administered to all students in year 10 (age range 14–15 years). The main purpose of this survey was to perform a social network analysis, which has been reported in other papers (Abel et al., 2002; Abel & Plumridge, 2004).1 Forty-four students were randomly selected from all year 10 students to participate in the prospective, qualitative component of the study. Information sheets were mailed to the parents of selected participants and their written consent was sought for students’ participation. When refusals were received from selected participants, substitutes were randomly selected until a cohort of 42 was obtained (21 boys and 21 girls).

This cohort study consisted of an initial phase of focus group discussions followed by in-depth individual interviews yearly over a three-year period from 1999 to 2001. At the start of the study, the interview team consisted of four experienced interviewers; one male and three females. The male interviewer conducted most of the interviews with males in the first round of interviewing. In subsequent rounds of interviewing, one of the female interviewers (the second author) conducted all interviews as she was able to build a greater rapport with all participants, both male and female, thus enhancing the quality of the data produced. Interviewing took place in private and in most cases on the school premises during school hours. At the start of the study nine of the 42 students were sexually active (21%), and by the end of interviewing three years later, when they were aged 16–17 years, 25 were sexually active (60%). The interview schedule included questions on school, social groups, smoking, alcohol and drug use, sexual activity and aspirations for the future. Each interview lasted for approximately one hour and was recorded and fully transcribed.
This paper is a qualitative descriptive one, reporting on data collected during the in-depth interviews, and focuses on participants’ reception of school-based sex education messages. Passages relating to talk on sexual education were identified from the transcripts and various themes within the talk identified. These themes included the content of the programme delivered by the school, how messages were received by the students, and what the programme lacked. The transcripts were coded according to these themes and a thematic analysis was undertaken. This involved exploring students’ talk within the themes looking for differences and commonalities, as well as exploring any gender differences. Names have been changed to protect confidentiality.

Results

The participants’ talk about sex education elicited three main themes: the content of the programme delivered by the school, the way in which this content was received, and issues that were not covered by the programme but which the participants indicated would have been beneficial.

Content of the programme delivered by the school

One of the main themes to come out of participants’ talk about sex education was their description of the content of the sex education programme they received. They described how the sex education received at school was focused on the negative aspects of sex. All participants reported that they were told mainly about ‘… just dangers and stuff’ (Karen) and ‘… the risks … of unwanted pregnancy and all that sort of stuff … and the diseases and STDs and that’ (Steve).

Although all claimed to have been told about STIs, none of the participants were able to articulate specific knowledge about STIs. Ann described learning about ‘diseases’: ‘… we’ve just had like about um diseases and always use a condom … all that kind of stuff … about what you can catch’. Dean, who was sexually active from early adolescence and confessed to seldom using condoms, was unable to provide any detailed information about STIs and did not acknowledge any vulnerability to acquiring one:

Dean: … like we talked about diseases and stuff.
Interviewer: Do you ever think about those diseases, do you ever think oh no I could get, I don’t know, syphilis or AIDS or …
Dean: Nah, nah. I’ve never heard of that before, that syphilis.

Although participants acknowledged the possibility of diseases transmitted through unprotected sexual intercourse, this was not personalised. Pregnancy remained a higher priority in terms of ‘risk’, possibly because this was a ‘risk’ more commonly observed and spoken about within the peer group. Many participants, both male and female, spoke about class mates who had had to leave school because of pregnancy: ‘… like there’s about 4 girls that have left school already this year … just from getting pregnant’ (Pamela). Few acknowledged that they knew of peers who had acquired
an STI. This lack of identification of people with STIs within their particular peer groups, the perceived ease of treatment and the fact that, unlike pregnancy, STIs are often not an observable phenomenon, may have encouraged a sense of invulnerability.

When prompted to discuss the most important message to come out of their sex education classes, most participants described a theme that sex should occur in a monogamous, heterosexual, ‘committed relationship’ and that sexual initiation should be delayed until this ideal relationship was achieved. This ideal relationship carried with it the connotations of ‘safety’. However, if sex did happen outside a relationship, they were advised to ensure that they had safe sex.

Yeah they’re probably saying hold off and … probably a bit of both … hold off and take … but if you’re going to, take care and … take all the precautions. (Steve)

The reality, however, was that although most participants expressed a wish for first sex to happen within such a committed relationship, the majority had their first sexual encounter in a casual, one-off encounter, which often carried with it later regrets, especially for boys.

John: Yeah, ended up that, and I kind of regret who I did it with. I don’t regret that I did it. I regret who I did it with. I don’t regret at all the age I did it at, it was just who I did it with.

Interviewer: Yeah.

John: I would have preferred to have waited for someone else, but I mean since then it’s […] since I’ve lost it who cares.

All of the participants identified themselves as being heterosexual and so no issues of dealing with identifying as homosexual or lesbian were brought up. The topic of homosexuality was covered very briefly within the syllabus—although not strategies of dealing with personal sexual orientations, but within a ‘risk’ discourse of HIV/AIDS.

… like we had … like I think it was yesterday or the day before we had two like … two guys come in and they were gay and … not together … but um they were like … one of them had … one of them was HIV positive and the other one was just … the other one was alright … and they were just talking to us about AIDS and you know … homosexuals and stuff like that … so we had a big talk about that … and we were asking questions and stuff about you know their lives and stuff. (Richard)

In addition to the ‘risk’ discourse, school sex education imparted information on the reproductive system. Participants reported that they learnt ‘Oh just about the body … just talking about like the body … just about the parts of the body and stuff’ (Peter). The salience of this exercise, and the repetitiveness with which it was delivered year after year, was not appreciated by participants.

How messages were received by students

Many participants felt that the programme did deliver some interesting and useful information: ‘… that’s always good to know … like all the safe things and stuff’ (Richard) and ‘… like … I’ve found out about the … like the good things and the bad things about some of the contraceptions … like the pill and those … all the other
things … yeah’ (Lynn). However, despite this, the programme was acknowledged by
many as being boring and repetitive, and was not valued. Vivien claimed that they
‘know all of it … because we already did it last year and the years before … because
it’s like … we haven’t really done anything interesting yet.’ Peter felt that he’d heard
it all from his mother and added that ‘… usually I just go to sleep during Health’.

Young people who were not sexually active had difficulty relating the relevance of
the information to their situation, and were unsure as to whether they would use this
information in the future when they did become sexually active.

Um … I mean … it hasn’t really been useful yet … it … I suppose it will be … can
imagine it will be … I can’t … cos didn’t know much … like at the start of the year or
last year or anything like that … so it’s been quite helpful. (Andrew)

Participants identified a number of areas that the sex education programme failed to
address adequately and that they considered of relevance to them. The content of
the sex education really had no place in their realities for many sexually active
participants.

Interviewer: So having had it [sex education], did you feel it wasn’t really that useful?
Ann: Ummm, I don’t really know … ‘cos like they just go um … ‘Don’t have
sex until you’re ready rah rah rah’ and then they just go ‘This is how you
put a condom on’ [laugh] and then … it’s just … it’s just you know you
don’t really think about it … like when you’re having sex you don’t really
think about ‘Hey what did they say in sex ed ehrehreh’ you just … I
never actually thought of that.

Ann’s quote highlights what many of the sexually active participants described
about sex education being of little relevance in the realities of their sexual experiences.
The sex education described sex as negotiated within committed relationships, which
in most cases among this cohort was far from the reality of their experiences.

What the programme lacked

Improvement of negotiating skills. Some participants discussed how their sex
education programme lacked details of specific sexual negotiating skills, strategies
and techniques. Many participants described the need to talk with a sexual partner
prior to engaging in sex in order to ascertain whether they had an STI or not:

Vivien: Like so that you ask them first … about them as a person.
Interviewer: Pardon.
Vivien: So that you ask them first and you’d like know if they have [indistinct].
Interviewer: If they have what?
Vivien: Got STDs or something.

Vivien’s discussion highlighted a common theme among participants about
communicating with a sexual partner. They indicated a need to talk to the sexual
partner prior to engaging in sex, and they implied a degree of trust in what the
prospective sexual partner communicated with regard to their sexual history. On all
occasions, they based assumptions on the safety of partners on appearances, if they
bathed on a regular basis: ‘... you just know her, and she's always like clean, and she's always having showers at everybody's house’ (Robert); how many previous relationships the person had had: ‘well, I wouldn't have sex with someone that I know has had sex heaps’ (Dean); and what their friends had told them about the prospective partner. Many participants felt that communicating with sexual partners was a difficult task in itself, let alone enquiring about their previous sexual history. Communication with sexual partners is especially difficult for young people when entering a new relationship. No techniques for communication or role-plays about how to talk to sexual partners were entered into in the school’s sex education programme.

Steve talked about the lack of information in the sex education programme on how to negotiate with girls in a way that would mean he was not shown up to be socially inadequate:

Interviewer: ... I mean, do they talk about relationships and how to meet ... you know, how to negotiate things with girls and ...
Steve: Well I haven't had that yet.
Interviewer: Do you think that would be useful to have.
Steve: Yeah, it would be so ... don’t make a dick of yourself [laugh].
Interviewer: Yeah, do you think that’s hard for people?
Steve: To ... what ...
Interviewer: To start.
Steve: Yeah, it is.

Steve reports what many sexually active male participants felt. They discussed how they would like more information, skills and techniques on how to negotiate sexual relationships, including the use of condoms.

Female participants also discussed how they lacked negotiation skills around sexual relationships, including safer sex and the use of a condom. Yet understandings of safer sex were complicated by dominant understandings about sexual ‘reputation’. For some female participants non-communication about the use of condoms with new partners enabled a discourse of unexpected sex, which allowed young women to have sex with new partners without imparting a sexually ‘promiscuous’ connotation. Discussions about condoms prior to sex would imply a ‘planned thing’. Most female participants reported their first sexual encounters with new partners as something that ‘just happened’.

It's going to sound really dumb saying it just happened, but [...] it just did. It wasn’t like both of us weren’t really thinking about that, I don’t think. (Bronwyn)

Um it just happened. I didn’t want to have like a planned thing. I thought I’d be more scared by a planned thing than a non-planned thing, so. (Lynn)

Bronwyn’s and Lynn’s discussions of their first sexual experiences show the socially induced tensions between having knowledge of safer sex practices and establishing a heterosexual female subjectivity that was not promiscuous. Such contradictions and dilemmas for young women were not explored in the sex education syllabus.

Alcohol consumption and sex. The fact that sex occurred many times when students were drunk also presented problems for their use of condoms. Although participants
reported that they had been told of the dangers of drinking with regards to the practice of safe sex, drinking was very much part of most young people’s social life and was one of the main vehicles for doing a viable ‘cool’ adolescence (Abel & Plumridge, 2004). Richard intimated that it was probably good to ‘know about’ the risk of having unprotected sex if you consume too much alcohol but ultimately it remained a personal ‘choice’ as to whether the knowledge was utilised.

... some people like get drunk and stuff but ... do stupid things ... but I don’t know ... they’re [school sex education] just trying to give you a bit of information for in ... like in the future ... so you know ... so they are at least telling you ... you know ... to be careful but if you ... it’s your choice if you want to do something stupid or ... you know at least you know about it. (Richard)

Ann exercised her choice when she was drunk by not using condoms even though she acknowledged that she was aware of what she was doing.

Yeah I’ve had sex with a condom yeah ... and so ... I don’t know why ... ’cos when I was drunk ... I suppose I knew what I was doing but I was too, you know, I just couldn’t be bothered ... and going [indistinct] you know and then ... but I suppose that that sounds really dumb ... but like what I thought ... but nothing has happened ... I’m fine, thankfully but next time you know ... I’m never ever going to do it again ... but like when you’re straight it’s like easy to you know make sure you get what you want ... you know like ‘put a condom on’ rah rah rah you know?

The difficulty of practising safer sex when in the social and cultural context of being intoxicated and attempting to establish a superior adolescent subjectivity is an area that did need greater attention. Both Richard and Ann understood this difficulty as a ‘choice’, and that the ‘choice’ to be a drunk and carefree young person overrode the ‘choice’ to negotiate safer sex.

**Practical applications.** Delivery on the practicalities of performing safe sex was minimal; confined to how to put a condom on, ‘... and the guys had ... the guys said that they had to put condoms ... condoms on cucumbers’ (Vivien), and how to say no when being pressured, but provided no method of how this would actually be achieved.

**Interviewer:** Oh yeah ... what sorts of things about relationships?

**Peter:** Oh just how you act and ... that you don’t have to be pressured into having sex and just stuff like that.

**Interviewer:** Oh yeah.

**Peter:** Yeah.

**Interviewer:** And so do they do ... sort of how do they ... how do they put that across?

**Peter:** Oh I don’t know ... they just ... they just tell you that if you don’t want to do it ... you know ... you don’t have to ... and they talk about like all contraception and stuff like that.

Although contraception was covered in the programme, some participants felt that details on where to obtain the different forms of contraception and the side effects of emergency contraception were lacking:

... like the morning after pill and like how it actually works ... ’cos the first time I had the morning after pill I didn’t know how ... what it did to you and now I know you get your period again ... and I never knew that ... I had never known. (Ann)
Richard felt that not enough of the programme was relevant to males and the problems that they had. He also felt that too much of the programme was taught by people who were not experts in the field:

... I don’t know ... just get an expert in ... cos we didn’t have an expert ... like they had a nurse ... a proper nurse ... we just had like um Mr Smith the counsellor guy ... and some other just normal teacher ... I reckon they should get a ... like a ... ah I don’t know ... someone that knows a lot about it so we can ask him all the real ... like difficult questions ... like some of the teachers can’t under ... like answer them ... like to do with all STDs and stuff like that. (Richard)

The practicalities of how to introduce a condom into the sex act were not covered and presented some difficulties to the sexually active participants. For females this was expressed by a form of embarrassment, with the possibility of being found socially inept by the sexual partner posing far more of a ‘risk’ than having unprotected sex.

Ann: And you always forget to take it [the contraceptive pill] and then you’re out of tablets, ‘Oh, shoo, I forgot to take it’. And then you feel you feel like a bit […] when you come to it you feel like a dork asking a guy to put a condom on. Unless you really know him and you’re comfortable with going, ‘Hey, dick, put a condom on’, it’s so unfair, you know.

Interviewer: Right.
Ann: Cause I used to ask and feel like a geek, but um […] yes.
Interviewer: So why do you feel like a dick?
Ann: Oh, you just do, cause um you know, cause […] I don’t know.
Interviewer: What, you feel embarrassed or [...]?
Ann: Not really embarrassed but just if […] I don’t know, it’s […] that’s what you feel. You just feel weird to say, ‘Can you put one on?’ You’re just like [...] I don’t know.

Male participants also discussed how the practicalities of when to introduce a condom into sexual activity was not covered by their sex education classes. Robert expressed concern over when the condom should be introduced, stating that this was something that was not covered by the syllabus and was of most concern to him. His primary concern was that negotiation over the condom would cause his erection to ‘die away’, to become impotent, creating a situation for him in which he would feel sexually inadequate. The resultant shame was thought to pose a greater ‘risk’ to him than unprotected sex.

Robert: I mean the guy knows that he’s going to do it. He’ll put it on before they actually get there.
Interviewer: Yeah.
Robert: Like, the girl, like, I think most of the girls really don’t know when to tell the guy when to put on the condom.
Interviewer: Yeah, don’t you learn about that in classes and that?
Robert: Hmm, no.
Interviewer: No?
Robert: We learn all the dangers and stuff about sex but we don’t yeah.
Interviewer: How to stuff.
Robert: Yeah like like like when you actually go […] like when to tell them to do this and like when is the right time to do that.
For many male participants such as Robert, using a condom threatened their potential to establish a credible male heterosexual subjectivity, which involved being sexually potent. This threat to their performance of masculinity was too important to risk by using a condom when one did not have the skills to apply the condom in a successful, sexually potent manner.

**Discussion**

The content of the sexual education programme provided by the school was information-based, assuming a rational, linear approach to safe sex practices. This notion of individual rationality emphasises the individual taking a safe sex approach provided he or she has adequate knowledge and perceives sufficient threat (Ingham & Kirkland, 1997). There is, however, increasing evidence that this assumption is flawed (Mellanby et al., 1992; Gevelber & Biro 1999; Franklin & Corcoran, 2000; Mitchell & Smith, 2000; DiCenso et al., 2002). Alternatives to penetrative intercourse, such as mutual masturbation or oral sex, were not options covered by the programme and there was an exclusion of a discourse of desire. Fine (1992) argues for a genuine discourse of desire, especially for females, within school sex education, which ‘would invite adolescents to explore what feels good or bad, desirable and undesirable, grounded in experiences, needs and limits’ (p. 35). Discussions of feelings and emotions were notably absent from the programme.

Participants generally found the content of the sex education boring and repetitive, and this was most probably due to the programme having little place in the realities of their personal lives. There was little relevant guidance about relationships. In many cases, sex occurred outside of the romantic, relationship sex promulgated by the programme. The students in turn articulated a number of aspects that they would have found helpful but that the programme neglected to cover. The programme made some attempt to deliver a negotiated approach, attempting to encourage participants to feel comfortable with refusing sex if they felt pressured. However, ways of increasing assertiveness and communication skills were not covered. Wight et al. (1998) point out that although encouragement of talk between partners of their sexual histories is encouraged by health promotion strategies, this exercise can often be counter-productive as talk on intimate matters is likely to culminate in intimacy, which in turn engenders trust that may increase risk-taking. Rather, they advocate the development of communication skills and the
ability to reflect on the ways in which sexual interactions are shaped, which will better equip young people for sexual negotiation and result in reduced risk-taking.

Although participants were told of the risks of drinking alcohol and having sex, the messages were not valued. Many studies have recorded a decreased likelihood of condom use while under the influence of alcohol or other substances (Fergusson & Lynskey, 1996; Hingson et al., 1990; Poulin & Graham, 2001). Within young people’s social lives, alcohol plays a key role in oiling the wheels of sociability (Abel & Plumridge, 2004). How far young people in this study deviated from the normal ‘rules’ of sober behaviour varied, depending on location within the social network, with a great deal of variation in what was considered acceptable behaviour (Abel & Plumridge, 2004). However, universally among these participants, alcohol became an excuse in that blame was not attached to individuals who had sex without a condom while drunk, and hence reputations remained untarnished.

As reported elsewhere (Lupton, 1997; Donovan, 2000), it was apparent from this study that young people do develop a ‘lay epidemiological’ response to negative sexual outcomes within their personal networks. All participants in this study had observed female peers leaving school due to pregnancy and this remained of greater concern than the acquisition of a STI, a phenomenon not readily observable in their networks. Although few participants reported using the contraceptive pill on a regular basis, there was much talk among participants about the use of the morning after pill as a method of safe sex in lieu of condom use.

The risk posed by information-giving, rationalistic approaches to sex education is that they pay insufficient attention to the social contexts in which risk-taking behaviour occurs, nor to mounting evidence that few young people place their first sexual experiences within a public health or medical discourse (Ingham & Kirkland, 1997). The context of the situation is very often responsible for whether a condom is used or not, with circumstances of individual sexual encounters and relationships determining actions (Thomson & Holland, 1998). The context for sex, according to the sex education programme provided, was within a long-term relationship and a certain amount of sexual safety was assumed by this, removing the need for precautionary measures (Willig, 1999). Within this romantic discourse of sex, negotiation over the use of a condom raises a number of problems, which were clearly articulated by participants in this study. Talking about condoms with a sexual partner held the potential of introducing some awkwardness to the situation and it acted as an interruption to the natural flow of sexual desire (Willig, 1999). Interrupting the flow posed a serious ‘risk’ to sexual identity in the case of some boys through not delivering a credible performance of masculinity by erection, penetration and ejaculation. Talking about contraception is also seen as a premeditated intention to have sexual intercourse (Coleman & Ingham, 1999); planning for sex holds the adverse ‘risk’ to sexual identity for young women through gaining the reputation of being a ‘slut’. Similar to many other studies (Lees, 1993; Lear, 1997; Thomson that Holland, 1998), the young women in this study thus reported sex as something which ‘just happened’ to them, a circumstance that, in some cases, obviated any responsibility for negotiating condom use. Rational
decision-making as envisaged by sex education programmes is thus compromised, where ‘risks’ are seen very differently within young people’s framework of meaning.

All the young people in this study were well versed in the health promotion discourses of safe sex. Yet the imperatives of these discourses were resisted on many occasions when they were not compatible with a desired sexual identity. Educators can gain greater understanding of sexual subjectivities through reconstructing schooling as an empowering context in which the meanings and experiences of gender and sexuality revealed by the adolescents themselves are heard (Fine, 1992). Developing sexuality education messages that recognise the diversity and complexity of young people’s sexual selves could provide a more sophisticated approach to health promotion (Allen, 2003). We acknowledge that this is not an easy task, as programmes would need to broaden to cover students’ diverse meanings and experiences of gender and sexuality. Reconstructing schooling as an empowering context would involve not only curriculum development, but also a broader examination of school organisation and pedagogic practice (Markham & Aveyard, 2003). These are challenging but necessary tasks to promote young people’s sexual health in school-based sexuality education programmes, and warrant further investigation.

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Notes

1. Information was collected on friendship links within the year group, and the software package, Negopy, was used to assign group membership to students. This provided context to the qualitative analyses. The social network data have not been drawn on in this paper.
2. Discussion centred around use of the male condom as, in the New Zealand context, the female condom is not readily available from youth health centres. Young people are also not as aware of this option.

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