Boys and Young Men: ‘Half of the Solution’ to the Issue of Teenage Pregnancy – a Literature Review

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The first step is to put the needs of boys and young men firmly on the agenda of the local teenage pregnancy/sexual health partnership. (Teenage Pregnancy Unit 2000c, p. 7)

Britain has the highest teenage pregnancy rate in Europe. The British Government is determined to tackle this issue because teenage pregnancy is associated with difficulties for the mother and her children. The aims of the Teenage Pregnancy Strategy are to halve the conception rate among under 18s by 2010 and to get more teenage parents into education, training or employment (Social Exclusion Unit 1999). The second aim has been clarified as the ‘aspiration … that 60 per cent of teenage mothers will be in learning or employment by 2010’ (Department of Health et al. 2002).

Until the publication of the Teenage Pregnancy Strategy the focus was almost entirely on young women and their children. Now some attention shifts towards boys and young men. The Teenage Pregnancy Report has identified young men as ‘half of the solution’ and aims to tackle ‘previously overlooked’ young men by providing them “with information about the consequences of sex and fatherhood, including the financial responsibility to support their children” (Social Exclusion Unit 1999). This insight is not a new one. Furstenberg et al. (1987) express one conclusion emerging from their research on (American) teens as following:

“The problem of teenage parenthood cannot be solved by simply directing services exclusively to females. Indeed, our failure to address the marginal position of males in disadvantaged communities may contribute to the perpetuation of teenage parenting.” (Furstenberg et al. 1987, p. 153)

The need to include boys and young men in strategies preparing young people to live in an increasingly sexualised society has been acknowledged in the UNICEF report (2001). However, whether boys and young men in Britain hold different motivations, for example to engage in sexual intercourse or to abstain, and need access to different means of advice and contraception compared with girls has not been adequately addressed.

Gaining an understanding of teenage pregnancy and of how boys and young men are envisaged to become half of the solution in achieving a sharp decline of teenage conception from reviewing the literature, is hindered by gender-neutral language of aims and objectives and of gender-neutral representation of research findings. For example, Pamela Gillies begins the foreword of a literature review with “Teenage pregnancy can be associated with adverse social and health outcomes for the young parents themselves and their children” (Meyrick and Swann 1998). Yet it is unlikely that young men suffer the same kind of adverse health outcomes as young women do, and the extent of social disadvantages associated with teenage pregnancy depends on the level of involvement. There even may be advantages for young men. Most of the guidance published by or in co-operation with the Teenage Pregnancy Unit uses gender neutral language (Teenage Pregnancy Unit 2000a; b; Department for Education and Employment 2001; Teenage Pregnancy Unit 2001a; b). The National Strategy of Sexual Health and HIV (Department of Health 2001) has been criticised by the Men’s Health Forum for not making explicit the different needs of men and women (Men’s Health Forum 2001). However, this is in
part counter-balanced by the guidance addressing the problem of how to reach boys and young men (Teenage Pregnancy Unit 2000c).

Research on teenage pregnancy has, in some cases, not taken into account young men altogether. For example, a report published by the Alan Guttmacher Institute (Darroch and Singh 1999) attempting to answer the question why US teenage pregnancy is declining is entirely based on data of the sexual behaviour of young women. Similarly, a review of data from Europe focuses on young women (Kane and Wellings 1999). An Ofsted (2002) investigation, in response to a recommendation to look at how Sex and Relationship Education (SRE) worked for boys and young men and girls and young women, omits any real discussion of differences. Two reviews of mostly American studies do not provide much insight into gender differences regarding male and female behaviour, nor do they highlight differences of effectiveness of school-based programmes on males and females (Kirby et al. 1994; Kirby 2001a). A review of two reviews of published studies examining the effects of sex education on young people’s sexual behaviour (Grunseit and Aggleton 1998) refers only to young people, ignoring any possible differences between young men and women.

**Context of the literature review and overview**

This literature review was written in support of the research project ‘working with boys and young men’, funded by NHS Northern and Yorkshire Regional Office, which aims to further understanding and knowledge around the variety of approaches and models used by workers to engage boys and young men around issues of sexual health and sexuality. It was written in a time of change, where all over the country new projects targeting boys and young men are emerging, and information about more established projects became available.

The strong link of the research questions to the policy framework of the Teenage Pregnancy Strategy and its aim to reduce teenage conceptions leads to a focus on heterosexual boys and young men. To some extent, this is unfortunate because it renders homosexual boys and young men invisible, and ignores bi-sexual young people. This is not our intention, but reflects the content of literature on teenage conception and pregnancy, and the need to limit this literature review to a manageable size.

Another effect of the purpose of this literature review is that it covers a wide age group of boys and young men. In order to understand how boys and young men can be half of the solution we need to gain an insight into issues surrounding puberty, sexual practices, knowledge and experience of fatherhood.

Much of the research on teenage pregnancy and effectiveness of sex education programmes comes from the United States of America. This presents a potential problem because findings of boys’ and young men’s behaviour in one cultural, social and political context cannot easily be transferred to another cultural, social and political context. Additionally, a description of this context is often missing in the literature. It is not only a problem of comparing nation state data, but also endemic in research based in one country. Young people’s experiences vary according in which region they live. For
example, living in London may be very different to living in a rural community in the Northeast of England. One of the reflections of regional difference are diverse teenage conception rates across England (Social Exclusion Unit 1999). In this research review an attempt has been made to identify where research has not taken place in England. It is an invitation to the reader to remain cautious in viewing problems and possible solutions as easily transferable from one cultural, social and political context to another.

A review of literature on boy’s and young men’s sexual behaviour and knowledge has to be aware of methodological challenges regarding the sensitivity of data and the gendered context in which data is created. Male and female respondents may have good reasons to exacerbate or under-report certain behaviour or certain knowledge.

This literature review begins with a brief description of theoretical approaches to sexuality. This will be useful to locate explanations of boys’ and young men’s behaviour and resulting approaches to sex education. It is followed by a section that looks at what boys and young men know about sex and sexuality and at their (sexual) behaviour. It includes exploring boys’ experience of puberty, first sex, risk-taking and fatherhood. The third section examines approaches taken to influence and/or support boys and young men. It looks at the possible content of sex education, who should receive sex education and who should deliver it. The literature review ends with a short section on findings to date and methodological implications.

**Sexuality**

If boys and young men are “half of the solution” to the issues raised by teenage pregnancy, we need to understand boys’ and young men’s sexual development and behaviour, their attitudes, and how they relate to girls and young women as well as to each other, and the meaning they attach to fatherhood. Biologists, psychologists and sociologists have looked at these facets of boys’ and young men’s experience. None of these take place in a vacuum and explanations for human sexual behaviour are conflicting. At the heart of the controversy over the nature of human sexual expression lies the debate about the extent to which our sexuality is biologically determined and about the extent to which it is determined by social processes. Ideologies of sexualities have been viewing sexuality as a fixed essence of individuals located within the individual (Padgug 1999). This essentialist perspective views sexuality as an instinct or drive which ‘naturally’ is fulfilled by heterosexual vaginal intercourse (Richardson 1997). Social constructionist approaches, by contrast, are perhaps more difficult because they seem to go against the ‘common-sense’ understanding of sexuality as a physical phenomenon. How we make sense of our sexual experience in our physical bodies depends on the culture in which we live and the current discourses. The sociological approach to sexuality implies that questions about the historical have to be asked and that sexuality could be reinvented and remade (Measor et al. 2000). The
most radical approach within social construction theory\(^1\) argues that we learn what ‘sex’ means, who or what is sexually arousing and also to want sex (Gagnon and Simon in Richardson 1997). Yet instead of viewing essentialists’ and social constructivists’ perspectives as distinct and opposed Richardson (1997) suggests we should view these perspectives as relative terms, and place theories on a social constructionist/essentialist continuum. Then it becomes possible to think about theories as being more or less essentialist than more or less constructionist. For the purpose of researching boy’s and young men’s role in reducing teenage pregnancy rates in Britain the theoretical stance taken is of interest. A stance leaning toward essentialist theory may look for ways to control, confine and channel male sexual urges to achieve set goals. A social constructivist perspective is likely to attempt to change how boys and young men construct masculinity, in so far as this is a key aspect of the social construction of gendered sexuality.

Sexuality does not start or end with the onset of puberty. However, physical changes are important and the timing has to inform policies regarding sex education. On average boys are older than girls at the onset of puberty. Puberty lasts approximately two years and usually begins for boys with a growth spurt (Rutter and Rutter 1993; Berk 1998). Sexual interests and motivation increase noticeably with puberty and this appears to be so regardless of culture (Udry 1990; Rutter and Rutter 1993). The rise of hormone levels is also associated with an increased sex drive, although more strongly in males than females and the increased hormone concentration seems to be a powerful indicator of boys’ sexual experience (Udry 1990). However, it is important to emphasise that the relationship between hormone concentration and sexual experience is neither simple, nor necessarily a one way relationship.

Biology does not tell the whole or even the main story of what motivates and directs adolescent sexual behaviour. However, puberty provides the signal to the outside world that the child is now physically, if not emotionally a man or a woman. Physical changes within the context of social pressures will act together to influence the direction of young people’s sexual behaviours and attitudes. What young people perceive to constitute unacceptable difference in appearance or behaviour within peer groups can be hard to understand and empathise with for adults (Moore and Rosenthal 1998). Young people may feel confused, excited and anxious or uncomfortable, self-conscious, experience mood swings, and are in need of reassurance. Being an early or late developer can be experienced as problematic. Puberty is a time in which people’s friends and social groups change, as well as the nature of their close relationships. Measor (1989) observed sudden rigid separation between boys and girls during the ages ten to twelve. It has been suggested that this separation is based on the onset of adolescent sexuality. The separation signals that things are changing dramatically. When contact is resumed it will be of a different kind (Measor 1989).

\(^1\) Social construction theory is one sociological perspective.
When developmental psychologists, e.g. Rutter and Rutter (1993) or Berk (1998) explain sexual behaviour, for example early initiation of sexual intercourse\(^2\) there seems to be a tendency to offer a mixture of personal attributes and structural explanations. All items of the following list are derived from US research: low intellectual ability, low educational achievement; poor parent-child communication; broken home or single-parent family, mother who had unusually early sexual experiences; involvement in other adult-like activities that are socially disapproved of in the young (smoking, drinking, delinquency); and lack of religious commitment. Yet young people may be most influenced by peer-group mores. Here a differentiation according to gender is frequently not offered.

As has been noted earlier, it is rare to find differentiation along gender lines. Yet boys and young men grow up and develop their sexuality within a variety of contexts in which gender is negotiated. For example Mac An Ghaill’s (1994) work draws attention to the cultural work schools perform in the production of heterosexual and hegemonic masculinity and double standards. Young men’s heterosexuality is constituted by the cultural elements of contradictory forms of compulsory heterosexuality, misogyny and homophobia. It may be difficult to define what constitutes masculinity or masculinities based on class, race and ethnicity. Whether one argues that attempts should be made to define masculinities because the encountered difficulties and ambiguities are a marker of the current cultural flux in gender relations (Connell 2000), or whether this is viewed as a fruitless task because it does not explain and challenge the power difference between men and women rooted in the material struggle over the division of labour (MacInnes 1998, p 2) it highlights important questions and may turn out to be vital in understanding approaches of working with boys and young men and success or failure of programmes. The following attempts to unravel boy’s and young men’s motivations and sexual experience in Britain will return to the gendered context in which working with boys and young men takes place.

**What boys and young men know and do**

Young people often have difficulties in getting clear and accurate information on puberty, sex and sexuality (Walker 1994). "Much information is passed through a form of Chinese whispers, with accurate information confused by embarrassment and bravado" (Winn et al. 1998, p. 24). McNulty and Richardson (2002) see here a chance for good Sex and Relationship Education in school, which feeds accurate information into peer networks. It seems to be extremely difficult to provide boys and young men with the knowledge about sexual health matters\(^3\). For example, Ray and Jolly (2002) report that a sizable group of Year 6 boys who had received SRE covering puberty the previous year were expecting to have a period.

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\(^2\) It has to be assumed that these authors exclude sexual abuse of young children from their definition of ‘early initiation’. That beggars the question whether research on which the following claims are based made the distinction or was able to make this distinction between sexual abuse and sexual activities less likely to be harmful to the young person.

\(^3\) This view is not shared by all. Mack (2002) is adamant that it is not really difficult.
The gap between girls’ and boys’ knowledge about sex, sexuality and contraception is seemingly due to the fact that boys receive less sex education at home, are less likely to receive information from health care professionals, and that boys tend to learn much about sex from male friends (Sex Education Forum 1997), from pornography (Measor et al. 1996; Lenderyou and Ray 1997; Hilton 2001) and now from an increasing number of men’s magazines. This information carries quite different values and uses different language compared to sex education offered in schools. Measor et al. (1996) report that boys claimed to value pornography because it provided specific and explicit information about what to do in a sexual situation.

Studies suggest that boys know less about STIs than girls. However, the tracking survey assessing the impact of the Teenage Pregnancy Strategy’s media campaign found that most are aware of HIV/AIDS, but less than half of the boys know about Gonorrhoea and Chlamydia even after two waves of media campaign (BMRB 2002). However, the media campaign is on-going and private sector partnerships will be sought to carry campaign messages through brands that are popular and appeal to boys and young men in particular (Department of Health et al. 2002). Girls are more likely to be aware of most methods of contraception, including emergency contraception. Research has shown that only 10 per cent of year 10 boys – in contrast to 26 per cent of girls – knew the correct time limit of the effectiveness of oral emergency contraception (Graham et al. 2002).

A literature review in the 1990s concludes that services aimed specifically at boys seem to be lacking (Peach et al. 1994; Hadley 1998). With that a chance to emphasise the joint responsibility of young men and women in avoiding unintended pregnancy and STIs is lost. Young men were less likely to know where sexual health services were and how to access them (Freeman 2000). Boys and girls knew little about professionals roles and competences of health care staff, including their right to confidentiality (Blair et al. 2001).

Teachers are the most popular source of contraceptive advice for boys (BMRB 2002; Durex 2002). In the study by the BMRB (2002) the most popular source of contraceptive supplies was a vending machine (23 per cent), followed by a pharmacy/chemist (18 per cent). An interpretation of the figures relating to boys and girls going for contraceptive advice the first time after the first experience of sexual intercourse is difficult. There were 22 per cent of boys stating this order of action in comparison with 38 per cent of girls. Older teenagers (18-21 year olds) were more likely to access contraceptive advice after having sexual intercourse for the first time. Additionally there were 16 per cent of young people who have had intercourse and had never used any source of contraceptive supply (BMRB 2002)\(^4\). Boys and girls may buy condoms from vending machines; receive them at home or from their partners. Yet when innovative services are on offer, e.g. C-Card Scheme in Newcastle and North Tyneside\(^5\) they are well taken up by young people (Teenage Pregnancy Unit 2002a).

\(^4\) Unfortunately this report does not differentiate these figures according to gender.

\(^5\) The C-Card Condom Distribution Scheme targets young people under 25 at increased risk of unplanned teenage pregnancy, providing them with a card entitling them to free condoms and sexual health advice. C-Card outlets include sexual health services for young people and youth and community settings as well as venues used by particular groups of young people.
Puberty and first sex

Boys experience puberty differently than girls. Puberty is an important time for the development of sexual scripts. Boys commonly feel quite proud of the changes of their body – overriding some feelings of embarrassment. In girls’ accounts feelings of embarrassment and humiliation were highlighted (Measor et al. 2000).

Sexual behaviour develops over time from kissing to fondling over and under clothes (Moore and Rosenthal 1998). Ideally – at least from the ‘adult’ perspective found in the literature – first intercourse should be anticipated, wanted, protected and enjoyed (Mitchell and Wellings 1998a). It is an important event in a person’s life. Less than one per cent (0.66 per cent of men and 0.46 per cent of women) could not recall their exact age at first intercourse (Wellings et al. 2001)\(^6\). Heterosexual ‘first sex’ is an induction into adult masculinity as defined in a heterosexist world (Holland et al. 1996; Thomson and Holland 1998). For both girls and boys a sense of curiosity, feeling love, or that to have sexual intercourse was a natural development in their relationship were the highest rating factors contributing to the decision to have sexual intercourse for the first time. But only 17 per cent of boys reported being in love as being their main motivation (38 per cent of girls) and 11 per cent of boys reported losing their virginity as an important factor (less than one per cent of girls) (Wellings et al. 1994). Men's reasons for having sexual intercourse the first time is usually ‘curiosity’, compared to women’s reason of ‘being in love’ (Aggleton et al. 1998). It also links in the construction by boys and young men of women as ‘nice girls’ or ‘girlfriends’ opposite to ‘slags’ or ‘tarts’ (Measor 1989; Lees 1993). The division of girls into ‘slags’ and ‘girls they like’ paradoxically leads boys into having sex with girls they don’t like (Lees 1993) or say they don’t like.

British data from 1999/2000 reported by the National Survey of Sexual Attitudes and Lifestyles (Natsal II) shows that for boys and young men the median age of first heterosexual intercourse was 16 years for those aged 16 to 19 years when researched (Wellings et al. 2001). Data from Natsal I, ten years earlier, showed that the median age had been 17 (Wellings et al. 1994). Although the median age of first intercourse has changed, the proportion of men having intercourse before the age of 16 has remained fairly constant across all ages (Wellings et al. 2001). More African and African-Caribbean boys reported first sexual intercourse before age 16 (a quarter) compared with white boys (a fifth) or Asian boys (a tenth). Family structure, educational level, and main source of information about sex remained independently associated with early age at first intercourse (Wellings et al. 2001). Boys first sexual partner is generally of the same age. (Wellings et al. 1994).

The Natsal I data from 1990 shows that 40 per cent of boys (50 per cent of girls) had their first sexual intercourse within the context of an established relationship, another 30 per cent of boys knew their partner for a while (16 per cent of girls). Eight out of 10 boys felt their first experience of sexual

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\(^6\) To date two National Surveys of Sexual Attitudes and Lifestyles have been conducted, usually referred to as Natsal I and Natsal II. The findings of Natsal I, reported by Wellings et al. (1994) are based on responses given by a random sample of nearly 20,000 Britons, aged 16-59. This data was collected 1990/1991. The findings of Natsal II, reported by Wellings et al. (2001) are based on a sample of 11,161 men and women aged 16-44. The data for Natsal II was collected between 1999 and 2001.
intercourse came at the right time (6 out of 10 girls) and only 15 per cent of boys compared to 36 per cent of girls regretted their first experiences (Wellings et al. 1994). A later study of Scottish young people showed higher levels of regret for boys compared to Natsal I and lower levels of regret for girls compared to Natsal I. Concerning boys the only variable that could have been related to regret was that they had exerted pressure on girls to have sexual intercourse (Wight et al. 2000).

First intercourse at a young age is often characterized by silence. It may occur as surprise and shock (Mitchell and Wellings 1998a). Alcohol Concern (2002) cite research by Ingham (2001) in which 20 per cent of young men between 16 and 19 years state that alcohol was the reason for first heterosexual intercourse (13 per cent young women). Being drunk or ‘stoned’ was associated with regret and the feeling sexual intercourse should not have happened at all in Scottish young men (Wight et al. 2000).

Young men appear to see themselves as sexual actors (the person who does sex) and position young women as objects of sex (Thomson and Holland 1998). Results from Natsal I suggest that young men were more likely to claim to be the more willing partner at first intercourse and are less likely to feel that they had first intercourse too early compared with young women (Wellings et al. 1994). Data from 1999/2000 continues to show that women are three times more likely to report being the less willing partner (Wellings et al. 2001). Young women can feel pressurised into sex too early by their male partners or their friends (Freeman 2000; Measor et al. 2000). Some of the pressure felt by young women and men may be rooted in misconception about the proportion of young people who have had first sexual intercourse. Just under half of the respondents (however 58 per cent of girls and young women) thought that more than half of young people had had sexual intercourse before their 16th birthday. Yet Natsal II shows that 30 per cent of men and 26 per cent of women reported first sexual intercourse at younger than 16 years (Wellings et al. 2001).

For young men peer pressure is significant. They may have intercourse because they don’t want to be called a wimp or ‘gay’ (Holland et al. 1993; Berk 1998; Thomson and Holland 1998; Winn et al. 1998; McNulty and Richardson 2002). Boys expressed anxiety about first heterosexual intercourse. They feel they are only told what kind of contraception to use but not how to do it, for example, how to put a condom on. For boys (first) sex is a ‘technical feat to be mastered’ (Forrest 2000). They may feel that it is the responsibility of the male partner to know what to do in a sexual encounter (Holland et al. 1993; Measor et al. 1996; Measor et al. 2000). Pressure from male peers on boys and young men to have sexual intercourse in combination with anxiety around not knowing what to do or being able to perform can eclipse concern for the partner (Forrest 2000). This may result in young men seeking a partner for first sexual intercourse who is unlikely to feed judgment back to their peer group (e.g. holiday encounter, older partner) (Thomson and Holland 1998). However, the definition of peer-groups remains loose (Shucksmith 2002) and young people’s relationships may turn out to be more complicated. Peer pressure may also arise from female to male peers and vice versa.

Of those who had first intercourse before the age of 16 only a quarter of men compared to over half of the women regretted it (Wellings et al. 1994). The silence during first intercourse is followed by inability to talk about it afterwards. Lack of anticipation and poor communication – due to embarrassment – tends to lead to dissatisfaction with the experience (Mitchell and Wellings 1998a).
Yet young men are more likely than young women to perceive their first intercourse as positive (Thomson and Scott in Measor et al. 2000).

**Sexual practices**

We know very little about adolescent masturbation. This may be so because it is perceived as a very private or even shameful activity (Moore and Rosenthal 1998) and it is difficult discussing anything which makes boys feel vulnerable or threatened (Mitchell and Wellings 1998a). There is, however, anecdotal evidence, as for example forwarded by Fisher (1994), in an advice book on sexual health written for boys. Letters collected during his work as an agony uncle for a teenage magazine suggest that masturbation plays an important role in male adolescence, that boys share a culture of masturbation, that boys learn in groups about masturbation and therefore they share a culture of knowledge about physical strategies for ensuring their own sexual satisfaction. Masturbation ensures that their own sexual responses are known to them and they understand something of the nature of their own desires (Measor et al. 2000). Research on Australian school children suggests that masturbation was positively correlated with sexual self-esteem of boys and girls (Rosenthal in Moore and Rosenthal 1998).

There is anecdotal evidence on an increasing number of young people engaging in oral sex in Britain and the US. However, it seems to be more likely that that young women perform oral sex for men than men engaging in cunnilingus (Fisher 1994; Measor et al. 2000). Natsal I reported that oral sex is a common experience but does not shed a lot of light on the question whether fellatio is more often performed than cunnilingus by heterosexual partners (Wellings et al. 1994). Data from the US shows that many people do not classify oral sex as sex. This begs the question whether oral sex counts as sex in the eyes of young people or if it is seen as abstinence (Remez 2002). Similarly, a small sample of young English men and women had mixed views whether oral sex counts as sex, suggesting differences according to age and experience (McNulty and Richardson 2002).

**Risk-taking and contraception**

Risk-taking by heterosexual young people when engaging in sexual intercourse can result in STIs including HIV/AIDS or in the consequences of an unintended or unwanted pregnancy for the female partner. Sexual decision-making is not an entirely rational, individual process with free choice available to individuals. The ability to negotiate safe sex is rooted in symbolic and social meanings and is structured by unequal gendered power relationships. Safe sex may be negotiated in one relationship but not in the next and at different times in the same relationship (Thomson and Holland 1998). Planning ahead may be regarded as lacking excitement and spontaneity. This may counter balance good intentions to take precautions against STIs and conception when anticipating sexual intercourse. Risk is a notion that may be defined differently by young men and women. Women’s list of risks is
long: STIs, conception, and a damaged reputation. Each of those carry complicated consequences for physical, social and psychological well-being. Men’s risks also include STIs and conception. Yet the consequences of their female partner’s conception are quite different for men, and engaging in risky sexual behaviour appears to improve boy’s and men’s reputation. If partners have conflicting agendas, there is a tendency to draw upon the male sex drive discourse and the male script dictates what happens. In such situations negotiations become virtually impossible (Crawford et al. 1994). Women may try to find excuses, but when conditions constructed like this are met, there seems no room to refuse. Young women may consent to intercourse out of fear of losing her partner (Mitchell and Wellings 1998a), fear of violence or of being shamed.

Some plan and discuss engaging in sexual intercourse and the use of contraception. This is more likely for older young people and those in long-term relationships. However, often the use of ambiguous language leaving a lot unclear, leads to disappointment. Condoms are often not discussed and embarrassment is a dominant reason for poor communication (Mitchell and Wellings 1998a).

Developments in contraceptive technology have moved responsibility for sexual safety from men to women (Thomson and Holland 1998). It would seem that contraceptive responsibility is largely irrelevant to males' sexual self-concept (Breakwell and Millward 1997). Many boys do not feel responsible for contraception (Lees 1993). Focus group interviews and some individual interviews of a small group of young men in the Northeast of England showed that some young men felt that contraception is entirely the woman’s responsibility and not theirs. These young men engage in highly risky sexual practices (Freeman 2000). The pill and the morning after pill are perceived by men as not intrusive in the act of sexual intercourse, unlike barrier methods. A widely held perception is that using oral contraception ensures spontaneity. It makes the risk of spoiling the act by the mechanics of putting on a condom unnecessary (Fisher 1994; Thomson and Holland 1998).

Younger teenagers are less likely to use contraceptives at the first time they had sexual intercourse (Ford 1991). British data from 1999/2000 shows that 31 per cent of 13 – 14 year old boys did not use a condom at first intercourse and 18 per cent used no contraception. Of the young men having first intercourse at the age of 17, 18 per cent did not use a condom and only 3 per cent used no contraception (Wellings et al. 2001). Natsal II showed that there was a significant increase in the prevalence of condom use at first intercourse in the decade separating the two Natsal studies. This corresponds to a decline in the proportion of men and women using no contraception at first intercourse (7.4 per cent of 16-19 year old men and 9.8 per cent of 16-19 year old women) (Wellings et al. 2001). However, this data does not entirely correspond with (less robust) research findings of the Durex 1999 report. This research undertaken for Durex found that 16 per cent of the 16 to 21 year old UK respondents did not use any form of contraception at first intercourse (in Lloyd and Forrest 2001).

The British data from 1999/2000 shows that sexual intercourse before the age 16 and non-use of contraception were higher for men and women who did not live with both parents until age 16, those who left school at age 16, and whose parents were manual workers. Young people having sexual intercourse before the age of 16 and not using contraception were more likely to be young men and women whose main source of information about sex was not only school. Non-use of contraception
was higher for men and women who did not discuss sexual matters with parents and among those whose main source of information about sexual matters was friends and others. Education level and source of information about sex, and discussion remained significantly associated with non-use of contraception among both men and women. For men the lack of discussion with parents about sexual matters was significantly associated with non-use of contraception. (Wellings et al. 2001). A survey of sixth-form students showed three factors significantly associated with the use of contraceptives at first intercourse among young men. They were discussing contraception beforehand, an intimate reason for having sex the first time and having parents who portrayed sexuality positively during childhood and early adolescence (Stone and Ingham 2002). Apart from ‘discussing contraception beforehand’ factors associated with the use of contraceptives at first intercourse among young women differed. The study also showed that young men were less likely to discuss contraception compared to young women, forty-two per cent of young men did not discuss contraception compared to 27 per cent of young women (Stone and Ingham 2002).

The element of surprise continues to be present in young people’s sexual life. Sexual encounters of young people have been connected to alcohol and drug use. Alcohol and drug use are negatively associated with successful condom use (Lloyd and Forrest 2001). Yet, the association between alcohol and risky sex is not a straightforward one. It can be seen as a connection between the likelihood to have risky sex when under the influence of alcohol; or as an association of people who drink alcohol and engage in risky behaviour (not only sex) but not necessarily at the same time (Alcohol Concern 2002).

A quarter of 16-19 year old boys regretted having sex that happened when they had been drinking (Ingham in Alcohol Concern 2002). Young people in another study revealed that being drunk was connected to ‘bad’ sex, because they felt out of control and not able to remember what has happened (McNulty and Richardson 2002). Yet it is important to keep in mind that being drunk may provide a legitimate excuse for behaving in a way that may have been otherwise unacceptable or too risky. It may be easier to claim risky sexual behaviour took place because of alcohol or drug use than because they wanted to do so (Rhodes and Quirk in Alcohol Concern 2002). As a reason to have sex with someone they knew for less than one day about half of the respondents (48 per cent boys, 51 per cent girls) reported the use of alcohol or drugs (Ingham in Alcohol Concern 2002). Yet similarly the effects of alcohol may take away people’s inhibition to have discussions about sexual safety and then act on it.

Typically, intercourse is unexpected but not a complete surprise. Young men are less likely to have any expectations but were open to sex as a possibility. Young women appear to be more likely to have certain expectations of a date, but not including sex. Men appear to carry condoms ‘just in case’. There may be greater gains in encouraging young men to carry condoms, perhaps more than young women (Mitchell and Wellings 1998a). Girls carrying condoms may fall into the trap of double standards, implying that they premeditated sex, which conflicts with popular ideas of romantic spontaneity and implicitly labels them as ‘slags’ (Lees 1993). The Durex report 2002 indicates an interesting shift of attitude towards women carrying condoms. Eighty per cent of men and 88 per cent of women believe that women who carry condoms are sensible and responsible. Only five per cent of all respondents
thought a women is promiscuous if she carries condoms, however 16 to 20 year olds were more likely to believe this than older respondents (Durex 2002).

Lloyd and Forrest (2001) cite research from America by Ku et al., 1994 that shows young men’s use of condoms is influenced by the stage of their relationship with a young woman and, when the relationship has consolidated, the use of the contraceptive pill is likely to overtake condom use. Feeling vulnerable to infection or being concerned about pregnancy renders young men more likely to use condoms. Confidence in using condoms also allows us to predict condom use (Lloyd and Forrest 2001).

Factors most likely to prevent condom use in young men are beliefs that condoms will ‘interrupt’ sex, be embarrassing to use and may affect their ability to obtain and maintain an erection (Braeken in Fisher 1994; Lloyd and Forrest 2001). Not using condoms is associated with the expression and demonstration of trust. Condoms are often used in the early stages of a sexual relationship but later on transfer to oral contraceptives takes place. These decisions, whether negotiated or not are laden with symbolic meaning and can be used to signify the seriousness of a relationship (Thomson and Holland 1998).

A small scale study of 16-19 year olds reveals two contrasting strategies used to ensure condom use at first intercourse with a new partner (Coleman and Ingham 1999). These are defined as verbal communication based strategies (involving some explicit discussion about contraception before intercourse) and non-verbal communication based strategies (where one partner takes responsibility for using condoms without discussing this with their partner). Whilst the former is argued as being the more effective strategy, Coleman and Ingham (1999) suggests an important role for the latter, particularly when young people find themselves in situations where initiating discussions about condom use is perceived as being particularly difficult. One-night-stand situations are more likely to be approached with non-verbal strategies. They suggest that young people should be provided with necessary skills and confidence to initiate discussions with their partners before intercourse occurs. However, their findings concerning non-verbal strategies, because initiating communication about contraception is perceived to be too difficult, lead to the recommendation to instil people with the confidence and skills to take sole responsibility for condom use - e.g. by teaching both young men and women how to use condoms (Coleman and Ingham 1999). Another study showed that women were less successful with both of these methods. Twenty-one per cent of women reported that their male partners had refused their verbal or non-verbal request to use a condom (Thomson and Holland 1998).

**Sexual health services**

Young men are poor attendees of health services and sexual health services. Suggested reasons for this include, that sexual health services are traditionally geared towards women and are mainly female staffed. Some young men perceive sexual health services as ‘women-only’ (McNulty and Richardson 2002). Staff may feel intimidated and not able to offer opportunities for young men to overcome their
inhibition and express their real needs. Sexual health services operate in a context in which men access health services only when the need is evident and serious (e.g. an injury) and men associate health with fitness (Lloyd and Forrest 2001). Accessing health services may be seen by men as unmanly and it may challenge their reputation of ‘knowing it all’ (McNulty and Richardson 2002). Men may find it difficult to talk about their health, their sexuality, sexual functions and emotions (Lloyd and Forrest 2001). Services around the birth of children are traditionally geared towards women and practitioners may also find it difficult to target and to address men. An inclusion of teenage fathers may be right at the bottom of practitioners’ priority lists. A small scale study of young fathers found that young men felt excluded by staff, particularly when accessing services before the birth (Sewell 2002).

Sex, masculinity and double-standards

Sex and contraception may have different meanings for young men and young women, influencing their behaviour (Holland et al. 1998). This is connected to the existing double standard, that boys and men prove their masculinity by being sexually active and sexually successful. Amassing sexual experience is not as acceptable in girls and women, and boys appear to be well aware of the prevailing double standard (Lees 1993). It becomes apparent that masculinity does describe the possession or non-possession of certain traits. Masculinity as constructed by boys and men is the maintenance of particular kinds of relationships between men and women and between men and men. The sense of being a man comes to the fore in their relation to women (Morgan 1992). Young working class males construct male power by simultaneously degrading women's bodies and by celebrating their 'natural' male urges in the sexual realm (Hollands 1990). There is a minority of ‘new’ young men who view partner relationships democratically and a minority of ‘male chauvinist pigs’. More common is ‘mixed up man’ who had learned something from the gender equality agenda but still retains significantly patriarchal and sexist attitudes and patterns of behaviour (O'Donnell and Lees 2000).

Social mythologies, such as the belief that boys cannot control their sex drive have implications for sexual behaviour. Boys and young men may feel that they have the right to force girls into sexual activities, and that kissing and fondling can be read as permission for intercourse (Moore and Rosenthal 1998). ‘Persuasion’ is seen by many young men as a legitimate (even requisite) component of the masculine sexual role (Thomson and Holland 1998). The privilege of male sexual pleasure can be seen as expression of power in sexual relationships. It has to be regarded as important for the use or refusal to use condoms. Another expression of the mythology of the uncontrollable male sex drive is the ‘heat of the moment’ argument both young men and young women employ to explain what is standing in the way of using condoms (McNulty and Richardson 2002).

Boys are locked into regarding girls in a contradictory way. Girls are seen as conquests and on the other hand boys do like girls (Lees 1993). Girls and women have to negotiate within this construct. They find themselves in a cultural context that frequently blame females and in which the myth that women like it rough is maintained (Lee in Lees 1993). This does not necessarily mean that boys misread girls’ signals, as claimed by Measor (1989) – but that boys and young men refuse to recognize...
that girls have the right to refuse (Lees 1993) and can use it to their advantage. When young men and women in our study explored name calling, they felt that the existing double standards are not fair but were unsure how this could be changed (McNulty and Richardson 2002). It appears that girls and young women often buy into the male discourse of pressing biological urges, the difficulty in controlling their behaviour as an expression of masculinity or the effects of alcohol (Lees 1993).

Fatherhood

In a sample of 746 13 to 21 year-old young people boys were less likely than girls to report pregnancy under 18, defined as “girls who were pregnant before the age of 18, or boys having made a girl aged under 18 pregnant (no matter how old the boy was at the time)” (BMRB 2002, pp 13-14). The difference may be a combination of the likelihood that men impregnating teenage women tend to be older than their female partner, of young men not being aware of the occurrence of teenage conception or under-reporting. It has been estimated that 25 per cent of young men under 21 in Young Offenders Institutions are already fathers or expectant fathers (Teenage Pregnancy Unit 2001a). Whether these pregnancies were intended or welcomed by teenage fathers is not known. Fisher’s advice book for boys on sexual health (1994) does not explicitly mention pregnancy or fatherhood, but seems to be written on the assumption that members of the target group (young men around puberty) do not want to become fathers.

There is little known about the role of young men when their partner is pregnant. In studies such as Allen and Dowling (1998), young fathers were generally more positive about continuing an unplanned pregnancy than their partners (Allen and Dowling 1998) and more likely to oppose abortion (Speak et al. 1997). Boys and young men in general tend to hold more traditional values concerning children and marriage compared with young women (Lees 1993; Oakley 1996). A small sample of teenage mothers who had been or recently left public care reported that their male partners were in favour of keeping the baby. They described it as an emotional response in line with ‘it’s my flesh and blood’ (Corlyon and McGuire 1997). Qualitative studies with young fathers or potential fathers report initial reactions of ‘feeling shocked’ and confused. Two qualitative studies of fathers or potential fathers showed that these young men often felt that they were part of the decision making process in whether to continue with the pregnancy or to abort to some extent (Holmberg and Wahlberg 2000; Sewell 2002).

The British policy context does not appear to encourage including young men in the decision making process whether to continue with the pregnancy, resort to adoption or abortion (Department for Education and Employment 2001; Teenage Pregnancy Unit 2001a). Yet there may be scope for policies supporting more male involvement. 1991 US data suggests that, with or without policies encouraging male participation, young men play a role. It shows that male partners of pregnant teenagers attending

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7 Young women tend to have sexual intercourse with male partners older than themselves (Wellings et al. 1994). Interviews with teenage mothers show that most of the fathers were older than the mother (e.g. Allen and Dowling 1998; Vary 2000).
abortion clinics were involved in the decision to terminate the pregnancy (three-quarters) and that some young men supported their partner in accompanying the young women to the clinic (one-third). The proportion of pregnant teenagers reporting involvement in decision making by, and support from, their boyfriends in attending the abortion clinic and paying for a termination was even larger when the young woman’s parents did not know about the pregnancy (Henshaw and Kost 1992). Half of a sample of 13 to 15 year old Scottish boys presented with a fictional story of teenage pregnancy felt that the male partner should have a say in the decision about continuing or not with the pregnancy (Hooke et al. 2000).

There seems to be a lack of knowledge about attitudes and motivations of fathers of babies born to young mothers (Aggleton et al. 1998). The majority of research on teenage parenthood originates from the US. However, the populations in the UK and US are not easily comparable and the conclusions of one country cannot simply be applied to the other (Coleman and Dennison 1998). One reason that there is so little known about how young men experience fatherhood is the difficulty of involving young men in the research process (Coleman and Dennison 1998). Small scale studies suggest that young fathers want to be involved in decision making, would like to support their pregnant partners and want to play a role in the upbringing of their children. Young fathers who want to be involved with their children may be hindered by the mother, the mother's new boyfriend, and/or maternal grandparents of the child (Speak et al. 1997; Sewell 2002). Support in their role of fathers may come from the young father's parents. Support from other sources, e.g. youth work, appears to be rare. Additionally the socio-economic circumstance, poor housing, unemployment, and a lack of understanding of how benefits, employment and maintenance payments interlink, makes it difficult to develop a positive caring role (Speak et al. 1997; Sewell 2002). There is also the possibility that young men do not know that they are fathers.

It may be difficult to develop a realistic stance on fatherhood for boys and young men from single parent families or who grow up in the public care system. Corlyon and McGuire (1999) report that boys who have grown up in the public care system strongly aspire to be married and have children at an early age. Yet teenage mothers who had grown up in public care explained that often the father of their child was pushed out of the relationship. In their experience their male partner was not mature or supportive enough in bringing up a child (Corlyon and McGuire 1999). A project in London aims to allow boys and young men who do not know who their father is or have no or little contact with him to explore their feelings and reflect on their experience. This seems to be successful in leading to an understanding of the benefits of delaying fatherhood (Davis 2002).

Different approaches working with boys and young men

Boys and young men’s sex education has to be set in the wider context – not only in order to prevent teenage pregnancy. The failure to meet needs regarding sex and relationship education of boys may
have serious implications for their emotional and sexual health, for example expressed in boys’ reluctance to seek help and the high suicide rate among boys\(^8\) (Lloyd 1997; Sex Education Forum 1997). When boys’ needs are met it may contribute in reducing STIs and may have the long-term effect that the fathers of tomorrow are more likely to talk to their own children about sexual health matters (Sex Education Forum 1997). The planning of sex education has to address the lack of boys’ knowledge compared with girls. The Sex Education Forum approaches gender as an outcome of early socialisation and gender role modelling. At school children learn what is appropriate behaviour for boys and girls from the formal and ‘hidden’ curriculum (Sex Education Forum 1997). School is not only the place of intended and unintended learning outcomes but one important site where pupils and teachers construct of masculinities (Mac An Ghaill 1994).

There is as yet no clear evidence, emerging from the variety of programme evaluations, that gives an indication of what precisely works with boys and young men. Some authors have set out characteristics of effective programmes addressing young people’s sexual behaviour. These characteristics include a clear focus on reducing one or more sexual behaviours; goals, methods and materials appropriate to the age, sexual experience and culture of students; sufficient time; basic and accurate information; methods that involve participants; address social pressures related to sex; models of and practice in communication; and teachers or peer educators who believe in the programme and have participated in practical training (Card 1999; Kirby 2001a). The emergence of a strong association between variables which are amenable to intervention (school sex education, source of information) also give reason for optimism at least from the standpoint of prevention (Wellings et al. 2001). Other authors are less optimistic because their research showed that sex education in schools and other interventions geared at young people did not change young people’s sexual behaviour (DiCenso et al. 2002; Wight et al. 2002). Stepping back from a gender neutral approach may result in findings that provide fewer reasons to be optimistic. Particularly abstinence programmes in the US were associated with an increase in the number of pregnancies in partners of young male participants (DiCenso et al. 2002). Other programmes which have been associated with a decline of teenage pregnancy rates, particularly Service Learning Programmes (Kirby 2001a) could not answer whether this success only could be observed in young women because the sample of male participants was too small (Allen et al. 1997). Other programmes were successful regarding young women but did not reduce sexual risk-taking among young men (Kirby 2001a). There is a wide variety of programmes, with varied intensity, duration, different components, approaches, geared at different ages and they target different groups of the population. Until recently programmes in the UK tended to focus on young women, rather than young men and women or young men alone (Peckham 1994). A compilation of 41 British practice examples of working with boys and young men shows a variety of possible approaches (Davidson and Lloyd 2001). Some projects target vulnerable young men, e.g. at risk of social exclusion, young offenders, or young men involved in prostitution, others target boys and young men from ethnic minorities or gay or bisexual young men. Some projects aim to promote sexual health, others general health or mental

\[8\] For men aged 15 to 24 there were 16 suicides per 100,000 population in 2000. For women of this age group the rate was 4 in 100,000 in 2000 (Office for National Statistics 2002).
health. Some projects are geared towards fathers or young men ‘at risk’ of becoming fathers. They can take the form of working within youth projects, schools or have their own premises; they may be a theatre group, road show or a telephone help line.

In practice, the development and implementation of programmes addressing boys’ and young men’s needs for knowledge and services can reveal tensions between research and practitioners. When programmes are delivered by individuals who have not designed the specific programme, for example teachers and school nurses, their professional philosophy may get in the way of recognising theoretical insights gained by social scientists. Expertise gained by years of practice may be valued more than knowledge offered by scientists (Wight and Charles 2000).

**What should working with boys and young men contain?**

Sex and relationship education has to address knowledge, skills and attitudes. Knowledge, skills and attitudes are interdependent. Knowledge alone will not promote sexual and emotional health and well-being (Sex Education Forum 1999). However, given the amount of misinformation that particularly boys are subjected to, an attempt to improve knowledge about issues surrounding sexual health appears to be called for (Winn et al. 1998; Ray and Jolly 2002). Boys also express the wish to gain information about homosexuality, oral sex, and various other sexual practices, including masturbation (Measor et al. 2000; Biddulph and Blake 2001).

Wight and Charles (2000) conclude that on the ground the 'behaviour change' approach to health education which has characterized government initiatives (e.g. safer sex promotion to halt the spread of HIV), has been replaced by an approach that emphasises the goals of empowering participants and raising their self-esteem. This is reflected in programmes that emphasise the need to explore the meaning and construction of masculinity (e.g. Biddulph and Blake 2001). The latter approach can be perceived as sitting uncomfortably with the aim of the Teenage Pregnancy Strategy to change the behaviour of boys and young men in a way that it contributes to the reduction of teenage conceptions. Empowered young men may or may not use knowledge and skills to prevent conception.

A review of what has been identified as desirable content of sex and relationship education for boys and young men provides a long list. It is based on experience and theoretical insight but not confirmed by research evidence. Primary school age children need to learn the accurate terminology for body parts. Boys and girls have very little vocabulary available to talk about sex and sexual relationships which is neither derogatory or clinical (Lees 1994). Boy’s genitals do generally get named, however often the words used are family names or slang. At least the existence of their genitals is acknowledged in contrast to girl’s genitals (Ray and Jolly 2002). Accurate terminology for body parts provides boys with another language than that observed by Lees (1993). In her study boys used only derogative language to describe the female body, menstruation or breastfeeding. Providing a common language that can be accepted by boys and practitioners is important groundwork making future education and support easier.
Boys and young men need to know about puberty and likely changes to their body. This ought to pick up on pre-occupations of boys with penis size and masturbation (Fisher 1994; Measor et al. 2000). The issue of pornography should be discussed with boys in school because if this is not done the gender stereotypes and values contained within it are not challenged (Hilton 2001). The content of sex education for boys and young men should always address men’s issues like how to prevent fatherhood, how to protect oneself against disease (Hilton 2001). Sex and relationship education aims to prepare all young people for an adult life in which they can avoid being pressured into unwanted or unprotected sex and avoid being exploited or exploiting others (Department for Education and Employment 2000).

There is also a call for providing boys and young men with practical skills. Advice on how to talk about sex beforehand may be superfluous/redundant where discussion does not occur (Mitchell and Wellings 1998a). Non-verbal strategies may be effective and appealing for first intercourse with a new partner, especially for young men e.g. putting on a condom without consultation (Coleman and Ingham 1999). The reluctance to use condoms may be due to boy’s and young men’s fear to lose face if they get it wrong. This can be addressed by practicing the use of condoms with the help of a demonstrator (Sex Education Forum 1997).

There is also a need for information about sexual health provision. Ideally young men should be targeted with separate clinic provision (Aggleton 1996). Evidence from other European countries suggests that making condoms available to young people does not hasten or increase sexual activity (Kane and Wellings 1999). Yet condom-use exercises may meet resistance in schools, i.e. head teachers, governors, parents and school nurses. However, a session devoted to learning how to obtain condoms and practising correct use emerged as one of the most successful in providing teachers with knowledge and skills, and received praise by teachers who delivered this session (Wight and Charles 2000).

Programmes emphasising the prevention of behaviour that places young people at risk for STIs or teenage pregnancy tend to ignore young people’s need to explore interpersonal needs and develop skills and attitudes supporting the formation of intimacy in adult relationships (Morgan 1992). Acknowledging the wider context of gender role modelling, it has been recommended that primary schools should promote a range of positive masculinities and provide role models which include showing emotions, talking about feelings, showing the caring side of their natures, and fathering (Sex Education Forum 1997). Key objectives are to improve young people’s understanding of the attitudes and experiences of the opposite sex. This includes lessons for older children around the topics: the gendered construction of sexuality; gender differences in sexual expectations and pressures; dominant images of women and men and their effect on young people; and the way power operates within sexual encounters (Wight and Charles 2000). How to engage boys and young men in the exploration of relationships may be challenging to the practitioner. Boys in contrast to girls did not complain about the lack of attention given to emotional issues in school sex education in one study (Measor et al. 2000). Yet in a project supporting boys’ sex education, boys wanted opportunities to talk about emotions and relationships (Lenderyou and Ray 1997). For boys the crisis-based response to HIV/AIDS has clearly spelt out that desire is now inextricably mixed with danger. This may result in
sex education being perceived by boys as negative (Lenderyou and Ray 1997). The link between desire and personal danger is a new one for (heterosexual) males in contemporary society (Measor et al. 2000). Yet the possible solution of not having a certain kind of sex is dangerous too. Men may feel threatened and vulnerable facing the prospect of not having heterosexual penetrative sex (Holland et al. 1993).

Abstinence education is particularly strong in the USA (Blake and Frances 2001). There is currently no evidence that abstinence-only programmes do delay the onset of intercourse (Card 1999; Jepson 2000), however, there has been very little rigorous evaluation of abstinence-only programmes and evidence is not conclusive (Blake and Frances 2001; Kirby 2001a). In Britain the emphasis within Personal, Social and Health Education (PSHE) on the benefits of married couple families (Department for Education and Employment 2000) sets the moral framework. Yet an approach that encloses information about sex in the ‘morality of the family’ renders sex education less accessible to many young people. Young people may not live with both parents, may have experienced sexual abuse within the family or may be, or about to become, engaged in sexual activities that do not fit this moral framework. Young people require information relating directly to their personal circumstances. The ‘morality of the family’ does not guarantee protection from pregnancy or STIs (Holly 1989).

The sex education curriculum should be reviewed in co-operation with boys and young men. It is important to deliver what they want and need, avoid a negative approach of telling boys what not to do, and the curriculum and the delivery must show respect for boys (Sex Education Forum 1997). Wight and Charles (2000) declare that in practice, it is extremely difficult to genuinely negotiate sexual learning needs with teenage students in classroom settings. Additionally, sex and relationship education within schools is perceived to be regulated and restricted by the Sex and Relationship Education Guidance (Department for Education and Employment 2000) and Clause 28 (Epstein and Johnson 1998) despite the duty and power of governing bodies of schools to develop their sex and relationship education policy. The uncertainty of who determines the content and method and the right of parents to withdraw their children from SRE may result in teachers feeling insecure and worried about doing or saying the ‘wrong thing’.

Sexual health agencies need to overcome blocks preventing boys and young men using their services. Important issues for success are confidentiality, a stress that services are for young men, and creating a welcoming environment (Sex Education Forum 1997; Teenage Pregnancy Unit 2000c). Outreach work can support this, and social workers, youth workers or foster carers can invite staff from sexual health services or may take young people to these services (Teenage Pregnancy Unit 2001a; b).

**When is the right age?**

When children try to make sense of the world around them – something they do from a very early age – it is important that they receive accurate information to prevent misinformation or misinterpretation (e.g. by families, friends, TV). Ideally all three themes, contraception, sexual health and parenthood are approached holistically and start at primary school age (National Council of Voluntary Child Care Organisation 2002; Ray and Jolly 2002). Boys and young men advocate early SRE, partly in order to
normalise it and it may help to reduce their own giggles and embarrassment. Similarly, it has been asserted that if sex education has not commenced by the start of primary school practitioners find themselves having to provide remedial work (Mack 2002).

SRE for primary school aged children aims to support children's emotional development and to build positive self-concepts; intends to prepare children for puberty, and is intended to support academic achievement. It is important that all children, including those who develop earlier than the average, learn about puberty before they experience the onset of physical changes (Ray and Jolly 2002).

Sexual intervention programmes may be less effective when they focus on a certain age group, ignoring the wide variability in dating and sexual experience (Morgan 1992). Many of the 13 to 15 year old survey respondents claimed that sex education is too little and offered too late (BMRB 1994). This has to be seen against the backdrop of a lower age at the onset of puberty (Wellings et al. 1994) and lower age of engaging in first sexual intercourse (Wellings et al. 2001). A more recent qualitative study with 13 to 16 year olds suggests that for some young people SRE sessions in Year 9 are already too late. In this study many young people expressed the view that they would like SRE that gradually increases detailed discussion of sex and relationships (McNulty and Richardson 2002). However, due to the wide range of individual experience the needs for information are also wide ranging (Measor et al. 2000).

Sex and relationship education should be an integral part of the lifelong learning process, beginning in early childhood and continuing into adult life (Sex Education Forum 1999).

Who should be responsible for delivery?

Ideally boys and young men have access to sex and relationship education, advice and sexual health services from a variety of sources as and when they need it. Yet policies regarding sex and relationship education reflect the tension between, those who emphasise the rights of parents to educate their children in sexual matters and view the privacy of the family as a realm of discretion. Others argue for children’s rights and freedom from parental and adult control, which can be supported by sex education (Wyness 2000). The relationship between parents and children may be considered the ideal context to pass on information and advice on puberty, sexuality, contraception and fatherhood. Yet, fathers frequently fail to take on paternal responsibly regarding sex education of their sons – or boys prefer not to be educated and advised by their fathers (Wyness 1996; BMRB 2002). Often mothers take on this responsibility reluctantly and may feel embarrassed (Wyness 1996).

Decline theorists' claim that teachers undermine parents’ capacity to introduce sex education⁹. Parents do not seem to share the same fear. Most parents feel that the responsibility for sex education lies with school and parents. Many parents prefer the school to introduce sex education because they feel embarrassed and unqualified. The formal way to teach may overcome and prevent children's embarrassment. Wyness’ (1996) study shows that parents perceive teachers as qualified to know what

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⁹ Decline theory posits that the welfare state is responsible for parents declining function concerning their children’s socialisation. One of the mechanisms contributing to the weakening parent’s rights and duties is perceived to be the introduction of sex education in schools. See Wyness (1996) for a more detailed description of this theory.
to teach and how to teach it. Some parents found it easier to answer their children’s questions after the school had been involved (Wyness 1996). Traditionally, in Britain sex education has been framed in the context of physiological and biological knowledge. The integration of sex education into PSHE is a very recent development (Measor et al. 2000). Yet the moral content of sex education is a more difficult issue, as well as who ought to be responsible for it (Wyness 1996).

Unfortunately many teachers are not likely to feel as competent as parents perceive them in this respect. A survey of providers of Initial Teacher Training showed that STIs, relationships, sexual health services, condoms and emergency contraception rated very low in terms of quantity and quality of coverage. Respondents felt that trainees were not likely to be highly competent teachers of SRE (Forrest 2002). Teachers may feel uncomfortable engaging pupils in role play even if they have received training in how to deliver a particular sex education programme (Buston et al. 2002). In the light of the important role of teachers in providing information and advice to boys and young men (BMRB 2002; Durex 2002), this is an important issue to address.

Youth work has been identified as a promising site, away from the intimacy (and embarrassment) of family and formal delivery (and restrictions) of school. “The voluntary nature of the relationship between youth workers and young people puts them in ideal position to offer young people, when they are ready, the information and support they need to develop safe and responsible sexual relationships” (Teenage Pregnancy Unit 2001b, p. 4).

There has been an interest in involving young people as peer educators (Teenage Pregnancy Unit 2002b). Peers have been identified as providing information and as a source of material for developing a ‘sexual script’, albeit the information may not be accurate and the ‘sexual script’ developed may not be a ‘safe’ sex sexual script. Training young people in delivering sex education may overcome some communication problems between adults and adolescents. However, the term ‘peer group’ has been only loosely defined and adult definitions may differ from how young people would define this term (Kidger 2002; Shucksmith 2002). There is also the question whether employing peer educators loads responsibility on young people’s shoulders letting adults off the hook who may find it difficult to deliver sex education (Mack 2002). Another problem is that this work has not been systematically evaluated and there is little detailed understanding about the processes involved. Consequently, the design and implementation of new peer education programmes lack validated guidelines concerning timing, recruitment, nature of the targeted behaviour, effects on participants etc. (Milburn-Backett 2001). The Teenage Pregnancy Unit (2002b) has published a guide to establishing sex and relationships peer education projects in order to redress this problem.

In general, a need for more male role models and more male practitioners working with boys and young men has been expressed (National Council of Voluntary Child Care Organisation 2002). This may overcome boys’ resistance to sex education as observed in school sex education (Measor et al. 1996; Measor et al. 2000). However, as pointed out for the provision of training programmes for trainers, just being a man does not automatically result in being a good trainer and women also provide high quality training around masculinity and sexuality (Biddulph and Blake 2001). There is a need to examine critically what is a positive male role model, whether there is only one or more positive male
role models, and how boys and young men would benefit from that. Additionally, even if research were to support the need for involvement of men working with boys and young men, to provide young people with male role models is hampered by the lack of men in ‘caring roles’

A consultation with schoolboys identified the characteristics of a good sex educator as

**A good sex educator:**

- Knows his or her stuff;
- Doesn’t get embarrassed;
- Has a sense of humour – he or she makes it fun;
- Doesn’t ridicule or embarrass pupils;
- Is able to control the class;
- Is either male or female, but with some male input for certain aspects of sex education

(source: Sex Education Forum 1997, p5)

Inviting health care practitioners into school to support sex education may, for example, result in a sex education provider who is less likely to be embarrassed. However, then there may be problems of controlling the class (Measor et al. 2000).

**Who should be targeted?**

Clearly boys and young men have been identified as being in need of careful targeting. Additionally the identification of risk factors concerning teenage conception and pregnancy has provided a list of particularly vulnerable people: young people who do not attend school; young people who are looked after by or who are leaving, local authority care services; young people who are homeless; young people who are the children of teenage parents; young offenders. These are also the groups of young people most difficult to reach (Meyrick and Swann 1998; Health Development Agency 2001). Little is known about the needs of ethnic minorities (Health Development Agency 2001). The lack of male workers from ethnic minorities may compound this.

Young people in public care may have experienced many traumatic events, which may include sexual abuse, which may affect their understanding of sex, sexuality and personal relationships. They may lack skills and confidence to form and sustain positive relationships with other people. Additionally they are less likely to receive guidance and support from parents and carers, and they are more likely to have missed school-based sex education. Boys in public care may feel that they have no one to turn to. However, to enable boys to take responsibility for their sexual behaviour and enable them to make informed sexual choices they need support by staff, residential care staff and foster carers. Especially male carers need to make an effort to make sex education available to boys. (Sex Education Forum 1998)
Working with children who have been sexually abused makes the delivery of individualised programmes necessary. It cannot be assumed that because a young person has been sexually active in whatever circumstances, he or she knows about how their bodies work, about contraception and about sexual health protection (Sex Education Forum 1998). However, when working with young people one never can be certain whether one or more are or have been sexually abused. Therefore it is important to develop programmes that are suitable for all, offer information that would allow young people to make the next step in order to receive help, and to support group work with survivors (Mack 2002).

Children with disabilities have the same right and need to receive SRE education. Topics covered should not differ from topics covered with children with no disabilities, although they may require specific advice depending upon their disabilities. However, it needs great care to ensure that the intended messages are getting across to young people, particularly when addressing pupils with learning difficulties (Stewart and Ray 2001). An important aspect of SRE for young people in need of intimate care is to develop knowledge about what is acceptable behaviour, from staff as well as from a child, for example meeting strangers. Young people with disabilities may be vulnerable to exploitation abuse. Therefore it is important to support children in developing the ability to recognise and respond to abusive behaviour (Stewart and Ray 2001). Again, this may be more a question of method of delivery than of content. It can be assumed that all young people should be able to recognise and respond to abuse, and have an understanding of acceptable behaviour.

How to reach boys and young men?

Research comparing data from Europe shows that a climate of openness and acceptance and the way in which sexual behaviour is socially represented affects the effectiveness of local and national interventions (Jones 1986; UNICEF 2001). Successful sex education for boys and young men has to reach behind the mask of masculinity as it is constructed, for example, in schools (Mac An Ghaill 1994; Sex Education Forum 1997). This may sometimes be difficult for practitioners, particularly if boys and young men demonstrate hostility towards sex education. Here it is important to understand that boys may feel threatened, not because sex education messages challenge boys’ relationships with girls and femininity, but because these messages are incompatible with the ways boys structure relations between themselves (Forrest 2000). However, positive written evaluation and, for example, the demands by boys to be taught on the issue of homosexuality and relationships stand in sharp contrast to displayed behaviour (Measor et al. 2000). Teachers working with young people need to reflect on the difficulty and perhaps inappropriateness of taking a ‘gender neutral’ approach, and particularly on their attitudes towards boys and young men (Sex Education Forum 1997).

Accepting the wider context of the construction of masculinities (Mac An Ghaill 1994), leads to the acknowledgement that addressing issues like bullying successfully, can create an atmosphere where boys can ask for help and advice, and are allowed to show feelings (Sex Education Forum 1997). The
way in which sex education is organised also needs to be specified (Sex Education Forum 1997). Successful sex education can only be delivered in a safe environment. This can be achieved by developing confidentiality policies, by avoiding the ‘need’ for personal exposure and recognition that not everything can be dealt with within the group setting (Sex Education Forum 1997; Biddulph and Blake 2001).

Some methodological problems in delivering effective sex education is connected to the situation and the context within which it is delivered. Being part of a captive audience may be one reason why boys had a seriously disruptive impact on many of the sex education lessons that were observed in one study (Measor et al. 2000). In order to overcome problems of reaching boys and young men a separation of boys and girls – at least for education around issues of contraception and STIs has been suggested (Wood 1998). Same-sex sessions have been recommended in order to protect girls from male harassment and to have the chance to develop programmes that meet boys interests and needs (Measor et al. 1996). Yet the approach to separate girls and boys during sex education has been questioned (Blake 1997). Research by Wight and Charles (2000) showed that working in small mixed-sex groups had the advantage that boys worked better in them, because they were partially liberated from defensive masculine norms. Girls were more willing to apply themselves to the exercises and male participants sometimes became involved and interested in opposite gender perspectives (Wight and Charles 2000). McNulty and Richardson (2002) also found that young people who had experienced sex education, either in same-sex or mixed-sex groups, did identify advantages and disadvantages for each.

Another approach emphasises the different learning styles of boys and girls. Hilton (2001) recommends the use of videos or theatre, and to combine teaching methods in a way that takes into account boys reluctance to talk and their preference for short factual answers. Active learning methods seem to work well – task-focused activities; using music or other aspects of culture popular with boys; also circle time\(^\text{10}\) to address emotions, feelings and relationships. A project that allowed boys with emotional and behavioural difficulties to develop a puppet show appeared to be successful in allowing boys to express emotions and gain self-esteem (Sex Education Forum 1997). Whether these observations by involved practitioners have a lasting effect on boys’ ability to express emotions and self-esteem has not been measured.

A review of a variety of different programmes delivered in the US and Canada concludes that active learning methods: scenario activity and role play, work best in sex education (Kirby et al. 1994). Yet in the context of the Scottish education system, attempts to use role play resulted in embarrassment and proved to be counter productive (Wight et al. 2002). Another research team also planned an intervention as a scenario activity and a role play with a male lead role on the grounds that research has shown that boys tend to feel excluded from sex education (Lenderyou and Ray 1997). However, pupils thought this unrealistic and the lead role was changed to a female. Finally role play was dropped because pupils found it difficult to actively engage with it. (Graham et al. 2002). Yet young men and

\(^{10}\) Circle time allows members of a group to communicate with each other more easily, by sitting in a circle. Often this allows creating a less formal atmosphere.
women in a small scale study in England suggested role play and opportunities to practice talking about
sex with a partner would help them to rehearse how to negotiate sexual encounters (McNulty and
Richardson 2002).

Role play exercises designed to enhance pupils’ skills to deal with situations in which they might take
sexual risks, may not work because pupils lack experience of sexual relationships, their unfamiliarity
with this kind of analysis and their wish to avoid disclosing details of their own relationships. This can
be avoided by providing surrogate experience of sexual negotiation instead of role play, e.g. transcripts
of interviews with young people about their first sexual experiences, or video demonstrating a romantic
relationship without sex, how young women can resist pressure to have sex and how young people can
acquire, discuss and use condoms correctly (Wight and Charles 2000). A good way to overcome
embarrassment is the secret box approach to answer questions pupils do not dare to ask (Measor 1989)
and to answer questions that were not asked but educators felt that should be addressed (Holly 1989).

Independent of whether sex and relationship education emphasises the promotion of knowledge, of
skills or the exploration of masculinity practitioners will be confronted with choosing appropriate
language and material. Young people frequently find it difficult to find acceptable vocabulary to
discuss sexual desire in classroom settings (Wight et al. 2002) or in other environments. Young people
may not want practitioners using slang or using medical terms that they may not understand and creates
a too distant atmosphere (Mitchell and Wellings 1998b). In a study by Measor et al. (1996) boys taking
part in school sex education felt that the material used was inappropriate because they ‘knew it all
before’. Perhaps one of the difficulties with sex education is that young people know a lot, but what
they need is, an opportunity to explore and challenge attitudes regarding sex and sexuality, and support
in developing skills may not be offered.

In the same study boys stated that they value pornography because “it provided specific and explicit
information about what to do in a sexual situation” (Measor et al. 1996), or in general about the female
body (Holland et al. 1993). This learning valued by boys and young men could be captured and
presented in other ways. One of the problems with pornography is that it contributes to unrealistic
expectations, rendering boys and young men, as well as their female partners, vulnerable. Sex
education lessons in school may be perceived to be too tame. However, behaviour observed during sex
education lessons indicates considerable male anxiety about sex and sexuality (e.g. expressed by jokes
about penis size). Status can be won or lost by having or lacking knowledge about sex in adolescent
male culture (Mac An Ghaill 1994; Measor et al. 1996) – at least in the school environment. Situations
like sex education lessons that may expose ignorance are a threat to the developing adolescent
masculinity (Measor et al. 1996). Boys were more positive about the topic of contraception when it
offered specific information showing how to use contraceptives or how to stop ‘getting a girl pregnant’. The
positive evaluation of sex education written by boys stands in great contrast to the disruptive
behaviour of many boys in classes where contraceptives were demonstrated. (Measor et al. 2000).

Material used for working with boys and young men needs to be reviewed and checked according to
what forms of masculinity are reinforced or presented in them (Sex Education Forum 1997). The Sex
Education Forum (1997) advises practitioners to scrutinise images used for sex education along these questions:

**Do images in teaching resources:**

- Polarise women and men and, if so, are men presented as the bad guys?
- Address emotional aspects of male sexuality, or do they present male sexuality as primarily physical?
- Represent men in competition with one another and, if so, are women shown to be the reward?
- Depict men as sexually irresponsible and women as the enforcer of sexual safety and sexual morality?
- Present a narrow definition of what it is to be a man?
- Prescribe roles for men that are restrictive and constraining?
- Represent male sexual desire as more potent, more urgent than female sexual desire?
- Visually promote the norms of heterosexuality?
- Present the visual context for sex as being disease, reproduction or pleasure?

(Source: Carey Jewitt - prepared for the Sex Education Forum in: Sex Education Forum 1997, p 5)

Choosing material for use with vulnerable people needs particular attention. Programmes for young people who have been sexually abused need to be carefully adapted to the individual’s needs. Attention has to be given to ensure that appropriate material is used. For example, videos and photographs are not suitable materials for young people where filming and picture taking was part of the abuse (Sex Education Forum 1998). As mentioned before, young people attending sex education programmes may be sexually abused without disclosing it. Material has to be chosen so it is suitable for all young people.

A less direct approach is to place adverts in magazines and TV and radio programmes. A central component of the Teenage Pregnancy Strategy is media activities (Social Exclusion Unit 1999; Department of Health et al. 2002). The impact of the media campaign is measured by a tracking survey of young people in a number of waves (BMRB 2002)\(^1\). Boys’ awareness of any advertising or publicity remained the same at the first wave as at the benchmark survey at 49 per cent but declined to 44 per cent at wave four. Boys were less likely to recognise radio and particularly magazine ads (magazines only 25 per cent of boys but 49 per cent of girls). The highest recognition concerned adverts promoting the use of contraception, in particular to wear a condom, and when having sexual

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\(^1\) The first wave served to develop a benchmark and took place in October/November 2000, just when the first phase of media campaign started. The second wave of survey took place in February/March 2001, when the first phase of media campaign had been running for about four months. The third wave of surveys took place in June/July 2001 during a quiet phase of the media campaign. Wave four was undertaken in October/November 2001, when phase two of the media campaign had been running approximately one month.
relationship to engage in safe sex (BMRB 2002). Some of the recognition, particularly at wave one when the campaign was just beginning has been attributed to ‘noise’ in the media about teenage pregnancy. As mentioned earlier the government seeks to develop further private sector partnerships, particularly with brands that appeal to boys and young men (Department of Health et al. 2002).

When pamphlets on condom use and coupons for free condoms were sent to American teenage boys in 1987 a large percentage received them, read them and discussed them with friends and parents. It did not change attitudes toward STIs or birth control, nor were there differences in actual sexual activity or in the use of birth control. Kirby et al. (1989) conclude that as a sizable proportion of young men ordered condoms prior to first intercourse, therefore sending out pamphlets etc. may be an important early intervention. However, the extent of the positive impact may be questioned. If attitudes towards STIs or contraception do not change then the learning effect may come down to be able to order condoms.

There appears to be a certain tension when contemplating the difficulties in working with boys and young men. A focus on boy’s and young men’s behaviour in sex education situations can be read as ‘blaming the victim’. Yet moving the attention to practitioners responsible for sex education seems to call for more training and professionalism. Perhaps a wider framework of good pedagogical work within and outside of school – not only regarding sex education – would be beneficial in the long run.

**Evaluation**

That there is no clear evidence emerging from the variety of programme evaluations giving an indication of what precisely works in reducing teenage pregnancy, may be connected to research methods used. For example, Wight et al. (2002) point out that quasi-experimental studies show that sex education can beneficially affect young people's behaviour, whereas randomised trials show that they have no effect on young people's behaviour. Most of these studies were conducted in the USA. Researching knowledge, skills, attitudes and behaviour regarding to sexual health poses methodological challenges. It may be difficult to control for a multitude of variables when randomised trials are chosen as evaluation design. There were also ethical concerns of randomly assigning young people, classes or entire schools to treatment or control groups (Kirby 1999). These may be the reasons why only a few programmes have been subjected to this design. However, a division of studies into using either randomised trials or experimental or quasi-experimental design is not very clear cut. Kirby (1999) favours experimental designs with random assignment, as well as longitude studies. Another example is a study by Graham et al. (2002) where a cluster randomised controlled trial was applied. Wight et al. (2002) designed a cluster randomised study with follow up two years after baseline in order to research the effects of the SHARE intervention (Sexual Health and Relationships: Safe, Happy and Responsible), a teacher training programme plus a 20 session pack. They found that improved teacher-led whole class sex education has some beneficial effect on the quality of young people's sexual relationships but do not influence reported sexual behaviour. Kirby et al. (1994; 2001b), researchers based in California, draw our attention to important methodological issues. In 1994 Kirby et al. published the review of 23 studies of school-based sex education programmes delivered in the...
USA and Canada (in a variety of settings, a variety of target groups and using a variety of methods). They conclude that the methodological difficulties resulted in major limitations of the studies. Difficulties include the need to rely upon respondents’ recall of whether or not they received sex education, to measure in any detail the characteristics of sex education and the problem of controlling for all other explanatory variables that might produce spurious relationships between education and sexual behaviour (Kirby et al. 1994). A later review of 73 studies lead to the development of a conceptual framework ‘social norms – connectedness’ (Kirby 2001b). Methodological problems are connected to the difficulty to provide objective measures of the extent to which programmes present a clear message and of the extent to which programme leaders can form connections with young people. Additionally it would be necessary to measure simultaneously the impact of family, peer and partner norms upon sexual behaviour (Kirby 2001b). However Kirby et al.’s (1994; 2001a) reviews indicate that primary prevention strategies evaluated to date do not delay the initiation of sexual intercourse, improve use of birth control among young men and women, or reduce the number of pregnancies in young women. Yet when boys and young men are beginning to access family planning services, as for example is being reported in Northumberland (Gelder et al. 2002), or when boys and young men become peer educators (McNulty and Turner 1998) this may be an indicator for imminent changing behaviour of boys and young men. The first step is, in a literal sense, to reach boys and young men. They need to know that projects, programmes and services exist, and they need to feel comfortable to make use of them. Innovative approaches of how to reach boys and young men, for example the C-Card Scheme in Newcastle, appear to be successful (Teenage Pregnancy Unit 2002a). A closer look at processes that lead to these changes and listening to boys and young men will fill the gaps that are inevitable when compiling quantitative data based on questionnaires and statistical analysis.

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