

**Contraceptive Careers: Young Women's Choices,  
Influences and Risks**

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## Abstract

**Background:** Reducing rates of unintended pregnancy among young women in the United Kingdom (UK) requires that we understand why young women use particular contraceptive methods, why they stop using them, and why, in turn, they switch to other methods. The majority of studies in this area have been quantitative, and few have taken place in the UK. This study examines the patterns of contraceptive use among young women from the East of Scotland, and uses a qualitative approach to explore if they have contraceptive careers.

**Methods:** Quantitative analyses of data collected as part of the SHARE (Sexual Health and Relationships) Sex Education Trial were used to explore young women's contraceptive use, discontinuation, method switching, and patterns of use over time at age 16. In-depth interviews were conducted with 20 young women from this sample to examine their full sexual and contraceptive histories and the contexts within which they occur. Purposive sampling was used to select a heterogeneous sample of young women at age 20 based on sexual experience, area of residence, educational attainment and social background.

**Findings:** Young women's contraceptive use is complex and, in the quantitative data, multiple individual patterns of use were apparent. In the qualitative study, three contraceptive career types were apparent: consistent, complex, and chaotic. Consistent contraceptive careers were characterised by uniform and regular use over time; complex by manageable change depending on relationships, partner type, and experiences of method use; and chaotic by frequent method changes and multiple experiences of contraceptive failure, which were further complications in their already, somewhat disordered lives.

All of the young women who were interviewed recognised their need for contraception but their ability to manage use, and therefore their experience of method discontinuation and contraceptive risks, varied depending on career type. All reported that they had changed their contraceptive method at least once, although most had only used condoms or the contraceptive pill. Most change was between these two particular methods. The need for pregnancy prevention underpinned all of the young women's contraceptive choices, but for each method there were specific push factors, which encouraged use, and pull factors, which discouraged use. Ease of access and social norms around use encouraged condom use but the young women's personal dislike of the method and their experience of condom

failures resulted in change to the pill, particularly once the young women were in relationships with boyfriends. The pill was perceived to be more reliable, and its non-contraceptive benefits, particularly menstrual regulation, set it apart from other available methods and encouraged continued use. Use of alternative methods, such as long acting reversible contraceptives (LARC), was only initiated when the young women experienced major problems or side effects with the pill and change was advocated by a health professional. However, all who used alternatives, discontinued use because they disliked the side effects they experienced. Half had had unprotected sex, and for a few this was an unplanned, unexpected, one-off event, but for most it was a frequent behaviour, which became the norm. Most had used emergency contraception at some point, mainly as a result of contraceptive failure, and it remained a temporary, back-up method rather than a regular contraceptive.

**Conclusions:** Contraceptive discontinuation and method switching was common among the young women in this study. Assessing their different patterns of use demonstrated that for some, contraceptive use was straightforward, while for others, it remained a constant struggle. A range of contraceptive methods should be made available to young women as one size does not fit all. However, it is important to recognise that pill use can be unproblematic if managed well. Sexual and reproductive health policies and interventions should consider what might really suit each individual young woman, based on her lifestyle and contraceptive experiences.

# Table of Contents

<b>Abstract</b> .....	2
<b>Table of Contents</b> .....	4
<b>List of Tables and Figures</b> .....	8
<b>Acknowledgements</b> .....	10
<b>Author’s Declaration</b> .....	11
<b>Chapter One</b> .....	12
1.1 Introduction.....	12
1.2 Aims of the Study.....	12
1.3 Research Questions.....	12
1.4 Contraception.....	13
1.4.1 <i>A Brief History</i> .....	13
1.4.2 <i>The Efficacy of Contraceptive Methods</i> .....	14
1.4.3 <i>Side Effects and Problems with Contraceptive Use</i> .....	14
1.5 The UK Context.....	16
1.6 The Career Concept.....	18
1.7 Thesis Chapter Plan.....	18
<b>Chapter Two – Literature Review</b> .....	20
2.1 Introduction.....	20
2.2 Methods.....	20
2.3 Factors Associated with Contraceptive Use and Non-use.....	21
2.3.1 <i>Structural, Cultural and Social Factors relating to Contraceptive Use</i> .....	21
2.3.2 <i>Psychological &amp; Individual Factors relating to Contraceptive Use</i> .....	24
2.3.3 <i>Relationship Factors relating to Contraceptive Use</i> .....	26
2.3.4 <i>Availability and Accessibility Factors relating to Contraceptive Use</i> .....	28
2.3.5 <i>Medical Factors relating to Contraceptive Use</i> .....	29
2.3.6 <i>Summary</i> .....	31
2.4 Contraceptive Discontinuation and Method Switching.....	31
2.4.1 <i>Rates of Contraceptive Discontinuation and Method Switching</i> .....	31
2.4.2 <i>Factors Associated with Discontinuation and Method Switching</i> .....	33
2.4.3 <i>Summary</i> .....	36
2.5 Patterns of Contraceptive Use.....	36
2.5.1 <i>Patterns of Contraceptive Use: Quantitative Study</i> .....	37
2.5.2 <i>Explaining Patterns of Contraceptive Use: Qualitative Studies</i> .....	37
2.5.3 <i>Summary</i> .....	44
2.6 Conclusions.....	45
<b>Chapter Three – Quantitative Analysis of Young Women’s Contraceptive Use</b> .....	47
3.1 Introduction.....	47
3.2 Methods.....	48
3.2.1 <i>The SHARE Sample</i> .....	48
3.2.2 <i>Sample Inclusion</i> .....	48
3.2.3 <i>Data Considerations</i> .....	49
3.2.4 <i>Data Analysis</i> .....	50
3.3 Results.....	50
3.3.1 <i>Contraceptive Use</i> .....	50
3.3.2 <i>Influences on Contraceptive Use</i> .....	51
3.3.3 <i>Patterns of Contraceptive Use</i> .....	59
3.3.4 <i>Consistency and Change in Young Women’s Patterns of Contraceptive Use</i> .....	69
3.4 Discussion.....	70
3.4.1 <i>Contraceptive Use</i> .....	70
3.4.2 <i>Influences on Contraceptive Use</i> .....	71
3.4.3 <i>Contraceptive Method Switching and Discontinuation</i> .....	72
3.4.4 <i>Patterns of Contraceptive Use</i> .....	73

3.4.5	<i>Limitations of the Quantitative Data</i> .....	76
3.5	Conclusions .....	77
<b>Chapter Four - Methods</b> .....		79
4.1	Introduction .....	79
4.1.1	<i>Aims of the Study</i> .....	79
4.2	Research Methods .....	80
4.2.1	<i>Pilot Study</i> .....	80
4.2.2	<i>Interview Schedule</i> .....	81
4.2.3	<i>Sampling</i> .....	83
4.2.4	<i>Recruitment</i> .....	85
4.2.5	<i>The Sample</i> .....	86
4.2.6	<i>Data Analysis</i> .....	88
4.3	Methodological Considerations .....	90
4.3.1	<i>Why Do a Qualitative Study?</i> .....	90
4.3.2	<i>Qualitative Interviewing – Talking to Young Women</i> .....	91
4.3.3	<i>Sensitive Topics – Talking about Sex</i> .....	94
4.3.4	<i>Reflexivity – Researcher Influence</i> .....	95
4.3.5	<i>Participants’ Representations of Self</i> .....	96
4.3.6	<i>Interpreting the Data</i> .....	98
4.3.7	<i>The Reliability and Validity of the Study</i> .....	99
4.3.8	<i>Limits of Generalizability</i> .....	99
4.4	Conclusions .....	100
<b>Chapter Five – Young Women’s Contraceptive Use</b> .....		101
5.1	Introduction .....	101
5.2	The Sample .....	101
5.3	Characteristics of the Interviewees .....	102
5.3.1	<i>Family and Living Arrangements</i> .....	102
5.3.2	<i>Education and Employment</i> .....	102
5.3.3	<i>Sexual History and Relationship Experience</i> .....	103
5.3.4	<i>Pregnancy and Sexually Transmitted Infections</i> .....	108
5.3.5	<i>Knowledge of Contraceptive Methods</i> .....	111
5.3.6	<i>Learning about Contraception</i> .....	112
5.3.7	<i>Accessing Contraception – Reproductive Health Service Use</i> .....	116
5.3.8	<i>Contraceptive Use</i> .....	117
5.4	Typology of Contraceptive Careers .....	118
5.4.1	<i>Consistent Contraceptive Careers</i> .....	118
5.4.2	<i>Complex Contraceptive Careers</i> .....	119
5.4.3	<i>Chaotic Contraceptive Careers</i> .....	121
5.5	Differences and Similarities between the Contraceptive Careers .....	122
5.6	Summary .....	124
<b>Chapter Six – Condoms</b> .....		126
6.1	Introduction .....	126
6.2	Condom Use .....	126
6.3	Push Factors – Reasons for Using Condoms .....	127
6.3.1	<i>Accessibility</i> .....	127
6.3.2	<i>Social Norms and Expectations of Condom Use</i> .....	130
6.3.3	<i>STI Prevention</i> .....	131
6.4	Pull Factors – Reasons for Discontinuing Condom Use .....	133
6.4.1	<i>Condom Dislike</i> .....	133
6.4.2	<i>Condom Failure</i> .....	135
6.4.3	<i>Expectations of Stopping Condom Use with Boyfriends</i> .....	137
6.5	Summary .....	139
<b>Chapter Seven – The Contraceptive Pill</b> .....		141
7.1	Introduction .....	141
7.2	Pill Use .....	141
7.3	Push Factors – Reasons for Using the Pill .....	142
7.3.1	<i>Greater Efficacy and Safety</i> .....	142
7.3.2	<i>Non-contraceptive Reasons for Use</i> .....	145
7.3.3	<i>Expectations of Pill Use with Boyfriends</i> .....	146

7.3.4	<i>Accessibility</i> .....	148
7.4	Pull Factors – Reasons for Discontinuing the Pill.....	150
7.4.1	<i>Experience of Side Effects</i> .....	150
7.4.2	<i>Forgetting to Take, or Running Out of the Pill</i> .....	151
7.4.3	<i>Not Having Sex</i> .....	152
7.5	Summary.....	153
<b>Chapter Eight – Alternative Contraceptive Methods</b> .....		155
8.1	Introduction.....	155
8.2	Alternative Contraceptive Method Use.....	155
8.2.1	<i>Injection</i> .....	155
8.2.2	<i>Progestogen-only Pill</i> .....	156
8.3	Push Factors – Reasons for Use of Alternative Contraceptive Methods.....	157
8.3.1	<i>Having to Stop the Pill (Side Effects / Problems with Routine)</i> .....	158
8.3.2	<i>Health Professional Influence</i> .....	159
8.4	Pull Factors – Reasons for Discontinuing Alternative Methods.....	161
8.4.1	<i>Experience and Dislike of Method Side Effects</i> .....	161
8.5	Reasons for not Trying Alternative Methods.....	162
8.5.1	<i>Negative Experiences of Others</i> .....	163
8.6	Summary.....	163
<b>Chapter Nine – Unprotected Sex and Emergency Contraception</b> .....		165
9.1	Introduction.....	165
9.2	Unprotected Sex.....	165
9.3	Push Factors – Reasons for having Unprotected Sex.....	167
9.3.1	<i>Unexpected / ‘Heat of the Moment’ Sex</i> .....	167
9.3.2	<i>Lack of Access to Contraceptives</i> .....	169
9.3.3	<i>Inability to Use Available Contraceptives</i> .....	170
9.3.4	<i>Misperceived Risk</i> .....	171
9.4	Pull Factors – Reasons for not having Unprotected Sex.....	174
9.4.1	<i>Regret</i> .....	174
9.4.2	<i>Experience of Pregnancy</i> .....	175
9.5	Emergency Contraception.....	176
9.6	Push Factors – Reasons for Emergency Contraception Use.....	178
9.6.1	<i>Unprotected Sex and Contraceptive Failure</i> .....	178
9.6.2	<i>Recognising Risk</i> .....	178
9.6.3	<i>Ease of Access to EC</i> .....	180
9.6.4	<i>Being Responsible and Taking Control</i> .....	181
9.7	Pull Factors – Reasons for Not Using Emergency Contraception.....	182
9.7.1	<i>Negative Perceptions of EC Use: Irresponsibility and Social Norms</i> .....	182
9.8	Summary.....	184
<b>Chapter Ten – Discussion</b> .....		186
10.1	Introduction.....	186
10.2	The Young Women’s Contraceptive Use.....	186
10.3	Reasons for Contraceptive Method Use.....	188
10.3.1	<i>Social Norms</i> .....	189
10.3.2	<i>Relationships</i> .....	195
10.3.3	<i>Access</i> .....	201
10.3.4	<i>Efficacy</i> .....	208
10.4	Young Women’s Contraceptive Careers.....	220
10.4.1	<i>Patterns of Contraceptive Use</i> .....	221
10.4.2	<i>Contraceptive Careers</i> .....	221
10.4.3	<i>How are Contraceptive Careers Different from other Models of Contraceptive Use?</i> .....	225
10.5	Summary.....	230
<b>Chapter Eleven – Conclusions and Recommendations</b> .....		232
11.1	Introduction.....	232
11.2	Aims of the Study.....	232
11.3	Main Conclusions.....	233
11.3.1	<i>What were the patterns of contraceptive use among these young women?</i> .....	233
11.3.2	<i>Did these young women have contraceptive careers?</i> .....	233
11.3.3	<i>What were the reasons for use and non-use of different contraceptive methods?</i> .....	234

11.3.4	<i>What were the sexual and reproductive health implications?</i> .....	236
11.4	Policy Implications and Recommendations .....	236
11.5	Strengths and Weaknesses of the Study .....	240
11.6	Recommendations for Future Research .....	242
<b>Appendices</b> .....		244
<b>References and Bibliography</b> .....		288

## List of Tables and Figures

### Tables

Table 3.1: Structural influences on contraceptive use (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)

Table 3.2: Peer influences on contraceptive use (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)

Table 3.3: Psychological and individual influences on contraceptive use (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)

Table 3.4: Relationship influences on contraceptive use (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)

Table 3.5: Availability and accessibility influences on contraceptive use (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)

Table 3.6: Medical influences on contraceptive use (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)

Table 3.7: Final model of influences on contraceptive use at first sexual intercourse (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)

Table 3.8: Final model of influences on contraceptive use at most recent sexual intercourse (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)

Table 4.1: Interview sampling frame (SHARE study numbers available for interview)

Table 4.2: Interview sampling frame (interviewee pseudonyms)

### Figures

Figure 3.1: Contraceptive use at first (N=1098), first with most recent partner (N=452), and most recent intercourse (N=993)

Figure 3.2: Flowchart of contraceptive pattern between first, first with most recent partner, and most recent sexual intercourse (condom use at first intercourse)

Figure 3.3: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (pill use at first intercourse)

Figure 3.4: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (pill and condom use at first intercourse)

Figure 3.5: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (pill, condom and emergency contraception use at first intercourse)

Figure 3.6: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (emergency contraception use at first intercourse)

Figure 3.7: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (non- use at first intercourse)

Figure 3.8: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (withdrawal at first intercourse)

Figure 3.9: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (condom put on just before ejaculation at first intercourse)

Figure 5.1: Contraceptive methods named and used by the young women

Figure 5.2: Consistent Contraceptive Career (Kate)

Figure 5.3: Complex Contraceptive Career (Megan)

Figure 5.4: Chaotic Contraceptive Career (Fiona)

Figure 6.1: Push and Pull Factors for Condom Use

Figure 7.1: Push and Pull Factors for Contraceptive Pill Use

Figure 8.1: Push and Pull Factors for Alternative Contraceptive Methods

Figure 9.1: Push and Pull Factors for Non-use of Contraception

Figure 9.2: Push and Pull Factors for Emergency Contraception Use

Figure 10.1: The Process of the Consistent Contraceptive Career

Figure 10.2: The Process of the Complex Contraceptive Career

Figure 10.3: The Process of the Chaotic Contraceptive Career

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## Author's Declaration

I declare that, except where acknowledged, all the work has been undertaken by myself.

A handwritten signature in black ink, reading "Lisa Margaret Williamson". The signature is written in a cursive style with a large initial 'L' and 'W'.

Lisa Margaret Williamson B.A.(Hons) M.Phil

# 1 Chapter One

## 1.1 Introduction

Improving the reproductive health of sexually active young women requires that they have access to, and are able to use, safe and effective methods of fertility control. In the United Kingdom (UK), levels of reported contraceptive use are high, yet so are rates of unintended pregnancy. This suggests that problems with contraceptive use, and discontinuation, may be a significant factor. To date, very few UK studies have examined this. Reducing unintended teenage pregnancy and improving contraceptive service provision continue to be major goals for policy makers. Understanding more about young women's patterns of contraceptive use will aid this endeavour.

## 1.2 Aims of the Study

The aims of this study, based on a sample of young women in the East of Scotland in the early 2000s, are to examine contraceptive use, to assess patterns of use, and to explore the concept of contraceptive careers. These issues are addressed through the following four research questions.

## 1.3 Research Questions

*(i) What were the patterns of contraceptive use among these young women?*

The first step was to profile the young women's contraceptive use, and to examine their patterns of use. This involved mapping and comparing their individual patterns of contraceptive use.

*(ii) Did these young women have contraceptive careers?*

Could these patterns be described as contraceptive careers? Was there one particular pattern, or set of patterns, they all followed?

*(iii) What were the reasons for use and non-use of different contraceptive methods?*

Why did the young women use or not use particular contraceptive methods, and why did they change from one method to another? What factors were associated with these changes? What roles did their backgrounds, partners, parents and peers have? Did young women from socially disadvantaged backgrounds have different experiences than those from more advantaged ones? What role did efficacy, of method and user, have? Finally, was it maintenance, rather than initiation, of contraceptive use that was problematic in public health terms?

*(iv) What were the sexual and reproductive health implications of young women's contraceptive patterns?*

Finally, the study will conclude by addressing the sexual and reproductive health implications of its findings. Did different patterns of contraceptive use have different sexual and reproductive health implications? How did the different experiences of the young women affect their sexual and reproductive health?

## **1.4 Contraception**

### **1.4.1 A Brief History**

The desire to control fertility has been evident throughout societies and throughout time (Connell 1999; Himes 1963), but the experience changed considerably with the introduction of the contraceptive pill in the 1960s. Advances in medical methods of contraception are important, and the introduction of the pill, in particular, gave women access to a method that was both more effective and female centred. Unlike women in the United States (US), few UK women ever used the diaphragm, instead relying on male methods such as condoms or withdrawal (Cook 2004). The introduction of the pill offered an alternative.

It was in the 1970s that the pill became more widely available to young women (Marks 2001), and in the UK, free National Health Service provision of contraception started in 1972 (Cook 2004). This was accompanied by the so-called revolution in sexual attitudes and behaviour of that period, and followed by changes in gender equality, but there is

considerable debate on the part the pill played in this (Cook 2004; Diczfalusy 2000; Marks 2001). Regardless, it is apparent that the introduction of the pill changed the reproductive health experience of a generation of women. Since then, long-acting reversible contraceptives (LARC), such as the implant and the injection, have been introduced. New contraceptive technologies, such as the contraceptive patch and the vaginal contraceptive ring, continue to be developed. Indeed, in May 2007, the US Food and Drug Administration licensed the first contraceptive pill designed to be taken every day to eliminate menstruation indefinitely (Garavelli 2007). While the newest contraceptive technologies described here are not yet widely available in the UK, the range of methods available to young women continues to grow.

### ***1.4.2 The Efficacy of Contraceptive Methods***

Contraceptive methods can be classed into different categories: natural family planning (rhythm method, withdrawal), barrier methods (male condom, female condom, diaphragm/cap, spermicide), and hormonal or LARC methods (combined contraceptive pill, progestogen only pill, injection, implant, intrauterine device (IUD), intrauterine system (IUS)). They offer varying levels of protection from pregnancy. Among women not using any contraception, 85% could be expected to become pregnant within a year (Kubba et al. 2000). In comparison, efficacy is highest for LARC methods, with less than 1% of users becoming pregnant within a year. While efficacy of the contraceptive pill is similarly high, it decreases with typical (i.e. imperfect) use; 5% of pill users would become pregnant with typical use. The greatest difference in efficacy between perfect and typical use occurs for barrier methods. For condoms, 3% would become pregnant with perfect use, 14% with typical use (Kubba et al. 2000). The difference in the figures for perfect and typical use demonstrates that contraceptive use is not necessarily straightforward. Compliance is a complex issue based on the user's personal characteristics and their comprehension of the chosen method, combined with their assessment of the contraceptive's efficacy, safety, non-contraceptive benefits, and side effects (Pinter 2002). Understanding young women's patterns of use requires recognition of this.

### ***1.4.3 Side Effects and Problems with Contraceptive Use***

The introduction of hormonal methods of contraception was heralded as a revolution, but these have not been without problems. Hormonal contraceptive use is associated with

increased risk of venous thromboembolism, stroke, breast cancer, cervical cancer and myocardial infarction (Bryden and Fletcher 2001; Heinemann et al. 1998; Kemmeren et al. 2001; Lewis et al. 1997; Walker 1998). However, the incidence of these side effects is low, screening of women for associated risk factors (i.e. smoking, high blood pressure) is effective, and they are less often associated with newer, lower dose methods (Heinemann et al. 1998; Lewis et al. 1997; Tyrer 1999). Other more minor and common side effects include weight change, breast tenderness, nausea, skin problems, abdominal bloating and irregular bleeding patterns (Bryden and Fletcher 2001). LARC methods have also been associated with weight gain and changes in bone density (Bonny et al. 2006; Clark et al. 2005; Kaunitz 1999a; Risser et al. 1999). Indeed, the association between the contraceptive injection and changes in bone density mean that it is no longer recommended for young women (National Institute for Health and Clinical Excellence 2005).

On the other hand, positive health benefits of hormonal contraceptives include: protection against ectopic pregnancy, pelvic inflammatory disease, ovarian cysts, benign breast disease, and endometrial and ovarian cancer (Bryden and Fletcher 2001; Kaunitz 1999b). Hormonal contraceptive use can also alleviate menstrual problems such as menorrhagia (heavy blood loss), dysmenorrhoea (painful menstruation), and irregular menstruation (Archer 2006; Bryden and Fletcher 2001; Kaunitz 1999b).

While free from such health-related side effects, non-hormonal methods are not without problems either. However, these are more often associated with method or user failure. Indeed, the experience of condom failure is relatively common (Crosby, Yarber et al. 2005; Crosby, DiClemente et al. 2005; Hatherall et al. 2005; Loxley 1996; Sanders et al. 2003).

These are important issues in understanding young women's patterns of contraceptive use. Method efficacy is based on the clinical definition of how effective the contraceptive method is at preventing pregnancy. Therefore, hormonal methods, like the pill, are more effective than barrier methods, like condoms. However, this definition does not account for young women's own experiences of use. What is clinically effective may be personally ineffective if, for example, side effects are experienced, or if coping with the routine of use is a struggle. This distinction is important. Where possible, therefore, user efficacy is considered separately from method efficacy throughout the thesis.

## 1.5 The UK Context

The majority of women of reproductive age in the UK are using contraception (Taylor et al. 2006). However, this varies by age. In the 2005/06 Office for National Statistics Omnibus Survey (a random probability survey of 3,000 households), only half of all 16-17 year old women were using contraception compared with two thirds of 18-19 year olds, and over three quarters of 20-24 year olds (Taylor et al. 2006). Among those defined as 'at risk' of pregnancy (in a heterosexual relationship and not pregnant or sterilised), over three quarters of women aged 16-29 years were using the pill or condoms, with one in five using both (Taylor et al. 2006).

In the UK, around a third of pregnancies resulting in births, and nine tenths of those resulting in abortions, are estimated to be unintended (Fleissig 1991; Lakha and Glasier 2006a; Schünmann and Glasier 2006). These unintended pregnancies are often the result of contraceptive failure rather than unprotected sex (Fleissig 1991; Schünmann and Glasier 2006). Note that 'unintended' is used here with recognition that there is debate over the interpretation of this term, and that the extent to which a pregnancy is 'intended' or 'unintended' could be reliant on numerous factors (Barrett and Wellings 2002). The UK also has one of the highest teenage pregnancy rates in the developed world; surpassed only by the US (UNICEF 2001). In Scotland in 2003/04, the teenage pregnancy rate was 42.4 per 1000 (Scottish Executive 2006). Unintended pregnancies among young women are of particular concern because of their association with deprivation and social disadvantage (Department for Education and Skills 2006). Indeed in Scotland, pregnancy rates (in 1991-1995) were almost three times higher among young women from the most deprived areas than among those from the most affluent (McLeod 2001).

In recent years, rates of common sexually transmitted infections (STIs), such as *Chlamydia trachomatis*, have also increased among young women (The UK Collaborative Group for HIV and STI Surveillance 2006). In 2005, young women aged 16-24 years accounted for over 70% of chlamydia and gonorrhoea diagnoses, and over 60% of (first attack) genital wart diagnoses in the female population (The UK Collaborative Group for HIV and STI Surveillance 2006). Using data from opportunistic screening programmes in the UK, it is estimated that around one in ten young women have chlamydia (LaMontagne et al. 2004; Williamson et al. 2007). However, in the National Survey of Sexual Attitudes and Lifestyles (NATSAL), prevalence of chlamydia was lower at the population level, with 3%

of women aged 18-24 years testing positive (Fenton et al. 2001). Levels of condom use are high among young women, with over three quarters of 16-19 year olds and almost two thirds of 20-24 year olds reporting use in the previous year. However, most cite pregnancy rather than STIs as the reason for use (Taylor et al. 2006).

Young women from disadvantaged backgrounds are more likely to experience adverse sexual and reproductive outcomes (Bonell et al. 2003; Bonell et al. 2005; HEA 1999; Jewell et al. 2000). Some studies report that teenage mothers are more likely to be living in poverty, have no qualifications, poor mental health, and have children with poorer health outcomes, as a result of their early pregnancies (Department for Education and Skills 2006). However, others suggest that having a child can be a positive experience for a young woman and question the construction of teenage motherhood as problematic (Breheny and Stephens 2007; Duncan 2007; Greene 2003; McDermott and Graham 2005). Having a child could be an attractive option given the limited alternatives available (Arai 2003; Coleman and Cater 2006; Greene 2003; HEA 1999; Hoggart 2006; Thomson 2000), and being brought up in disadvantaged communities where teenage pregnancy is common, could reinforce the normality, and the desirability, of this as a life choice (Arai 2003; Coleman and Cater 2006; Martyn and Hutchinson 2001; Thomson 2000). On the other hand, environments that promote educational attainment have been associated with the avoidance of negative sexual and reproductive health outcomes (Maxwell 2006). For these reasons, the impact of social disadvantage is given particular consideration in this thesis.

Improving the sexual and reproductive health of young people in the UK is a policy priority. This is reflected in the national sexual health strategies, at the centre of which is the aim of reducing unintended pregnancies and STIs (Department of Health 2001; Scottish Executive 2005). Why then, if contraception is widely available, and supported by UK policy, is its use problematic? As a young woman and a contraceptive user, I am acutely aware that use is not always straightforward. It is about much more than just having a particular method available at a particular time. Numerous studies have examined young women's contraceptive use, but few have researched their particular patterns of use and how or why these develop. This is the focus of my study. We need to understand why young women start using particular contraceptive methods, why they stop using them, and what path they take when they switch between methods. Doing so could aid in the design of appropriate interventions with the ultimate aim of improving the sexual and reproductive health of young women.

## 1.6 The Career Concept

The career concept is used here to examine young women's patterns of contraceptive use. A career can be defined as "a person's course or progress through life (or a distinct portion of life)" (Oxford University Press 1989). The career concept has been applied to the study of people's experiences of deviant behaviour, drug use, illness, and pregnancy (Becker 1963; Goffman 1961; Hunt 1997; Macintyre 1977; Roth 1963; Taylor 1993; Thomas 2003). The concept allows consideration of change over time, a person's path through this process, and the factors affecting this. Career studies rely on the common experiences of those involved, the experience of specific events at specific points in time, and a definite end-point or goal.

However, the use of this concept in a study of young women's patterns of contraceptive use is slightly problematic. Firstly, is there really a specific end-point or goal? The main goal of contraceptive use is pregnancy prevention, and it could be argued that the end-point is when young women find the most effective contraceptive method (in terms of both method and user efficacy). However, this suggests that an ideal will be reached with no more changes thereafter. As contraceptive use continues over the reproductive life course, this does not sound plausible. With the potential for future changes, perhaps young women's patterns of contraceptive use represent only the initial stages of the contraceptive career. Secondly, it is possible that patterns of use will be too varied for the career concept to meaningfully apply. This could be expected given the range of methods available to young women. However, it is entirely possible that there will be commonalities in their experiences. Using the career concept to examine these patterns is a tool towards explaining the process behind contraceptive decision making.

## 1.7 Thesis Chapter Plan

The thesis begins by reviewing the relevant literature on young women's contraceptive use (Chapter Two). Three specific topics are reviewed: reasons for contraceptive use and non-use, contraceptive discontinuation and method switching, and patterns of contraceptive use. Chapter Three uses quantitative analyses to explore the contraceptive use of a sample of young women from the East coast of Scotland, to examine the factors associated with contraceptive use among these young women, explore their consistency of use and method switching, and assess their patterns of use over time. Chapter Four presents the

methodology of the main qualitative research study, describing the sampling, recruitment, interview, and data analysis process. It also discusses the choice of a qualitative approach and the theoretical assumptions of the study.

The qualitative findings are presented in Chapters Five through Nine. Chapter Five introduces the 20 young women who were interviewed, and examines their individual patterns of contraceptive use. Chapter Six explores their use of condoms, focusing on why condom use is predominant during the early stages of their sexual histories, but replaced with other contraceptive methods over time. Chapter Seven explores the young women's use of the pill, focusing on why they start using the pill and why their use of this method is more consistent than their use of condoms. Chapter Eight explores their use of other, alternative, contraceptive methods, specifically the injection and the progestogen-only pill. Chapter Nine explores non-use of contraception (i.e. unprotected sex) and use of emergency contraception (EC), focusing on why some young women have unprotected sex but others do not, and why, and when, they use EC.

These findings, and how they relate to the literature, are discussed in Chapter Ten, before finally, I examine the young women's patterns of contraceptive use within the construct of the contraceptive career. Chapter Eleven presents the conclusions that can be drawn from the research, within the context of the original research questions, along with the policy implications, strengths and weaknesses of the study, and recommendations for future research.

## 2 Chapter Two

### Literature Review

#### 2.1 Introduction

In this chapter, literature relevant to the thesis is reviewed. The literature on contraceptive use is extensive but three specific topics are of interest here. First, the bulk of the literature focuses on reasons for contraceptive use and non-use. Understanding why young women do and do not use particular contraceptive methods is important because it can suggest reasons for contraceptive change. Second, some literature focuses specifically on contraceptive discontinuation and method switching. This is reviewed to address the extent of, and factors associated with, these issues. However, it is limited by the fact that few of these studies focus specifically on *young* women. Finally, a much smaller number of studies have examined patterns of contraceptive use. These studies are critically appraised to understand what young women's patterns of use might look like, and what the processes behind these are. The limitations of these studies provide the rationale for the research presented in this thesis.

#### 2.2 Methods

Literature searches were conducted using the following databases: Copac, Web of Science, Embase, Medline, Cambridge Scientific Abstracts, Psychlit, OCLC, Cinahl, Cochrane database, SOSIG, HEBS, and HEA. Literature from developing countries, on specific interventions, or which only focused on studies of young men was excluded. The literature searches were conducted using all combinations of the following terms: young woman/young women, young people, female, adolescence/adolescents, teenage/teenagers, girl/girls, contraception/contraceptives, condom, birth control, emergency contraception/morning-after-pill, sexual intercourse/safe sex/safer sex, and pregnancy/pregnant.

The abstracts from the references identified in the searches were reviewed and relevant papers selected for inclusion. Further references were identified via citation searches of key authors and hand searches of the reference lists of included papers. The original

searches were conducted in 2001, and updated in early 2006 (additional literature of relevance was added throughout 2006 and 2007).

## **2.3 Factors Associated with Contraceptive Use and Non-use**

A variety of factors in relation to young women's contraceptive use and non-use have been explored. In a recent review, Kirby (2002) identified over 100 antecedents of sexual initiation, contraceptive use and pregnancy. The factors associated with contraceptive use were related to community, family, peers, biology, ethnicity, educational aspirations, religiosity, relationships and sexual experiences, personality, health and risk taking behaviours, emotional well-being, and sexual beliefs, attitudes and behaviours (Kirby 2002). In the review presented here, factors associated with contraceptive use and non-use are organised into five sections: structural, cultural and social; psychological and individual; relationships; availability and accessibility; and medical. A brief overview of the literature is provided and factors of particular interest will be discussed in more detail in Chapter Ten.

### ***2.3.1 Structural, Cultural and Social Factors relating to Contraceptive Use***

Structural, cultural and social factors relating to contraceptive use include the influence of background characteristics, such as socio-economic status, and the influence of the family, peer groups, the media, and wider social norms.

#### **2.3.1.1 Background Characteristics**

Young women from low socio-economic status or poorer backgrounds are often found to be most at risk of not using contraception, and of unintended pregnancy (Arai 2003; Bonell et al. 2003; Bonell et al. 2005; HEA 1999; Kirby 2002; Martyn and Hutchinson 2001; Young et al. 2004). Teenage pregnancy rates are highest within the most deprived areas (McLeod 2001), and those from disadvantaged backgrounds often experience difficulties accessing reproductive health services (Jewell et al. 2000). Many of these young women feel excluded and have low educational aspirations or lack career-orientated future expectations (Bonell et al. 2003; Bonell et al. 2005; HEA 1999; Hoggart 2006; Jewell et al.

2000; Lamanna 1999; Stevens-Simon et al. 2005; Thompson 1995; White 1999). It is argued that:

“They do not typically plan to have sex and their generally passive and fatalistic attitudes towards life mean that contraception simply does not figure. Living life from day to day with little sense of the future does not encourage thought for the consequences of their actions.” (HEA, 1999, page 48).

This is a particularly important issue, and as described in Chapter One, a specific focus of my study.

Racial and ethnic differences in contraceptive use are regularly reported in much of the American literature (Kirby 2002), but are less often the focus of UK research. This is frequently because studies only achieve small sample sizes among ethnic minorities. However, particular expectations of young women within these communities have been reported to negatively affect their contraceptive use (French et al. 2005; Hennink et al. 1999).

Community and neighbourhood characteristics have also been found to influence both sexual activity and contraceptive use. Although contraceptive use has been reported to be lower in communities characterised by unemployment, poverty and social disorganisation (Baumer and South 2001; Brewster et al. 1993), a recent study using nationally representative data from the US National Longitudinal Study of Adolescent Health found that the only factor associated with not using contraception was living in a neighbourhood with more idle youth (Cubbin et al. 2005). The authors suggest that this factor represents a lack of positive role models or opportunities, which in turn can lead to lower future or career-orientated aspirations. Indeed, being brought up in disadvantaged communities where teenage pregnancy is common can reinforce the normality, and the desirability, of this as a life choice and reduce the likelihood of contraceptive use (Arai 2003; Martyn and Hutchinson 2001; Thomson 2000).

### **2.3.1.2 Social Norms of Sexuality**

Social norms around sexuality influence young women's contraceptive use by defining what is socially acceptable and expected behaviour for them. It is argued that the dominant discourse of female sexuality confines young women to a passive role in their sexual relationships, within which they cannot plan or prepare for sex (Allen 2003a; Gavey and

McPhillips 1999; Holland et al. 1998; Hudson and Ineichen 1991; Warr 2001). As such, using contraception is associated with being promiscuous, and this makes it difficult for young women to introduce contraception because doing so poses a threat to their sexual reputations (Browne and Minichiello 1994; Finlay 1996; HEA 1999; Hillier et al. 1998; Holland et al. 1998; Jackson and Cram 2003; Kirkman et al. 1998; Kitzinger 1995; Lees 1993; Milnes 2004; Stewart 1999b; Tolman 1994; White 1999; Wight 1992). However, other studies have argued that this may not necessarily be the case any more. Instead, changes in social norms have allowed young women to reject this dominant discourse and gain more control over their contraceptive use (Allen 2003a; Allen 2004; Gavey and McPhillips 1999; Jackson and Cram 2003; Milnes 2004; Stewart 1999a).

### **2.3.1.3 Family Influences**

Family influences which can have a positive effect on contraceptive use include positive parental expectations, family involvement and interaction, communication within the family (particularly in relation to sex education and communication between mothers and daughters), parental monitoring, the closeness of relationships and connectedness, and siblings' experiences (Aspy et al. 2007; Frisco 2005; Miller et al. 2001; Whitaker et al. 1999; Wight et al. 2006). However, discussions with parents can also be limited by embarrassment or concerns about disclosing sexual activity (HEA 1999; Sharpe 1987; Thomson and Scott 1991; West 1999).

### **2.3.1.4 Peer Group Influences**

In a qualitative research report from the English Health Education Authority (1999) friends' experiences was one of the main influences on the young people interviewed, particularly among the more vulnerable groups. Safer sex has been found to be more likely amongst individuals who report having friends who talk about and practise this (Lear 1995). Norms of contraceptive use can also be reinforced by peer support (Harper et al. 2004; HEA 1999; Lear 1995; Lindsay et al. 1999; Shoveller et al. 2004). On the other hand, peer stories can often contain misinformation and act to reinforce contraceptive 'myths', such as not being able to get pregnant if you have sex while standing up (Gilliam et al. 2004; HEA 1999; Kuiper et al. 1997; Sharpe 1987; Thomson and Scott 1991). Peer group information is regarded as highly credible, and stories based on friends' bad experiences with contraceptives are accepted as 'facts', regardless of their level of truth (Cheung and Free 2005; Gilliam et al. 2004; HEA 1999; Kuiper et al. 1997). Even if not

the most accurate, advice from peers is often the most salient (Buston and Wight 2002; HEA 1999; Holland et al. 1998; Sharpe 1987).

### **2.3.1.5 The Media**

The media is often described as a potential influence on contraceptive use, but the process of this influence is less well defined than that of some of the other factors discussed here. In fact, some have concluded that mass media contraception campaigns have limited effect on contraceptive use, due to the complexities of the subject (Batchelor et al. 2004; Bostock and Leathar 1982; Hudson and Ineichen 1991; Kuiper et al. 1997). Despite this, teen magazines are often reported by young people to be an important source of information on sex and contraception (Batchelor et al. 2004; Buston and Wight 2002; HEA 1999; Thomson and Scott 1991).

### **2.3.2 Psychological & Individual Factors relating to Contraceptive Use**

The psychological and individual factors relating to contraceptive use include issues of self-efficacy, self-esteem, comfort, planning, and motivations.

#### **2.3.2.1 Self-efficacy, Self-esteem, and Comfort**

Studies have shown that contraceptive self-efficacy and self-esteem are related to contraceptive use (Adler and Rosengard 1996; Gebhardt et al. 2003; Johnson and Green 1993; Longmore et al. 2003; Salazar et al. 2005; Seal et al. 1997; Sheeran et al. 1999; Speier et al. 1997; Tschann and Adler 1997). Young women who are more comfortable with their sexuality, and with interacting with the opposite sex, are more likely to use contraceptives (Hudson and Ineichen 1991; Stone and Ingham 2002). One study found that greater “sexual self-acceptance” led to better communication about contraception with partners and more frequent contraceptive use (Tschann and Adler 1997). Conversely, it is often those who lack these characteristics who do not use contraception (Coleman 2001; HEA 1999; Lees 1993).

### 2.3.2.2 Planning and Motivation

Failure to plan has been associated with non-use of contraception, particularly at first sex (Adler et al. 1997; Thompson 1995). The young women interviewed by Thompson spent a great deal of time planning their first sexual experiences, but contraceptive use was generally not part of this. Instead their plans centred completely on when, and with whom, it was going to happen. Research has also described how sex is often unplanned and opportunistic, and as such, there is little chance to plan for contraceptive use (HEA 1999). The context within which sex occurs has to be considered, and the use of alcohol is important here. Being drunk constrains the use of contraception, and as such is related to having unprotected sex (Coleman and Cater 2005; Dunn et al. 2003; Hoggart 2006). However, the literature is not entirely consistent, and others have argued that alcohol use is not always associated with condom non-use because it depends on the situation and the partner type (Cooper 2002; Leigh 2002; Morrison et al. 2003).

Related to this is the misperception often reported by young women that pregnancy cannot happen to them (Breheny and Stephens 2004; Finlay 1996; HEA 1999; Jones et al. 2002; Lamanna 1999; Larsson et al. 2002; Rainey et al. 1993; Sharpe 1987). If you do not think pregnancy will happen, you will not feel a need to use contraception. Some of the young mothers in Sharpe's (1987) study reported thinking that they could not get pregnant when it did not occur after their first experiences of unprotected intercourse.

Actual motivation to avoid pregnancy is also considered in a number of studies. When pregnancy is not desired, contraceptive use is more consistent (HEA 1999; Kuiper et al. 1997; Lamanna 1999; Woodson and Koo 1999), while among young women who are ambivalent, it is less consistent (Adler and Rosengard 1996; Breheny and Stephens 2004; Bruckner et al. 2004; Crosby et al. 2002; Hoggart 2006; Jaccard et al. 2003; Stevens-Simon et al. 1996; Zabin et al. 1993). White argues that, for some young women, having a child is linked to increased status:

“Motherhood becomes appealing if it is one of the few social statuses a young woman believes she can achieve.” (White, 1999, page 113).

It has been argued that the lack of alternative future aspirations makes having a child a more attractive option (Arai 2003; Bonell et al. 2003; Bonell et al. 2005; HEA 1999; Hoggart 2006; Jewell et al. 2000; Lamanna 1999; Stevens-Simon et al. 2005; Thompson

1995; White 1999; Young et al. 2004). On the other hand, having realistic expectations about what having a child would mean and how it would affect future plans, have been shown to predict young women's avoidance of pregnancy (Stevens-Simon et al. 2005).

### ***2.3.3 Relationship Factors relating to Contraceptive Use***

Young women make the majority of their contraceptive choices within sexual and romantic relationships. Factors influencing these include communication and negotiation, partner type, trust, and unequal power relations.

#### **2.3.3.1 Communication and Negotiation**

Communication with partners is one of the strongest predictors of contraceptive use (Coleman and Ingham 1999b; Edgar et al. 1992; Harden and Ogden 1999; Henderson et al. 2002; Sheeran et al. 1999; Stone and Ingham 2002). However, this can be problematic for young people (Coleman and Ingham 1999b; Hillier et al. 1998; Wight 1992). Coleman and Ingham argue that this is because having such discussions requires an indication of the intent to have sex, and many find this difficult. As condoms are worn by the male partner, they require more negotiation than other methods. Some studies have found that contraceptive use is less likely when it is the male partner who makes the decision (Buysse and VanOost 1997; Crosby et al. 2000; Plichta et al. 1992), although one found that some young women only avoided pregnancy because their partners insisted on using contraceptives (Martyn et al. 2002).

#### **2.3.3.2 Partner Type**

A number of studies have reported that condom use is more common with casual partners than in regular relationships with boyfriends (Bauman and Berman 2005; Crosby et al. 2000; Ford 1991; Fortenberry et al. 2002; Hatherall et al. 2005; Lear 1995; Plichta et al. 1992; Poppen and Reisen 1999; Woodsong and Koo 1999). In a survey of 16-24 year olds in South West England, Ford (1991) found that almost three quarters of females would insist on using a condom when they next had sexual intercourse with a new partner, but very few would do so with their current partner. Similarly, studies have reported that condoms are commonly replaced by the pill as relationships with boyfriends become more established and the perceived risk of STIs, or the partner being unfaithful, lessens (Bauman and Berman 2005; Crosby et al. 2000; Ford 1991; Hammer et al. 1996; Hirsch and Zelnik

1985; Holland et al. 1998; Kirkman et al. 1998; Lear 1995; Reisen and Poppen 1995; Schaalma et al. 1993; Skinner 1986; Thomas 1991; Woodsong and Koo 1999). This change represents a demonstration of trust. As White (1999) states, "Introducing condoms is an accusation; one's partner is guilty of either having had unsafe sex, or being diseased." (page 122). Holland et al. (1998) argue that safe behaviour evolves into unsafe behaviour as couples develop closer, more intimate relationships. Indeed, changing from condom to pill use demonstrates the seriousness of the relationship: "a way of showing someone that they are special" (Holland et al., 1998, page 50).

### **2.3.3.3 Unequal Power Relations in Relationships**

Much of the literature has argued that this change in contraceptive use in relationships is not necessarily a joint decision, because of unequal gender power relations between men and women (Browne and Minichiello 1994; de Visser 2005; Holland et al. 1998; Kirkman et al. 1998; Kuiper et al. 1997; Pollock 1983; White 1999). As I have discussed already, the dominant discourse of female sexuality defines a young women's role as passive. Therefore, she must appear sexually unknowing, or inexperienced, to protect her reputation, and cannot negotiate contraceptive use (Holland et al. 1998). Even if young women are able to successfully negotiate condom use within these constraints, it will not be maintained because their male partners will want to stop using condoms. Reports of male dislike of condoms, particularly in relation to reduction in sexual pleasure, are common in the literature (Browne and Minichiello 1994; Flood 2003; Hammer et al. 1996; Holland et al. 1998; Measor 2006). It is argued that young women then comply with this decision because they feel responsible for their partners' pleasure (Holland et al. 1998; Kirkman et al. 1998; Pollock 1983).

At the most extreme level, these inequalities, and the dominance of male power, translate into negative sexual pressure and coercion, although several studies report that some young people do have more egalitarian relationships (Allen 2003b; Chung 2005; Gavey 1991; Gavey et al. 2001; Hird 2000; Holland et al. 1998; Lamanna 1999; Maxwell 2006; Sharpe 2001; Stewart 1999a; Thompson 1995; Tolman et al. 2003; Tschann et al. 2002; White 1999). Relative power between partners in emotional intimacy and decision making, rather than gendered power, has also been found to be associated with condom use (Tschann et al. 2002).

## **2.3.4 Availability and Accessibility Factors relating to Contraceptive Use**

### **2.3.4.1 Sex Education**

School-based sex education could potentially be an important source of information on contraceptive use, particularly in relation to the availability and accessibility of methods. However, recently evaluated school-based sex education interventions within the UK have had limited effect, particularly in relation to improving contraceptive use (Stephenson et al. 2004; Wight et al. 2002). The potential of school-based programmes is widely recognised (Kirby et al. 2007), yet, questions of how best to deliver effective sex education, and what it should include, remain largely unanswered. Many young people report being dissatisfied with their school sex education, and what it includes, and what young people want to know may not necessarily be the same as what is taught (Abel and Fitzgerald 2006; Buston and Wight 2002; Fine 1988; Forrest et al. 2004; HEA 1999; Holland et al. 1998; Lear 1995; Thomson and Scott 1991; West 1999).

### **2.3.4.2 Access to Condoms**

It has also been suggested that knowing that condoms prevent pregnancy and STIs is not enough alone to encourage use (Adler and Rosengard 1996). Young people have to be willing to access them, and carrying condoms is one of the strongest predictors of use (Sheeran et al. 1999). However, desire to conceal sexual activity can still lead to embarrassment about buying condoms (HEA 1999). Studies have consistently reported that carrying condoms is problematic for young women because of the negative effect it can have on their sexual reputations (Browne and Minichiello 1994; Finlay 1996; HEA 1999; Hillier et al. 1998; Holland et al. 1998; Kirkman et al. 1998; Lees 1993; Stewart 1999b; White 1999; Wight 1992). As such, they often rely on their male partners to provide them (Mitchell and Wellings 1998). However, some studies suggest that some women do carry their own condoms (Coleman and Ingham 1999a; HEA 1999). Being able to obtain condoms from shops, pharmacies and vending machines is important for those who are unable to access services (Morrison et al. 1997; Stone and Ingham 2003). Another study found that obtaining free condoms from sexual health services was associated with consistent use (Parkes et al. 2005).

### **2.3.4.3 Access to Reproductive Health Services**

For contraceptive methods other than condoms, young women have to access reproductive health services, and variations in the availability and acceptability of these can influence contraceptive use (Hudson and Ineichen, 1991). Use of services is associated with knowledge of the service, accessibility, distance to clinics, attitudes of service providers, anonymity, confidentiality, embarrassment, and willingness to talk about sex (Aten et al. 1996; Burack 2000; Churchhill et al. 2000; Donovan et al. 1997; HEA 1999; Jaccard 1996; Morrison et al. 1997; Parkes et al. 2004; Seamark and Blake 2005; Sharpe 1987; West 1999). Indeed, a UK study found that almost a quarter of young women had been embarrassed, scared or worried about confidentiality before first attending a sexual health service (Stone and Ingham 2003). Young people living in rural areas face particular difficulties accessing contraceptive services (Hillier et al. 1998).

### **2.3.5 Medical Factors relating to Contraceptive Use**

Medical influences on contraceptive use involve factors related to the routine of use, the experience of side effects or contraceptive failures, and pregnancy and STIs.

#### **2.3.5.1 Contraceptive Routines and Method Failures**

The regime of the contraceptive pill has been reported to pose problems for users. Remembering to take the pill every day and what to do when one or more are missed, have been cited as reasons for discontinuation of the method (Balassone 1989; Breheny and Stephens 2004). Studies have shown that up to half of pill users will forget to take a pill during their monthly cycle (Fox et al. 2003; Lachowsky and Levy-Toledano 2002; Rosenberg et al. 1998; Wahab and Killick 1997). Hudson and Ineichen (1991) argue that this is particularly the case for young contraceptive users, who have difficulty remembering to take the pill due to infrequent intercourse or sporadic relationships. As a result, use of LARC methods, such as the injection or the implant, have been advocated as alternatives because they avoid this problem, and they have been positively evaluated by some young women because of this (Berenson and Wiemann 1993; Kuiper et al. 1997).

Experience of condom failure is another consideration, and this has been reported in a number of studies (Crosby, Yarber et al. 2005; Hatherall et al. 2005; Loxley 1996; Sanders et al. 2003), including one in which over one third of the sample had experienced condom

failure in the previous three months (Crosby, DiClemente et al. 2005). Such problems are associated with inconsistent use, and method discontinuation (Bracher and Santow 1992; Crosby, Yarber et al. 2005; Hammerslough 1984; Hatherall et al. 2005). Problems with the actual use of condoms (e.g. putting them on partners) are also related to inconsistent use among young women (Hatherall et al. 2005; Sanders et al. 2003).

### **2.3.5.2 Contraceptive Side Effects**

Perceived side effects and concerns over safety and efficacy are important for young women, particularly in the initial months of method use (Gilliam et al. 2004; Cheung and Free 2005; Weisman et al. 1991). Positive side effects, such as menstrual regulation, have been cited as reasons for hormonal contraceptive use (Johnston-Robledo et al. 2003), while menstrual irregularity resulting from use has been associated with the opposite (Clark et al. 2004). Issues around menstrual irregularity appear to be particularly important for young women, and menstrual suppression can lead to doubts about method efficacy and pregnancy (Clark et al. 2006; Cheung and Free 2005; Gilliam et al. 2004; Gold and Coupey 1998; Hatherall et al. 2005; Johnston-Robledo et al. 2003; Kuiper et al. 1997).

### **2.3.5.3 Experience of Pregnancy and STIs**

The actual experience of pregnancy, or a pregnancy scare, can influence contraceptive use (Coleman 2001; Hewell and Andrews 1996; Kershaw, Niccolai, Ickovics et al. 2003; Lamanna 1999; Orcutt and Cooper 1997; Pauku et al. 2003). While use commonly increases following such an experience, it is often only in the short-term. Kershaw, Niccolai, Ickovics et al. (2003) found that use increased in the first six months, but decreased thereafter. Furthermore, a recent systematic review found that adolescents who had experienced pregnancy were unlikely to use contraception and rates of repeat pregnancy and STIs were high (Meade and Ickovics 2005). These authors also found that the outcome of the pregnancy was important. Births were associated with subsequent use of long-term contraceptives such as the injection, but abortions or miscarriages were associated with subsequent inconsistent contraceptive use or repeat pregnancy.

Desire to prevent STIs influences condom use, but the extent to which young women think they are at risk can vary (Kershaw, Niccolai, Ethier et al. 2003). In much of the literature it is apparent that STIs are often viewed as a less salient threat than pregnancy (Abel and Brunton 2005; de Visser 2005; Flood 2003; Hatherall et al. 2005; Hillier et al. 1998; Lear

1995; Ott et al. 2002; White 1999). Young people's perception of STI risk is often general rather than personal, and may differ from the actual level of risk to which they are exposed (Abel and Brunton 2005; Hatherall et al. 2005; White 1999). Even actual experience of STIs has been found to have little effect on future risk behaviour (Kershaw et al. 2004).

### **2.3.6 Summary**

In this section I have described the literature on the factors associated with contraceptive use and non-use. Young women's contraceptive use is first and foremost affected by their social backgrounds, where they grow up, their families, their friends, and the norms that they support. Those from socially disadvantaged backgrounds are often most at risk of negative sexual and reproductive health outcomes. Contraceptive use is also affected by the individual characteristics of the young woman herself, including her own self-esteem and motivation, along with her ability to plan for this event. However, contraceptive use is generally not an individual activity, but occurs within a relationship, whether this is with a boyfriend or more casual acquaintance. Communication with partners is one of the strongest predictors of contraceptive use, and method use varies by partner type. Young women are subject to specific risks within relationships when decisions are based on trust or unequal power relations. Use can also be limited by the young women's knowledge of, and access to, different contraceptive methods. Finally, use is complicated further by previous experiences, particularly in relation to problems with particular methods (e.g. putting condoms on) and experience of side effects, pregnancy or concerns over STIs.

## **2.4 Contraceptive Discontinuation and Method Switching**

### **2.4.1 Rates of Contraceptive Discontinuation and Method Switching**

The focus in this section is on contraceptive discontinuation and method switching, and the factors facilitating these. The literature in this area, comprised of quantitative studies only, is not as extensive as that on general contraceptive use. It is also limited mainly to studies from North America.

There have only been four UK studies of contraception discontinuation (Lakha and Glasier 2006b; Rai et al. 2004; Rosenberg et al. 1995; Smith and Reuter 2002). The Rosenberg et

al. study of contraceptive pill use was conducted as part of a five city European comparison (Denmark, France, Italy, Portugal and the UK). It is based on street interviews with convenience samples of 16-30 year old women in two large urban cities in each country (the actual cities used are not reported). The authors report that over three quarters of the women surveyed were consistent and effective pill users, while one in ten regularly missed two or more pills per month (Rosenberg et al. 1995). Unfortunately, compliance rates were not reported separately by age group or country, and as the results were based on a convenience sample, they may not be representative of the wider population. The remaining UK studies were clinic-based reviews of Implanon® (a contraceptive implant) continuation rates, and these will be discussed further below.

Since the 1980s, a number of studies have used data from the US National Survey of Family Growth (NSFG) to examine method discontinuation and switching. The NSFG is a series of nationally representative surveys of the fertility, contraceptive use and pregnancies of women aged 15-44 years in the US. It was first conducted in the early 1970s. Although based on nationally representative data, most papers focus on all age groups rather than young women. In addition, the early papers focused on married women (Grady et al. 1983; Grady et al. 1988; Hammerslough 1984). Their incentives to maintain contraceptive use or avoid pregnancy could be quite different from those of unmarried women. However, the more recent papers do include unmarried women (Grady et al. 2002; Trussell and Vaughan 1999). In general, around one in ten women report contraceptive failure (in the first year of use), and around three or four in ten report discontinuing use of a method (Grady et al. 1983; Trussell and Vaughan 1999). Grady et al. (2002) also found that almost two thirds of unmarried women in the 1995 NSFG switched method during the first two years of use. However, specific rates for young women are not shown.

Some US studies have focused on young women, using either the NSFG data (limiting inclusion to those aged <25 years old), or other nationally representative surveys such as the 1995/96 National Study of Adolescent Health. These have examined consistency of contraceptive use in the past year, in first sexual relationships, and in most recent sexual relationships (Glei 1999; Manlove et al. 2003; Manlove et al. 2004; Manlove and Terry-Humen 2007). In each, around two thirds of young women report consistent contraceptive use. Similarly, in an analysis of data from the 1979 US National Survey of Young Women (15-19 year olds), Hirsch and Zelnik found around one third reported switching methods

within the first year of use. Manlove and Terry-Humen (2007) also found just over a quarter reported switching method in their first sexual relationship, and most switched to a more effective method (e.g. from condoms to the pill). In another national, prospective, US clinic-based study, around half of 13-25 year old pill users, who discontinued use, switched to condoms. Less than one in ten switched to LARC methods (injection, implant or IUD). Overall, at least two thirds of those who started the pill were still using the method at six months follow-up (Rosenberg and Waugh 1998).

Findings from other specific or clinic populations of young women are similar. In a Canadian study, one third of 18-29 year old women had discontinued use of the pill at some point (Fletcher et al. 2001). In a STI clinic population, 29% discontinued use of their chosen contraceptive method within the first year of use (Ramstrom et al. 2002). Compliance with clinic visits also varies. Studies report that between one and two thirds of young women do not return for their three month follow up appointments after initiating the pill (Balassone 1989; Chacko et al. 1999; Emans et al. 1987).

Finally, some studies, including three from the UK, have focused specifically on discontinuation of the contraceptive injection or implant. These report that between half and three quarters of contraceptive injection users discontinue use within the first year (Davidson et al. 1997; Paul et al. 1997; Polaneczky et al. 1996; Sangi-Haghpeykar et al. 1996; Trussell and Vaughan 1999). Only around 10-20% discontinue use of the contraceptive implant (Berenson and Wiemann 1993; Berenson et al. 1997; Kalmuss et al. 1996; Sivin et al. 1998; Stevens-Simon and Kelly 1998; Suman et al. 1998; Trussell and Vaughan 1999). Two of the UK implant studies reported similar discontinuation rates (Rai et al. 2004; Smith and Reuter 2002), and the other reported that one quarter had discontinued within the first year (Lakha and Glasier 2006b). However, none of the UK studies focused specifically on young women. In a case control comparison of implant and contraceptive pill use in adolescents, Berenson et al. (1997) found that almost one in ten implant users discontinued in the first year compared with two thirds of pill users.

### ***2.4.2 Factors Associated with Discontinuation and Method Switching***

A range of factors are related to discontinuation and method switching. These include user characteristics, method related factors, and relationship factors.

### **2.4.2.1 User Characteristics**

Younger women are often reported to be more likely to discontinue method use, or to be more inconsistent contraceptive users, than older age groups (Bracher and Santow 1992; Gleib 1999; Grady et al. 1983; Grady et al. 1988; Hammerslough 1984; Trussell and Vaughan 1999). Yet frequently such studies do not report specific discontinuation rates for these groups.

Poverty, ethnicity, and education have all been identified as factors related to contraceptive discontinuation. Lower socio-economic status, in particular, is a significant predictor of discontinuation (Emans et al. 1987; Gleib 1999; Grady et al. 1988; Hammerslough 1984; Ramstrom et al. 2002; Trussell and Vaughan 1999). Ethnicity is frequently associated with discontinuation in the US studies, with generally higher rates among Black and Hispanic women (Emans et al. 1987; Davidson et al. 1997; Gleib 1999; Grady et al. 1983; Grady et al. 1988; Grady et al. 2002; Hammerslough 1984; Hirsch and Zelnik 1985; Manlove and Terry-Humen 2007; Polaneczky et al. 1996; Stevens-Simon and Kelly 1998; Trussell and Vaughan 1999; Weisman et al. 1991). Living with both parents and higher parental education are associated with greater contraceptive consistency (Manlove et al. 2003; Weisman et al. 1991). Similarly, school enrolment, educational goals and attainment have predicted compliance with contraceptive use in other studies (Bracher and Santow 1992; Chacko et al. 1999; Emans et al. 1987; Grady et al. 1983; Grady et al. 2002; Hammerslough 1984). Although the socio-demographic patterning of method discontinuation and change appears similar to that for general contraceptive use and non-use, some studies have found that demographic characteristics, such as education and income, are not necessarily related to pill discontinuation (Davidson et al. 1997; Kalmuss et al. 1996; Rosenberg and Waugh 1998).

Prior pregnancy experience and risk factors for repeat pregnancy (including background, psychosocial, and pregnancy outcome factors) have also been associated with contraceptive discontinuation (Chacko et al. 1999; Stevens-Simon and Kelly 1998; Suman et al. 1998).

### **2.4.2.2 Method Related Factors**

Different methods have different discontinuation and method switching rates. Thus rates are generally lower for hormonal methods (particularly LARC methods such as the

implant) and higher for condoms (Bracher and Santow 1992; Berenson et al. 1997; Grady et al. 2002; Hirsch and Zelnik 1985; Manlove et al. 2004; Ramstrom et al. 2002; Trussell and Vaughan 1999). It is often users of less effective methods, such as condoms, spermicides, rhythm, or withdrawal, who are more likely to switch. Indeed, Hirsch and Zelnik (1985) found that two fifths of those who used a less effective method switched, compared with one fifth of those who used an effective method (e.g. pill, IUD). Results are somewhat inconsistent, as other studies have found no association between method type and contraceptive consistency (Manlove et al. 2003; Manlove and Terry-Humen 2007). Indeed, Manlove and Terry-Humen (2007) only found an association between method type and consistency among white females (as opposed to Hispanics). However, when compared with those who maintained use of the same method, they did find that females who switched to more effective methods were more likely to report uninterrupted use (use of a contraceptive method in every month of the relationship), while those who changed to a less effective method were less likely to report this.

Negative side effects, such as irregular menstrual bleeding and weight gain, have been associated with inconsistent pill use (Balassone 1989; Emans et al. 1987), and with discontinuation of the pill, the injection and the implant (Balassone 1989; Berenson and Wiemann 1993; Berenson et al. 1997; Bracher and Santow 1992; Davidson et al. 1997; Kalmuss et al. 1996; Lakha and Glasier 2006b; Paul et al. 1997; Polaneczky et al. 1996; Rai et al. 2004; Rosenberg et al. 1995; Rosenberg and Waugh 1998; Sanders et al. 2001; Sangi-Haghpeykar et al. 1996; Sivin et al. 1998; Smith and Reuter 2002; Stevens-Simon and Kelly 1998; Suman et al. 1998). On the other hand, positive side effects, such as reduced menstrual bleeding or cramping, have been associated with consistent pill use among young women (Weisman et al. 1991). It should be noted that discontinuation is not inevitable, and in one study, one fifth reported experiencing side effects, but this was not associated with discontinuation (Ramstrom et al. 2002).

Method discontinuation has also been related to method problems and failures (Berenson et al. 1997; Hammerslough 1984; Ramstrom et al. 2002; Sanders et al. 2001). Forgetting to take, or running out of, the pill are associated with its discontinuation (Balassone 1989; Berenson et al. 1997), while not having an adequate routine for taking the pill and not receiving enough information from health service providers have also been associated with poor compliance (Rosenberg et al. 1995). Among condom users, accidental pregnancy and method dissatisfaction are associated with discontinuation (Bracher and Santow 1992).

### **2.4.2.3 Relationship Factors**

Supportive partner influences have been associated with consistent oral contraceptive use among adolescents (Weisman et al. 1991). Manlove et al. (2003) reported that consistent use was also more likely among those who had waited longer and talked about contraception before first sexual intercourse. Method switching and inconsistent use are associated with greater sexual experience and the likelihood they will occur increases with the length of the relationship (Hirsch and Zelnik 1985; Manlove et al. 2003; Manlove and Terry-Humen 2007). However, this is also related to the frequency of sexual intercourse (Hirsch and Zelnik 1985). Hirsch and Zelnick found that switching was more likely among those using ineffective methods, such as condoms or withdrawal, when the frequency of intercourse was high. Findings are mixed in respect of partner age; some studies have found inconsistent contraceptive use among those with older partners (Manlove et al. 2003; Manlove and Terry-Humen 2007; Weisman et al. 1991), but others have found the opposite (Emans et al. 1987).

### **2.4.3 Summary**

In this section I have discussed the potential for, and factors associated with, contraceptive discontinuation and method switching. It is important to note that there is little UK research in this area, and what there is, is limited to studies of particular methods. The mainly US findings, suggest that around two thirds of young women will be consistent contraceptive users, while the remainder will be at risk of method discontinuation or switching. Again, the young women's social backgrounds often predict this and there are variations across relationships. The actual experience of method use is of particular importance.

## **2.5 Patterns of Contraceptive Use**

Following the reviews of the literature on factors related to contraceptive use, discontinuation and method switching, this section critically reviews literature on actual patterns of use. This includes studies that have identified, described, and attempted to explain patterns of contraceptive use. The lack of literature in this area limits this examination to six key studies (one quantitative and five qualitative).

### ***2.5.1 Patterns of Contraceptive Use: Quantitative Study***

Matteson and Hawkins have studied American women's contraceptive use and reproductive choices over the life course (Matteson and Hawkins 1993; Matteson and Hawkins 1997). They reviewed the records of 800 women (aged 14-44 years) using a family planning clinic in the Boston area over a 15 year period. They found that women aged under 25 had used between one and seven different contraceptive methods. Those aged 14-19 had changed methods up to six times and those aged 20-25 had done so up to nine times (Matteson and Hawkins 1993). In a later paper, they further described the varying nature of women's individual contraceptive use patterns. In total, the 800 women used 16 different contraceptive methods and made 1889 changes; only one quarter continued to use the method they had first chosen (Matteson and Hawkins 1997). However, three quarters of those who had switched only reported two method changes, with those who started with a non-medical method reporting more changes than those who started with a medical one. Diverse patterns of individual use were apparent, with few women displaying the same patterns. The previous method used did not appear to influence the next, and patterns were not necessarily based on the efficacy of methods. Some also changed back to methods they had used previously. Matteson and Hawkins found that the women gave a variety of reasons for changing contraceptive methods. However, the sample was restricted to one clinic, and whether the same patterns would be found amongst women who have accessed contraceptives elsewhere, or who have not used clinics, has to be considered.

These two papers demonstrate that women have patterns of contraceptive use but they do not address the reasons for such patterns. To do this, we need to look at the qualitative studies that have attempted to explain women's patterns of use.

### ***2.5.2 Explaining Patterns of Contraceptive Use: Qualitative Studies***

Five qualitative studies are reviewed; four from the US and one (Free et al. 2005) from the UK. Two examine the nature of young women's patterns (Lindemann 1974; Miller 1976), and three examine the process of change (Luker 1975; Luker 1977; Matteson 1995; Free et al. 2005). One of the first things to note is that most of this literature is dated, with one

study over ten years old and three over 20 years old. As such, they could be of limited relevance to our understanding of young women's patterns of contraceptive use today.

Lindemann (1974) studied 2500 13-26 year old unmarried American women between 1968 and 1970. They were from various sexual and public health clinics and schools, and in different socio-economic and ethnic areas. Their experience of sexual intercourse and contraceptive use varied. Some had experienced pregnancy, some had never used contraceptives, and some had never had sexual intercourse. Her research methods included participant observation, individual and group interviews, and self-complete and administered questionnaires. Grounded theory was used to analyse the data.

Lindemann argues that young women go through three stages of contraceptive choice and use, calling this the "birth control prescription process" (Lindemann 1974). The first, "natural" stage, characterised by no contraception, begins with the first experience of sexual intercourse, although non-use of contraception may continue after this. Sexual intercourse at this stage is unpredictable, spontaneous, natural, and infrequent. Therefore, contraceptive use is only considered at the time of sexual intercourse, with non-use being the most likely outcome. After the first experience, the increasing frequency of intercourse raises awareness of the need for contraception, resulting in progression to the next stage of the process. In this "peer" stage, young women seek advice (generally from friends and siblings rather than professionals) and experiment with different contraceptives. The number of methods tried and the length of time for which they are used varies, as does the level of planning involved. The contraceptive methods identified by Lindemann as common in this stage are the rhythm method, withdrawal, foam, condoms, and douche, all of which are coitus dependent. In the final "expert" stage of the model, young women approach a professional (e.g. a clinic or doctor) for contraceptives. This requires knowledge of the availability of such services and disclosure of sexual activity. The contraceptive methods at this stage include the contraceptive pill, IUDs and diaphragms, all of which are not coitus dependent and have to be prescribed by a health professional.

Lindemann (1974) argues that young women's relationships, patterns of sexual behaviour, partners' awareness, and sources of information regarding contraception all influence progression through the three stages of the model. The "birth control prescription process" is an evolving process; as the reasons for wanting to use contraception change, so do the contraceptive choices the young women make.

While the model is linear, Lindemann concedes that movement through the three stages might occur in both directions, and stages may be skipped – so as well as progressing, young women may regress. Regression would result from a lack of understanding of the contraceptive methods used, lack of communication in relationships, lack of availability of and access to services, and fear or experience of complications and side effects. Indeed, in examining the young women's patterns of contraceptive use she found:

“When the individual careers of girls in the prescription process are traced by single methods, one finds virtually as many careers as there are individuals.” (Lindemann, 1974, page 76).

However, she argues that the most common pattern is linear. Those who follow the linear process precisely, or who enter the process at the expert stage, do not regress:

“This indicates that awareness that has a chance to increase throughout the prescription process and awareness that is at the highest level at the start of sexual activity, as evidenced by the use of an expert method of birth control, are most conducive to maintaining the use of an expert method.” (Lindemann, 1974, page 78).

However, Lindemann does not explain why not all of the young women progressed to the expert stage, and the descriptions also appear to be based on a small sub-sample of the 2500 she reportedly studied.

Luker (1975, 1977) argues that contraceptive risk taking is based on a process whereby women consider their level of risk and decide whether to “take a chance”. Her model, based on a study of women at a San Francisco abortion clinic, includes four stages: “assignment of utilities to contraceptive use”; “assignment of utilities to pregnancy”; “assignment of probabilities to pregnancy”; and “assignment of probabilities to reversing pregnancy”. She argues that women go through the process rationally by making a decision on each, and then come to a final decision on risk taking.

In the first, “assignment of utilities to contraceptive use” stage, women assess the costs of contraception. These include the social norms of use, difficulties getting partners to continue use, embarrassment going to services, and potential side effects. These are compared with the benefit of contraception (i.e. pregnancy prevention). If the costs outweigh the benefits, contraceptive non-use is more likely. In the “assignment of utilities to pregnancy” stage, women consider the costs (e.g. need for abortion) and benefits (e.g.

gaining independence and status, testing partners' commitments, or testing fertility) of pregnancy. Luker argues that women consider the costs and benefits of contraception and pregnancy simultaneously in their decision making process. After this, they move to the next stage "assignment of probabilities to pregnancy", and consider how likely they are to become pregnant. This decision is based on a subjective consideration of probability and is reinforced if risk taking does not lead to pregnancy; the "it won't happen to me" approach. In the last stage of the process, "assignment of probabilities to reversing pregnancy", they consider the likelihood they could reverse the situation (i.e. have an abortion).

Luker argues that the possibility of risk taking results from a combination of all four steps. Thus risk taking is most likely to occur when the cost of contraception is high but that of pregnancy low, and the likelihood of pregnancy low but knowledge of the availability of abortion high. The result of the risk taking could also reinforce the behaviour. Avoiding pregnancy could lead to further risk taking. Experiencing pregnancy could lead to the reconsideration of the costs, benefits and likelihood of this, and subsequently lead to contraceptive change. Choice of contraceptive method depends on the balance of the factors above, all of which could change depending on circumstances. The process is one of continual reassessment of contraceptive use, which will continue over the reproductive life course:

"...being a contraceptive once is no guarantee that a woman will remain one throughout her childbearing years. It is more likely that the changing circumstances of a woman's life will result in continual re-evaluation of pregnancy and contraception." (Luker, 1977, page 193).

However, there are limits to this study. First, Luker's model is based on a sample from only one abortion clinic. All of these women had taken a risk and become pregnant and so might have had different patterns of contraceptive decision making than women who had not experienced pregnancy. Second, it suggests that all of the women experienced pregnancy as a result of risk taking rather than because of contraceptive failures. This may not necessarily be the case elsewhere. Third, the study was conducted at a time before EC was widely available. The availability of EC, particularly without prescription, could change the model as abortion would not be the only consideration in the "assignment of probabilities to reversing pregnancy" stage.

In 1976, Miller published a study of the contraceptive experiences of young, American women. This included those who were using contraception successfully and those who had experienced unplanned pregnancy, and were seeking abortion as a result. He, like Lindemann, describes a linear process of contraceptive use, which develops from non-use to coitus-dependent use, to prescription use. Like Luker, he argues that young women continually assess their risk, pregnancy anxiety and contraceptive behaviour. Young women's assessment of pregnancy risk is affected by their level of knowledge and the experiences of others around them (i.e. their pregnancies or pregnancy scares). However, pregnancy anxiety does not necessarily correspond with actual behaviour. Some in his sample displayed high levels of anxiety even though they were using the pill, and others low levels while not using any method. Miller argues that the most effective contraceptive use (in the clinical terms of pregnancy prevention) is apparent when anxiety over pregnancy risk is moderate.

At first sexual intercourse, the young women in Miller's study reported use of no contraceptives or methods that required no preparation or prior planning (e.g. rhythm or withdrawal). This pattern of use could continue for up to six months, accompanied by varying levels of anxiety concerning the risk of pregnancy. Such anxiety was associated with experience of pregnancy scares during this time. For some young women, pregnancy scares reduced anxiety since they reinforced the perception of low risk. For others, they increased anxiety and pushed them towards a change in contraceptive use. The first change was to methods such as condoms. These require a level of prior planning and acknowledgement of sexual activity but do not require contact with health professionals. However, they are problematic because they interrupt and affect the experience of sexual intercourse. Finally, young women progress to prescription contraception (e.g. the pill).

Miller (1976) argues that this last stage generally only occurs within 'steady', committed relationships. This is because young women have to be ready to acknowledge their sexual activity, sex has to be frequent enough to merit this, and the commitment from the partner strong enough to avoid any negative connotations of being sexually available. As a result, Miller suggests use of prescription methods will discontinue at the end of a relationship, and young women will return to the contraceptive methods from the first and second stages of the model. Use of prescription methods is also countered by fears regarding the clinic experience, family disapproval, and actual ability to take the pill on a daily basis.

Like Lindemann, Miller argues that while young women have individual patterns of contraceptive use, their patterns are predictable and the model is mainly linear, but variable movement in both directions through the stages is possible. However, there have been major changes in the availability of contraception and in cultural attitudes and expectations, since all three of these studies. The advent of HIV/AIDS has further changed the context of young women's contraceptive decisions. Therefore, the social costs of contraceptive risk taking for young women in Scotland in the 2000s could be very different from the social costs in the 1970s in the US.

More recently, Matteson (1995) examined 16-39 year old American women's strategies for managing their fertility, using grounded theory to analyse her interview data. The women in this sample had a mean timescale of contraceptive use of six years and reported having used up to seven different contraceptive methods, and having changed methods up to 12 times. Matteson argues that five main stages influence women's use of contraception: "personalisation of pregnancy risk", "exploration of options", "use of an option", "contending with the ramifications of use", and "contending with use effectiveness". In the first stage, women recognise they are at risk of pregnancy and that there are options available to prevent it. Next they consider the contraceptive methods available to them, and what the consequences of using each method will be. They follow this by putting into practice the method chosen in the previous stage. However, consistent contraceptive use will not necessarily follow, because actual experience of use can then affect further choices. In the fourth stage, women assess the consequences of using their chosen method and evaluate whether continued use is appropriate or desirable. Finally, they contend with monthly concerns over the consequence of using a particular method (e.g. experience of side effects) and the possibility of experiencing an unintended pregnancy. Matteson argues that women move through each of these stages in sequence and determine their contraceptive use as a result. However, the process is continual and cyclical, being repeated as long as pregnancy risk is a factor.

Matteson argues that women have individual patterns of contraceptive use, which are not linear. Instead they may take a variety of forms depending on the personal needs and circumstances of the individual involved; a process more similar to the decision making model in Luker's theory. However, she concedes that it might not be possible to generalize her findings to other groups because all of the women in her sample had accessed reproductive health services. It is possible that the patterns of contraceptive use

she found would not be replicated among women who have not accessed services, or among those who have only used barrier methods, such as condoms. Furthermore, her findings are based on a sample of women aged 16-39 years. She does not discuss whether younger women had particular experiences of the decision making process.

A more recent UK study attempts to explain young women's changes in contraceptive use and non-use over time, to develop a dynamic model. Free et al. (2005) conducted in-depth interviews with 16-25 year old women (most of whom had experience of sexual activity). They were purposively sampled from the London area and varied on area of residence, ethnicity, education and pregnancy experience. Free et al. argue that the young women's experiences of contraceptive use could be explained through three main constructs: social goals; perceptions of vulnerability; and constraints and facilitators. It is suggested that these are part of a dynamic process interacting, and at times contesting, with the young women's changing situations, experiences and knowledge. This study is a useful, more up to date, demonstration of the dynamic nature of contraceptive use and the processes by which it changes over time.

In respect of the first construct, Free et al. describe how social goals influence young women's contraceptive use. These include factors related to life aspirations, risk identity, sexual identity, sexual experience, relationships, health and morality. Thus those young women in their sample with set career or educational aspirations stated that these were their reasons for using contraception; becoming pregnant would ruin their plans. They described wanting to 'be safe' and acted accordingly, using the pill rather than condoms, changing to a more reliable method after experiencing problems, and using EC if something went wrong. Balanced with this was the need to maintain a positive sexual identity, avoiding the labels 'easy' or 'slag' for being sexually active, while at the same time being seen to be responsible by using contraception. Even so, the young women sought positive sexual experiences and adjusted their contraceptive use accordingly. They acted to maintain their sexual relationships (their partners' sexual pleasure in particular), and to keep healthy (represented by having regular periods and the avoidance of negative or harmful side effects of contraception). They also acted according to what they thought was right or wrong in relation to abortion.

The second construct, perceptions of vulnerability to pregnancy, concerns the extent to which young women think they are at risk. Most thought they were not at risk or

dismissed it. Rather, they reported how they had been safe, or that pregnancy simply would not happen to them. The young women justified situations that had been unsafe and dismissed risks as being higher for others than for themselves.

The third construct centres on constraints and facilitators, which include personal, situational, and socio-structural factors, together with the influence of others. Personal factors include the young women's knowledge of contraceptive methods and ability to negotiate use with their sexual partners. As was described earlier in this chapter, those with the greatest confidence are most likely to use contraception as a result. Situational factors centre on the effect that alcohol use and the availability of methods have on use. Socio-structural factors centre on access to methods. Barriers to use include the cost of condoms and lack of access to contraceptive services. Finally, young women's contraceptive use is also influenced by the experiences of those around them, and their own experiences of interacting with health professionals.

Free et al. suggest social goals, perceptions of vulnerability to pregnancy, and constraints and facilitators interact with young women's changing relationships, experiences of side effects and knowledge to create a dynamic process of contraceptive use, which is fluid, varied, and can change over time. This means that a range of factors can determine method use at any one time, and as such, young women develop their own patterns of contraceptive use. However, these authors do not discuss exactly what patterns of contraceptive use the young women they interviewed experienced. Most importantly, they do not discuss the young women's range of experiences, or how contraceptive changes are experienced and managed in the light of this dynamic process.

### **2.5.3 Summary**

A limited number of studies have examined young women's patterns of contraceptive use. Of the six reviewed here, only one is from the UK and was conducted in the last ten years. In the 1970s, studies suggested that young women would follow a linear pattern of contraceptive use, progressing from non-use to coitus-dependent method use to prescription method use. More recent studies suggest that patterns of use are more fluid and varied than this, and are influenced by a complex process of consideration of the costs and benefits of contraceptives and pregnancy.

## 2.6 Conclusions

In this review I have considered the factors associated with contraceptive use, discontinuation and method switching, and patterns of use. A wide range of factors, from social and personal backgrounds to the experience of relationships and method use, affect use. Young women's contraceptive use is complex. Although the literature on young women's contraceptive use is extensive, the reviews on discontinuation, method switching, and patterns of use have shown that this literature is much more limited, particularly in relation to young women living in the UK.

From the studies of contraceptive discontinuation and method switching it would appear that substantial numbers of young women do discontinue or switch their contraceptive methods. However there is little UK research in this area. Of the four UK studies reviewed, one was based on a non-representative, convenience sample from which the data were presented in combination with four other countries. The others were small, clinic-based studies of discontinuation of one particular method (the implant). The true extent of patterns of discontinuation and switching in the UK remains unknown. Similarly, only one of the patterns studies was from the UK, and it was apparent that cultural differences could affect the interpretation of the remaining US studies. Differences in young women's experiences in North America and the UK in relation to contraceptive use and sexual behaviour have been reported elsewhere (Darroch et al. 2001), and there are specific cultural differences between the two countries to be taken into consideration. A considerable gap in the knowledge base remains here.

One particular issue of concern is that much of the literature on patterns of use is dated, with three of the studies being conducted during the 1970s, and one in the early 1990s. Temporal changes have to be considered and the relevance of these studies to young women in the 21st Century has to be questioned. Little if any attention is given to HIV/AIDS and other STIs in this literature. The importance of young women's sexual (as opposed to reproductive) health, and the effect this has on their contraceptive use patterns, has to be addressed. The UK patterns study (Free et al. 2005) was the first in almost ten years and represents an up to date demonstration of the dynamic nature of contraceptive use and the processes by which it changes over time. However, it did not examine exactly what young women's patterns of contraceptive use were or how they managed these.

Although the literature suggests that there are particular patterns of contraceptive use, there is no definitive view on the nature of these among young women. While the research from the 1970s suggests linear patterns, others suggest these will be more fluid or varied. It is possible that these patterns could have common themes, something which the studies on the dynamic nature of the contraceptive process have explored.

Questions remain with respect to the patterns and management of contraceptive use among young women in the UK, and it is these I will address in this thesis. In the next chapter, this begins with a quantitative exploration of young women's contraceptive use, method switching and patterns of use.

## 3 Chapter Three

# Quantitative Analysis of Young Women's Contraceptive Use

### 3.1 Introduction

The literature review in the previous chapter demonstrated the complexity of young women's contraceptive use. In this chapter, the factors associated with use, method switching, and patterns are examined using quantitative data from a sample of young women from the East coast of Scotland.

The aims are to:

- describe the contraceptive use of this sample of young women;
- examine the factors associated with their contraceptive use;
- explore their consistency of use and method switching;
- assess their patterns of contraceptive use over time.

The SHARE (Sexual Health and Relationships: Safe, Happy and Responsible) study was a randomised trial of a specially-designed, school-based sex education intervention (Wight et al. 2002). The trial evaluation data included extensive detail on the sexual and contraceptive behaviour of the participants. These data were the starting point for this research study.

The chapter begins with a detailed description of the methods: the sample, the sexual experience and contraceptive use measures in the SHARE dataset, and the methods of analysis used. This is followed by the results section, which presents data on contraceptive use, influences on use, and contraceptive patterns. These findings are then reviewed in the discussion, and compared with relevant literature. Finally, the limitations of the

quantitative data, and the influence of these on the design of the qualitative research, are discussed.

## **3.2 Methods**

### **3.2.1 *The SHARE Sample***

The data in these analyses were collected between 1996 and 2000 as part of the cluster randomised trial of the SHARE intervention. Two cohorts of male and female students, from subsequent years, in 25 secondary schools in east Scotland, were surveyed at age 14, and two years later at age 16. Baseline questionnaires (age 14) were completed by 7616 male and female students. The sample was representative of all 14 year olds in Scotland in terms of social class and family structure, using 1991 Census data (Wight et al. 2002). Follow-up questionnaires (age 16) were completed by 5864 students (3117 females and 2737 males). The study was approved by Glasgow University's Ethics Committee for Non-Clinical Research Involving Human Subjects, and the relevant local authorities' education departments. The results of the trial, and a number of other papers using data collected in the surveys, have now been published (Henderson et al. 2002; Wight et al. 2000; Wight et al. 2002; Wight et al. 2006). The intervention did not improve contraceptive use among those who received SHARE sex education (Wight et al. 2002), so it was not thought that this would affect the results presented here.

Data collection involved the distribution of self-complete questionnaires to pupils, which were completed in classroom settings under exam conditions, in the presence of a researcher. At follow-up (age 16), questionnaires were also mailed out to those who had already left school, for return in pre-paid envelopes. The questionnaires collected detailed information on the young people's backgrounds, family life, aspirations and expectations, sexual attitudes, sexual experiences and contraceptive use.

### **3.2.2 *Sample Inclusion***

Criteria for inclusion in the analyses in this chapter were: to be female; to have completed questionnaires at both first (age 14) and second (age 16) waves of data collection; and to have reported sexual experience by age 16. In total, 1175 young women fit these criteria (37.7% of the sample). Of these, 1098 (93.4%) reported on their contraceptive use.

### **3.2.3 Data Considerations**

The questionnaire asked about three episodes of sexual intercourse: first, first with most recent partner, and most recent. First intercourse was reported by all who were sexually active and most recent by those who had had sexual intercourse more than once. In addition, those who had had more than one partner reported on their first intercourse with their most recent partner. Data on contraceptive use at each episode were collected: at first intercourse (N=1098), at most recent intercourse (N=993), and at first intercourse with most recent partner (N=452).

In the questionnaire, young women were asked to indicate which methods of contraception they used, choosing from a list of eight options (as described at the end of this paragraph, but excluding the combined categories). More than one option could be selected and space was provided to indicate methods not included on the list. For the analyses reported here, the most medically effective method (for pregnancy prevention) was selected when more than one method was stated. For example, if the respondent selected withdrawal and the pill, they were coded as a pill user. Combined use of the pill and the condom was considered as a separate category because this could have represented a particular choice of dual prevention from both pregnancy and STIs. Combined use of the pill, the condom and EC was also considered as a separate category because this represented a group for whom it is possible that something went wrong. The responses were therefore categorised into the following groups: none; withdrawal; condom put on before ejaculation; condom used throughout; contraceptive pill; contraceptive pill and condom used throughout; EC; contraceptive pill and condom used throughout, and EC; injection; and other/don't know.

The contraceptive method categories were recoded into a dichotomous measure of 'any contraceptive use' versus 'non-use' for the analyses of the factors related to use. Young women who reported withdrawal could have regarded this as a contraceptive method but, in the context of this chapter, it was coded as 'non-use' because it is not a medically effective method. 'Other' and 'Don't know' were also classed as 'non-use'. EC was coded as 'use' here, even though it could have been the result of non-use, because taking it suggests an active decision on pregnancy prevention.

### **3.2.4 Data Analysis**

Statistical analyses were conducted using SPSS Version 12. The Pearson  $\chi^2$  test was used for bivariate comparisons unless otherwise stated. Logistic regression was used to examine the factors associated with contraceptive use, and multivariate backward stepwise logistic regression was used to produce adjusted odds ratios and to assess their significance. Cohen's kappa scores were calculated to assess the overall agreement in contraceptive method use between the three episodes of contraceptive use.

## **3.3 Results**

### **3.3.1 Contraceptive Use**

Figure 3.1 (overleaf) shows the proportion of young women reporting each contraceptive method at each of the three episodes of sexual intercourse. Condom use throughout was the most common method at each of the three episodes but decreased from first to most recent intercourse (57.1% at first, 43.8% at first with most recent partner and 40.4% at most recent). On the other hand, contraceptive pill use (4.4%, 14.6% and 18.3%) and dual use of the pill and the condom throughout (8.2%, 11.3% and 12.4%) increased over the three episodes. Dual method use at first intercourse was reported by double the proportion reporting pill use only, but then sole pill use exceeded dual method use at the next two episodes.

The proportions reporting use of no method (14.0%, 17.0% and 15.0%), withdrawal (7.1%, 6.0% and 6.4%) and putting on a condom before ejaculation (1.5%, 1.8% and 1.5%) were fairly consistent. This demonstrates that a significant minority of the young women were at risk of pregnancy at each episode of sexual intercourse. There was a decrease in EC use (4.7%, 2.9% and 2.6%), while combined use of the pill and condom throughout plus EC was low at each episode (2.0%, 0.9% and 1.3%). Very few young women reported using the contraceptive injection, but the proportions increased slightly over the three episodes (0.2%, 1.1% and 1.4%). Less than 1% reported use of other methods or not knowing the method used at each episode. If we restrict analyses to only those young women who reported all three episodes of contraceptive use, the overall pattern is unchanged (data not shown).

Overall, 78.3%, 76.5%, and 78.2% of the young women used some form of contraception at first, first with most recent, and most recent sexual intercourse (none, withdrawal and don't know were classed as non-use).

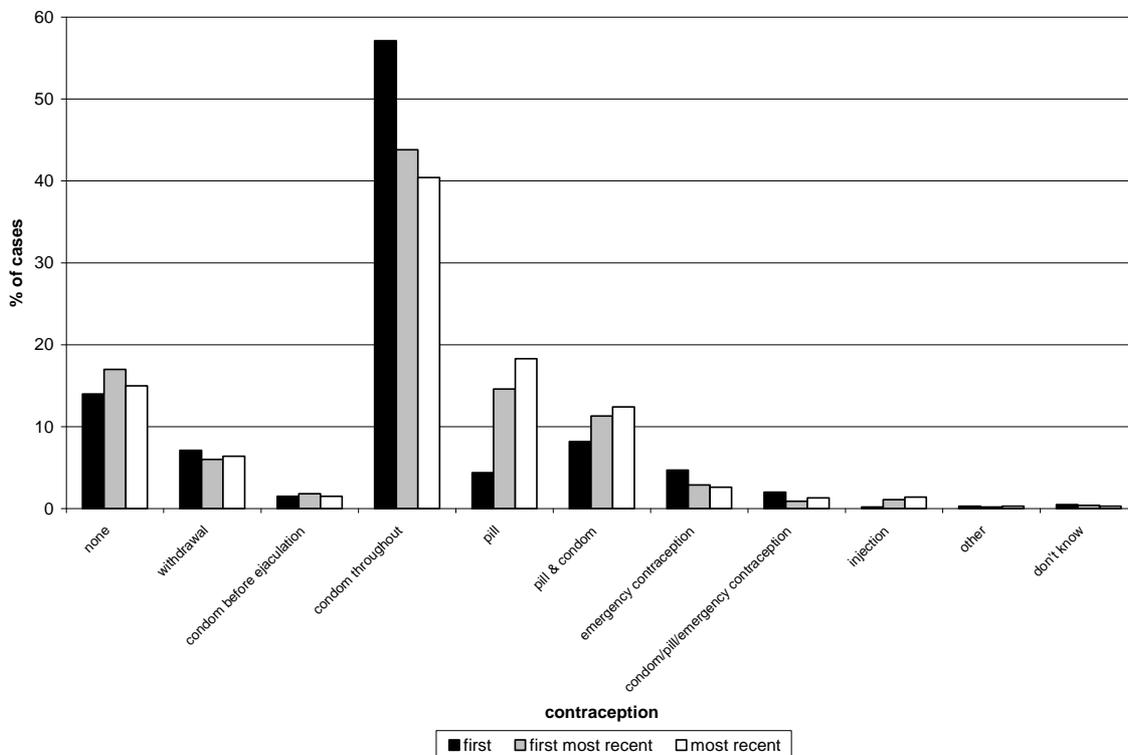


Figure 3.1: Contraceptive use at first (N=1098), first with most recent partner (N=452), and most recent intercourse (N=993)

### 3.3.2 Influences on Contraceptive Use

This section focuses on the characteristics of those who did and did not use contraception. As discussed in the previous chapter, the literature has examined various influences on contraceptive use. Variables that represented these influences were identified in the SHARE dataset and differentiated into the specific topic areas used in the literature review. Logistic regression was used to assess their associations with contraceptive use at first and most recent intercourse (use at first intercourse with most recent partner was also assessed and the results were consistent with those for the other two outcomes so were excluded from the chapter). Factors found to be significant in the bivariate analyses are shown in Appendix A. Here, the factors that remained significant in the multivariate analyses are presented.

### 3.3.2.1 Structural, Cultural and Social Factors

In the bivariate analyses, parental social class and qualification level, parental monitoring, living in privately owned housing, and own educational attainment were significantly associated with contraceptive use at first and most recent sexual intercourse. Ethnicity, religiosity, living with both parents and mother's age were also significantly associated with use at first intercourse. Table 3.1 shows the factors that remained significant in the multivariate model. The only one that remained significant in both models was educational attainment; young women who obtained credit level standard grades were more likely to have used contraception at first and most recent intercourse. The likelihood of contraceptive use at first intercourse was increased for young women whose fathers had non-manual occupations, and decreased for those of non-white ethnicity and those who were not religious. The likelihood of use at most recent intercourse was increased for those with further or higher educated fathers and those with high parental monitoring at age 14.

	Contraceptive use at first sexual intercourse (n=1090)		Contraceptive use at most recent sexual intercourse (n=993)	
	OR	95% CI	OR	95% CI
Non-manual social class – father <sup>1</sup>	1.47	1.02-2.13		
Father's qualifications – further/higher education level			1.68	1.19-2.38
Non-white ethnicity	0.40	0.17-0.94		
Religiosity – age 16 (5 point scale: very religious – not at all religious)	0.74	0.62-0.88		
High parental monitoring – age 14			1.56	1.13-2.13
Standard grades – credit level	1.74	1.25-2.41	1.95	1.37-2.77

*Table 3.1: Structural influences on contraceptive use (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)*

### 3.3.2.2 Peer Influence

A separate structural component was peer influence, and, at the bivariate level, the proportion of friends who had left school, the proportion of friends who smoked,

<sup>1</sup> In the interests of space, the reference categories for dichotomous variables have not been included in the tables. The reference categories for each variable are the opposite of the listed factor (e.g. the reference category for non-manual social class – father is manual social class – father).

expectations of peers' sexual experience and condom use were significantly associated with contraceptive use. Having talked to friends about contraception in the last year was also significantly associated with contraceptive use at most recent intercourse. Table 3.2 shows the factors that remained significant in the multivariate model. The only one that remained significant in both models was expectations of friends' condom use. Young women who agreed that most of their friends would use condoms when having sex with someone for the first time were more likely to have used contraception at first and most recent intercourse. The likelihood of contraceptive use at first intercourse was increased for those with a lower proportion of friends who smoked and for those who thought fewer of their male peers had had sex<sup>2</sup>. The likelihood of use at most recent intercourse was decreased for young women with more friends who had left school and increased for those who had talked with friends about contraception, for those who thought fewer of their female peers had had sex, and for those who thought that friends would want them to use condoms.

	Contraceptive use at first sexual intercourse (n=1069)		Contraceptive use at most recent sexual intercourse (n=900)	
	OR	95% CI	OR	95% CI
Proportion of friends left school – age 16 (5 point scale: none – all)			0.82	0.70-0.97
Proportion of friends who smoke – age 16				
Most/all	1			
Half	1.25	0.81-1.92		
A few	1.85	1.27-2.70		
None	1.91	0.90-4.05		
Talked to friends about contraception in the last year			1.97	1.28-3.03
Proportion of 16 year old girls who have had sex (7 point scale: all – none)			1.26	1.08-1.46
Proportion of 16 year old boys who have had sex (7 point scale: all – none)	1.19	1.05-1.35		
Most friends would use condoms when having sex with someone for the first time				
Disagree	1		1	
Unsure	1.33	0.81-2.19	1.17	0.67-2.06
Agree	4.33	2.76-6.80	2.22	1.35-3.65
Friends would want you to use condoms when having sex with someone for the first time – agree			1.90	1.25-2.88

*Table 3.2: Peer influences on contraceptive use (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)*

<sup>2</sup> Respondents were asked 'How many 16 year old boys/girls from your school do you think have had sexual intercourse?' – 7-point scale from 'all of them' to 'none of them'.

### 3.3.2.3 Psychological and Individual Influences on Contraceptive Use

A range of psychological and individual influences on contraceptive use was examined, including self-esteem and future aspirations, other risk behaviours (alcohol and drug use), planning, experience, and comfort with sex and sexuality. Table 3.3 shows the factors that remained significant in the multivariate model. The likelihood of contraceptive use at first and most recent intercourse was increased for young women who thought it unlikely they would have a child in the near future and who disagreed that using condoms would be embarrassing, but decreased among those with 3 or more sexual partners. The likelihood of use at first intercourse was also decreased among those who thought it unlikely they would go to college or university in the near future when they were aged 14, those who had tried drugs, those who were drunk or stoned at first intercourse, and those who did not like the idea of being touched sexually. The likelihood of contraceptive use at most recent intercourse was also decreased among those who thought they were unlikely to be in a steady relationship in the near future, and who were drunk or stoned at most recent intercourse, and increased for those who agreed it was important to plan pregnancy prevention and those who found it easier to talk openly about sex with boyfriends.

	Contraceptive use at first sexual intercourse (n=955)		Contraceptive use at most recent sexual intercourse (n=823)	
	OR	95% CI	OR	95% CI
Future aspirations (age 14) (5 point scale very likely to very unlikely)				
Unlikely to be at college / university	0.82	0.69-0.98		
Future aspirations (age 16) (5 point scale very likely to very unlikely)				
Unlikely to be in a steady relationship			0.76	0.60-0.95
Unlikely to have a child / children	1.19	1.01-1.40	1.49	1.25-1.77
Ever tried drugs – age 14	0.65	0.46-0.92		
Drunk or stoned at first intercourse	0.60	0.43-0.83		
Drunk or stoned at last intercourse			0.51	0.34-0.76
3 or more sex partners	0.58	0.41-0.82	0.64	0.44-0.93
Important to plan pregnancy protection before you have sex (4 point scale: disagree – strongly agree)			1.79	1.33-2.40
Talk openly about sex with a boyfriend (age 14) (5 point scale: very difficult – very easy)			1.27	1.04-1.55
Using condoms would be embarrassing (age 16) (5 point scale: strongly agree – strongly disagree)	1.43	1.17-1.75	1.49	1.18-1.88
I really like the idea of being touched sexually (age 14) (5 point scale: strongly agree – strongly disagree)	0.78	0.63-0.95		

Table 3.3: Psychological and individual influences on contraceptive use (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)

### 3.3.2.4 Relationship Influences on Contraceptive Use

General relationship factors, and factors related to the relationship for which contraceptive use was reported, were examined. Number of partners, age at first sexual experience, sexual coercion, pressure, planning, and current partner status were associated with contraceptive use at the bivariate level. Age at first kiss (using tongues), heavy petting, oral sex and sexual intercourse were also significant at the bivariate level, with older age at each associated with a greater likelihood of contraceptive use at first and most recent intercourse. However, these variables were not included in the multivariate analyses because not everyone was asked these questions. Table 3.4 shows the factors that remained significant in the multivariate model. Number of sexual partners in the previous year and talking about contraception prior to first intercourse remained significant in both models. Young women who had a greater number of sexual partners in the previous year were less likely to have used contraception. Those who had talked with their partners about contraception prior to first sexual intercourse were more likely to have used contraception. The likelihood of contraceptive use at first intercourse was increased for those who expected sex to happen or had planned it beforehand, but decreased for those who had felt pressured by their partners at the time. The likelihood of contraceptive use at most recent intercourse was increased for those who said their most recent partner was their boyfriend, and for those who had used contraception at first intercourse.

	Contraceptive use at first sexual intercourse (n=1053)		Contraceptive use at most recent sexual intercourse (n=880)	
	OR	95% CI	OR	95% CI
Number of sex partners in last year (range 0-20)	0.88	0.80-0.98	0.82	0.74-0.90
Pressure at first intercourse				
No pressure	1			
Pressured by partner	0.60	0.41-0.89		
Put pressure on partner	0.73	0.23-2.32		
Talked about protecting ourselves before sex (at first sexual intercourse)				
No	1		1	
Yes, just before	8.05	4.63-13.98	1.95	1.18-3.22
Yes, well before	25.36	10.36-62.09	4.54	2.54-8.11
Planning first sex intercourse				
It was completely unexpected	1			
It just happened on the spur of the moment	1.03	0.67-1.60		
Expected it to happen, but was not sure when	2.05	1.28-3.30		
Planned it together beforehand	2.52	1.07-5.97		
Most recent sexual partner was boyfriend			1.73	1.17-2.56
Used contraception at first intercourse			2.78	1.86-4.15

*Table 3.4: Relationship influences on contraceptive use (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)*

### 3.3.2.5 Availability and Accessibility Influences on Contraceptive Use

In bivariate analysis, school sex education, use of reproductive health services, ease of access to services and access to condoms were significantly associated with contraceptive use. Table 3.5 shows the factors that remained significant in the multivariate models. Access to contraceptives remained significant in both. Young women, who had bought condoms in the previous year, reported that they knew where contraception could be prescribed, and lived in City A (where there was greater access to contraceptive services) were more likely to have used contraception at both first and most recent intercourse. Those who had been to a health service in the past two years for advice about being pregnant were less likely to have done so. The likelihood of contraceptive use at first intercourse was increased for those who thought their sex education’s coverage of condom use was OK, and for those who thought it made them more confident about use. The likelihood of contraceptive use at most recent intercourse was increased for those who thought it easier to obtain condoms.

	Contraceptive use at first sexual intercourse (n=1032)		Contraceptive use at most recent sexual intercourse (n=920)	
	OR	95% CI	OR	95% CI
In sex education, how to use condoms properly was covered – age 16				
Not well	1			
Okay	1.84	1.08-3.15		
Well	0.90	0.56-1.45		
Sex education made me more confident about using condoms properly (5 point scale: strongly disagree – strongly agree)	1.42	1.19-1.68		
Bought condoms in the last year	1.92	1.36-2.71	1.82	1.26-2.61
Went to a health service in the last two years for advice about being pregnant	0.59	0.42-0.84	0.58	0.40-0.83
Know where can be prescribed contraception	2.12	1.25-3.60	2.37	1.35-4.15
Easy to get a condom – age 16 (5 point scale: very difficult – very easy)			1.32	1.02-1.70
Live in main city A	2.16	1.42-3.30	1.54	1.02-2.31

*Table 3.5: Availability and accessibility influences on contraceptive use (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)*

### 3.3.2.6 Medical Influences on Contraceptive Use

Experience and fear of pregnancy, ease of condom use, knowledge of contraceptive efficacy and STIs, EC awareness, and knowledge of contraceptive myths were

significantly associated with contraceptive use at the bivariate level. Table 3.6 shows the factors that remained significant in the multivariate models. Pregnancy fear and condom use skills remained significant in both. Thus young women who were afraid of becoming pregnant and those who thought it easier to use condoms properly were more likely to have used contraception at first and most recent intercourse. The likelihood of contraceptive use at first intercourse was also increased for those who thought the pill was an effective means of preventing pregnancy, and who knew the time frame for EC use. The likelihood of use at most recent intercourse was increased for those who thought that it was important to think about STIs, and who were aware that a girl could get pregnant if the man withdrew before ejaculation.

	Contraceptive use at first sexual intercourse (n=1041)		Contraceptive use at most recent sexual intercourse (n=862)	
	OR	95% CI	OR	95% CI
One of the things I fear most is becoming pregnant – age 16 (5 point scale: strongly disagree – strongly agree)	1.34	1.18-1.52	1.37	1.19-1.58
Easy to use a condom properly – age 16 (5 point scale: very difficult – very easy)	1.58	1.29-1.93	1.58	1.25-1.98
It is important to think about STDs when you choose a contraceptive (5 point scale: strongly disagree – strongly agree)			1.27	1.00-1.61
The contraceptive pill is effective in preventing pregnancy – age 16 (5 point scale: strongly disagree – strongly agree)	1.23	1.02-1.48		
Know that emergency contraception has to be used within 72 hours – age 16	1.47	1.07-2.02		
Know that a girl can get pregnant if the man / boy withdraws before ejaculation / coming – age 16			1.89	1.32-2.72

*Table 3.6: Medical influences on contraceptive use (backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)*

### 3.3.2.7 Final Models of Influences on Contraceptive Use

All of the above variables, which were significantly related to contraceptive use, were entered into final models for use at first and most recent intercourse (Tables 3.7 and 3.8, overleaf).

At first intercourse, the factors which remained significant in the final model were father's social class, expectations of friends' condom use, number of sex partners in the previous year, talking about contraception and planning prior to first intercourse, fear of pregnancy, average evaluation of sex education's coverage of condom use, and having bought condoms in the previous year (Table 3.7).

Contraceptive use at first sexual intercourse (n=922)		
	OR	95% CI
Non-manual social class – father	1.62	1.00-2.63
Most friends would use condoms when having sex with someone for the first time		
Disagree	1	
Unsure	1.20	0.61-2.36
Agree	2.80	1.52-5.14
Number of sex partners in last year (range 0-20)	0.87	0.77-0.98
Talked about protecting ourselves before sex (at first sexual intercourse)		
No	1	
Yes, just before	7.92	4.26-14.73
Yes, well before	23.74	8.79-64.13
Planning first sex intercourse		
It was completely unexpected	1	
It just happened on the spur of the moment	0.93	0.55-1.57
Expected it to happen, but was not sure when	1.96	1.11-3.47
Planned it together beforehand	4.58	1.47-14.25
One of the things I fear most is becoming pregnant – age 16 (5 point scale: strongly disagree – strongly agree)	1.35	1.14-1.61
In sex education, how to use condoms properly was covered – age 16		
Not well	1	
Okay	2.81	1.44-5.52
Well	1.03	0.60-1.77
Bought condoms in the last year	1.96	1.24-3.11

*Table 3.7: Final model of influences on contraceptive use at first sexual intercourse*

*(backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)*

Contraceptive use at most recent sexual intercourse (n=836)		
	OR	95% CI
Father's qualifications – further/higher education level	1.53	1.02-2.29
Standard grades – credit level	1.61	1.06-2.45
Future aspirations (age 16)		
Unlikely to be in a steady relationship	0.77	0.60-0.98
Unlikely to have a child / children	1.33	1.11-1.60
Drunk or stoned at last intercourse	0.56	0.36-0.85
Important to plan pregnancy protection before you have sex (4 point scale: disagree – strongly agree)	1.74	1.26-2.40
Using condoms would be embarrassing (age 16) (5 point scale: strongly agree – strongly disagree)	1.47	1.15-1.89
Number of sex partners in last year (range 0-20)	0.84	0.75-0.94
Talked about protecting ourselves before sex (at first sexual intercourse)		
No	1	
Yes, just before	1.84	1.07-3.17
Yes, well before	4.02	2.09-7.72
Used contraception at first intercourse	2.36	1.51-3.67

*Table 3.8: Final model of influences on contraceptive use at most recent sexual intercourse*

*(backward stepwise multivariate logistic regression – adjusted odds ratios and 95% confidence intervals)*

At most recent intercourse, the factors which remained significant were father's, and own, educational attainment, expectations of future relationships and childbearing, being drunk at most recent intercourse, perceived importance of planning pregnancy prevention,

condom embarrassment, number of sex partners in the previous year, and talking about and use of contraception at first intercourse (Table 3.8).

### **3.3.3 Patterns of Contraceptive Use**

The following two sections focus on change of contraceptive use over time. Firstly, the level of consistency in contraceptive method use between first and most recent sexual intercourse is described. Secondly, the pattern of contraceptive change between first, first with most recent partner, and most recent intercourse is examined. The full extent of change between methods is described for one method, taking the young women who used condoms at first intercourse as an example. Then the patterns of change to and from effective methods are described for the remaining methods.

As was discussed in Chapter One, the (medical) efficacy of contraceptive methods varies. Here, use of the injection, the pill, condoms or a combination of both was taken to demonstrate effective pregnancy prevention. EC use was also included in the effective group because its use demonstrated an active choice to avoid pregnancy (even if the reason for use was contraceptive non-use or failure). Non-use, use of withdrawal, and putting a condom on just before ejaculation were taken to demonstrate ineffective pregnancy prevention, as all three involved unprotected intercourse.

#### **3.3.3.1 Consistency of Contraceptive Use between First and Most Recent Sexual Intercourse**

Of the young women who reported sexual experience, 921 (78.4%) had had sexual intercourse on at least two occasions and reported on their contraceptive use at both the first and most recent of these. Appendix B shows the patterns of change in contraceptive use between these two episodes (consistent use, by method, is shown in the shaded diagonal). Almost half (452, 49%) were consistent in their use, using the same method at both episodes. However, this varied by the method used at first intercourse.

Over half who used a condom, the pill or both at first intercourse did so again at most recent. Of the young women who reported putting a condom on before ejaculation at first intercourse, just over one third did so again at most recent, but another third instead reported condom use throughout. Of those who reported using no contraceptive method at first intercourse, just under half did so again at most recent, while around one in five

reported condom or pill use. One in five who used withdrawal at first intercourse did so again at most recent, while one third reported condom use, and less than one in five reported using no method instead. Only one in seven of the young women who reported EC use at first intercourse did so again at most recent, while over one third reported condom use throughout instead. Only two of the 21 who had combined the condom, pill and EC at first intercourse did so again at most recent, while just less than half reported condom use instead.

Change was least likely among those who used a condom, the pill or a combination of both at first intercourse. It was higher among those who reported withdrawal, putting a condom on before ejaculation, and EC use at first intercourse. Thus there was more consistency among young women who started with effective methods than among those who started with ineffective ones. Just under one in five of those who started with an effective method changed method compared with almost one third of those who started with an ineffective one. Of those who used an effective method at first intercourse, most (four in five) again used that method or changed to another effective method at most recent intercourse. Of those who used an ineffective method, just under half continued to use, or changed to another, ineffective method, while the rest changed to an effective method.

### **3.3.3.2 Patterns of Contraceptive Use between First, First with Most Recent Partner, and Most Recent Sexual Intercourse**

Patterns of contraceptive use over time were explored for young women who reported their use at first intercourse ('time 1'), at first intercourse with their most recent partner ('time 2') and at most recent intercourse ('time 3') (N=447). Possible change both between and within relationships was examined: reported contraceptive use at 'time 1' and then at 'time 2' demonstrated change between relationships (each episode is with a different partner); reported contraceptive use at 'time 2' and then at 'time 3' demonstrated change within a relationship (both episodes are with the same partner).

Over the three episodes of contraceptive use, the 447 young women reported 122 different patterns of contraceptive use. The range of patterns varied by the initial contraceptive method used at 'time 1' and the pattern for young women who reported condom use at first intercourse is shown as an example (Figure 3.2).

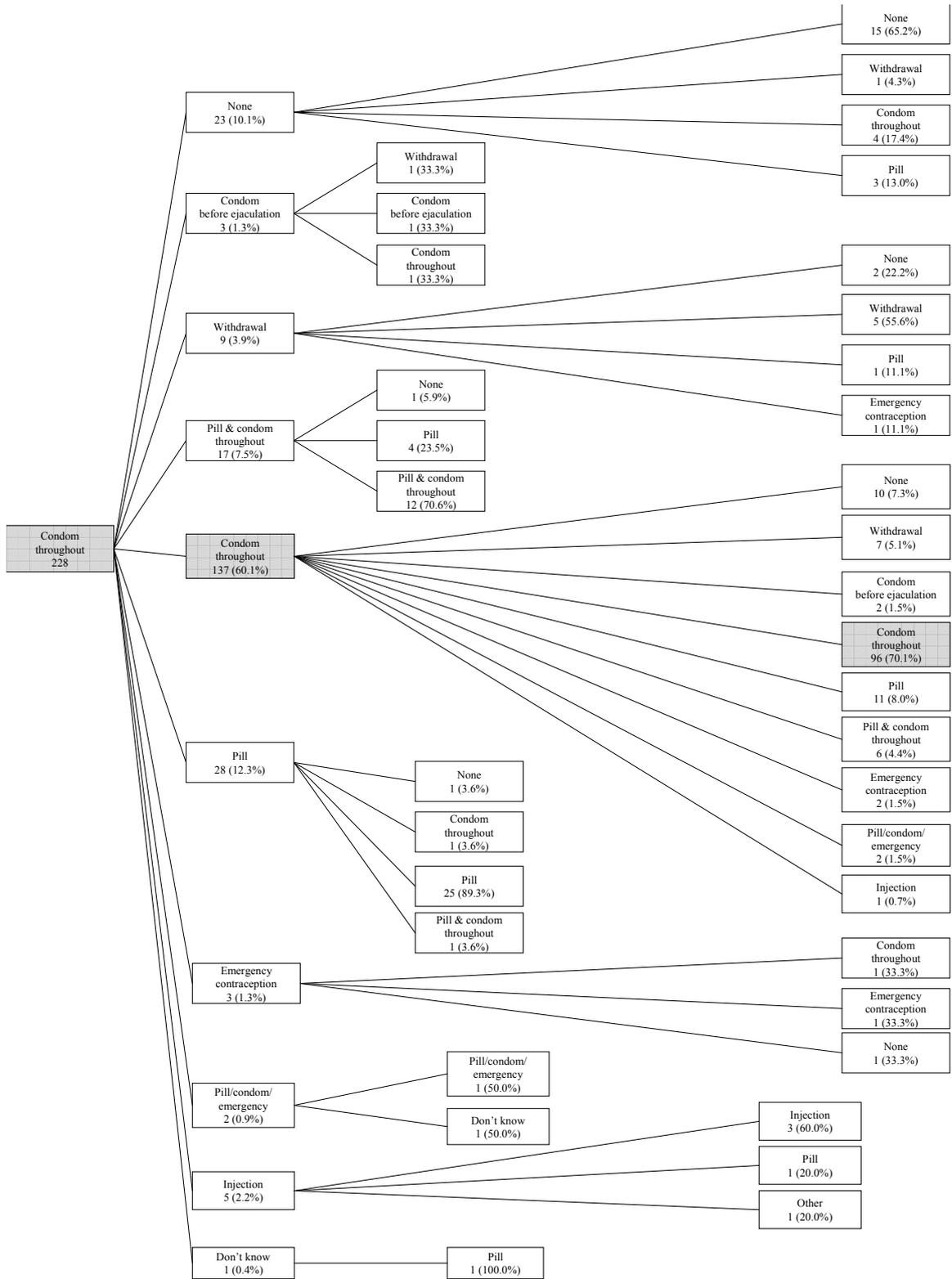


Figure 3.2: Flowchart of contraceptive pattern between first, first with most recent partner, and most recent sexual intercourse (condom use at first intercourse)

***Patterns of Use – Condom Use at First Intercourse***

In Figure 3.2 the total number of young women who reported condom use at ‘time 1’ is shown in the first box of the flowchart (n=228). The method used at ‘time 2’ is shown in the next line of boxes to the right, along with the number of young women reporting each method (and % of the ‘time 1’ total). The method used at ‘time 3’ is shown in the line of boxes to the far right of the chart, along with the number of young women reporting each method (and % of the ‘time 2’ total). Consistent use of the original method is shown in the shaded boxes. Therefore, 137 (60.1%) of the 228 young women who used condoms at ‘time 1’ used condoms at ‘time 2’; and of those, 96 (70.1%) used condoms at ‘time 3’. Just under half (42.1%) reported consistent condom use. Overall, there were 35 different patterns of use over the three episodes. This demonstrates the variation and the complexity of the young women’s patterns of use.

In addition to those who reported consistent condom use, another 55 (24.1%) young women reported use of an alternative effective contraceptive method<sup>3</sup> at ‘time 2’; all but five of whom also reported use of an effective method at ‘time 3’. On the other hand, 36 (15.8%) of those who reported condom use at ‘time 1’ then reported use of an ineffective method at ‘time 2’; 25 (69.4%) of whom did so again at ‘time 3’. So overall, among the young women who had started their contraceptive pattern with condoms, almost three quarters (73.7%) reported that they had used these or another effective contraceptive method at all three episodes. The remainder had used an ineffective method at least once. Less than one third of those who reported use of an ineffective method when they first had sex with their most recent partner (‘time 2’) had moved on to an effective method when they last had sex (‘time 3’).

The extent of change between effective and ineffective methods is important because change between methods is not necessarily problematic if pregnancy prevention is maintained. As the extent of patterns varied by the initial method used, so did the extent of change with regard to efficacy. The rest of the flowcharts in this section demonstrate the change to and from effective methods for each of the remaining main contraceptive methods (the complete patterns flowcharts for each are shown in Appendix C).

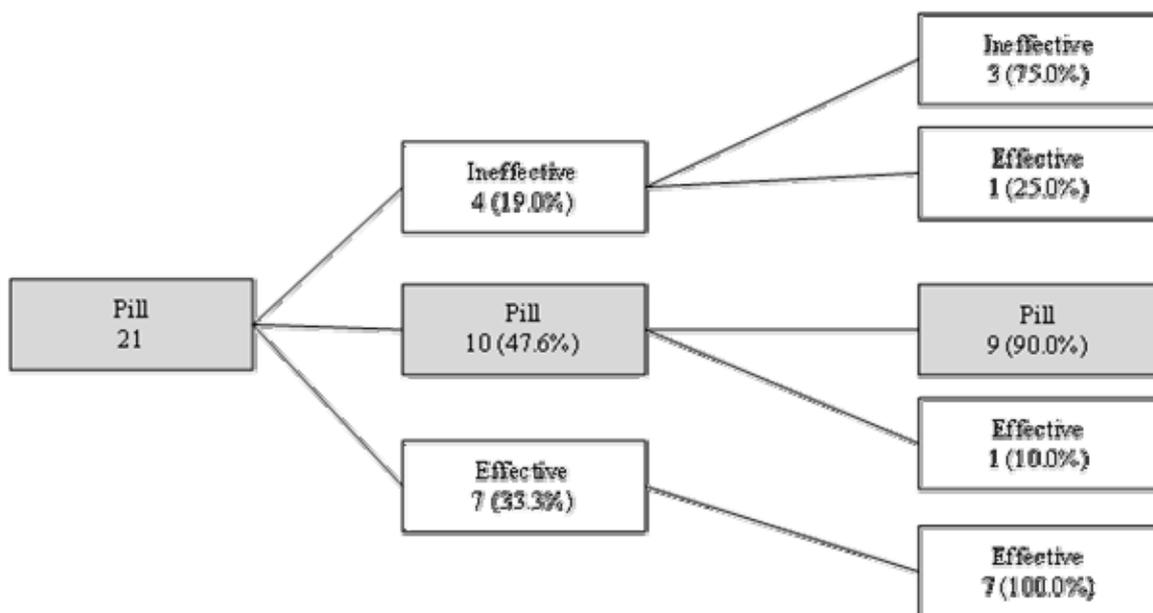
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<sup>3</sup> In these analyses, condom use, pill use, pill and condom use combined, use of condom, pill and emergency contraception, and emergency contraception are defined as effective contraceptive methods. Non-use, withdrawal, and putting on a condom before ejaculation are defined as ineffective contraceptive methods.

***Patterns of Use – Contraceptive Pill Use at First Intercourse***

Sole use of the pill at ‘time 1’ was reported by 21 young women, among whom there were seven separate patterns of contraceptive use (Appendix C). Of these young women, 10 (47.6%) reported pill use at ‘time 2’; all but one of whom again reported use at ‘time 3’ (Figure 3.3). Just under half (42.9%) reported consistent pill use over the three episodes.

Of the 21 pill users, seven (33.3%) reported use of an alternative effective method at ‘time 2’; all of whom also reported use of an effective method at ‘time 3’. Use of an ineffective method was reported by four young women (19.0%) at ‘time 2’; three (75.0%) of whom again reported such use at ‘time 3’. Overall, over three quarters (81.0%) reported use of the pill or another effective method at all episodes.



*Figure 3.3: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (pill use at first intercourse)*

***Patterns of Use – Pill and Condom Use at First Intercourse***

Another 41 young women reported that they used both the pill and condoms at ‘time 1’, among whom there were 11 separate patterns of contraceptive use (Appendix C). Of these young women, 22 (53.7%) reported pill and condom use at ‘time 2’; all but three of whom again reported use at ‘time 3’ (Figure 3.4). Therefore, just under half (46.3%) reported consistent use over the three episodes.

Use of an alternative effective method was reported by 17 (41.5%) at ‘time 2’; all but two of whom also reported use of an effective method at ‘time 3’ (Figure 3.4). Use of an

ineffective method was reported by two young women (4.9%) at ‘time 2’; both of whom again reported such use at ‘time 3’. Almost all (90.2%) reported combined use of the pill and condoms or another effective method at all episodes.

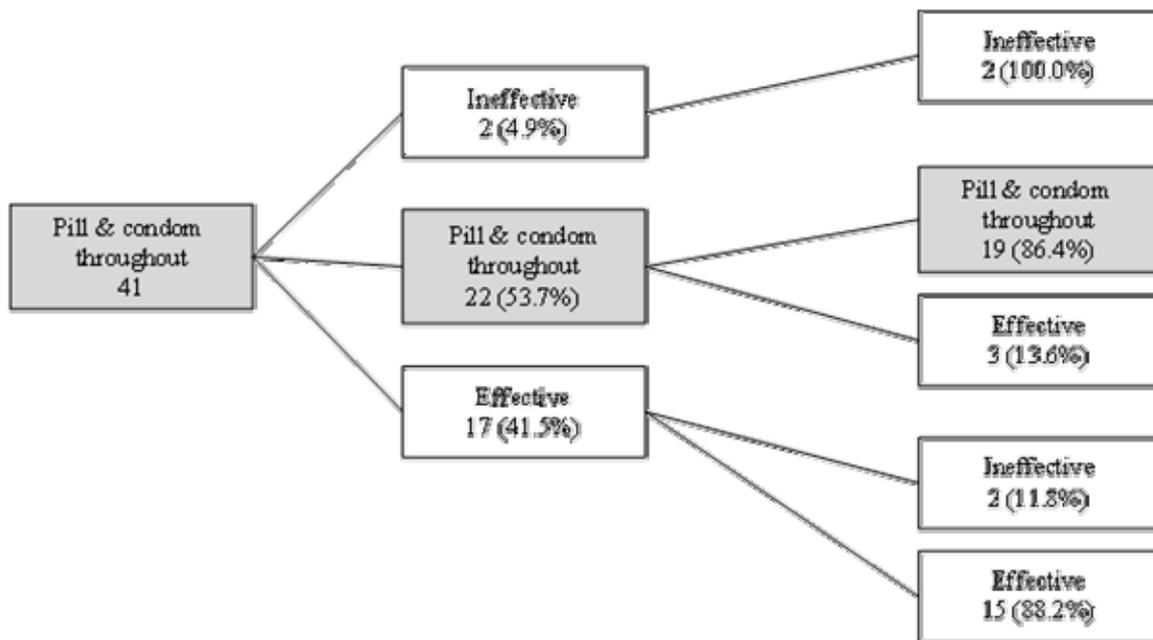


Figure 3.4: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (pill and condom use at first intercourse)

**Patterns of Use – Condom, Pill and Emergency Contraception Use at First Intercourse**

Combined use of condoms, the pill and emergency contraception was reported by 13 young women at ‘time 1’, among whom there were eight separate patterns of contraceptive use (Appendix C). Of these young women, only one (7.7%) reported such combined use at each of the three episodes (Figure 3.5). All but one of the remainder (84.6%) reported use of an alternative effective method at ‘time 2’; of whom all but two again reported use of an effective method at ‘time 3’.

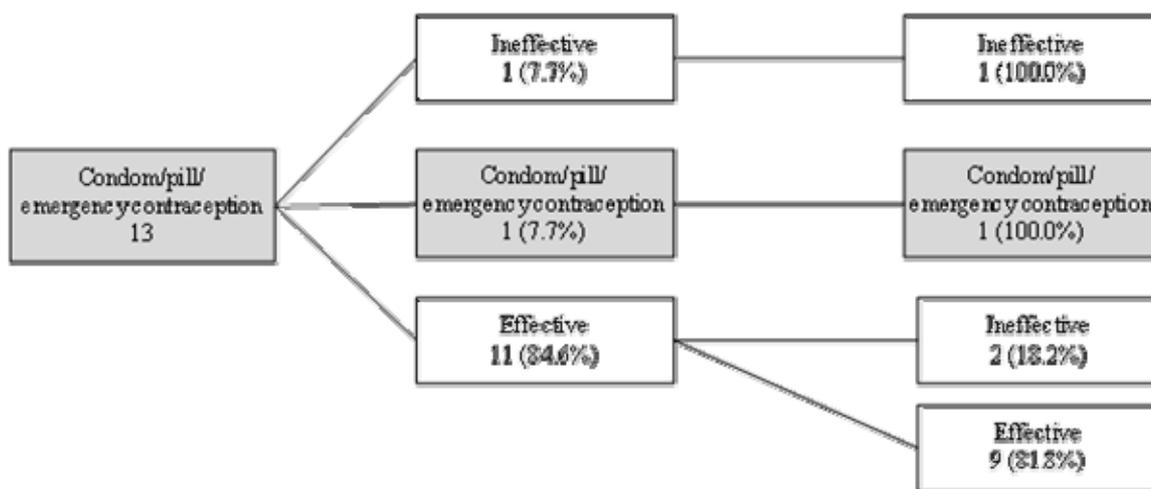


Figure 3.5: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (pill, condom and emergency contraception use at first intercourse)

**Patterns of Use – Emergency Contraception Use at First Intercourse**

Another 21 young women reported that they used emergency contraception at ‘time 1’, among whom there were 14 separate patterns of contraceptive use (Appendix C). Only five (23.8%) of these young women reported use of emergency contraception at ‘time 2’; three of whom again reported use at ‘time 3’ (Figure 3.6). Therefore, only one in seven reported consistent use of emergency contraception over the three episodes. Most of the young women (61.9%) reported use of an alternative effective method at ‘time 2’; all but two of whom also reported use of an effective method at ‘time 3’ (Figure 3.6). Use of an ineffective method was reported by three young women (14.3%) at ‘time 2’; two of whom again reported such use at ‘time 3’. So overall, three quarters (76.2%) reported emergency contraception or another effective method at all episodes.

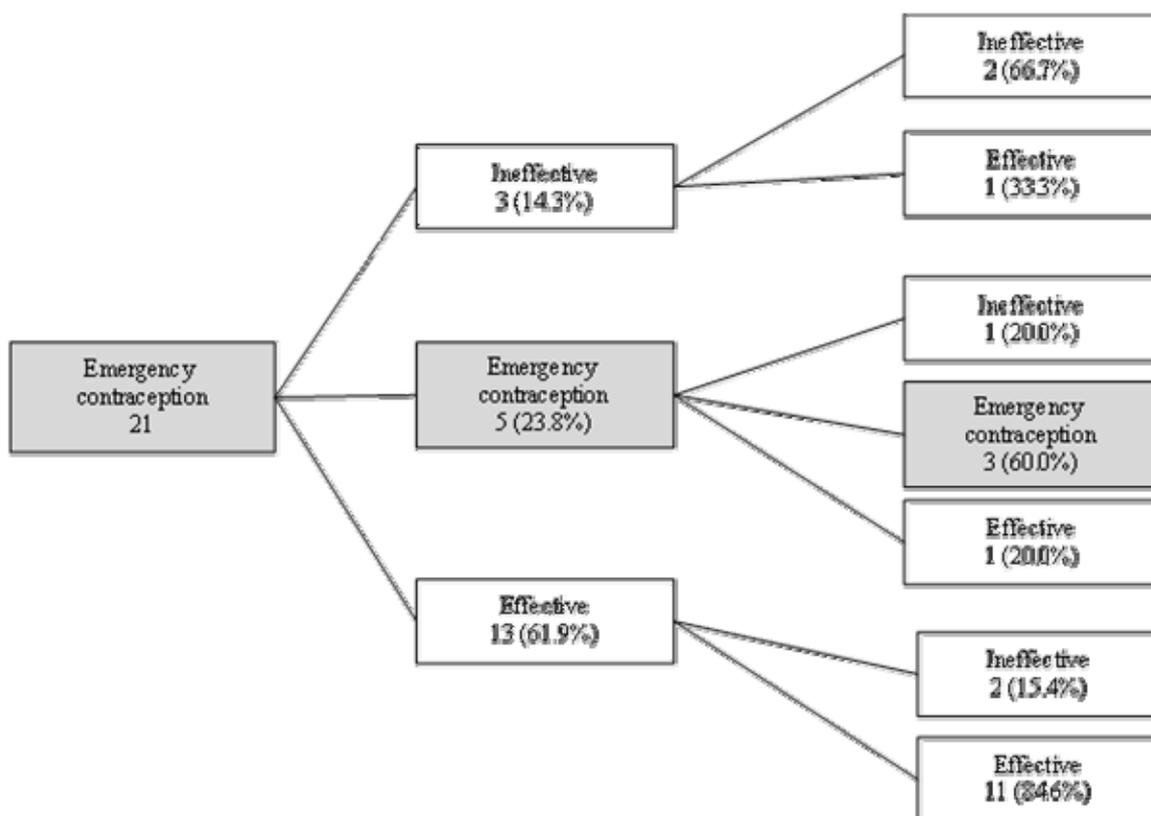


Figure 3.6: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (emergency contraception use at first intercourse)

All of the above young women (Figures 3.2-3.6) started their contraceptive pattern with an effective method, and three quarters (248/324, 76.5%) used an effective method at all three episodes of sexual intercourse. In the three following figures the young women started their contraceptive pattern with an ineffective method, so the proportions reporting consistent ineffective method use and change from ineffective to effective methods were examined. Overall, 117 young women started their contraceptive pattern with an ineffective method and 49 (41.9%) used such a method at all three episodes of sexual intercourse.

**Patterns of Use – Non-use of Contraception at First Intercourse**

Non-use of contraception at ‘time 1’ was reported by 73 young women, who had 19 separate patterns of contraceptive use (Appendix C). Of these young women, 37 (50.7%) reported non-use at ‘time 2’; 28 (75.7%) of whom again reported non-use at ‘time 3’ (Figure 3.7). Therefore, just over one third (38.4%) reported consistent non-use at the

three episodes. Only one young woman reported non-use at ‘time 1’, condom use at ‘time 2’ and pill use at ‘time 3’.

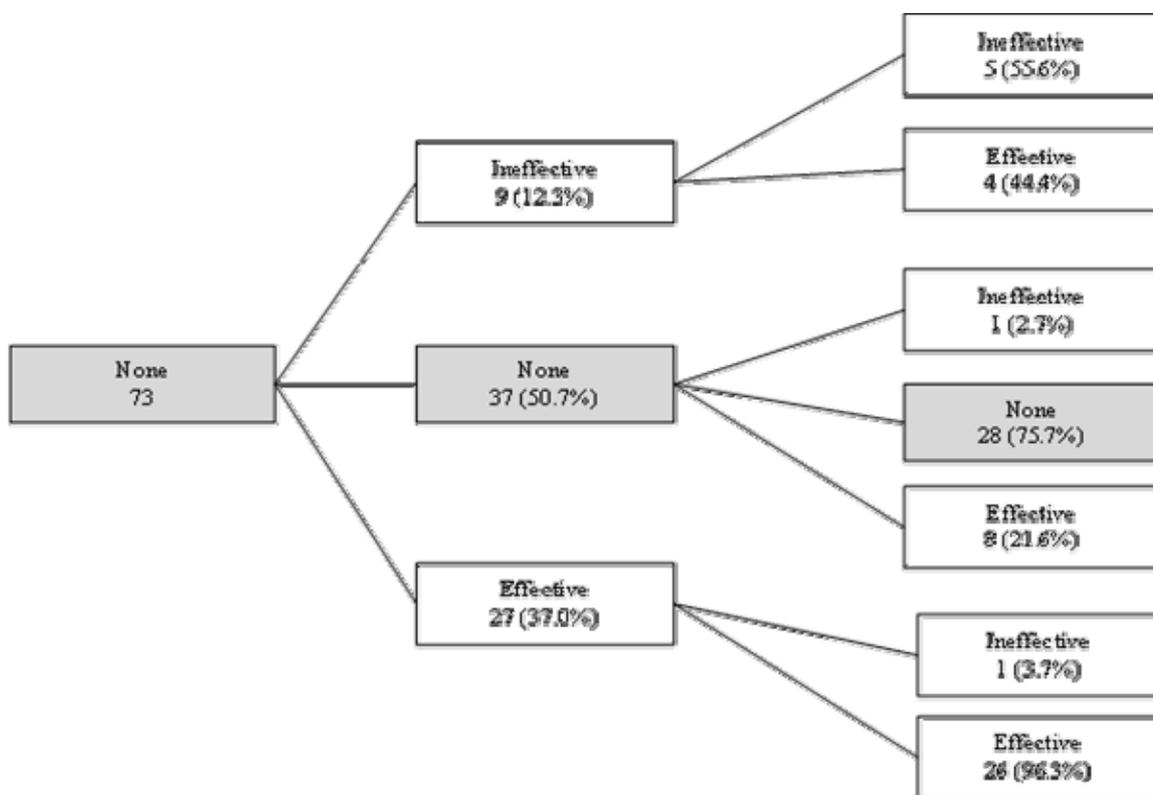


Figure 3.7: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (non-use at first intercourse)

Use of another ineffective method was reported by nine (12.3%) at ‘time 2’; five of whom also reported use of an ineffective method at ‘time 3’ (Figure 3.7). Just over one third (37.0%) of the young women who reported non-use at ‘time 1’ used an effective method at ‘time 2’; all but one of whom again reported use of an effective method at ‘time 3’.

Overall, just under half (46.5%) reported non-use or use of another ineffective method at all three episodes. At ‘time 3’, 47.9% continued to report non-use or use of another ineffective method, while the rest reported use of an effective method.

**Patterns of Use – Withdrawal at First Intercourse**

Withdrawal at ‘time 1’ was reported by 38 young women, who had 18 separate patterns of contraceptive use (Appendix C). Of these young women, nine (23.7%) reported withdrawal at ‘time 2’; four (44.4%) of whom again reported this at ‘time 3’ (Figure 3.8). Therefore, less than one in ten of this sample reported withdrawal at all three episodes.

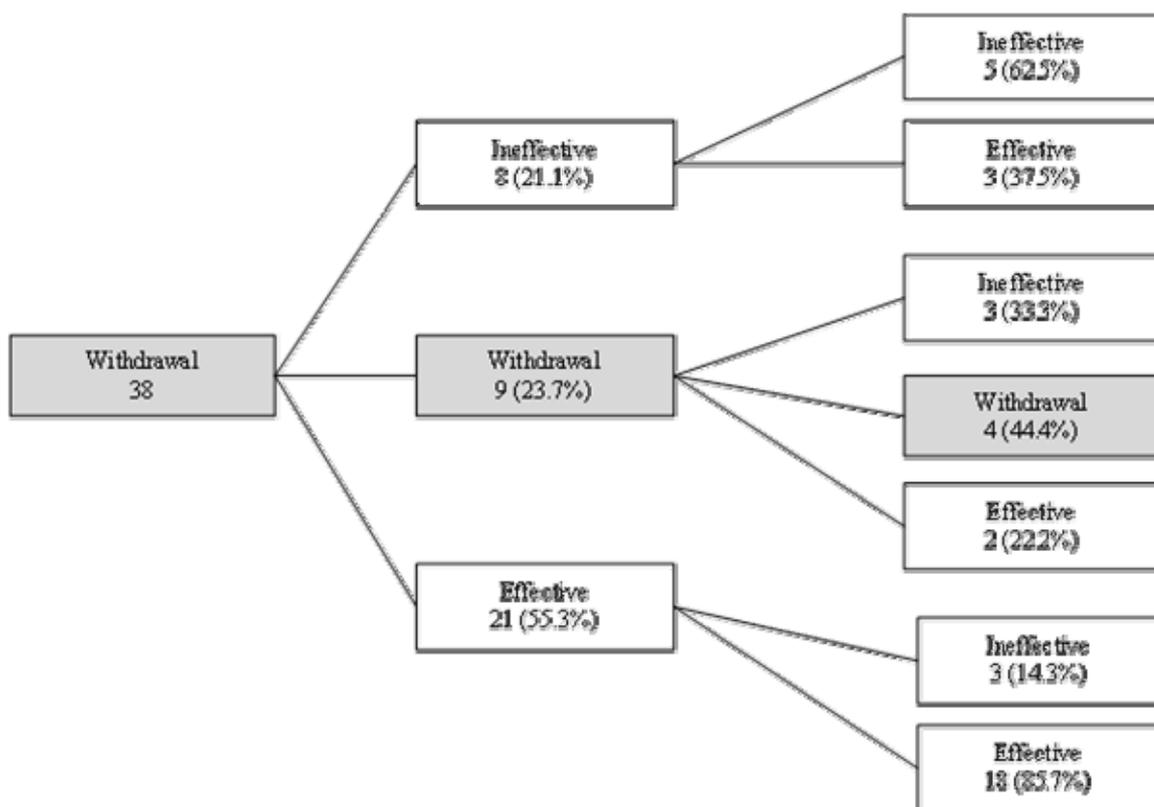
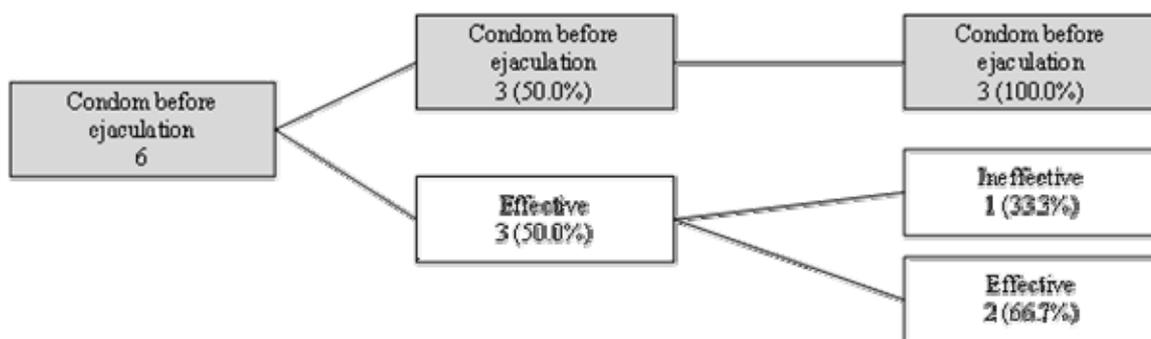


Figure 3.8: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (withdrawal at first intercourse)

Use of another ineffective method was reported by eight (21.1%) at ‘time 2’; five of whom also reported use of an ineffective method at ‘time 3’ (Figure 3.8). Just over half (55.3%) of the young women who reported withdrawal at ‘time 1’ used an effective method at ‘time 2’; all but three of whom again reported use of an effective method at ‘time 3’. Overall, just under one third (31.6%) reported withdrawal or use of another ineffective method at all three episodes. By ‘time 3’, almost two thirds (60.5%) reported use of an effective contraceptive method.

***Patterns of Use – Condom put on just before Ejaculation at First Intercourse***

Only six young women reported that their partner put a condom on just before ejaculation at ‘time 1’, and among them there were four separate patterns of contraceptive use (Appendix C). Of these young women, half again reported putting on a condom just before ejaculation at ‘time 2’, and again at ‘time 3’ (Figure 3.9).



*Figure 3.9: Flowchart of contraceptive efficacy between first, first with most recent partner, and most recent sexual intercourse (condom put on just before ejaculation at first intercourse)*

The remaining three young women reported use of an effective method at ‘time 2’; two of whom again reported this at ‘time 3’ (Figure 3.9). At ‘time 3’, four young women (66.7%) continued to report use of an ineffective method.

### **3.3.4 Consistency and Change in Young Women’s Patterns of Contraceptive Use**

Of the young women who reported on all three episodes of sexual intercourse, just over half (248, 55.5%) had consistently used an effective contraceptive method, around one in ten (49, 11.0%) had consistently used an ineffective method, and one third (150, 33.6%) had changed between the two.

So were young women more likely to report changes in contraceptive use between relationships than within them? Changes between relationships (from ‘time 1’ to ‘time 2’) were reported by 223 of the 447 young women (49.9%) and within relationships (from ‘time 2’ to ‘time 3’) by 128 (28.6%). Cohen’s kappa scores (where 1 indicates perfect agreement and 0 indicates no better than chance) were calculated to assess the overall agreement in contraceptive method use between the time points. The kappa score for times 1 and 2 was 0.34 (95% CI 0.28-0.40) and the score for times 2 and 3 was 0.65 (95% CI 0.59-0.70). The significantly lower score for change between times 1 and 2 (between relationships) indicates that there was more change between those time points than between times 2 and 3 (within most recent relationships).

## 3.4 Discussion

In this chapter I have examined the contraceptive experiences of sexually active young women who took part in the SHARE study. I have explored their contraceptive use, influences on use and non-use at first and most recent sexual intercourse, experience of method switching and discontinuation, and patterns of contraceptive use over three time points. Each is considered in turn in the discussion. Finally, some data limitations are discussed.

### 3.4.1 Contraceptive Use

Over three quarters of the sexually active young women surveyed had used contraception at first, first with most recent partner, and most recent sexual intercourse. At first intercourse, just under two thirds used a condom and 12% used the pill. These rates are lower than those found in the 2000 NATSAL survey, in which over three quarters of young women aged 16-19 years reported condom use, and one quarter pill use, at first intercourse (Wellings et al. 2001). Within the SHARE sample, condom use decreased over the three episodes of sexual experience, use of the pill, combined use of condoms and the pill, and use of the injection increased. At most recent intercourse, half reported condom use and almost one third reported pill use. In the 2005/06 Office for National Statistics Omnibus Survey, just under two thirds of women aged 16-19 years were currently using the pill and a similar proportion was using condoms (Taylor et al. 2006). This difference may reflect the difference in the timing of these surveys or a difference in the proportions reporting first sex by a particular age. The SHARE data discussed here only include those who had had sex by age 16, while the NATSAL and Omnibus Surveys include those who first had sex between age 16 and 19. As will be discussed further later, those who first have sex before age 16 may represent a particular risk group.

The proportion of young women who reported using no contraception at first intercourse was 14%, compared with 10% of 16-19 year olds in NATSAL (Wellings et al. 2001). However, the levels of non-use (and withdrawal or putting on a condom just prior to ejaculation) remained consistent across the three episodes, demonstrating that a significant minority were at risk of pregnancy at each. In contrast, are those who reported combined use of the contraceptive pill, the condom and EC, representing a small, but interesting, group. It is possible that it 'all went wrong', that is they forgot to take the pill, the condom

split, and they used EC as a result. Alternatively these young women may have been over cautious. As the reasons for EC use were not reported it is not possible to determine exactly what happened.

### **3.4.2 Influences on Contraceptive Use**

Overall, a considerable number of factors were found to be associated with contraceptive use and there were similarities in those associated with use at first and most recent sexual intercourse. In the final multivariate logistic regression models, social background was a significant predictor of contraceptive use at both episodes, as was contraceptive planning. It was interesting that planning at first intercourse increased the odds of contraceptive use at that event and also at the most recent. This suggests that individual characteristics (i.e. tendency to plan) are stronger than the differences between, or influence of, particular relationships. Aspirations and expectations were also important features at each event, with pregnancy fear and not aspiring to have a child in the near future increasing contraceptive use. However, contraceptive use was tempered by the situational and experiential factors of being drunk or having more sexual partners in the previous year.

Research has consistently found that young women from socially disadvantaged backgrounds are at greater risk of pregnancy and negative sexual health outcomes (Arai 2003; Bonell et al. 2003; Bonell et al. 2005; HEA 1999; Young et al. 2004). Conversely, planning and communication with partners are some of the strongest predictors of contraceptive use (Adler et al. 1997; Edgar et al. 1992; Harden and Ogden 1999; Henderson et al. 2002; Sheeran et al. 1999; Stone and Ingham 2002; Tschann and Adler 1997). Both low educational attainment and ambivalence to pregnancy have been found to be predictors of pregnancy (Adler and Rosengard 1996; Bonell et al. 2003; Bonell et al. 2005; Bruckner et al. 2004; Crosby et al. 2002; Jaccard et al. 2003; Stevens-Simon et al. 1996; Stevens-Simon et al. 2005; White 1999; Young et al. 2004; Zabin et al. 1993). On the other hand, young women with the most career-orientated future expectations are more likely to use contraception (HEA 1999; Kuiper et al. 1997; Woodsong and Koo 1999). Failure to use contraception while under the influence of alcohol has also been reported elsewhere (Coleman and Cater 2005; Cooper 2002; Leigh 2002), and demonstrates how event-specific factors can become important. The decrease in the likelihood of contraceptive use with increasing partner numbers has limited support from other studies (Flisher and Chalton 2001; Richter et al. 1993). A greater number of partners may simply

reflect more chances to not use contraception, or alternatively, particular patterns of risk behaviour.

The inclusion of background, behavioural, situational and experiential factors in the final model demonstrates the complexity of contraceptive use. The influence of situational and experiential factors is of particular importance, given that these could change further over time.

### ***3.4.3 Contraceptive Method Switching and Discontinuation***

Method switching was apparent among the 921 young women who reported their contraceptive use at first and most recent sexual intercourse. Here, the focus was on change between specific episodes of sexual intercourse and I do not know what happened between them. It is therefore difficult to directly compare these data to much of the research on contraceptive discontinuation and method switching, which focuses on change within a given time period. However, most of the sexually active young women who were surveyed at age 16 would only have been sexually active for one or two years (median age at first sexual intercourse was 15 years), making tentative comparison possible.

Much of the literature has found that contraceptive method discontinuation and switching are relatively common, and often more likely among younger women (Grady et al. 1983; Grady et al. 1988; Grady et al. 2002; Hammerslough 1984; Ramstrom et al. 2002; Trussell and Vaughan 1999). This is supported by the finding that only half of the young women surveyed here reported use of the same method at both first and most recent sexual intercourse. The remainder switched to a different method (or non-use).

Change was less likely among those using more effective methods (condoms, pill, and dual method use) and more likely among those reporting less effective methods, such as withdrawal or putting on a condom just before ejaculation. Such variation was also apparent in the other studies of method switching and discontinuation (Bracher and Santow 1992; Grady et al. 1983; Grady et al. 1988; Grady et al. 2002; Hammerslough 1984; Hirsch and Zelnik 1985; Rosenberg and Waugh 1998; Trussell and Vaughan 1999). While studies have reported considerable contraceptive injection discontinuation rates (Davidson et al. 1997; Paul et al. 1997; Polaneczky et al. 1996; Sangi-Haghpeykar et al. 1996), both of the young women who were using the injection at first intercourse were still using it at most recent. It is also important to note that previous studies have suggested that change is more

often between methods than from method use to non-use (Glei 1999; Grady et al. 2002; Hirsch and Zelnik 1985; Rosenberg and Waugh 1998; Trussell and Vaughan 1999), as was also the case here. However, in their 2002 paper, Grady et al. found that while change was least likely among pill users, it was most likely among those who originally used no method. Significantly, this was not the case here. Almost half of the young women who reported non-use at first intercourse also reported this at most recent, suggesting that non-use could have been the normal behaviour for a significant minority of young women.

### **3.4.4 Patterns of Contraceptive Use**

Just under 450 young women reported on contraceptive use at all three episodes of sexual intercourse included in the SHARE questionnaire (first, first with most recent partner, and most recent sexual intercourse). Among them, there were 122 different patterns of contraceptive use. It is important to note that this was the case here even though data were only available for three specific time points. The classic pattern of contraceptive use (using no contraception at first intercourse, then condoms, and then the pill), which was reported as being dominant in the early literature (Lindemann 1974; Miller 1976) did not appear to be common here. It was only reported by one young woman in this sample. However, it is possible that more did follow this pattern, just that it was not evident over the three specific time points considered here.

The number of patterns by initial method used varied from 4 to 36, but the range could simply result from the number of young women in each category. For example, those who reported condom use at first intercourse had the widest range of patterns but this was the initial method reported by half of the sample (228 young women). Among those who reported pill use at first intercourse there were only seven patterns of contraceptive use, but there were only 21 young women in this category. Matteson and Hawkins (1993, 1997) found similarly high numbers of individual patterns of use, and that those who started with a non-medical method, such as condoms, reported more method changes than those who started with a medical method, such as the pill. This suggests there is real variation by method, which will be worth exploring further with the more detailed qualitative data. Such varied patterns of contraceptive use and changes from one method to another suggest that contraceptive use is event-specific, that is to say, dependent on specific time and person factors.

Just over half the young women had consistently used an effective contraceptive method at all three episodes of sexual intercourse reported in the data. The remainder had taken a contraceptive risk at some point. It is worrying to note that around one in ten had consistently used an ineffective method. There was evidence that those who reported initial use of the more effective contraceptive methods were more likely to be consistent in their use of these or to change to other effective methods as opposed to less effective ones. This supports the findings of the contraceptive method switching and discontinuation studies (Bracher and Santow 1992; Grady et al. 1983; Grady et al. 1988; Grady et al. 2002; Hammerslough 1984; Hirsch and Zelnik 1985; Rosenberg and Waugh 1998; Trussell and Vaughan 1999). However, change from more to less effective methods was also apparent. This was a finding also reported by Matteson and Hawkins (1993, 1997). Such changes from more to less effective methods may reflect the contradiction between medical and user efficacy. While contraceptive methods can be considered medically effective with respect to how efficiently they prevent pregnancy, this does not take into consideration how personally effective they are to the users themselves. For instance, while the contraceptive pill is medically effective, it could have low user efficacy for a young woman who experiences side effects or difficulties with the routine of taking it (Balassone 1989; Berenson and Wiemann 1993; Berenson et al. 1997; Bracher and Santow 1992; Breheny and Stephens 2004; Clark et al. 2004; Cheung and Free 2005; Emans et al. 1987; Ramstrom et al. 2002; Rosenberg et al. 1995; Rosenberg and Waugh 1998; Sanders et al. 2001; Wahab and Killick 1997). If this was the case it is entirely possible that use of the pill would be discontinued and another method, possibly a less effective one, would be adopted instead.

The number of method changes between and within relationships was examined to investigate whether change was relationship-specific. The results suggest there was more contraceptive method change between relationships than within them. This finding is contrary to much of the previous research. It has been argued that young women will stop using condoms and start using the pill once a relationship is established (Bauman and Berman 2005; Hammer et al. 1996; Hirsch and Zelnik 1985; Holland et al. 1998; Lear 1995; Reisen and Poppen 1995; Thomas 1991; Woodsong and Koo 1999). Here, only one in ten of the young women who reported condom use at the second episode of sexual intercourse (start of new relationship) had changed to pill use at the third episode (most recent sex in that relationship). However, this could have been because of the young age of this sample and the relatively short relationship time period covered by the

questionnaire. It is possible that greater change between relationships is because more time could have elapsed between first intercourse and first with most recent partner than between first and last with that most recent partner. Alternatively, it could be that first intercourse is so different from the later episodes of sexual intercourse that there is more often change after this first sexual experience than after those that follow.

In respect of change between relationships, previous studies have found condom use is more common with new partners (Bauman and Berman 2005; Crosby et al. 2000; Ford 1991; Fortenberry et al. 2002; Hatherall et al. 2005; Lear 1995; Plichta et al. 1992; Poppen and Reisen 1999; Woodson and Koo 1999). This might have suggested that there would be least change to condom use between the two episodes that occurred with new partners (first intercourse and first with most recent partner), but it was not the case here. The proportion of change from condoms to other methods was higher between than within relationships.

Partner influence is an important determinant of contraceptive method change, but these findings suggest the importance of additional factors. Perhaps this is not surprising, given the range of factors that have been associated with method change in previous research. I have already discussed how method and user efficacy could be important determinants of method change. User efficacy in particular could explain change from more to less effective methods. Studies have also reported that background characteristics such as lower socio-economic status, poverty and lower education levels are associated with contraceptive discontinuation (Bracher and Santow 1992; Emans et al. 1987; Grady et al. 1983; Grady et al. 1988; Grady et al. 2002; Hammerslough 1984; Ramstrom et al. 1992; Rosenberg et al. 1995; Trussell and Vaughan 1999). Within the SHARE sample, young women from socially disadvantaged backgrounds were less likely to have used contraception at both first and most recent sexual intercourse, so the suggestion that these could be the same young women most at risk of method discontinuation is worth exploring further. However, at this stage this is not possible because of limitations of the quantitative data.

### **3.4.5 Limitations of the Quantitative Data**

These data provide a rich and detailed picture of contraceptive use among a cohort of young women in the East of Scotland. However, there were limitations to the data that have to be considered before any conclusions are drawn.

The questionnaire contained a predetermined list of contraceptive methods for young women to choose from. There are a number of issues in relation to this that limit our understanding of their contraceptive use. Firstly, while all of the main methods were listed, and young women could both select more than one answer and add 'other' methods, it was possible that particular methods were under-reported or forgotten. The questionnaire did not list the rhythm method or the contraceptive implant and injection. As such, the injection was only reported by a small number of young women who specifically listed it in the 'other' category. However, it could be surmised that use of the injection and the implant would be low among such a young age group anyway.

While some of the analyses in this chapter present change between more and less effective methods, there were no data on the actual efficacy of method use. The pill and condoms are effective contraceptive methods when they are used correctly. The questionnaire, however, did not ask young women about this important aspect of contraceptive use. Furthermore, I categorised EC as an effective contraceptive method, in that it demonstrates an active attempt to avoid pregnancy. However, it was probably required as a result of non-use or contraceptive failure. Indeed most of the young women who used it at first intercourse went on to use more effective methods, and only three reported using it at all three episodes of sexual intercourse. The use of EC as a regular contraceptive method, if this was the case, raises questions as to the actual contraceptive efficacy of this user group. The complexity of this issue deserves further attention.

Young women were not asked why they used specific contraceptive methods at each of the episodes of sexual intercourse. Furthermore, the questionnaire was not designed to assess method change and discontinuation, or the factors associated with these. The consideration of what is associated with method switching, discontinuation and patterns of use is speculative at this stage because of this.

It should also be noted that the three episodes of contraceptive use examined here, especially first sexual intercourse and first with most recent partner, were very specific

events. While similar factors were found to be associated with contraceptive use at both first and most recent intercourse, it is possible that there are specific influences on first method use that become less salient with time. Similarly, it is possible that there are other influences on use that become more important in the longer term. There are also questions over what happened in between these episodes. In particular, I do not know what happened within the course of the relationship with the first sexual partner. Manlove et al. (2003) found that over one third of US adolescents were not consistent contraceptive users in their first sexual relationships. This suggests that considerably more change would have been apparent if this had been explored in the questionnaire. Indeed, among the 447 young women whose contraceptive use patterns were examined, over half reported having had three or more sexual partners and having had sex more than ten times in the previous year. Therefore, there could have been more method changes than were evident over the three episodes of sexual intercourse included in these analyses. Complete sexual and contraceptive histories would be required to accurately map the young women's patterns of contraceptive use.

Finally, all of the young women in the analyses in this chapter had reported first experience of sexual intercourse by the age of 16 years, and the 447 included in the analyses of contraceptive use patterns represent a very specific risk group with at least two different partners and relatively more sexual experience. While it is important to know about the contraceptive use of this potentially risky group, they may not be particularly representative of their peers who had not had sex at that age. Indeed, greater sexual experience is associated with method switching (Hirsch and Zelnik 1985). It is possible that those who had yet to become sexually active, and even those who had only one or two experiences of sexual intercourse, would have had different patterns of contraceptive use.

### **3.5 Conclusions**

These quantitative data form the first stage of this research study. While limited by the constraints of the data collected, these results demonstrate the complexity of the young women's contraceptive use. Contraceptive change was considerable and there were multiple individual patterns of use. There was less change among those using effective contraceptive methods, and change was more common between than within relationships. Worryingly, just under half of the young women had taken a contraceptive risk at some point. However, a number of unanswered questions remain.

I was unable to examine the young women's complete patterns of contraceptive use, or the factors associated with their particular method choices and changes. These issues would be better addressed through qualitative research, by examining young women's full sexual and contraceptive histories and the contexts within which they occur. The focus of this quantitative chapter was necessarily on a very specific risk group, and based on data obtained when they were aged 14 and 16. Following up this sample at an older age (20 years) would give access to young women with a much wider range of sexual experiences. This became the focus of the qualitative study, the methods of which are described in the next chapter.

## 4 Chapter Four

### Methods

#### 4.1 Introduction

In the previous chapter, I used quantitative analyses to examine the contraceptive use of the young women who took part in the SHARE study, and concluded that a qualitative approach would be more appropriate to explore this further. This chapter describes the qualitative work that was conducted as a result. The research process, from the pilot study through to sampling, recruitment and the interview process itself is documented, and the use of the framework data analysis method to code, interpret, and to generate explanations from the data is described. In the final section of the chapter, the choice of a qualitative approach and the theoretical assumptions of the study are discussed in more detail.

Particular issues in relation to interviewing young women on sensitive topics, reflexivity, and addressing the reliability, validity and generalizability of the study are addressed. These considerations informed the research design, analyses, and interpretation of the findings.

##### ***4.1.1 Aims of the Study***

The aims of this research study are to examine young women's contraceptive use, to assess their patterns of use, and to explore whether or not they have contraceptive careers. The research questions are:

- What were the patterns of contraceptive use among these young women?
- Did these young women have contraceptive careers?
- What were the reasons for use and non-use of different contraceptive methods?
- What were the sexual and reproductive health implications of young women's contraceptive patterns?

## **4.2 Research Methods**

In-depth interviews with a purposive sample of young women from the SHARE study were used to address the above research questions. Ethical approval for the pilot study was granted by the Greater Glasgow Primary Care - Community and Mental Health Research Ethics Committee, and for the main study by the Glasgow University Ethics Committee for Non Clinical Research Involving Human Subjects.

### **4.2.1 Pilot Study**

I conducted a small pilot study in August 2002 with young women recruited from a local family planning service. The purpose was to test the interview schedule, to assess the appropriateness of the questions and topics, and to identify any further issues for inclusion, over and above those previously identified through the literature review or the quantitative analyses. Participants in the pilot study were also asked what they thought of the interview experience and the questions and wording I had used. These interviews were not to be included in the final analysis and the participants were made aware of this.

I attended the family planning clinic over two days, with the intention of conducting five interviews. I approached young women while they were in the clinic waiting room prior to their appointments and gave them an information sheet about the study (described in more detail later). They were given time to read this and to ask questions. It explained that if they had the time, and agreed to be interviewed, their clinic appointment would be put on hold and they would be put at the front of the queue for appointments once the interview was finished. Those who agreed to participate were asked to sign a consent form. The interviews were conducted in a private room in the clinic. The clinic staff were informed that the interview was taking place and that the young woman's appointment was to be postponed. They were told when it had been completed in order for the young woman's appointment to go ahead. While clinic staff, therefore, knew which young women had participated in the study, they did not have access to the interviews. The young women were made aware of this prior to participating. It was arranged that should participants choose to reveal a serious problem they would be encouraged to discuss this with clinic staff or other organisations, a list of which was provided. None disclosed any such issues.

The inclusion criteria were that the young women were aged 19-21 years and were currently, or had been, sexually active. Of the nine approached, four agreed to be interviewed (three aged 19 and one aged 21). All five who declined said they did not have enough time to take part. The remaining clinic attendees approached were either aged less than 19 or over 21 and therefore could not be included.

The pilot interview schedule is shown in Appendix D. The four interviewees reported different experiences and patterns of contraceptive use, which suggested that this was indeed a topic worth exploring. All four reported feeling comfortable about being interviewed, said they found the questions straightforward, and the wording acceptable. The interview schedule elicited the desired information but some changes were required. First, I became aware that I needed to gather more general information from the participants about their backgrounds, including their families, friends, hobbies, and lives in general. This was important to set their sexual and contraceptive experiences in context. Second, more explanations were required of these experiences. The interview data were descriptive but lacking in explanation, so I became aware of a need to ask more 'why?' questions. For example, in the pilot interviews, the young women described what contraceptive methods they had used but not necessarily why they had chosen particular methods at particular times. They also said little about whom or what had influenced their decisions. I realised I needed to spend more time probing the young women to expand on their initial descriptions of their experiences. I was aware of time constraints and of the need to rush through some of the sections of the pilot interviews. Consequently, I was unable to collect all the required information and decided to slow down and ask for more detail in future interviews. Topics which had not been included in the initial interview schedule but were raised by the pilot respondents were added to the final version. These included sections on non-sexual relationships with the opposite sex (in particular those they considered to be boyfriends but whom they did not have sex with), the long-term risks of oral contraceptive use, and the influence of friends on their clinic use.

#### **4.2.2 Interview Schedule**

The interview schedule was designed in light of the findings from the literature review and the quantitative analyses, and revised as a result of the pilot study, as discussed above. The main interviews were conducted with two cohorts of young women a year apart, so the

schedule was further revised as a result of the preliminary analysis of the first cohort interviews.

The schedule was used as a topic guide rather than a set list of questions. There were nine specific sections: general background, knowledge of contraception, current or most recent relationship, first sexual intercourse, other sexual relationships and encounters, non-sexual relationships, personal use of contraceptives, STIs, and future contraceptive use (Appendix E). The interviews did not necessarily follow the precise layout of the schedule but were guided by the directions taken by the interviewees as they talked about their experiences. The schedule was used as a check list to ensure all topic areas were covered.

Starting the interviews by asking for general background information and about knowledge of contraception was intended to put the interviewees at ease. This would give them time to become comfortable with the interview situation before being asked more personal questions about their sexual experience and contraceptive use. Interviewees were then asked about their current or most recent relationship as I thought they would find this easiest to talk about. This was indeed the case. Rather than asking them specific questions, I simply asked interviewees to tell me about this partner. They did this animatedly, and often in great detail. I then asked them to tell me the 'story' of the first time they had sex with this partner. I let them talk without interruption, to tell me what was important to them. I asked follow-up questions to probe specific points when they had said all they wanted to say. The 'story' of all of their previous sexual partners was then requested in the same way, starting with their first ever experience of sexual intercourse. I also asked interviewees about any non-sexual relationships they had had, and probed how these fitted into their sexual histories.

The remainder of the interview was designed to cover topics that were of interest but had not so far come up. This included giving the interviewees a prompt card which listed all available contraceptive methods. I asked them to tell me about any they had used, but had not so far mentioned during the interview. The final section of the interview asked about their future plans or expectations of contraceptive use and to what extent they thought their own use followed a pattern. Questions on trust, regret and pressure in relation to contraceptive use, and on the importance of contraception to them, were added after the first cohort interviews. As well as open questions, probes and direct questions were used to elicit responses and to follow-up issues raised by interviewees.

### **4.2.3 Sampling**

Purposive sampling was used to identify young women in the SHARE study to be invited to participate in interviews (Silverman 2005). One of the advantages of using the SHARE sample was that it gave access to a group of young women from one age group. Many of the qualitative studies that have examined patterns of use among young women, have included a much wider age range of at least 16-25 years (Free et al. 2005; Lindemann 1974; Miller 1976). It could be argued that this is problematic because it could include young women with very different life circumstances, for which different contraceptive choices would have different implications. By interviewing young women of one particular age this factor is controlled for somewhat. However, even one age group of young women are likely to have different sexual and contraceptive experiences. Therefore, a sampling frame was designed to select a heterogeneous sample of young women on the basis of sexual experience, area of residence, social background, and educational attainment.

Young women with three different levels of sexual experience were to be included in the sample. ‘Group 1’ comprised young women who reported contraceptive use at three episodes of sexual experience in the age 16 SHARE questionnaire. These episodes were described in the previous chapter – first sexual intercourse, first intercourse with most recent partner, and most recent intercourse. ‘Group 2’ comprised the rest of the young women who were sexually active at age 16; that is reported on contraceptive use at one or two of these episodes (either first intercourse, most recent, or both). The young women in these groups are those whose experiences were explored in the quantitative analyses in Chapter 3. A further questionnaire was mailed to the SHARE sample at age 18<sup>4</sup>. As such, it was possible to identify those who had not had sex when surveyed at age 16, but did report sexual activity when surveyed at age 18 (i.e. they became sexually active between the ages of 16 and 18). ‘Group 3’ comprised of these young women. Those with no sexual experience by age 18 were not included in the sampling frame.

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<sup>4</sup> These data were not available for my quantitative analyses (Chapter 3), but when I came to select an interview sample, it was possible to use these data to identify young women who had become sexually active between ages 16 and 18.

Social background (father's social class – manual vs. non-manual<sup>5</sup>), educational attainment (Standard 'S' Grade results – credit vs. general/foundation<sup>6</sup>) and area (main study city v. rest of study area) were also used to stratify the sample. Father's social class and educational attainment were both associated with contraceptive use in the quantitative analyses and the literature review. Area was included because there were differences in the level of sexual and reproductive health service provision between the main city and the rest of the study area.

Overall, 814 young women were potentially available to be contacted for interview. This included those who had indicated that they were willing to continue participating in the SHARE study, and had no missing data on the sampling frame variables. However, the number available in each 'cell' of the sampling frame varied (Table 4.1).

Background Characteristics			Sexual Experience		
Social background	Educational attainment	Area of residence	Group 1	Group 2	Group 3
			n	N	n
Father's social class – manual	Credit level 's' grades	Main city	13	23	35
		Other	47	61	87
	General/foundation level 's' grades	Main city	7	11	10
		Other	22	34	22
Father's social class - non-manual	Credit level 's' grades	Main city	21	38	99
		Other	43	75	136
	General/foundation level 's' grades	Main city	3	3	4
		Other	7	5	8

*Table 4.1: Interview sampling frame (SHARE study numbers available for interview)*

Originally, 32 interviews were planned; one respondent from each cell for sexual experience 'Group 1' and 'Group 2', and two from each cell for 'Group 3'. 'Group 3' were to be over-sampled because it was possible that the young women in 'Group 1' and 'Group 2' represented a specific risk group, and were perhaps less representative of young women in general (as discussed in the previous chapter). The 32 interviews were to be split over the two cohorts of the SHARE sample. This would enable preliminary analysis of the first round of interviews to inform the second round, while interviewing all the young women when they were roughly the same age (20 years of age). The interviews took place approximately two years after they had participated in the age 18 SHARE questionnaire.

<sup>5</sup> Respondents were asked for the occupation of their father or male guardian, from which social class was calculated using CASOC (respondents with missing data were excluded).

<sup>6</sup> Standard Grades are the equivalent of GCSEs; classes are split across three levels from credit (highest) to foundation (lowest).

Interviewee selection was carried out randomly for each cell in the sampling frame, using the 'select random cases' function in SPSS (version 9). The randomisation process was run twice for each cell to identify first and back-up contacts, and then repeated for further contacts as required. If the first young woman declined to take part in the interview, or did not reply, the second was contacted, and so on.

#### **4.2.4 Recruitment**

The young women selected in the randomisation process were sent a letter about the study (Appendix F). The introductory letter was necessarily general because it could have been opened or viewed by their parents or others in their household. While the young women were selected because they were sexually experienced, it was important that this was not apparent in the letter because they may not have disclosed this to those they lived with. The letter was therefore framed within a general context of attitudes to contraception. A reply postcard and stamped addressed envelope were included so the young women could indicate whether or not they wished to participate, and how they could be contacted (via home or mobile telephone, or email address). If telephone numbers were available (in the SHARE contacts dataset) follow-up calls were made to those who did not return the reply postcards.

The interview recruitment period was from January-June 2003 for 'Cohort 1' and from January-May 2004 for 'Cohort 2'. For 'Cohort 1', letters were sent to 39 young women; 12 agreed to be interviewed, six declined, and the remaining 21 did not reply and could not be contacted by telephone. With 'Cohort 2', letters were sent to 43 young women; eight agreed to be interviewed, five declined, and 30 did not reply and could not be contacted.

Overall, of the 20 young women interviewed, 30% were from sexual experience 'Group 1', 35% were from 'Group 2', and 35% were from 'Group 3', 55% were from a manual social class background, 50% had gained credit level standard grades, and 45% lived in the main city. Of the 11 who declined to participate, 55% were from sexual experience 'Group 1', 36% were from 'Group 2', and 9% were from 'Group 3', 55% were from a manual social class background, 64% had achieved credit level standard grades, and only 18% lived in the main city. Of the 51 who did not reply and could not be contacted, 39% were from sexual experience 'Group 1', 39% were from 'Group 2', and 22% were from 'Group 3', 55% were from a manual social class background, 55% had achieved credit level standard

grades, and 41% lived in the main city. This suggests that the young women who did not reply were quite similar to those who were interviewed, but those who declined may have been different in that they were more likely to be in sex experience 'Group 1', and to have gained credit level standard grades, but less likely to live in the main city. However, there was no difference in social class background.

Young women who agreed to participate were contacted by telephone to be given more information about the study and to arrange the interviews. None withdrew from the study at this stage. Most of the interviews took place in the young women's own homes. Two chose to be interviewed at the MRC Social and Public Health Sciences Unit and one opted to be interviewed at another university research unit near to her home. At the interview, participants were provided with a copy of the information sheet (Appendix G) and given time to read this and ask questions about the study. This detailed the focus and purpose of the study, source of funding, use of information, confidentiality, and contact numbers. They were then asked to sign a consent form (Appendix H). The interviews were audio recorded with a mini-disc or digital recorder, both small devices specifically selected to be unobtrusive and therefore not off-putting to the interviewee. The interviews lasted between 30 minutes and two hours, with an average length of one hour. The shortest interview (30 minutes) was such because the interviewee was particularly uncomfortable discussing her sexual experiences, while in the longest (two hours), the interviewee talked slowly and paused frequently before answering a question or describing an experience.

At the end of the interview, participants were given the opportunity to ask any questions they had. I also gave them a card with my work contact details so they could contact me further if required (none did). Contact numbers for advice on sexual and reproductive health were provided if requested. Interviewees were given a £20 gift voucher as a thank you for giving up their time to be interviewed.

#### **4.2.5 The Sample**

In total, 82 young women were contacted and 20 interviews were completed. Table 4.2 shows the pseudonyms of each of the interviewees and their place in the sampling frame.

Background Characteristics			Sexual Experience		
			Group 1	Group 2	Group 3
Father's social class – manual	Credit level 's' grades	Main city	Lucy	Milly	Tammy <sup>7</sup>
		Other	Abby		Melanie
	General/foundation level 's' grades	Main city		Mary	Kim
		Other	Debbie	Louise Margaret	Melissa
Father's social class – non-manual	Credit level 's' grades	Main city	Neela	Michelle	Kate
		Other		Kathy	Vicky
	General/foundation level 's' grades	Main city	Fiona		
		Other	Heather	Lindsay	Megan

*Table 4.2: Interview sampling frame (interviewee pseudonyms)*

I had planned to conduct 32 interviews but the original sample size was changed because of recruitment difficulties and the time limits of the (part-time PhD) project. Recruitment proved to be a time consuming process with each phase lasting over five months. It would have been difficult to continue recruitment until 32 interviews had been completed.

The proposed sample size was reduced to 24 (one interview for each cell of the sampling frame). At the end of the first phase of recruitment 12 interviews had been conducted with young women from 'Cohort 1'. Recruitment from 'Cohort 2' proved to be even more difficult. Eight interviews were completed and five gaps in the sampling frame remained at the end of the second five month recruitment phase (Table 4.2). However, for three of these cells (shaded grey in Table 4.2) the possible contacts had been exhausted. That is, all of the young women in the cell had been written to and had declined to take part or had not replied and had been impossible to contact further. For the other two cells (blank in Table 4.2) I had made 14 and 10 approaches respectively with no success. Although these cells did have larger sample sizes (61 and 43 respectively, as shown in Table 4.1), the decision was made to discontinue recruitment.

At this stage, each of the sexual experience groups and each of the background characteristics groups were represented, so a diverse sample had been achieved. Extensive data had also been collected.

<sup>7</sup> The quantitative data coding had classified Tammy's father as manual social class but it was evident from the interview that he was employed in a non-manual occupation.

<sup>8</sup> The blank cells represent those for which approximately one quarter of the possible contacts had been contacted without success.

<sup>9</sup> The grey shaded cells represent those for which possible contacts had been exhausted.

## **4.2.6 Data Analysis**

### **4.2.6.1 Transcription**

All of the interviews were recorded on mini-disc or digital recorder and copied onto audio tape or CD. I listened to all of the recordings as soon as possible after the interviews. One recording was found to have had technical problems which left short sections of 1-2 minutes in length inaudible. I made notes on what I remembered had been said during these sections of the interview, and these were added to the final transcript. The tapes/CDs were transcribed by an independent contractor. I then checked each transcript in full and made any necessary corrections and clarified sections about which the transcribers had been unsure. The young women were given pseudonyms, and identifying data, such as names of people and places, were removed throughout the transcripts. The interviews were transcribed verbatim and quotes are presented as such throughout the thesis.

### **4.2.6.2 Identification of Themes and Data Coding**

Each interview transcript was read and reviewed for initial and emergent themes, ensuring that all text was coded appropriately. Themes identified from the 'Cohort 1' interviews were used to revise the interview schedule (as discussed above) where necessary so preliminary ideas could be explored further with the 'Cohort 2' interviews. Data coding was conducted by hand, using a numerical system whereby numbers, which corresponded with individual themes, were written against the corresponding interview text. This ensured all sections of the transcripts were coded and all text was accounted for in some way. I found it easier to start working with hard copies of the transcripts, and code these, than to read and code the transcripts on a computer. To enhance reliability, all of the interview transcripts were read by my two supervisors and we discussed emerging themes.

The transcripts were imported into NVivo version 2.0 to help organise data and aid analysis. Coded sections (themes) of the transcripts were entered into NVivo as 'nodes' and were applied to the corresponding text in each transcript. The benefit of this approach was that it facilitated a systematic approach and I could easily examine all text coded under each theme and look for interviews which had not been coded for particular themes. This allowed me to identify and further explore deviant cases (Seale 2005).

#### 4.2.6.3 Framework Analysis

I used Framework Analysis to analyse the qualitative data (Ritchie and Spencer 1994). This approach comprises five stages: familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation. I read the transcripts and listened to the interviews repeatedly to familiarise myself with the data. A thematic framework was obtained from the initial coding, as described above. The thematic framework covered five areas:

- Contraception – general use, access, choice and change
- Contraception – failures, first sex, non-contraceptive reasons and motivations
- Contraceptive methods – use, access, choice and change
- Influences on contraceptive use, choice and change
- Risks related to contraceptive use, choice and change

The full thematic framework is shown in Appendix I. This was used to organise the themes into topic areas and to chart the data for thematic analysis. Charts for each of the five areas were created in Excel with columns for each of the themes and all 20 interviewees listed in rows. A summary of what each interviewee had said in relation to that theme was added to the chart, along with comments for the analysis, and reference back to appropriate quotes in the original transcripts. Using this approach allowed for themes to be compared across all interviews. What each interviewee said about particular themes in a given chart could also be easily examined. By coding, presenting and summarising the data in this format the constant comparative method was used to examine the similarities and differences between the interviews, and to understand and explain deviant cases in relation to the rest of the data.

The final (main) stage of Framework Analysis was that of mapping and interpretation. The data were analysed to define and map key themes, create typologies, explore associations, develop explanations and build theories to address the research questions. The key themes associated with young women's contraceptive use, choice and change were identified by reading through the charts. Typologies were explored by examining the thematic

relationships and links within the data. Associations were explored to describe and explain the phenomenon of contraceptive change. Categories were then combined into an analytical scheme, which allowed the process behind the young women's contraceptive patterns to be described.

In the chapters that follow, these categories are presented as 'push' and 'pull' factors. That is, factors that encourage use of particular contraceptive methods are conceptualised as push factors, and factors that discourage use (and often result in young women changing from one particular method to another) are termed pull factors. This conceptualisation was an effective starting point and a very useful way of presenting the data. However, classifying categories as push or pull factors was not always straightforward and does over-simplify the data somewhat. Often, a pull factor for one method became a push factor for another, or the lack of a pull factor would make it a push factor for some young women. This is highlighted in the results chapters.

### **4.3 Methodological Considerations**

In the above section, I described the qualitative aspects of the study and the research methods used. This section focuses on the reasons for choosing a qualitative methodology, and the issues associated with this approach.

#### ***4.3.1 Why Do a Qualitative Study?***

A qualitative approach was chosen because the aim was to explore contraceptive use over time, and, most importantly, to understand the young women's reasons for the use of particular methods at different times. A qualitative approach was better suited to address the processes and mechanisms affecting contraceptive use. It also allowed for much more detail to be included, to provide a "deeper" understanding (Silverman 2001). As I described earlier, allowing the young women to talk freely about their own experiences facilitated this. One of the aims was to examine the meanings that they themselves placed on their contraceptive use. As such, a qualitative approach was more appropriate because "quantitative research methods do not adequately capture these meanings." (Weinberg, 2002, page 27). The value of qualitative research is that it is flexible, contextual, looks at process as well as outcomes, and at meanings as well as causes. However, Silverman (2001) argues that researchers should recognise that qualitative research is not an

indisputable concept. Issues around reliability, validity and generalizability remain important, and have to be considered to justify a qualitative approach.

As described above, Framework Analysis was used for the qualitative analyses (Ritchie and Spencer 1994). This method allows for use of strategies similar to those employed in the grounded theory approach (Glaser and Strauss 1967; Silverman 2005), but within a more structured framework. It was thought most appropriate because of its key features of being grounded, dynamic, systematic, comprehensive, accessible and replicable. It is grounded in that it is driven by the original data, dynamic in that the process is adaptable throughout, and systematic and comprehensive in that the analysis is methodically applied to all of the data (Ritchie and Spencer 1994). Furthermore, it allows for easy access to the original material (charted notes or verbatim text are referenced back to the original transcripts). Therefore, the clearly defined process is transparent and accessible to others, enabling replication if necessary.

#### ***4.3.2 Qualitative Interviewing – Talking to Young Women***

Interviews provide data in the form of verbal accounts rather than observations of actual behaviour (although the analysis can also take body language into account). To answer the research questions detailed above, I needed information on which contraceptive methods the young women had used, when they had used these, and why they had done so. In-depth interviews allowed the young women to provide this information and for it to be set in context. In addition they enabled greater nuance and subtlety in the data collection process, and a fuller exploration and explanation of new issues as they arose (Rubin and Rubin 2005). Further, interviews allowed the analysis to examine how present situations might have resulted from past events.

Other methods, such as diaries, focus groups or participant observation, would have been inappropriate for these purposes. Diary methods could be used to quantitatively collect data on young women's contraceptive histories. However, this may not have provided the contextual data necessary to understand these histories. Focus groups would not have allowed the young women to provide detailed accounts of their own behaviour and experiences, particularly given the personal nature of the information required. Focus groups are more appropriate for collecting data on normative issues and for examining group dynamics of people's experiences rather than individual accounts (Barbour and

Kitzinger 1999). Further, some young women would not be comfortable disclosing information about their contraceptive use in front of others, and it would be inappropriate to ask them to do so. Participant observation would also have been inappropriate, ethically unsound, and indeed impractical for this study.

Semi-structured interviews were used to allow specific topics, as defined by the literature review and findings from the quantitative analysis, to be included in the interview guide. In addition, they enabled participant led topics to be followed up, to fully explore “what the interviewee views as important in explaining and understanding events, patterns, and forms of behaviour” (Bryman, 2001, page 314). My use of the ‘tell me the story’ approach (Seidman 1998), combined with use of open, direct, and probe questions allowed the young women to focus on what they thought important. This was a very successful approach.

Seidman (1998), when describing an interview he had undertaken, argues that the ‘tell me the story’ approach was of particular use:

“Stories such as this, in which the student teacher gave a beginning, middle, and end to a segment of her experience, drew characters, presented conflict, and showed how she dealt with it, convey experience in an illuminating and memorable way.” (Seidman, 1998, page 72).

The young women I interviewed were animated and open in the stories they told me. I think this method put them at ease because they did not feel they were being quizzed about their experiences. Being asked more direct questions may have made them feel they were being judged, which could have limited their willingness to disclose the personal information I requested.

Qualitative methods texts frequently refer to the status of interviews as a means of data collection (Silverman 2001; Silverman 2005), in terms of “whether interview responses are to be treated as giving direct access to ‘experience’ or as actively constructed ‘narratives’” (Silverman, 2001, page 113). It can be argued that interview respondents use “culturally available resources in order to construct their stories.” (Silverman, 2005, page 156), and do so to describe and explain their experiences to the interviewer. As will become apparent in the results chapters which follow, the young women were aware of what they considered to be socially acceptable contraceptive behaviour, and their narratives were often framed within this context. This does not mean that they did not talk about behaviour which

contravened this; instead it appeared that setting the contravening information within the context of socially acceptable contraceptive behaviour enabled them to do so. In the analysis of such narratives, it is necessary to explore “the nature and sources of the ‘frame of explanation’ used by the interviewee” (Silverman, 2005, page 157) in order to understand its meaning. However, interviewees’ responses can represent both such narratives and factual statements of experience (Silverman 2005).

While the choice of in-depth interviews was appropriate to the research topic, their use meant that the data collected were retrospective. Asking young women to recall their contraceptive use over time could have affected the accuracy of their accounts. However, this was a necessity for a study that required analysis of contraceptive histories. Only a longitudinal, prospective study, over a considerable time period, would avoid this. Such an approach was not compatible with a time-limited PhD project. The young women were interviewed during the early years of their sexual activity, so for most, the recall period was short and as such the effect of recall errors on their accounts should have been limited. Even more so, the reconstruction of events – getting interviewees “to think back over how a certain series of events unfolded in relation to a current situation” (Bryman, 2001, page 329) – was of particular interest in the interpretation of their patterns of contraceptive use and their understanding of these.

Feminist critiques highlight how inequality is often inherent in the interview setting. It is most apparent when the interviewer’s sole role is to gather information rather than to provide any (Oakley 1981). Oakley described the many questions her interviewees asked her in her own research, and how she found it impossible not to respond to these, particularly given the requests she was placing on them in terms of time and personal information at such a period in their lives (during pregnancy and the transition to motherhood). There has been debate on the role of self-disclosure in reducing the unequal power distribution and increasing rapport between the interviewer and interviewee in the interview (Abell et al. 2006; Edwards 1993; Oakley 1981). I did not adopt the approach of complete self-disclosure. Instead I disclosed information if requested and answered questions as asked. As Oakley (1981) argues “an attitude of refusing to answer questions or offer any kind of personal feedback was not helpful in terms of the traditional goal of promoting ‘rapport’.” (page 49). However, my experience, unlike Oakley’s, was that requests were infrequent and generally only for information. Only one interviewee asked me a direct, personal question during the interview. The question was whether I lived

alone or not, posed while she was talking about her wait for a council house of her own and her fear of living alone. I told her I did live alone (at that time) and that I had got used to this quickly.

### **4.3.3 Sensitive Topics – Talking about Sex**

In this research study, interviews were a particularly appropriate choice given the sensitive nature of the topic. Sensitive research topics can be defined as follows:

*“...a sensitive topic is one that potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding, and/or dissemination of research data.”* (Lee and Renzetti, 1993, page 5, authors’ italics).

Asking young people about their sexual activity can be highly contentious. While the young women interviewed could have been uncomfortable with the subject area, often the strongest objections come from those not involved in the actual research (Sieber 1993).

This has to be considered and Sieber argues that:

*“Ultimately, the best strategy for protecting the sensitivities of research participants and community members and for avoiding the wrath of zealous opinion leaders is to design ethical and culturally sensitive research and to interpret findings tactfully and judiciously, with concern for the interests of the research participants, the gatekeepers, and society.”* (Sieber, 1993, page 17).

These issues were taken into consideration in the design of the study, with particular focus on the effects on the participants. Procedures were put in place to avoid and limit adverse effects, including contacts for advice on contraceptive use and sexual health being made available at the end of the interviews. For the most part these were unnecessary, but I became aware of how important this was when some of the young women disclosed negative sexual experiences. One of the young women had been raped, and talking about this could have brought back painful memories for her. I told her she did not have to talk about it if she did not want to, but she chose to do so. She said that she was used to talking about it, as she often felt she had to tell new people who came into her life. However, at the end of the interview, I was conscious not to leave her distressed and spent some time chatting with her to check she was alright, only leaving once I was satisfied she was.

Putting the young women at ease during the interviews was important. Allowing interviewees to use their own terms, and mirroring these, is a method of doing so (Holland

and Ramazanoglu 1994). However, it should also be recognised that young women may still struggle to talk about intimate details of their lives. Holland and Ramazanoglu argue that this is because the social construction of female sexuality does not allow young women to talk openly of this, and they may therefore struggle to do so in an interview situation. During the interviews, I tried to ease the interviewees into the more sensitive topics, and to accept and use the terminology they adopted to describe their experiences. As I have already described, to do this I started the interview with general questions about the young women's lives and used the 'story' approach to gather information on sexual experiences.

#### **4.3.4 Reflexivity – Researcher Influence**

In the process of data collection and analysis in a qualitative study, it is important to consider reflexivity. This issue has in particular been the focus of much feminist research (Edwards 1993; Finch 1984; Holland and Ramazanoglu 1994; Oakley 1981). The research interview does not occur in a vacuum, and as Holland and Ramazanoglu argue:

“If we locate the researcher as an actor in the research process, we open the way to recognition of the power relations within which the researcher is located. Each researcher brings particular values and particular self-identities to the research and has lived through particular experiences. While these values, identities and experiences do not rigidly determine particular points of view, they do give researchers variable standpoints in relation to subjects of research.” (Holland and Ramazanoglu, 1994, page 131).

The influences of both the researcher and the researched, and the way their values and experiences will affect the data collected have to be acknowledged. Interviews are a form of social interaction. However, this is not necessarily an equal interaction. It has been argued that there is a privileged position, and a more equal interaction, to be gained from women interviewing other women (Finch 1984; Oakley 1981). However, this may not always be the case, as Edwards argues:

“If, however, we accept that there are structurally based divisions between women on the basis of race and/or class that may lead them to have some different interests and priorities, then what has been said about woman-to-woman interviewing may not apply in all situations.” (Edwards, 1993, page 184).

How then did the young women I interviewed view me? In my role as the interviewer, they could have seen me as a university researcher with a certain degree of authority or as

a young woman with similar experiences to their own. The academic researcher can be viewed by research participants as having an authoritative role, which then affects the interview interaction (Cornwell 1984). Cornwell argues that when this is the case the interviewee will provide the account s/he thinks is acceptable. The young women I interviewed knew in advance that I was a researcher from an academic institution, undertaking a PhD. Their responses may have been influenced by this. That is, they could have provided the answers which they thought I wanted to hear, particularly in relation to what they thought was socially acceptable contraceptive behaviour. On the other hand, I was in my late 20s when I conducted the interviews, so not markedly older than the young women themselves. As such, they could have seen me as more similar to themselves than not. I had thought of this in advance of the interviews. When I conducted the interviews I deliberately dressed relatively casually rather than wearing more formal work clothes. I did this to present myself as more like the young women than a person in authority, to facilitate rapport, make them feel comfortable, and be less intimidating. As well as my age, I think my background served to highlight similarity rather than difference. I felt that being Scottish and therefore having a similar (albeit slightly different, coming from the West rather than East coast) accent was an advantage. This could have made it easier for the young women to relate to me. Indeed, thinking of the interviewees, those who appeared to view me as first and foremost a young woman with potentially similar experiences were by far the more comfortable in the interview situation (although it could have been because they were comfortable that they viewed me in a similar way). While many of those who appeared comfortable being interviewed were from non-manual backgrounds or in further education, some were also from the more disadvantaged backgrounds.

#### ***4.3.5 Participants' Representations of Self***

It is important to recognise that in using interviews the findings will be based on the participants' verbal constructs of their own behaviour (Silverman 2001). Cornwell (1984) argues that there are differences between the public and private accounts that interviewees provide, and that only public accounts are provided in first interviews because of the authoritative position of the interviewer already discussed. Private accounts are provided in later, repeat interviews, once the interviewer is better known to the interviewees. The public account may be that which interviewees think acceptable, while the private may be that which is closer to what the interviewee really thinks. I only interviewed the young

women once so could not check for differences in their accounts over time. However, it could also be argued that any account is a representation of the ‘truth’ at that particular time, in that particular interview (Silverman 2001). For Silverman:

“...interviewer and interviewee actively *construct* some version of the world appropriate to what we take to be self-evident about the person to whom we are speaking and the context of the question.” (Silverman, 2001, page 86, author’s italics).

Indeed, even Cornwell later conceded that the public/private distinction was too rigid, and not reflected in her later work to the same extent (Cornwell 1988).

It is important to note that if the young women I interviewed had provided only answers that they thought socially acceptable, one might hypothesise that all would have portrayed themselves as adequate or responsible contraceptive users. However, not all of the young women presented themselves in this way, and even if they did at first, it became apparent during the interview if this was not always the case. While the young women may have wanted to portray themselves as ‘good’ contraceptors, accounts of their behaviour also demonstrated deviances from this. Given the socially constructed perceptions of contraceptive use as good, and risk takers (particularly teenage mothers) as bad, it is not surprising that the young women I interviewed framed their accounts within these constraints and tried to present themselves in a particular light. Their attempts to do so are recognised in the analysis.

The detailed interviews I conducted discouraged misrepresentations and also highlighted contradictions in the young women’s accounts when they did occur. Using a prompt card, which included all available contraceptive methods, and asking specific questions to check for missed details towards the end of the interview also enabled me to check for contradictions and missing information. Indeed, for one young woman it was only when directly asked if she had been pregnant that she said she had. This revelation came at the very end of the interview, before which she had failed to mention her pregnancy (and subsequent miscarriage), despite having talked in great detail about her contraceptive use and experiences.

### **4.3.6 Interpreting the Data**

Just as the researcher and the participant can influence the data collected, in the interpretation of these data it is important to make the distinction between the emic (insider) views of the young women themselves, and the etic (outsider) view of myself, the researcher. That is, the distinction between what the young women actually say and what I have interpreted from this. The emic view is the starting point, and the data are interpreted from the young women's own viewpoints, to develop an understanding from their perspectives, and from what they themselves see as the meanings, connections and explanations of their experiences. However, this in itself is not enough, and such purely descriptive accounts of respondents' experiences, with no recourse to context, have been described as "naïve" (Silverman, 2001, page 287). This is therefore followed by the etic view, which involves higher level analytical points based on my interpretations of what the young women have said, and of the meanings and connections of their experiences, which may not have been apparent to the young women themselves (e.g. the role of social class or disadvantage). I do not mean to imply that these interpretations are more important than those derived from what the young women themselves say; rather the higher level analytical points add to our understandings of a given concept (Ely et al. 1997). For example, when asked why she always uses condoms, a young woman may state simply that 'this is what you do, it is what everyone does' – this is the emic view. However, the etic view could go further to explain that this is the case because she comes from a relatively advantaged background, is well educated, and, along with her peers, has strong career aspirations, which are incompatible with unplanned pregnancy. This understanding of condom use comes from my interpretation of the meanings and connections of her experiences.

In the results chapters which follow, I will present what the young women have said, and any deviation from this towards higher level analytical points, based on my own interpretations, will be highlighted. Conversely, the discussion and conclusions in Chapters Ten and Eleven, while grounded in what the young women have said, will centre on these higher level analytical points and references back to the young women's own perspectives and understandings will be highlighted. In this sense, the themes which emerged from the data are presented first, and then interpreted within a broader, thematic framework (Ely et al. 1997).

### **4.3.7 The Reliability and Validity of the Study**

The reliability and validity of qualitative data are as important as for quantitative data, but perhaps more difficult to demonstrate (Silverman 2001). To demonstrate reliability it is important to show that the data analysis has been systematic. Would a different researcher, at a different time, have obtained different results? It is entirely possible that this would be the case, so it is important to demonstrate that the analytical process was systematic and transparent. The use of Framework Analysis is useful here because the transparency of the approach serves to demonstrate reliability. Consistent coding and data charting for each interviewee and each theme ensures that findings are grounded in the data. My supervisors read the interview transcripts in full and commented on the initial coding, emergent themes, and analysis of the data to assess this.

Validity represents the extent to which the findings truly represent the phenomena referred to. Is my interpretation of what the young women said about their contraceptive use valid? To demonstrate validity it is important to show that the analysis was not based on a few, selected cases (Silverman 2001). I used the constant comparative method to test provisional hypotheses with each case and across the two cohorts of the sample. This ensured that the data were treated comprehensively and emerging themes were applied to all of the transcripts to identify supporting data. The framework charts were then used to identify deviant cases, through which differences were explored in relation to the rest of the data. This process, and the inclusion of supporting data in the form of extensive quotes, supports the validity of the findings.

### **4.3.8 Limits of Generalizability**

The use of non-random samples in qualitative research affects the generalizability of the findings. Generalizability can be assessed by combining qualitative and quantitative research, comparing interview cases to the wider, relevant population, or including survey research of a random sample of cases (Silverman 2001). However, this can be impractical and difficult to do within the time and financial constraints of a PhD study. The findings from a small qualitative study are difficult to generalise to the wider population. However, one of the strengths of my study is that the qualitative interviewees were selected from a larger quantitative study. As such, the findings can be set within the context of those from the wider SHARE sample, and this is discussed further in Chapters Five and Ten. To

further assess generalizability, the findings are also compared to those of other research studies on similar topics.

## **4.4 Conclusions**

In this chapter I have detailed the development of the qualitative stage of this research project and its theoretical base. Qualitative research, using in-depth interviews, was the most appropriate way to address the research questions of the study, particularly given the focus on the meanings the young women attached to their own contraceptive use. The next five chapters present what the young women told me about themselves and their contraceptive use.

## 5 Chapter Five

### Young Women's Contraceptive Use

#### 5.1 Introduction

This chapter has two aims: to introduce the 20 young women who were interviewed, and to examine their contraceptive career typologies. First, I will describe their backgrounds, sexual histories, relationships, and reproductive health experiences. Second, I will map the young women's individual patterns of contraceptive use, and explore similarities and differences between them.

#### 5.2 The Sample

The purposive sampling frame was used to select a heterogeneous group of young women with different levels of sexual experience and from different social backgrounds, based on area of residence, father's social class and their own educational attainment. The theoretical basis for this was described in the previous chapter. Although the sample size was smaller than originally planned, at least one young woman from each of the sexual experience groups and social backgrounds was interviewed. It is not suggested that the sample is representative, but the inclusion of young women from this range of backgrounds does increase the generalizability of the results.

The contraceptive use and pregnancy experience of the interviewees were compared with those of the rest of the SHARE sample (originally described in Chapter Three) who reported sexual experience by age 18. There were few differences between the two groups. Contraceptive use among the interviewees was very similar to that of the wider sample. At age 18, 60% of the interviewees reported pill use at their most recent sexual intercourse compared with 54% of the SHARE sample, 45% reported condom use throughout compared with 46% of the wider sample, 15% reported unprotected sex compared with 10%, and 5% reported emergency contraception use compared with 4%. The interviewees' contraceptive use was also similar to that of other national samples of young women. In the Office for National Statistics Omnibus Survey, 63% of women aged 20-24 years were currently using the pill and 43% were using condoms (Taylor et al. 2006).

However, pregnancy experience at age 18 was higher among the interviewees, reported by 30% of the interviewees compared with only 16% of the SHARE sample. This difference is difficult to explain, particularly given the similarities in their contraceptive use. It could be that young women who had experienced pregnancy were more likely to come forward for interview because they felt they had a particular story to tell, had the time to take part, or were encouraged by the incentive (a £20 gift voucher as a thank you for participating). In NATSAL, 6% of 20-24 year old women reported motherhood before age 18 compared with 15% of the interviewees in my study (Wellings et al. 2001). This difference could result from the East of Scotland pregnancy rate being higher than the national average. However, the national pregnancy rate among 13-19 year old women in Scotland was 42.4 per 1000 in 2003/04, and while the SHARE survey area in the East of Scotland contains Dundee, which has the highest rate at 64.4 per 1000, most of the other areas had teenage pregnancy rates closer to the national average (ISD Scotland 2005).

## **5.3 Characteristics of the Interviewees**

### ***5.3.1 Family and Living Arrangements***

Just over half (12) of the young women still lived at home with their parent(s). Of those who did not, three lived on their own with their children, three in student accommodation, and two with their partners. Two thirds (13) came from families where the parents were still together, and all but one had siblings. Half talked about the influence in their lives of other relatives, for example grandparents and aunts. Six of the young women had moved away from the area in which they grew up.

### ***5.3.2 Education and Employment***

Half of the young women came from a non-manual social class background and half came from a manual one. Half had gained general/foundation standard grades at school and half credit grades. Six of those with a non-manual background had obtained credit grades, compared with four of those with a manual background. Seven were working full-time, seven were in full-time education (four of whom also worked in paid employment, part-time or over the summer), four were working part-time, and two were full-time mothers. There was a clear pattern to the reproduction of social disadvantage, with those from manual backgrounds being more likely to have only obtained general or foundation level

standard grades, to have left school around the age of 16, and to be either unemployed or working in part-time (often menial) employment. This group were also often those who experienced the more negative sexual and reproductive health outcomes.

### **5.3.3 Sexual History and Relationship Experience**

Age at first sexual intercourse ranged from 12 to 17 years, and number of sexual partners from one to sixteen. Thirteen of the young women were in a sexual relationship at the time of interview. In this section I will illustrate the different types of relationships they had, and how they described their relationship and sexual experiences.

#### **5.3.3.1 Casual Sex Partners**

Most (16) of the young women described having casual sex partners. Casual sex involved one-off sexual encounters with casual acquaintances or men met in social venues. The term ‘one night stand’ was commonly used by the young women to describe these.

However, some had repeat sexual encounters with the same person, which they still classed as casual:

“With one night stands it tends to be like maybe either the one night or you’ll pull each other a couple of times, like once or twice and then you leave it and you know, you kind of just you both stand really awkwardly at the bar and you go ‘well I’m not really looking for a relationship’ and the other will go ‘oh thank God, neither am I, lets have a drink’ kind of thing.” (Kathy, complex career<sup>10</sup>).

Even though Kathy describes these relationships as her choice, there were other times (particularly when she was younger) when she hoped that something more would come of them:

“...we were kind of mucking about for a while at first and I was kind of raising the subject of you know we should go out. And he kind of went ‘oh I would rather we just kept it just sex’. But then you know, I kind of went along with it because I’d just came out of a relationship, I didn’t really know that much about it, I was 17, you always do stupid stuff at that age. And I thought ‘well I’ll win him over eventually’. Because I was all you know, big eyes and in love with him. ‘I’ll win him over, he must love me if I love him this way’.

<sup>10</sup> A typology of the contraceptive career was developed from mapping the young women’s individual patterns of use, and this is explained in more detail later in the chapter. Three types were apparent: consistent, complex, and chaotic. For context, the young women’s career types are noted with their quotes.

And you know, any relationship that's just sex, but just sex for three months is gonnae turn into some kind of relationship anyway. And at the end of it you know, he just went 'well, I don't want to sleep with you anymore' and I was all really upset, like, we'd broken up." (Kathy, complex career).

Indeed, some of the other young women described longer-term relationships with boyfriends that began with a casual encounter (see Section 5.3.3.2), but overall they made a clear distinction between casual encounters and relationships with boyfriends. Casual encounters were not serious and for the most part, not expected to develop further (see also Section 5.3.3.5).

While most of the young women had had casual partners, there was a sense among a few that they would be judged badly for doing this:

"...I would meet up with one of them, one of my friends I would have casual sex with but em... I hate using that phrase because it just makes it sounds such a slutty way of doing it..." (Neela, chaotic career).

This was particularly the case when they reported having a number of such partners:

"...once we kinda split up... not that I turned into a total slapper but I went out and had a few one night stands then." (Megan, complex career).

However, it is important to note that this did not stop them from having such encounters. Their use of terms such as 'slut' or 'slapper' is, perhaps, more indicative of how they felt they should talk about their behaviour to me than about how they actually regarded this behaviour.

### **5.3.3.2 Boyfriends**

All of the young women described having sexual relationships with boyfriends. Boyfriends were often simply described as such, but were distinguished from more casual sex by being longer term and involving an emotional attachment. For some, the initial start to these relationships was the same as for their casual encounters:

"...Just one drunken night, and we ended up speaking, em... pulling each other, then I got his number and sort of... started going out a couple of weeks after, maybe. And that was... nearly two and a half years ago. Em, actually I think to be... if I'm being honest, I'd just, like, split with my other boyfriend, like, four months before and we were still sort of s... kind of seeing each other, and if I'm perfectly honest, I probably was just pulling him to make him

[previous boyfriend] jealous but it led into something really good, so... that was an added bonus.” (Michelle, complex career).

Then such a relationship might simply develop into something further:

“...he never went to school wi’ me and I never actually knew him like at all but when I started work at [supermarket], he started work at like just after me. And I just like seen him there, I can’t even remember how we got together, I think somebody had said, ‘oh she likes you’ or something like really immature like that (laughs), and eh he phoned and then we just met up and just continued to meet up and then, I don’t know, we just kinda stuck together.” (Vicky, consistent career).

Vicky goes on to describe how he was different from her previous boyfriends, none of whom she had had sex with:

“I’ve never been with anybody as long as like... I’ve normally, I think it was about two or three months or something was like the length of my previous relationships and we do, we get on quite well. [...] I had kinda been wi’ other people before, like not like had sex with anybody before but I had had that feeling sometimes if I was with somebody, I was just like, ‘oh don’t touch me’ or, you know what I mean, ‘get away from me’ and I was kinda like, I wasn’t ever conscious of having that feeling like, you know what I mean, ‘No!’ kind of thing, em, but no, it was... it was quite good.” (Vicky, consistent career).

### 5.3.3.3 Non-sexual relationships

While many described having non-sexual relationships prior to first having sexual intercourse, only six of the young women had done so after this. The reasons for not having sex with these partners centred on finding they were incompatible or the relationship did not get to the stage of having sex:

“...with [non-sexual relationship partner] that was just the getting to know you stage. And I just didn’t get to know him very well (laughs). [...] I just didn’t think it was going to happen. I just didn’t feel like it was right.” (Kate, consistent career).

This is further illustrated in a quote from Milly:

“...it was just like a friend who we sort of got a bit closer and we sort of, we kissed and all that sort of stuff but, em, I didn’t really... it wasn’t really anything sort of... it wasn’t really much of a physical connection, it was more just having a laugh and everything. Eh, and then I found out that my friend fancied him (laughs), and, so I said to him, ‘We’re just having a laugh, I’m

going to end this now because I know someone who does actually fancy you'. And he ended up going out with my friend instead..." (Milly, complex career).

For the rest of the young women, after they became sexually active, all of their subsequent relationships involved sexual intercourse.

#### 5.3.3.4 Egalitarian and Coercive Relationship Experiences

Two young women reported coercive sexual experiences: one had been raped and another described being systematically "used for sex" over a three to four year period by two boys she was at school with:

"I think that eh..., I was kind of used. [...] Like I really, really thought that it was going to go somewhere. It might sound mad, but I did. Eh, I thought it was, was going to go somewhere with one of them at least one day, and I just kept hoping and they were these kind of popular guys, everyone knew them and I was never popular I was always bullied throughout my whole kinda school life and eh..., you know it was good, 'oh, you know these guys and everything'. [...] Yeah I kind of..., I think it was kinda like they were experimenting and I was kinda the same but I really liked them, and I knew that they never really... I know now they never really liked me like that. Em, I was just the girl that was easy to them, you know..." (Heather, chaotic career).

Another two young women also reported having been in abusive relationships:

"...we had a really bad relationship. Em, he was abusive and stuff so... em, I thought things would change after I fell pregnant, but they didn't. He was in and out of hos... eh, in and out of jail, and just... he got really abusive when he was drinking, he had a bit of a drinking problem. [...] He was a... em, it was always... there was always little comments... but I never really paid much attention to them. And then I think we were together for about seven months when he first hit me. But I just put it to the back of my mind thinking, 'oh, it won't happen again' sort of thing. But then it... it did hap... it... The first time he was all apologetic and things were great for a while and then, it just... it happened again and then it just kept on happening." (Debbie, chaotic career).

The young women who provided these accounts of coercive experiences or abusive relationships were from the more socially disadvantaged backgrounds. They were exceptions however, and most of the young women (15) reported much more positive experiences. They recognized and appreciated the equality of these relationships:

"I mean he didn't pressure us, I mean, know what I mean, he's... he said from the start of, 'you know, nothing you're wanting to do just tell us, and that's it', he said, you know, so you're not gonna be like disappointed or angry or

anything. He says, 'you know', he says 'it's up to you' he says 'on your terms' he says, 'that's, you know, totally fine'. Which I thought, well that's actually quite nice of you to actually say that, know what I mean, whereas like... maybe before, maybe boyfriends and that before they wouldn't say anything, and if they didn't get what they were wanting they would go off in a wee strop (laughs). So I just knew that he was different, just the feeling that I had. I knew he was different." (Margaret, complex career).

Some of the young women described ending relationships which were not meeting their expectations:

"...I didn't see him that often, which I like, cos I don't like being with someone all the time. I wouldn't like that. [...] But then I just kinda got bored (laughs). Erm, cos he was away, like through there, em, you couldn't really do much when he did come through kind of thing, it was just like sit in the house and watch the telly or whatever, cos he always had to get kind of home eh? [...] Em, I just think he wasn't really up for doing anything. I just kind of got sick of him. Like he was quite happy to just drive through here and sit and watch the telly, and I was just like 'no, it's just not happening'. It just wasn't there I don't think." (Kate, consistent career).

Positive experiences were not confined to their boyfriend relationships and many of the young women's casual encounters were described as wanted. These were also often events they felt they were in control of:

"Always made sure that, eh, but always made sure that I was the one, I was in control. So... I always wanted them. 'Nah, not really I'm going home now', and they'd be like 'eh, cool'. [...] It's always been me in control and it's always been, like, protected... and to a level where I'm happy with it, otherwise I'm just like 'go away'." (Neela, chaotic career).

While positive experiences were predominant, a further eight of the young women also reported more negative relationships with boyfriends or casual partners. These often involved being cheated on or deserted:

"It was fine, we had sometimes stayed the gither but then we found that we couldnae stay the gither, we were better off living apart. Then we stayed the gither again, then we would just like drift apart. And then he decided to go off and sow his seeds and... just before I had [second child] and that's about it really. He was a bum. [...]. And then a week before he was born he left me for somebody else." (Louise, chaotic career).

Again, these experiences were more common among, but not exclusive to, those from more disadvantaged backgrounds. It is important to note that some young women reported both positive and negative relationship experiences. Three of those who reported coercive

or abusive relationship experiences, and half of those who reported negative experiences, also reported more positive ones.

### **5.3.3.5 Sexual Experiences**

So far I have illustrated how the young women described their relationships, and in this section I will focus on the descriptions of their actual sexual experiences. In the interviews, only two described their first experience of sexual intercourse in a positive way and for many it was unpleasant, often described as “awful” or “horrible”. However, half went on to talk of having sex for fun or simply because they wanted to, and this was often the case when they described their casual sex encounters:

I slept with a few people that I had wanted to but didn't want to cheat on my boyfriend with. There had been chemistry there but... I felt 'right, I have to get this over and done with' and slept with the guy that I sit next to at the football. [...] He invited me over and I goes 'right, we're gonna get this over and done with'. He goes 'aye, I suppose we better had then, eh?' [...] ...it was something we needed to get out of the way, over and done with because we'd both... there was, there was sexual frustration between us because I couldn't stand seeing him with somebody else, he couldn't stand seeing me wi' somebody else. So we got it over and done with, never told anyone. That was that.” (Megan, complex career).

Six young women also described their willingness to initiate sex:

“Well, you'd sorta... you already knew them, like in the pub or whatever, em, and then just sorta one night decide 'I quite like you' and get together. And that was fine...” (Melanie, complex career).

However, it is important to note that this was not something the young women talked of in great depth, and none really went into great detail when describing their sexual experiences.

### **5.3.4 Pregnancy and Sexually Transmitted Infections**

Eight of the young women had experienced pregnancy. Four had children, two had been pregnant and miscarried, and two were pregnant at the time of the interview (and intended to keep the child). Pregnancy was more common among those from more socially disadvantaged backgrounds, particularly among those who had not done well in school. While nine of the young women had been tested for STIs, only one reported having had a

positive diagnosis (chlamydia). Five had actively sought STI screening. In general, it took recognition of personal risk for this to happen:

“Well, like... when I was first, em, like having sex, I was quite stupid. Not s... I don't know, you just really didn't care or something and... I thought I'd better just get tested at the GUM clinic and when you get it in your head, you just get really paranoid and you're like 'have to get tested'.” (Michelle, complex career).

The rest who had been tested were offered this opportunistically when accessing other reproductive health services.

Pregnancy fear was the main motivation for contraceptive use among these young women, and while the extent of it varied, all were influenced by it to some degree. It is important to bear this in mind in the chapters that follow. While the young women describe having specific reasons for using specific methods, use of all methods is underpinned by the need to prevent pregnancy. As such, pregnancy fear and prevention are central to understanding the young women's contraceptive method use, and the specific reasons for using specific methods have to be interpreted within this context.

Pregnancy fear ranged from not being bothered about becoming pregnant to fearing it greatly, and seeing pregnancy as completely unacceptable. This was affected by age, circumstances, relationship status, and experience. It is important to note that pregnancy fear for each individual changed over time, so a young women who was not bothered about pregnancy when interviewed could report stronger fear in the past and vice versa.

Some young women did not think that pregnancy would happen to them, and their level of pregnancy fear was very low because of this:

“And I knew... I knew it was stupid, that I knew there was a lot of risks involved, pregnancy and stuff. But I wasn't actually that bothered. I thought, oh it'll no happen to me. Just played it by ear sorta thing. And then when it did happen I'm like, 'oh great!' [said sarcastically].” (Debbie, chaotic career).

It is apparent that Debbie was aware of the general risk of pregnancy but did not seem to see herself as being personally at risk. In fact all of the young women who talked of pregnancy risk in this way reported unprotected sex (this will be discussed in more detail in Chapter Nine). It is also important to note that these were often the young women who

came from the more socially disadvantage backgrounds, or who lacked career-orientated future expectations and aspirations.

For other young women, pregnancy fear had lessened as they got older, and pregnancy was seen as something that would not be the end of the world. For some, their plan would be to have an abortion:

“Pregnancy’s not really a worry. It would be if it happened but, em... I wouldn’t consider keeping it at this age, so... you know, there’s like, it’s not as if you get pregnant, that’s it, you’re stuck with it now... nowadays anyway. Em, so it’s never really been a major worry. I would always, always hope that if I got pregnant, I would know soon enough to deal with it.” (Michelle, complex career).

Others were now in stable relationships (living together, engaged, long term) within which they planned to have children at some point, or were in a more stable situation (finished education or in stable employment). Therefore, an unexpected pregnancy was something they thought they could cope with:

“Now, well before, cause I counted it, cause now, if I get pregnant now I’ve already graduated by the time I have my baby, so it doesn’t matter. It wouldn’t be like ideal, it would be like, I would be like upset that I wasn’t able to travel, but it wouldn’t be, like before it would have been like, it would have really affected my life like, how can I finish my degree with a baby? But it’s not too, so, as much of a worry now. I don’t think.” (Tammy, consistent career).

It is important to note that many of these young women had experienced stronger pregnancy fear when they were younger. As they got older and gained more experience, they felt that they would be able to deal with a pregnancy. However, conversely, fear could increase if these young women experienced problems with their contraceptive method, such as condom failures or problems with the pill. These issues will be discussed further in Chapters Six and Seven.

Finally, among the young women with the highest level of pregnancy fear, pregnancy was completely unacceptable. They worried about the effect it would have on their lives:

“...I just keep thinking it would wreck my uni career, it would wreck his life and it’s just not... it’s not worth the worry I don’t think.” (Vicky, consistent career).

They were particularly influenced by their age (thinking they were too young), their circumstances (being at university), and their negative perceptions of teenage pregnancy, saying that it was not what they wanted for themselves. The more career orientated the young women were, the stronger their fear was, because pregnancy did not fit into, and would effectively ruin, the plans they had. It should be noted that theirs was a general pregnancy fear rather than being based on any actual risks or perceived personal susceptibility; especially given that most were efficient contraceptive users. Those with the strongest pregnancy fear combined pill use with condoms to be extra safe, and this will be discussed further in Chapter Seven.

### **5.3.5 Knowledge of Contraceptive Methods**

Before being asked about their own contraceptive usage, the young women were asked to name all the contraceptive methods of which they had heard, and each listed between three and nine. Knowledge of a wide range of methods was greatest among young women from more advantaged backgrounds, but overall most (15) could name between four and six different methods. Figure 5.1 (overleaf) charts the numbers mentioning particular methods, alongside the numbers reporting having used each method. All named condoms and the contraceptive pill. The injection and the IUD, referred to by most as 'the jag' and 'the coil', were named by 16 and 17 young women respectively; 13 mentioned the female condom, six the diaphragm, six the implant, three mentioned the rhythm method, two withdrawal and one listed EC. Interestingly, withdrawal was not mentioned as a method by any of the young women who had actually used it. Indeed, those who said they had heard of methods such as withdrawal or the rhythm method described these as ineffective:

“Em, well I suppose there’s, there’s all the dodgy ones, the early withdrawal, and the temperature and the em, working out your cycle. And ‘whoa, it’s safe today’ that one.” (Tammy, consistent career).

While the young women were able to name a number of different contraceptive methods, Figure 5.1 shows that their usage patterns were quite different, and in particular, limited to the more common methods of the male condom and pill (and EC). The contraceptive methods they had used are discussed further in Section 5.3.8.

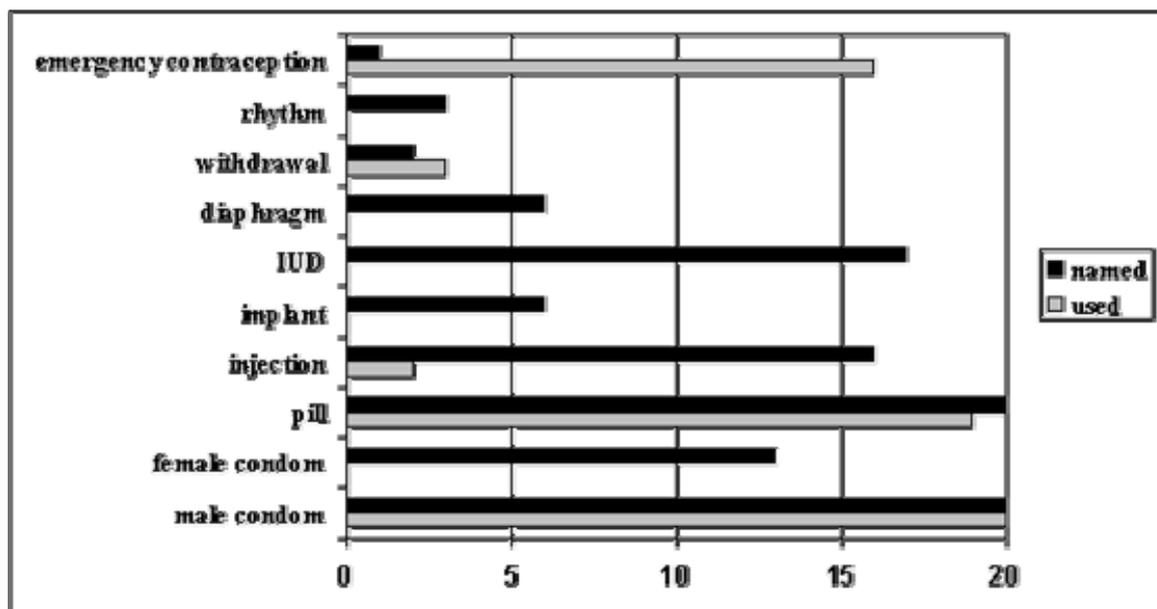


Figure 5.1: Contraceptive methods named and used by the young women

### 5.3.6 Learning about Contraception

The young women identified parents, school sex education, the media and friends as information sources on contraception.

#### 5.3.6.1 Parents

Only nine had talked to their mothers about contraception, and only one reported talking to her father about it. While those who had not talked to their mothers at all were more commonly from socially disadvantaged backgrounds, few of the young women from any background were comfortable discussing such things with their mothers. Indeed, for most (15) talking to their parents about anything to do with sex was not something they were comfortable with:

“I’ve never ever spoke to my mum about anything, no that, ken she wasnae, she’d quite happily speak to me about things like that. But I’ve always been shy and, can remember when she tried to talk to me about periods one day I could have died. I’m just so shy and quiet. Em aye my mum’s open about everything. But I’m just no.” (Fiona, chaotic career).

Even when they did talk to their mothers about contraception there were things they were willing to tell them and others they were not. One of the main conversations involved telling their mothers that they were starting the pill:

“Just because it’s sorta the next big step in your life, you know? Sorta... sorta a decision that you’re gonna have to make if you’re going to start sleeping with people and that so. [...] Em... but I wouldn’t hide something like that fae her [mother], you know, I’d tell her anyway.” (Melanie, complex career).

It was specific topics, such as the practicalities of pill use in particular, which the young women were most comfortable talking to their mothers about. They asked their mothers for advice when they had problems with their pill, discussed changing brands and the experience of side effects:

“Em, I spoke to my mum about it [side effects]. I just said to her how em, they were taking me off my pill because I had... I’d had side effects from it and everything. And, eh, she was a bit worried about me going back on a pill after it and I was just saying... I had to explain to her just what the doctor had explained to me about how like the different sort of levels, the different hormones in different pills and everything affect you differently, depending on your body and everything. Em, cos ma mum had always taken Microgynon 30 as well, em, but she’d always been fine with it. So I spoke to her about it briefly just to put her mind at rest, cos she was a bit worried about me and everything.” (Milly, complex career).

However, none of the young women who experienced condom breakages or had missed pills discussed this with their mothers. Neither did they mention their use of EC. While Lindsay told her mother she was starting the pill, she did not mention that she was doing so because a condom had burst. When asked why, she said:

“I think that might have just pushed her over the edge a wee bit.” (Lindsay, consistent career).

It appears that talking about such experiences would have required acknowledging sexual activity and pregnancy risk in a way talking about the practicalities of pill use (which could be for non-contraceptive reasons) did not.

### **5.3.6.2 School Sex Education**

When asked where they learned about contraception and the methods available to them, all said their school sex education had been a source of this information:

LW: “So how did you learn about these methods? Where did you...?”

Kate: “School.”

LW: “Yeah?”

Kate: “Aye. All at school, drummed into you (laughs). [...] God you started when you're in like primary six, when you're like 10, which I think is quite surprising. And then it just gets like more and more drumming it into you, about more specifics I think as you get older, eh? Like about contraception, whereas before it's just about actually what happens.” (Kate, consistent career).

However, while some of the young women were then aware of a wide range of methods (as described in Section 5.3.5), others felt they had only been told of a limited range:

“We just got told ‘it's the pill, there's the condom, and that's that, take either one, try and keep yourself safe’. So, it wisnae really that good eh, when I was at school...” (Melissa, complex career).

Over half of the young women rated their school sex education as alright or quite good, but positive evaluations were most common among those from more socially advantaged backgrounds. However, some felt the information on contraception had not been specific enough:

“Em, it [sex education] was useful, eh, we did... we did get like a general sort of information about it [contraception] all but, it wasn't... they didn't really tell you how to use it, they would just say, ‘Here's a condom, use this when you're having sex’ but then you wouldn't... you wouldn't’ actually get told how to use it, so then if you did come to have to use one, it would be like, eh, how do I use this then?” (Milly, complex career).

Even receiving more specific information, such as condom demonstration classes, did not necessarily increase user confidence:

“...the teacher use to have to put a condom on ken they sticks or something like that, I cannae dae they things anyway, I cannae put them on. But a lassie, very luckily it wasnae me, but wan o' the lassies in the class got blindfolded and made to dae it. Blindfolded and I was like that, oh my God (laughs).” (Abby, chaotic career).

### 5.3.6.3 The Media

Data on the utility of the media in informing these young women about contraception are limited. Those who did talk about the media tended to focus on the influence of magazines, but most of the available information was about sex or sexual health rather than contraception. A few were aware of information on contraception and thought this was useful:

“Y’know like, telling you what ones [contraceptives] is the safest to use and things like that.” (Mary, complex career).

However, it appeared that information on contraception was often limited:

“...quite a lot of magazines don’t so much talk about contraception now, it’s like you get magazines that have got like sexual positions in them rather than talking about contraception and protection or anything like that.” (Milly, complex career).

#### **5.3.6.4 Friends**

Most (16) had talked with friends about contraception, and learned about methods from them:

“...now at this age as well, like quite a lot of your friends are all using different, different types of contraception, maybe different to you and so they’ll maybe say, ‘Oh, I went to the doctor and...’ like you hear more about it from them now...” (Milly, complex career).

They were also influenced by their friends’ negative experiences and by those of their wider peer group. Friends’ experiences were particularly important if the young women were considering alternatives to their current method, and this will be discussed further in Chapter Eight. The effect of the knowledge of others who had become pregnant while using the pill was also important, and this will be discussed in Chapter Seven.

Most knew of a close friend or relative, or someone in their wider peer group, who had been pregnant. The former was more common, but not exclusive to, young women from more socially disadvantaged backgrounds. Some had friends who had had children, while others had friends who had had miscarriages or abortions. It was the influence of the former that was particularly strong, given the effect this subsequently had on their friends’ lives:

“And em... [I used condoms and the pill] more so that there was no chance that I got pregnant, cos my friend was only 15 when she had her wee boy and I seen how... well, not awful it was for her but... it was awful from what I seen for her.” (Lindsay, consistent career).

Having a close friend who had a baby made the young women aware of the hard work and stress involved in bringing up a child. It also made them aware of how it limited their

friends' options for the future, and lessened the extent to which they could go out or do the normal teenage things they wanted to do.

### **5.3.7 Accessing Contraception – Reproductive Health Service Use**

All but one of the young women reported accessing contraception through a health service – either a GP practice (16) or a young people's or family planning clinic (10), with seven having used both (nine had only used a GP and three had only used a clinic). Six said that they had learned about contraceptive methods from leaflets or staff at the family planning clinics they attended.

The actual experience of use depended on which service was used, and also on the age of the young women at the time. Lucy describes why she stopped using her local young people's clinic as she got older:

“Em... but that was again for a convenience thing, going to the doctor rather than the [clinic]... for it, and that there was too many young girls there, which we'd have been to the older people so many years ago but there were so many young people there that you're like... 'oh, whatever sort o' thing'.” (Lucy, complex career).

A few commented that the services offered by the young people's clinics were more limited than those elsewhere:

“Eh I'd say the family planning clinic was better than the [young people's clinic]. The [young people's clinic] it's mair like... it's like they've got the one pill that they would put you on. Whereas if you go to the family planning clinic and they've got the selection o... then you can choose really. [...] What you want to dae.” (Fiona, chaotic career).

However, half of the young women reported generally positive experiences of service use:

“Yeah they're fine. Yeah, it's for younger people, erm, they take under 16s and everything as well. And em, it used to be just down the road from my school so like, I knew everyone else had been to it, and then it moved down the town. So I knew that it was alright and not a problem. [...] They're all really nice there, it's not awkward at all. Erm, like every time I go now I go by myself. On my lunch hour and that, just to get more pills and stuff like that. They're good there.” (Kate, consistent career).

Ease of access and staff attitudes were important determinants of positive experiences, while the reverse was often associated with more negative experiences:

“...em, there was a doctor I went to, I remember, a while ago and I was asking him quite... [...] I asked him a question and I can't even remember what the question was, it was like a doubt about something anyway and, em, he said something like, em, 'I take it you're with somebody?' and I was like, 'Yeah' and he says, 'Well if you see that guy, em, cleaning you up or picking you up when you're 80, you've just pissed yourself' or something like that or 'When you can't feed yourself, if that's the guy who's going to be beside your side then you shouldn't need to worry. If it's not then I would suggest you don't do what you're doing' or something like that and I thought, 'I'm not a slapper by the way' (laughs). Oh my God. And I thought 'I'm never going back to him again'. But, em, naw, that was quite a bad experience like but, em, no, he was a bit of an idiot, I just don't go to him anymore.” (Vicky, consistent career).

Vicky was from a relatively socially advantaged background, but negative experiences were slightly more common among those from disadvantaged backgrounds. Some of the young women encountered negative experiences when they tried to access EC in particular, and this will be discussed further in Chapter Nine.

### **5.3.8 Contraceptive Use**

For most methods, more of the interviewees mentioned being aware of them than having actually used them, as was shown in Figure 5.1 (page 112). All reported having used condoms, and all but one reported use of the pill. Ten talked about using the pill, initially at least, for non-contraceptive reasons. Sixteen had used EC, three withdrawal, and two the injection. Dual method use (pill and condom) was reported by 13 of the young women, but only three reported always using both methods. The discrepancy in numbers between those who reported having used emergency contraception (16) and those who named it as a method of which they had heard (one) is striking. This suggests that EC was not thought of as a contraceptive method as such by these young women. Half also reported episodes of unprotected (in contraceptive terms) sex.

All of the young women had used more than one method of contraception, and had changed method at least once. Each had her own specific experience of use. Most (14) had used two or three different methods, and the number of method changes ranged from one to fourteen.

## **5.4 Typology of Contraceptive Careers**

Each young woman had her own individual contraceptive use pattern and these are shown in Appendix J. These patterns were subject to change within and between relationships, for non-contraceptive reasons (such as to regulate menstruation) and as a result of method and user contraceptive failures. Method failures include condom failures (condoms bursting, splitting or slipping off), and the experience of side effects. User failures centre on pill use problems (forgetting to take the pill within the safe period or running out of pills). The experience of these failures could lead to interruptions in contraceptive use, unexpected changes, and often EC use or pregnancy scares.

Within these individual and varied patterns of use, discrete, multidimensional groupings were apparent and I have developed a typology of contraceptive careers from this. This typology was used as a descriptive tool to examine the differences and similarities between the young women's patterns of contraceptive use. Overall three patterns were apparent: consistent, complex and chaotic. Consistent contraceptive careers were characterised by uniform use over time, complex careers by change and variability, and chaotic ones by frequent method change and complications. Four of the young women had consistent careers, ten had complex, and six had chaotic. In the following three sections, each of the career types is described in more detail and, for each, the contraceptive history of one young woman is shown as an example.

### **5.4.1 Consistent Contraceptive Careers**

Consistent contraceptive careers were characterised by uniform and regular use of contraception over time, regardless of relationship changes, and little experience of contraceptive failures. The four young women with consistent careers tended to use the same methods of contraception with all of their partners and often reported dual method use (of condoms and the pill). The method changes they did make appeared straightforward and rational. Contraceptive failures were uncommon and when they did happen, the young women simply reconsidered their method use. Three had experienced condom failure and all used EC as a result. Each then changed her contraceptive method soon after, by initiating pill use (two continued to use condoms as well). The other young woman with a consistent career initiated pill use (and combined this with condom use) because she was worried about condoms splitting and thus getting pregnant.

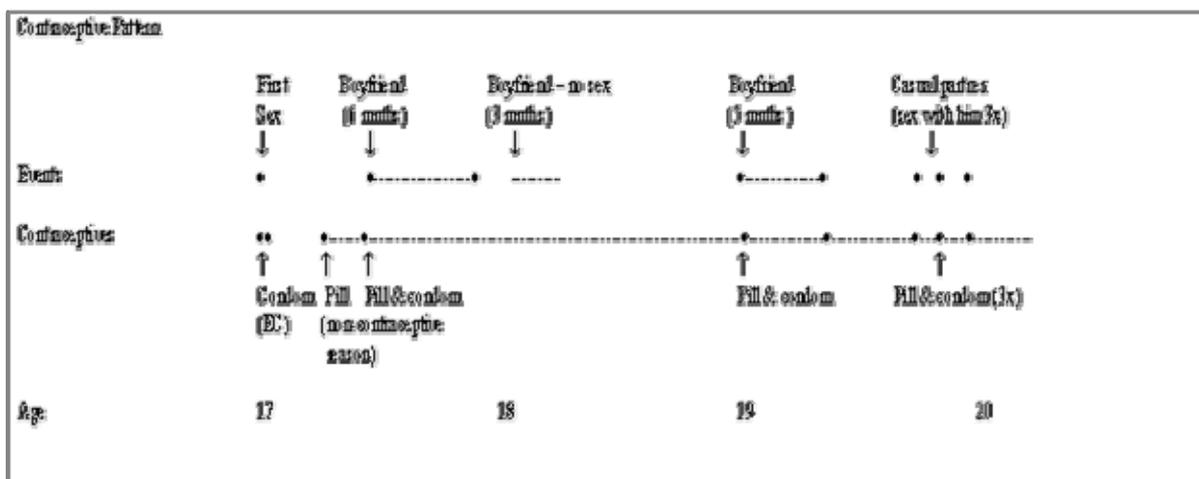


Figure 5.2: Consistent Contraceptive Career (Kate)

Kate came from a non-manual social class background, lived with her parents, was at university, and worked part-time. She did not have a partner at the time of interview, but had had a series of short term boyfriends (all less than 1 year) and one recent casual partner. She first had sexual intercourse at age 17 and had had four sexual partners. She had never been pregnant or had an STI. When asked, Kate could name six contraceptive methods and had used three: condoms, the pill and EC.

Kate’s individual pattern of contraceptive use was very straightforward and she had only changed method once (Figure 5.2). Kate used a condom when she first had sexual intercourse, but the condom split and she used EC. She later started the pill to regulate her periods. Therefore, initially, the pill was not used as a contraceptive. She then used condoms and the pill concurrently with all her subsequent sexual partners. Kate had no problems with the pill, coped with the routine of taking it everyday and had used it continually since starting it. She was particularly influenced by the social norms of condom use and, for her, always using condoms was just what you had to do.

### 5.4.2 Complex Contraceptive Careers

Complex careers were characterised by more change and variability. Method use was determined by relationships and partner type, and contraceptive failures (such as forgetting to take the pill) were more common. The management of these was also more varied. EC use was common but other strategies included temporary method or behaviour change (e.g. using condoms as extra contraception or avoiding sexual intercourse), main method change (e.g. changing from the pill to the contraceptive injection), and even borrowing pills from a friend. Pill use was initiated for non-contraceptive reasons by half this group (to regulate

menstruation, reduce period pain, or as a treatment for acne) and in these cases was maintained outwith relationships. The ten young women with complex careers often used condoms at the start of their relationships and then changed from condom to pill use (those who were on the pill already at the start of the relationship would use both methods and then discontinue condom use). If the relationship ended they would start using condoms again with new partners, repeating the same pattern of change. The young women with complex careers made more changes than those with consistent but these were not necessarily problematic for them and they incorporated change in a manageable way.

Megan had a non-manual social class background, lived with her parents, and was working full-time. At the time of interview, she had recently split up with her boyfriend of three years. She first had sex at age 16 and had had one other long-term relationship and eight casual partners. She had never been pregnant or had an STI. When asked, Megan could name four contraceptive methods and had used four: condoms, the pill, the injection and EC.

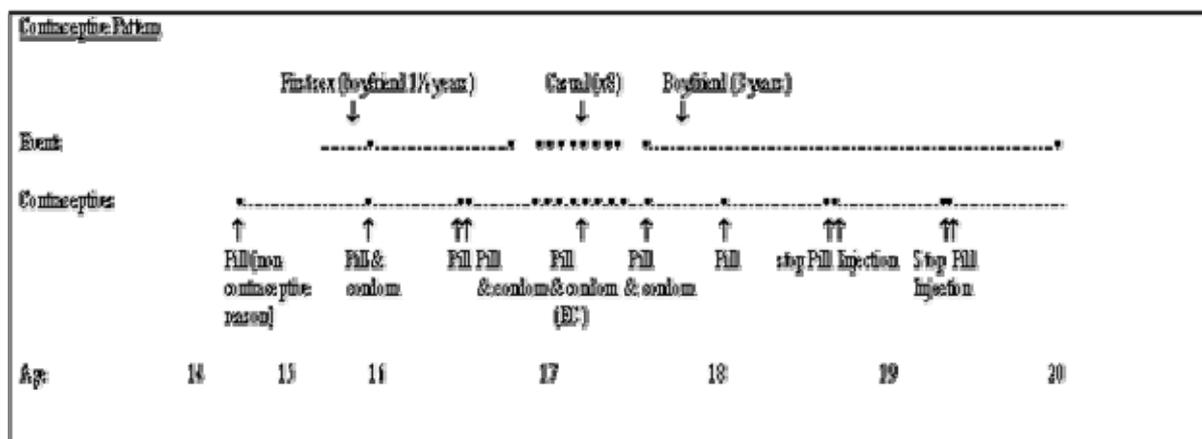


Figure 5.3: Complex Contraceptive Career (Megan)

Megan’s individual pattern of contraceptive use was more complicated than Kate’s and she had changed method six times (Figure 5.3). Megan started the pill to regulate her painful periods, before she first had sex. When she did have sex she used a condom as well as the pill, and in her first relationship she only had sex without a condom once, when neither she nor her boyfriend had one. When the relationship ended, Megan continued to take the pill and did not consider stopping because she was using it for a non-contraceptive reason. She used condoms and the pill with all of her casual partners. On one occasion she used EC after a ‘one night stand’ that she did not think had been completely safe, even though she was on the pill and they had used a condom. In her most recent relationship, she and her

partner stopped regular condom use after almost a year together, but they would still use condoms if she forgot to take her pill or was taking antibiotics. They stopped regular use because she thought they could trust each other, believing that they had each used condoms with all their previous partners, and were therefore not at risk of STIs. Megan struggled with the routine of the pill and frequently forgot to take it, so she was advised at the clinic to change to the injection (at age 18), because she would not have to remember it on a daily basis. She used the injection for nine months but changed back to the pill because she was unhappy with the amount of weight she had gained while using the injection. She attempted to improve her adherence to the routine of taking the pill by asking her boyfriend and friends to remind her, and by setting reminders on her mobile phone.

### 5.4.3 Chaotic Contraceptive Careers

Chaotic careers were characterised by frequent method changes within and between relationships, and multiple contraceptive failures. The changes were sometimes erratic, with the young women often changing back and forth between the same methods. All six of the young women with chaotic careers had used the contraceptive pill, had discontinued use of this at some point, and reported having unprotected sex on more than one occasion. Indeed, for all but one, non-use had become a regular occurrence rather than just something that happened occasionally. Contraceptive failures were much more frequent than they were among the rest of the young women, and were the result of forgetting to take the pill or condom failures. For these young women, frequent method change was a further complication in their somewhat disordered lives.

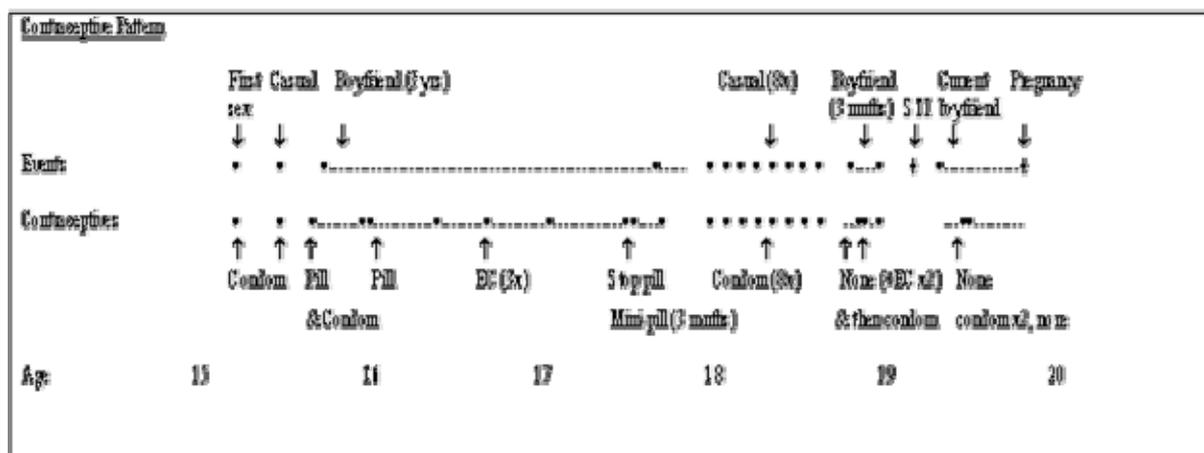


Figure 5.4: Chaotic Contraceptive Career (Fiona)

Fiona was from a non-manual social class background, lived with her mother (her parents were separated), and was working part-time. She was 3 months pregnant at the time of interview and had been with her boyfriend for 4 months. Fiona first had sexual intercourse when she was aged 15 and had had 13 sexual partners; two other boyfriends (of 3 years and 3 months respectively) and ten casual partners. Fiona was the only young women in the interview sample who reported having had an STI (chlamydia). When asked, Fiona could name five contraceptive methods and had used four: condoms, the pill, the progestogen-only pill and EC.

Fiona had changed method 11 times (Figure 5.4). She used a condom when she first had sex and with her next casual partner. In her next relationship she started the pill before they first had sex, and they used it and condoms for the first three months. She then stopped using condoms because she trusted him and did not think he posed an STI risk. During that three year relationship, Fiona used EC three times when she forgot to take her pill. Next, Fiona was taken off the pill by her GP when she experienced headaches, which could have been a side effect of the method. She started the progestogen-only pill instead but stopped this after 3 months because she disliked the fact that she did not have a monthly period. This was important to Fiona because she relied on having a regular period as a reassurance she was not pregnant. She did not start another prescription method, and instead used condoms with her subsequent casual partners. With her next boyfriend, Fiona had unprotected sex and twice used EC before starting to use condoms because she did not want to keep taking EC. After this relationship, Fiona found out, on going to her local GUM clinic for STI screening, that she had chlamydia (she knew a previous partner had this). She discussed using contraception and STI testing with her current boyfriend but they did not use any method of protection when they first had sex. She was worried about getting chlamydia again and they used condoms a couple of times after this before again having unprotected sex. She had arranged to go to a clinic to start the pill again, but found out she was pregnant the day before her appointment.

## **5.5 Differences and Similarities between the Contraceptive Careers**

The young women with consistent careers had made only one or two method changes, those with complex had changed method between one and eight times, and those with chaotic between five and fourteen times. As such, while there is some overlap, increasing

method changes from consistent to complex to chaotic are a feature of the career typology. However, it was not just this that distinguished the career types from each other. There were also differences in what the contraceptive changes actually were, how effective the methods used were, what the level of pregnancy risk was, what major events were experienced, and how often experiences (particularly of unprotected sex) were repeated.

There were also distinct differences in the social backgrounds of the young women in each of the career types. All four of those with consistent careers came from non-manual social class groups compared with only three of the ten with complex careers, and three of the six with chaotic careers. While most came from families where the parents were still together, of the five who did not, three were from the chaotic career group. There were also differences in terms of the young women's educational attainment. All but one of the young women with consistent careers had obtained credit standard grades at school, compared with six of the complex group and two of the chaotic. All with consistent careers were at, or about to go to, college or university, compared with four of the complex group and none of the chaotic.

The number of sexual partners that the young women reported ranged from one to sixteen and there was some variation between the career types. Although partner numbers tended to increase with each career type, there were exceptions. For instance, Tammy had a consistent career but seven partners, while Louise had a chaotic career but three partners, and Margaret had only one partner but a complex career. In terms of partner type, both casual and regular partners were common among young women with complex and chaotic careers. All with chaotic and eight of the ten with complex reported having casual partners. On the other hand, only two of the four with consistent careers reported this. Furthermore, only one of those with consistent careers reported experiencing negative or coercive sexual relationships, compared with six of those with complex and all but one of those with chaotic. When the career types were compared over the original sexual experience groups from the questionnaire data used to select the sample, it was apparent that there were also variations in early sexual experience between them. The young women with chaotic careers were mainly from the group with two or more sexual partners at age 16 while those with consistent careers were mainly from the group who first had sexual intercourse between age 16 and 18, meaning they had had less time to make contraceptive changes than those with chaotic careers. However, again there were exceptions. Lindsay, who had a consistent career, first had sex at age 14. The young

women with complex careers were more evenly split between the groups but were mainly from the groups with one sexual partner by age 16 or who first had sex between age 16 and 18.

There were also important variations in the types of contraceptive method changes that each group of young women made. By definition, those with consistent careers made very few changes, and used the same methods consistently over time, but in addition, the changes they did make were towards more effective methods, particularly the combined use of condoms and the pill, which offer pregnancy and STI protection. Young women with complex careers made more changes and used different contraceptive methods with different partner types, changing from condom to pill use with boyfriends and back to condom use with new or casual partners. Young women with chaotic careers made frequent changes within and between relationships. Their changes were erratic and often from effective to less effective methods (e.g. pill use to condoms or non-use), leaving them at increased risk of pregnancy and STIs. The young women's experiences reflected their different levels of risk; pregnancy had been experienced by none with consistent careers, three of the ten with complex careers, and five of the six with chaotic careers (one of whom had also had a STI).

## **5.6 Summary**

The young women interviewed came from a range of social backgrounds and had varying levels of sexual experience. All described relationships with boyfriends and most also reported having casual partners. For the most part, their sexual relationships and experiences were positive, and only a few reported having been subjected to the most negative sexual pressure and coercion. Each young woman could name a variety of contraceptive methods, yet they often struggled to identify the exact source of this information. Parents, schools, and the media were general information sources, while friends were particular ones. Young women from more socially disadvantaged backgrounds were more likely to report negative sexual experiences, appeared less knowledgeable about contraceptives, and were slightly more likely to report negative experiences of accessing services. However, it is important to note that such experiences were not necessarily exclusive to this group. While the extent of pregnancy fear and awareness of personal risk varied, it was apparent that pregnancy prevention was the young women's main motivation for contraceptive use. As will become apparent in the chapters

that follow, there are specific reasons for using specific contraceptive methods, but these are all underpinned by the need to prevent pregnancy.

While all were aware of a variety of contraceptive methods, most had only used two or three. All had changed methods but the pattern for each young woman was unique. Three contraceptive careers were evident: consistent, complex and chaotic. Consistent careers were characterised by uniform contraceptive use, complex by manageable change and variability, and chaotic by complication and disorder. Most of the young women had complex careers, with consistent and chaotic careers each being less common.

There were differences in the contraceptive careers according to social background and educational attainment. Young women with consistent careers were most likely to be in higher education and to have future expectations that included a defined career path. These differences could be linked to their more effective contraceptive use. The career types were also distinguished by increasing method changes, differences in the changes made, and the efficacy of chosen methods. The number of method changes increased through the career types from consistent to chaotic. While it is obvious that by being sexually active longer the young women with chaotic careers had had more opportunity to change contraceptive methods, there were also variations in the type of method changes each group made. The likelihood that these changes would be to less effective methods increased through the career types and it was only among the chaotic careers that non-use became a frequent occurrence. As a result of these differences, the level of pregnancy risk, and the experience of pregnancy, also increased through the career types.

The young women's contraceptive careers were made up of changes between use of condoms, the pill, alternative methods, EC, and non-use. To understand the contraceptive choices they made, the development of their contraceptive careers, and the reasons for differences between these, it is necessary to explore the young women's reasons for use and non-use of these particular methods. In the following four chapters each is investigated further.

## 6 Chapter Six

### Condoms

#### 6.1 Introduction

In this chapter I explore the young women's use of condoms. Condoms were the main method used, particularly when the young women first had sex, but most then changed to other methods. The following questions will be addressed: why was condom use so predominant during the early stages of the young women's sexual histories; and why had most then changed to other contraceptive methods?

To answer these questions I will discuss what I have termed the push and pull factors, which were apparent in the young women's narratives of their contraceptive use. That is, the factors that led to condom use and the factors that led them away from use of this method. As was highlighted in the previous chapter, while the young women describe having specific reasons for using specific methods, the starting point for use of any method is pregnancy prevention (see Section 5.3.4). It is important to bear in mind that the push and pull factors, which are specific to condom use and discussed in this chapter, are underpinned by the need to prevent pregnancy.

#### 6.2 Condom Use

All of the young women had used condoms but only three reported always doing so. The rest had changed from condom use to other methods, most often the pill, though they typically went back to using condoms occasionally. In fact, only one never returned to condom use after she started the pill. Most (17) used a condom when they first had sex, but only five did so when they most recently had sex. Eight had experienced condom failure (condoms breaking, bursting, splitting, or slipping off) at some point.

So, what processes, decisions and stories lie behind these numbers? In discussing the push and pull factors I will highlight the commonalities and differences in these young women's experiences. First, those factors that encourage condom use are discussed. These are accessibility, social norms and expectations of use, and STI prevention. Second, I focus on

those factors that discourage use. These are dislike of the method, condom failure and expectations of stopping condom use with boyfriends. These factors are shown in the diagram in Figure 6.1.

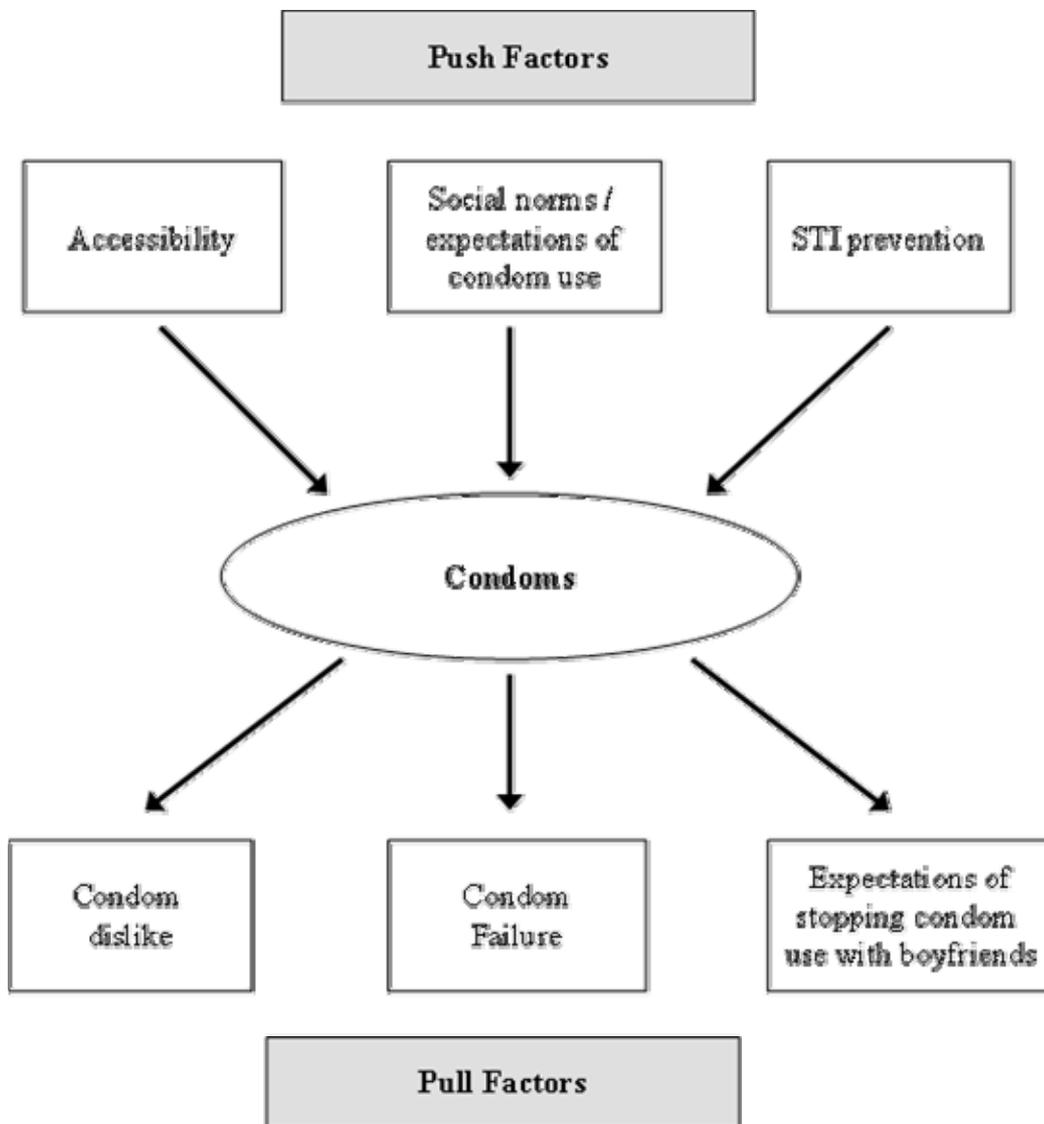


Figure 6.1: Push and Pull Factors for Condom Use

## 6.3 Push Factors – Reasons for Using Condoms

### 6.3.1 Accessibility

Condoms are available from a range of sources, are the only method that can be obtained without having to access health services, and can be provided by partners. Condoms can be bought from shops, pharmacies and vending machines, as well as being free from

clinics. This accessibility was commented on by the young women and was often provided as the reason for use at first sex:

“...it’s like the most readily available, out of any form of contraception, it’s condoms really. Em, because you can just buy them anywhere really...”  
(Milly, complex career).

For Milly and her partner, condoms were the obvious choice because of their availability. Access to condoms outwith health services was also important for those who were unwilling to use such services, either through embarrassment or concerns over confidentiality:

“Cos I didnae really want to go and ask the doctor for any’hing like that or... Well, I felt embarrassed going to ma doctors to ask so...” (Mary, complex career).

Mary was strongly affected by this, and was the only young woman who did not go on to start the pill. As was described in the previous chapter, there were few people with whom the young women were comfortable discussing their contraceptive use, particularly when they were younger. Contacting a health service prior to first having sex, for a method such as the pill, would have required such discussions. Using condoms at first sex avoided this. However, it should be noted that clinics often became an important source of free condoms for many of the young women, so it was not that they were unwilling to use these services altogether; rather it was that they were unwilling to access them when they first started having sex.

Condoms were also the only method that partners could provide and some young women relied on this; again particularly at first sex. Indeed, most (11) who used a condom at first sex said that their partner had provided it. However, only four went on to rely solely on their partners for condoms:

“Em, he would always supply them, so I don’t know where he got them from. Probably like Superdrug or Boots or something. Em... I never... I never carry them, he always carried them. That was his department to look after.”  
(Margaret, complex career).

This was important because it meant the young women did not have to access the condoms themselves. However, it did not appear that this was because they did not want to take

responsibility for contraception. Indeed, for many the decision to use condoms was a joint one:

“Well, he had condoms. Cos he had got them when we had talked about it. And he felt that we were to use them as well. We both agreed on that.”  
(Lindsay, consistent career).

This agreement to use condoms was common, and only a few talked of being pressurised into not using condoms (until other methods were initiated, which will be discussed further in section 6.4.1). However, relying on partners to supply condoms did mean the young women could be subject to pressure from partners not to use these:

“He was trying to be smart and said he only had one condom and deliberately never put it on properly and... em but I, he, he used a condom and then he stopped or something and he says ‘Oh it’s no working’. The condom, he’d says that it had come off and then I stopped him. I knew, I wasnae that daft, I stopped there and then. I was like ‘Well nup, I’m no daing it.’” (Fiona, chaotic career).

As they got older, most (16) of the young women did go on to access and carry condoms themselves. This meant that condoms were always available to them, regardless of whether their partners carried them. Here Megan describes having, and using, her own supply:

“I think because I always had one in my bag and normally... not that you’re drunk but I would normally just kinda put it on the bed or throw it at him or, like, well, ‘there you go’ kinda thing. And you know, you see a few guys that are like ‘I’m not using this’. It’s like ‘well, you either do or nothing’s gonnae happen’ kinda thing. So cos I’ve always got one in my bag, I’ve always... been able to say like ‘there you go, use that’.” (Megan, complex career).

Megan insisted on condom use, and this was reinforced by having her own supply. In this sense, some of the young women regarded producing the condom as more powerful than simply asking a partner if they had a condom. Others waited to see if their partner would introduce the condom first, and then insist on use if it appeared their partner was not going to:

“It was erm, I think he would have been, he would have not really bothered, em but I was... He’d just like, he’d em, finished with someone to go out with me, so he’d just come out of a relationship. I didn’t know this girl, I’d never met her or anything. Em, and he’d been with her, with her for about 8 months, so I assumed they would have not been using condoms so I was like ‘look’, and as well, cos I wasn’t on the pill. And I was like ‘look, I want you to use

condoms'. And he was like right okay'. And that's all, that was the discussion over really (laughs)." (Kim, complex career).

Having access to their own supply of condoms was particularly important in relation to casual partners, when sex could have been unplanned or unexpected. Indeed, it was often at these times, when condoms were unavailable, that the young women had unprotected sex (this will be discussed further in Chapter Nine). While some of the young women had indicated during their interviews that they thought having casual partners was associated with a negative sexual reputation (see Section 5.3.3.1), none suggested that carrying condoms was associated with such.

### **6.3.2 Social Norms and Expectations of Condom Use**

Social norms and expectations are also a push factor for condom use. Most (15) of the young women had some expectation of condom use but for many, expectations differed by partner type. That is, they had expectations of condom use with new or casual partners but these became less important in their more established relationships with boyfriends.

There were only three young women with strong expectations of use, regardless of partner type. They always used condoms as a result, but they were the exception. For them, it was just what you had to do:

"I think it's just kind of that's what you just think you're gonnae do, there's not kind of any objections or anything. Cos it's just what you should do..." (Kate, consistent career).

For Kate, there was no question of not using condoms and she did not expect any objections to her stance. She had always used them, and, as she thought that her partners shared her expectations, she did not find it difficult to negotiate use. In fact, she thought this expectation was shared by her entire peer group, as she describes here:

"I think they would, it's always been go on the pill and use condoms. That's what everyone's always done. That I'm friends with anyway." (Kate, consistent career).

This further reinforced her condom use. For these young women condom use had become the social norm and they found it difficult to further justify or explain their use. However, it should be noted that these young women were the ones from more socially advantaged

backgrounds, with strong career aspirations, and who regarded becoming pregnant as unacceptable.

The rest of the young women had expectations of condom use with new or casual partners only:

“I’ve never had like unprotected sex with somebody like that. Erm, because it’s, you don’t know who you’re, you don’t know who the person is really, eh? So... it’s always been condoms.” (Kim, complex career).

Here Kim is talking about casual partners whom she met in clubs and only had sex with once. Nearly all of the young women used condoms with their casual partners and there was a sense that not to do so would be irresponsible:

“...you kind of think ‘it’s [not using a condom] not the most sensible thing to do’ and you know ‘god knows where they’ve been’ and in quite a lot of cases you know where people have been and you think ‘oh dear that’s bad’ and you kind of go ‘oh ok’. But it’s not so much regret, like I said, it’s just kind of like oh you should kind of know better than to do that...” (Kathy, complex career).

This perception of irresponsibility is linked to STI risk, which is discussed further in the next section.

It is important to note that even the young women who did not use condoms in these circumstances thought that they should:

“I know I should..., I know I should use it [condom]. ...because I don’t want to catch anything. I don’t want to get pregnant again and... you just should use it because there’s so many things going about. You just never know, and because I don’t really, I do know him but I don’t know him that well, like I don’t know who he last slept with, I mean I did ask him. Em, but... I just should have used it.” (Heather, chaotic career).

While Heather believed in the social norm of condom use, she struggled to use them, even though she carried her own supply. Her experience, and the reasons for this, will be discussed further in Chapter Nine.

### **6.3.3 STI Prevention**

The final push factor for condom use is STI prevention. However, it is important to bear in mind that condom use was first and foremost for pregnancy prevention, so STI prevention

was secondary to this. Indeed, the young women talked of being more worried about pregnancy than STIs:

“I think being pregnant is probably the main thing. Especially when you’re younger, it scares you.” (Kate, consistent career).

It is possible that their fear of pregnancy was stronger because they thought pregnancy would affect their lives more than contracting an STI would, given that the STIs they worried about most were those that were curable or easily treatable:

“I take quite a naive view I think, it’s, I worry more about the things that can be cured rather than HIV or AIDS. That’s something, HIV and AIDS is not something that I’ve ever, I’ve never really considered that I could catch it. I know that’s really, really, really stupid, but when somebody says like, ‘but what if you catch something?’, the first thing that pops into my mind is like er, chlamydia or genital warts or something like that.” (Kim, complex career).

Pregnancy, on the other hand, was seen as a life changing event, particularly if they were to decide to have the child. This was particularly the case when they knew of friends who had children (see Section 5.3.6.4).

Regardless of their primary concern with pregnancy prevention, all of the young women were aware of STIs, and the protection that condoms provided did encourage use:

“It’s so much hassle for, you know, for saying ‘can you put a condom on?’ to having to take antibiotics and having everything shaved off...” (Megan, complex career).

Risk perceptions varied though, and did not always correspond with actual risk. The young women who had always used condoms knew their STI risk was low:

“I’ve been pretty much careful, so, I know that they’re there and that you have to be aware of them, but I’ve never worried that I’ve got anything I don’t think.” (Kate, consistent career).

However, even though their own, actual risk was low, STIs were something they worried about:

“Well my friend that I’m talking about, that’s got the wee boy, she’s not had much luck cos she got something [STI] as well. And then after that we talk about it all the time and panic about it. Quite a bit.” (Lindsay, consistent career).

For these young women, the need for STI prevention supported the social norms of condom use described above. Again, these were the young women from more socially advantaged backgrounds. This encouraged their continued use of condoms, even after they started using the pill. This will be discussed further in the next chapter.

For the rest of the young women, the need for STI prevention was limited to new or casual partners, just as the social norms of condom use were. Debbie used condoms with her new or casual partners:

“...with my one night stands there were condoms involved because you didnae know what’s going on... (laughs) You don’t know who else he’s been with and what stuff like that.” (Debbie, chaotic career).

Casual partners were perceived to pose a greater STI risk because the young women did not know them or who else they had had sex with. As such, they thought there was a greater need for STI prevention, which encouraged condom use. However, partner type was not always clear cut and the distinction between casual partners and boyfriends was often tenuous. While Debbie would always use condoms with casual partners, she did not use them with partners she classed as boyfriends, even when she had relatively short relationships with them. The association between casual partners and STIs meant that the influence of this factor was reduced for this group of young women in relationships with boyfriends.

The accessibility, social norms and expectations of use, and the additional benefit of STI prevention encouraged condom use among the young women, particularly during their first sexual experiences. However, most had changed to other contraceptive methods. To explore why, I will now discuss the pull factors, which discourage condom use. These are: condom dislike, condom failure and expectations of stopping condoms in relationships.

## **6.4 Pull Factors – Reasons for Discontinuing Condom Use**

### **6.4.1 Condom Dislike**

Strikingly, 14 of the young women talked about their own, personal dislike of condoms. They described how condoms interrupted sex and “ruined the moment”. The young

women disliked having to stop to put on a condom before intercourse because it got in the way, ruined foreplay, and the time taken could result in the partner losing his erection. In general, it ruined the mood:

“I think like stopping and putting it on is a moment killer you know?” (Kim, complex career).

“Em... it kinda got a routine, you know, after a couple of months of like... ‘go and put the condom on and come back’. He sorta... he went away to the bathroom and he’d come back through and by that time I was like... out like a light [asleep].” (Melanie, complex career).

Melanie and her partner had stopped using condoms as a result of this. Condoms lessened the young women’s enjoyment of sex and, for some, their use even resulted in sex being painful during or after the event. While lessened enjoyment was often the reason that their partners gave for wanting to stop use, it is important to note that here the young women were talking about their own enjoyment of sex. Sex did not feel as good with condoms because they reduced the sensations:

“I don’t know, they just don’t feel right. Just something weird about... I don’t know, I think it’s cos I know that they’re there sorta thing. It just doesn’t feel right.” (Debbie, chaotic career).

Debbie would use condoms with her casual partners but, as discussed earlier, would quickly discontinue use with her boyfriends and it was apparent that her strong dislike of the method was part of her decision.

Finally, a minority of the young women reported finding condoms difficult and awkward to use:

“And then all the magazines that tell you they can become a fun part of foreplay. Lies! Lies! They’re the worst things. I’ve been having sex since I was 14 years old and I still can’t put one on somebody properly.” (Kathy, complex career).

This young woman also went on to talk about how condoms were awkward to dispose of, particularly given that she stayed in shared student accommodation:

“...once you’re done with them it’s kind of like, they just, you’re just like that... there’s never anywhere to put them, never anywhere discreet to put them... You can’t, you know, like you put them in the bin but then you’ve got

to empty the bin and I live in a place where you've got to empty the bin in the kitchen..." (Kathy, complex career).

Kathy had the strongest dislike of condoms among the young women and it was apparent that she would only use them when she felt she absolutely had to, when she had missed a pill or was taking antibiotics. Her use was intermittent with both casual partners and boyfriends. It was not inevitable that the young women would stop using condoms as a result of their own dislike, and only three disliked them so much that they would not have sex rather than use them.

In addition, a minority of the young women had experienced pressure from their partners not to use condoms, because of their dislike of the method, as this quote from Margaret demonstrates:

"Now I got put on the pill, I always remember he [boyfriend] turned round and said 'it's a lot better if you don't use one' and I was like that, 'well what is the difference?'. Eh, and he was just like... 'oh it's a different feeling' and all this sorta stuff..." (Margaret, complex career).

Margaret stopped using condoms as a result even though she did not share his feelings.

### **6.4.2 Condom Failure**

Eight of the young women had experienced condom failure, and all used EC as a result. Fear of failure played a part in the young women's dislike of the method and their enjoyment of sex:

"...it's just that they burst and I'm always feart in case of it comes off inside you. And I'm like that, no way! Imagine haein' that, inside you (laughs). Going to the hospital, excuse me!" (Abby, chaotic career).

For Abby, this was particularly related to her belief that the condoms she was using, which she got free from her local clinic, were of poor quality. She had experienced a condom splitting and her fear that it would happen again, combined with her perception of the condoms being poor quality, led directly to her stopping use.

As noted in the previous chapter, and at the start of this one, pregnancy fear was the young women's main motivation for contraceptive use, and underpinned all their contraceptive decisions (see Section 5.3.4). Their use of condoms, particularly when they first had sex,

was primarily to prevent pregnancy. So when condoms failed, they came to be seen as an ineffective pregnancy prevention method, leading to change to another method. For Tammy, failure affected her enjoyment of sex, but also raised concerns for her about pregnancy risk, particularly because failure happened more than once:

“...we just kept having like condom disasters. They kept coming off and I was just, I think it happened, it must have happened twice but... No it happened twice that it actually came off and we didn't notice and had to go and get the morning after pill but it, it just was really, it was really off-putting.” (Tammy, consistent career).

Even though she used EC each time, she was worried that if it kept happening, or happened at the wrong time, pregnancy would be unavoidable. Tammy started the pill and stopped using condoms, but this change only occurred in the context of a relationship with a boyfriend. She had insisted on condoms with her previous casual partners, and it is possible that she would have continued to use condoms in those situations. On the other hand, Lindsay started the pill after a condom failure but did not stop using condoms, even with her boyfriend. Here is her description of the experience:

“I went on the pill because one night when we were drunk, and we had sex the condom burst. So I took the morning after pill and then after that we had a talk, a couple of days after it and decided it would be best that that didn't have to happen again.” (Lindsay, consistent career).

It is apparent that her experience was considerably different from Tammy's. Lindsay only experienced condom failure once and she blamed it on her own behaviour (being drunk at the time) rather than on a problem with the condom itself. In this sense Lindsay is different from the rest of the young women who experienced condom failure. For her, it was more of a user than a method failure. Tammy, on the other hand, blamed her experiences of failure on the condoms; as did the rest of the young women who experienced this. The distinction between user and method failure was important to the young women. It recurred throughout their descriptions of their contraceptive choices and will be discussed further in later chapters. Furthermore, Lindsay did not have the same dislike of condoms as Tammy, or expectations of stopping use in relationships. Instead she was strongly influenced by the social norms around condom use and was one of the young women who thought that it was just what you had to do, regardless of partner type. Lindsay wanted to use an additional method to ensure she was protected against pregnancy because the failure had lessened her trust in condoms and increased her pregnancy fear. She saw each method as a back-up to the other. While she did not trust condoms enough

to rely on them alone, her strong expectations of use encouraged her to continue using them. Therefore, the likelihood of condom discontinuation after experiencing failure was countered by expectations of their use.

### **6.4.3 Expectations of Stopping Condom Use with Boyfriends**

Expectations of not, or stopping, using condoms in relationships with boyfriends also discouraged use. As discussed earlier, the young women did not necessarily see themselves as being personally at risk of STIs and if they did, it was often only in their sexual relationships with new or casual partners. Therefore, being in a relationship with a boyfriend allowed the young women to stop using condoms. This happened when they felt that the relationship was well enough established. However, there was no set timing for this, with condoms being stopped after anything from a few weeks to almost a year.

Condom discontinuation was seen as a demonstration of trust within a relationship:

“...at first we did use contraception but then a couple of months into the relationship we were like ‘nah, it’s alright now’, you know? [...] ...so basically I had a wee discussion about that and said we don’t need to use them any more, we’re quite safe wi each other.” (Melanie, complex career).

As discussed in section 6.4.1, Melanie particularly disliked the interruption of her partner stopping to put on a condom. Just as the decision to start using condoms was often a joint one (see Section 6.3.1), so was the decision to stop their use. This meant that stopping condom use was just as common in the young women’s more egalitarian relationships as it was in their more negative ones (where they may have been under pressure to make this change because of partner dislike of condoms). Melanie stopped using condoms because she trusted her boyfriend enough, but then they split up for a few months. When they got together again, this trust had been lost and she felt they needed to use condoms again:

“And when we split up and got back together, it was a big conversation about have you been with anybody, have you... and em... we sorta, we did go back on using condoms for a month or so. Because... I didnae feel safe enough not to. I didn’t know where he’d been and what he’d been up to in the time we’d been apart, because the first six months I’d learnt to trust him and then after we broke up I was like oh... I’m no too sure now.” (Melanie, complex career).

This trust was based on the belief that boyfriends did not pose a risk of STIs. For Melanie, her original decision to stop using condoms was based on neither her partner nor herself

being at risk of STIs. When they split up and got back together, there was a possibility that he had had sex with someone else during their time apart. Therefore, it was possible that he was now at risk, so they needed to use condoms again. On stopping condom use, most relied on the pill instead. This contraceptive change, within relationships, was one of the main ones the young women made, and it will be discussed further in the next chapter.

Although the young women trusted that their boyfriends did not pose an STI risk, they did not always know for sure if this was actually the case. In total, nine had been tested for STIs; five of whom had actually sought out screening. However, only one (Milly) had actually been for STI screening before she stopped using condoms with her boyfriend. This was the first boyfriend Milly had considered stopping condoms with, having used them consistently with all her previous boyfriends and casual partners. Milly was from a socially advantaged background, and it was only these young women who accurately assessed and dealt with their STI risk (by either being testing or consistent condom use). The rest of the young women, including all of those from disadvantaged backgrounds, simply assumed that neither they nor their partner had an STI. Although they did not think they were at risk, theoretically they could have been. The lack of symptoms of STIs was sometimes used as a reassurance:

“Eh, cos I mean, you don’t know... about the girls that he’s been with, you don’t know their background and the background before them and what have you. So... I mean obviously, I sort of worried about it at the start, I mean, now... I know that if something’s gonna happen it would have happened by now.” (Margaret, complex career).

Margaret’s boyfriend asked her to stop using condoms after she started the pill and she agreed to do so. Her concerns were overcome by the fact that neither she nor her partner had experienced any STI symptoms since. She talks about her original concerns over stopping use in the same terms that the young women used when describing the need for condoms with casual partners. Even so, it was the fact that this partner was a boyfriend, rather than a casual partner, which allowed stopping condom use to be considered.

The young women frequently repeated this pattern of condom discontinuation. If their relationship ended, they would start using condoms with their next partner, before again discontinuing use when they felt they could trust the boyfriend enough to do so.

It is important to note that the pull factors, which discouraged condom use, were often combined. Most of the young women who disliked condoms would continue to use them with new or casual partners because of their expectations of use and the need for STI prevention in these situations. However, they would stop use within relationships with boyfriends. So while dislike was a potential reason to discontinue use, the likelihood that it would lead to discontinuation was limited by the young women's relationships and partner type at the time. Furthermore, while all of the young women started the pill after experiencing condom failure, only some then discontinued condom use. They only did so if they were in a relationship with a boyfriend.

## 6.5 Summary

All of the young women had used condoms at some point but only three had done so consistently. The rest changed to other methods, most often the pill, but they typically went back to using condoms occasionally. Condoms were the most readily available contraceptive method, and this accessibility combined with the young women's ingrained expectations of use meant that they were most often the first contraceptive method they used. Condoms were available from a range of sources, were the only method that could be obtained without having to access health services, and could also be provided by their partners. When partners provided condoms, the young women did not have to, which saved them the embarrassment of accessing services. However, it is important to note that for many, the decision to use condoms was a joint one. These factors were particularly important during the young women's early sexual experiences, and explain the predominance of the method at that time in particular.

As most of the young women went on to carry their own condoms, other influences on their use of the method became important. For some, expectations of condom use began to change. The young women with the strongest expectations thought that condom use was just what you should do, and as a result, they always used them. These were also the young women from the more socially advantaged backgrounds. However, they were the exception. For the rest, expectations varied by partner type. Social norms of use centred only on their new or casual partners, with whom not using condoms would be irresponsible. This was because these social norms were defined by STI risk, and condom use was encouraged by the need for STI prevention with casual partners.

Why then did the young women change from condoms to other contraceptive methods? Condom dislike was common among both the young women and their partners, and the experience of condom failure lessened trust in the method. Even so, it was not inevitable that the young women would stop using condoms as a result and very few disliked condoms so much that they would never use them. Those with the strongest expectations of condom use (that it was just what you do) and the greatest pregnancy fear continued to use condoms with all of their partners all of the time. Those with expectations of use with only new or casual partners would use them in those situations, but move away from use with boyfriends when the perceived need for STI prevention lessened (although an element of trust in the boyfriend was essential to this). Condoms were seen both as contraceptives and prophylactics. Since the young women's contraceptive choices were underpinned by the need to prevent pregnancy, the prophylactic properties of condoms were always secondary to this. Therefore as the perceived risks of STIs lessened in relationships with boyfriends, so did condom use. While change from condoms to other methods was prompted by negative experiences or problems with use, it was being in a relationship with a boyfriend that allowed the change to take place.

## 7 Chapter Seven

### The Contraceptive Pill

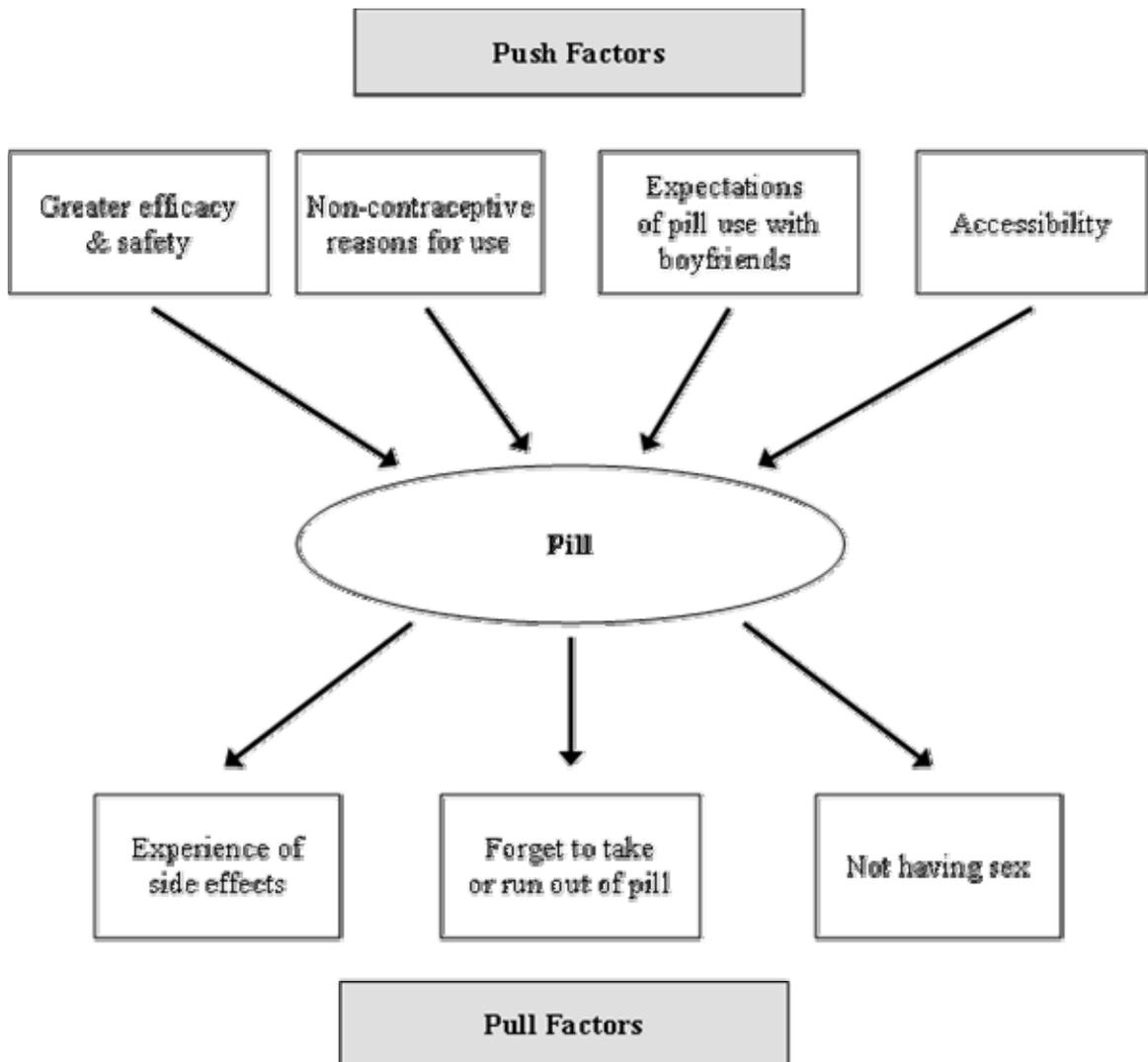
#### 7.1 Introduction

In the previous chapter, I discussed why most of the young women started their contraceptive careers by using condoms, but subsequently discontinued use because of their negative experiences of the method and expectations of stopping use in relationships. In this chapter, I will examine why, for most, this involved change to the contraceptive pill. The following questions will be addressed: why did the young women start using the pill; why did some stop using it; and why was their use of this method more consistent than their use of condoms?

#### 7.2 Pill Use

All but one of the young women had used the pill. Age at first use ranged from 13 to 19 years. Around half used the pill continuously; even outwith relationships when they were not having sex. For the rest, pill use was interrupted by relationship changes and problems with use (although most restarted the pill after breaks rather than discontinuing use altogether). Only three of the young women had started the pill prior to first having sex, but at most recent sex, fourteen were using it. So while condom use decreased over time, pill use increased. While many reported combining condoms and the pill occasionally, only three reported consistent 'dual' method use.

Here the push and pull factors, which led to and from pill use, are examined to highlight the differences and commonalities in the young women's experiences of the method. Firstly, the push factors, which encourage use of the pill, are greater efficacy and safety of the method, non-contraceptive reasons for use, expectations of pill use in relationships with boyfriends, and accessibility (again, it is important to bear in mind that these are underpinned by the need to prevent pregnancy). Secondly, the pull factors, which discourage use, are the experience of side effects, forgetting to take or running out of the pill, and stopping having sex. These factors are shown in Figure 7.1.



*Figure 7.1: Push and Pull Factors for Contraceptive Pill Use*

## 7.3 Push Factors – Reasons for Using the Pill

### 7.3.1 Greater Efficacy and Safety

When compared with condoms, the pill was considered more reliable, made the young women feel safer, and gave them a greater sense of control over their pregnancy prevention. This is particularly important in explaining the change from condoms to the pill, given that most were looking for an alternative as a result of dislike of, or negative experiences with, condoms. An alternative was necessary because the young women still needed to prevent pregnancy, and the pill was perceived to be the most effective pregnancy prevention method.

When the young women talked about the efficacy of the pill they had only a rough, although not entirely inaccurate, idea of the extent of this:

“I like the fact that, you know... there is 90 what is it, is it 99 something per cent effective, and the only way that it's gonnae... its not like condoms which can burst of their own accord and stuff, the only way the pill's gonnae go wrong is if you muck it up yourself, so as long as you're careful with taking it then it's fine...” (Kathy, complex career).

While Kathy had started the pill for a non-contraceptive reason, she stopped using condoms soon after this, so the efficacy of the pill was particularly important to her. She had experienced a condom failure, and strongly disliked condoms, so wanted to avoid their use where possible. It is important to note that her emphasis is on the relative efficacy of the pill to condoms, in that she views the pill as more reliable because it would work as long as she took it properly, but condoms as less so because they could fail regardless of what she did. As I mentioned in the previous chapter, the distinction between user and method failure was important to many of the young women. User failure was something they could attempt to control, but method failure was something they could do little about. For Milly, the pill gave her a greater sense of control:

“I think in a way because I'm in control of it as well. I like the fact that I take it, if I forget, it's my fault. [...] ...it's still nice knowing that you've got some sort of control over it yourself. Because if anything was to go wrong, it would be like my body that would be... it would be happening to, so I like the fact that I take the pill and it's... it's up to me.” (Milly, complex career).

Being in control allowed the young women to better manage their pregnancy prevention, something they could not do to the same extent with condoms. The perceived efficacy of the pill, and the control that they had over whether it would fail or not, increased their trust in the method. This was one of the reasons they changed to it.

A small number of young women did express some doubt about the efficacy of the pill. They talked of this in relation to its physical size, and the fact that they could not see it working. However, they had changed to the pill, and continued to use it, despite these doubts:

“...it's like cos you're taking this one totie [tiny] wee tablet and it's like, how can that stop the main things in your body fae, fae working the way they should, eh? So that was aw' really, eh, it's just like the worry, how can that one thing dae that? So you use other things and... as well so. Its no... I

wisnae like really confident... I wisnae really confident in it either but I still took it just to be on the safe side.” (Melissa, complex career).

Melissa, who had been using condoms, started the pill, at age 19, as a result of a pregnancy scare when her period was late. As she had already had a child when she was 17, she was particularly worried about having another. She saw the pill as a way of ensuring this did not happen, even though she was unsure about how it worked.

The greater efficacy and safety of the pill and the sense of control it provided encouraged uptake, and also continued use, of the method. Unlike condoms, use was maintained even in the light of negative experiences or knowledge of pill failures. Margaret, who had become pregnant, and miscarried, while on the pill, still trusted the method and had continued using it:

“Em... nothing really changed after that [the pregnancy]. Just thought, you know, unlucky month (laughs). Never thought like any less of... coming off the pill or what have you. No, cos my mum fell pregnant wi me when she was on the pill, so I just thought ‘och, it’s just one of these things that happen’ and... what have you. So... but I would still say it like, sort of, still take it and what have you, cos I mean nothing's ever happened since and that was three year ago, so... no. Touch wood, still OK.” (Margaret, complex career).

So for Margaret, her belief in the efficacy of the pill outweighed not only her own experience of becoming pregnant while using it, but that of her mother as well. Friends’ negative experiences of the pill had the same limited effect on the young women’s own use. These were often accounted for by blaming the user rather than the method. This distinction between user and method failure was important in the young women’s assessments of method efficacy. When a friend became pregnant while using the pill, it was blamed on her incorrect use of the method. Thus the young women could maintain their trust in the pill, and continue to use it, by reasoning that this would not happen to them if, unlike their friend, they took it properly.

Three young women consistently used condoms in combination with the pill, and it was the increased safety of ‘dual’ method use that was particularly important to them. Again, it was only those from the more socially advantaged backgrounds, with strong career aspirations, who reported this. These were the young women with the highest level of pregnancy fear (see Section 5.3.4). Here is Vicky’s description of her ‘dual’ method use:

“...we’ve talked about it, not using anything [condoms] just because I’m on the pill, and like I know my pill is working, like cos everything’s like really regular, em, but I don’t know, there’s so many people I know that are pregnant...” (Vicky, consistent career).

As described in Chapter Five on page 110, Vicky was particularly concerned about the effect a pregnancy could have on her life. She goes on to say:

“But, em, och I don’t know, the doctors always tell you to use both as well, like well for like disease... more diseases and that as well, they say but och, it’s always a worry cos they say like if you’re sick or got diarrhoea or anything like that, even if you’re stressed out, it can sometimes knock it off or... and you just... I just don’t want to take the chance really. I wouldn’t... I don’t think it would be worth a wee one running around (laughs). Not right now anyway...” (Vicky, consistent career).

Vicky was aware of STIs and wanted to avoid them, but her main focus was on pregnancy prevention. It is important to note that she recognised the pill was the more effective method, in that she realised she could rely on it alone. Continuing to use condoms provided her with additional reassurance. The idea of using both methods to be ‘doubly safe’ therefore had two meanings: to be protected from pregnancy through pill use, and to be protected from STIs through condom use; and also to be doubly protected from pregnancy through the combined use of both methods.

### **7.3.2 Non-contraceptive Reasons for Use**

The pill has a number of non-contraceptive benefits, in that it can be used to regulate menstruation, relieve period pain or pre-menstrual symptoms, and to treat acne. Half of the young women said that they started the pill for one or more of these reasons. However, most (seven of ten) then also used condoms when they next had sex, and all three of the young women who started the pill before they first had sex did so. Condoms were used for the reasons described in the previous chapter, suggesting that the non-contraceptive properties of the pill were more important to the young women than the contraceptive properties at that time. However, given the problems with condom use that many of the young women experienced, over time the pill’s contraceptive properties became as important as its non-contraceptive ones.

One of the main non-contraceptive benefits of the pill was that it regulated menstruation, and many of the young women (14) liked this aspect of it. Even if they had not actually

started the pill for this reason, they would continue use because of it. The presence of the monthly withdrawal bleed was extremely important to them, particularly given that many had irregular cycles. It did not matter that it was not actually a proper period; they had a regular period and this was their reassurance that they were not pregnant:

“I like the fact that it’s peace of mind, you get your period at the end of every month, it’s like the same time, so you know that you’re not pregnant as well.” (Milly, complex career).

This was of particular importance to the young women given their fear of becoming pregnant. So while regular menstruation was a non-contraceptive benefit, it became important for a contraceptive reason. This encouraged continued use of, and increased reliance on, the pill.

### **7.3.3 Expectations of Pill Use with Boyfriends**

The previous chapter described how most of the young women expected to stop using condoms with boyfriends. As pregnancy prevention (the starting point for all their contraceptive decisions) was still necessary, an alternative contraceptive was required when the young women wanted to stop using condoms. Most chose the pill for the reasons already discussed: it was perceived to be more efficient and safer than condoms, and it had various non-contraceptive benefits. However, some did talk of how they thought their partners expected them to be on the pill:

“...the thing is it always seems to be taken for grant... which I find, you know, that’s how my friend ended up in the situation that she was in [pregnant]. I’m sure the guy that she was with took it for granted that if she wasn’t using a condom she was you know, on the pill. Which is actually, I think that, I mean, it’s a fair assumption, I mean, I know it’s stupid not to ask, you should always ask, but it’s a fair assumption to think that if she’s not saying anything she is being careful. But you know, a lot of people that I was with, you know, if we didn’t have a condom they’d go ‘you’re on the pill right?’. And I’m, going ‘yes, I’m on the pill, what do you think I’m mental?’.” (Kathy, complex career)

Some said that they had discussed starting the pill with their boyfriends:

“He wanted me to [start pill]. He was keen on it. Just because of, we kept having problems with the condom. He didn’t pressure me or anything, in the end I was just like ‘well this is just gonna go on’, and I was like ‘right, I’ve decided’. And that was that.” (Tammy, consistent career).

For Tammy, this discussion came about because of their experience of condom failure, and it appears it was this that gave her partner a role in the decision to change to the pill. While a decision to stop using condoms was necessarily a joint one, given male control of the method, a decision to start the pill could just as often be unilateral for the young women. Lucy said that her original decision to start the pill was her own, and not something she discussed with her boyfriend at the time:

“I think I just done it myself and then I would have told him I was on the pill. I think, wouldn't have brought it up in conversation, I don't think. Or it might have been a case of 'I'm like gonna go on the pill', then I went and done it.”  
(Lucy, complex career).

Lucy was interesting because she was the only young woman who never used condoms again after starting the pill. While she was the exception here, her experience is worth considering further in comparison with the rest of the young women. Lucy strongly believed that her partners expected her to be on the pill:

“I think guys expect all women to be on the pill these days. I think they expect it from as soon as they're what, 13, 14, that they should be on the pill, know what I mean? Cos otherwise they wouldn't be saying it all the time, 'oh, are you on the pill?'. It's obviously so publicised that that's what girls do to stop getting pregnant, that that's what they say. [...] I never felt pressured or forced to do it, but I think it's something that... is expected of you, to be on the pill.”  
(Lucy, complex career).

She had used a condom when she first had sex at age 12, but started the pill soon after and thought that using the pill was 'just what you did' to avoid pregnancy:

“...I suppose it's quite naïve just relying on the pill cos the pill only... I suppose stops you from getting pregnant, it doesn't stop the diseases but you don't, I never thought of that at the time. [...] ...you just rely on the pill. [...] So you're just wrapped up in... the phrase of the pill. But you don't really, you never worried about diseases or... anything like that. Never worried about that at all.” (Lucy, complex career).

Lucy then relied on the pill alone for contraception with all of her partners, both boyfriends and casual. As she had not been worried about STIs, she did not see the need to use condoms for their prevention. This made her different from the rest of the young women, who thought this necessary, even if only with new or casual partners. Her perception that her partners expected her to use the pill appeared to reinforce her reliance on this as her sole contraceptive method.

### 7.3.4 Accessibility

The previous chapter discussed how condoms were the main method used at first sex, largely because they were the most readily available method, and could be accessed without contact with a health professional. To access the pill, the young women had to go to a GP or clinic, and while they may not have been willing to do this when they first had sex, all but one did go on to do so. While, at sexual debut and the immediate period following this, the pill was perceived to be a relatively *inaccessible* method, it later came to be regarded as an '*easily accessible*' method. For some, access to the pill had been very straightforward, and indeed, half of the young women described positive experiences of service use (see Section 5.3.7). Here is Kim's description of her experience:

Kim: "Em, when I went in, when I went in to see her I just says 'I want to go on the pill' and that was it. I'd already like, I'd already discussed the jag wi [friend], and none of my friends use any other form of contraception except the pill and the jag. Em and he [boyfriend] was like totally dead set against the jag, so I was like 'well, I'll just take the pill then', eh?"

LW: "And the clinic didn't suggest any other methods?"

Kim: "No. They were just em, like they said, 'have you thought about any other methods?' And I says 'well, I was thinking about the jag, but I'm set on the pill now. So I'll just take the pill'. And they were fine with that, they were happy." (Kim, complex career).

While Kim's friend had recommended the injection, her boyfriend thought that it could affect her fertility and did not want Kim to use it. It should be noted, though, that most said they were not offered an alternative contraceptive method when they started the pill, and for some there was a sense that the method was chosen for them. In fact, six of the young women described being "put on" the pill by a health professional, rather than of choosing it themselves:

"The [clinic] put me on the pill. Em, think I was 15 when I started the pill. The [clinic] put me on it..." (Fiona, chaotic career).

However, the young women had made the choice to go to a health service, which suggests they had actually sought out this contraceptive method (unless they started the pill for non-contraceptive reasons, which has already been discussed).

The only young woman who had never used the pill said that she had been too embarrassed to go to her doctor for it (see Section 6.3.1). However, others also talked of problems of access, and these were related to the (negative) perception of services and issues of anonymity and embarrassment. Some of the young women, when younger in particular, were worried about being seen using services:

“...and they [clinic] gave you it there and then. Em, rather than having to go to the chemist and... In case your mum was there, your auntie was there or your next door neighbour was there and they're saying 'oh, what are you doing here?'. They'll say 'oh, I seen Lucy at the doctor getting a prescription'. It's quite embarrassing and I suppose you just think 'oh, what if my mum finds out?', cos I hadn't told her.” (Lucy, complex career).

Lucy was worried that someone who knew her would see her picking up her prescription and she might then have to explain what it was for. However, instead of not using the pill, she managed this problem by going to a local clinic instead, where the pill was given to her on-site. Conversely, those who were worried about being seen using clinics, because they were identifiable as contraceptive service providers, used their GPs instead. Indeed, it appears that the availability of the pill from a number of alternative sources increased the extent it was seen as an '*easily accessible*' method.

The greater efficacy of the pill, its non-contraceptive benefits, expectations of use with boyfriends, and the general accessibility of the method encouraged not only uptake but consistent use of the method, and eight of the young women had used the method continuously since starting it. They did so for non-contraceptive reasons or for protection from pregnancy 'just in case' they needed it:

“I'd keep on taking the pill. Keep on taking it, no matter what happened. Cos it... it's safer for you anyway, just in case. You always have to be prepared, in case something happened.” (Debbie, chaotic career).

It is important to note that in the absence of problems with pill use, most of the young women had not had to change from the pill since starting it. In this sense, taking the pill became accepted and routine, as this quote from Kim demonstrates:

“It's convenient and it takes what a second to pop it in your mouth, that's it so. It does me, it suits me and my lifestyle perfectly..” (Kim, complex career).

Kim had only started the pill at age 19 but continued to take it when her relationship with her boyfriend ended. The pill was convenient, easy, and became something she did

automatically. As such, it became a routine part of the young women's lives. This was particularly the case among those from more advantaged backgrounds.

So, why then did some stop using it? To recap, the pull factors, which led to change from the pill, are: experience of side effects, forgetting or running out of the pill, and not having sex.

## 7.4 Pull Factors – Reasons for Discontinuing the Pill

### 7.4.1 Experience of Side Effects

Experiencing side effects meant that the young women had to stop using the pill. It is important to note that stopping the pill was unavoidable when this happened, but it was only experienced by a minority of the young women. Four had experienced side effects and all either changed pill brand or stopped taking the pill altogether following this:

“I had tae actually get taken off the pill cos I was getting really really bad headaches. .And I had to go to the hospital for a brain scan and a C.T. scan or something it's called. And they took me off the pill saying it could be that. Em... and they told me stay off it for a wee while, and then maybe try another one.” (Fiona, chaotic career).

Fiona emphasises being *taken off* the pill rather than choosing to stop use. As such, having to stop the pill because of side effects was an unintended and unexpected method change. These four young women did not equate the symptoms they were experiencing with their pill use. Instead the connection, and the decision to discontinue pill use, was made by the health professional. As Milly says:

“I took a break from it [pill], eh, for a wee while because it was giving me headaches or the doctor thought it was that that was giving me really bad headaches. Em, and during that time, we used condoms then again, and then I went back on the pill but I went on a different pill, em, and I've not had any problems with it since then.” (Milly, complex career).

Again, the need for pregnancy prevention remained, so the young women had to change to another contraceptive method. Milly took a three month break from the pill, used condoms instead, and then started a different brand. On the other hand, Fiona changed to an alternative method (progestogen-only pill). While changing pill brand was straightforward

for Milly, change to an alternative method proved more problematic for Fiona. This will be discussed further in the next chapter.

### **7.4.2 Forgetting to Take, or Running Out of the Pill**

Around half of the young women said that they had problems with the routine of the pill and frequently forgot to take it, and this was more common among those from more disadvantaged backgrounds. However, only five stopped taking the pill as a result (four of whom had started using it again). The young women who struggled with the routine of the pill and stopped taking it, only did so because they were not in a relationship at the time:

“...see like when you’re on the pill and you’re seeing your boyfriend every day, it’s like you remember to take it for some reason but if you’ve no got any guy that’s on your heid or that, it just... it just went right out of ma heid, eh? Because I was thinking about other things...” (Melissa, complex career).

Melissa had remembered to take the pill when she was with her boyfriend but when they split up she started to forget it. Not being in a relationship allowed her to stop the pill, because she no longer needed it for pregnancy prevention. However, it was the problem she experienced with remembering to take it, and not the relationship ending itself, which encouraged this. As discussed earlier, there was a certain expectation of pill use with boyfriends (and a definite need for pregnancy prevention within these sexual relationships), so those who struggled with the routine had the incentive to continue use when they were in these relationships. Outwith such relationships, they did not feel the same need to continue use, knowing that they could use condoms instead with a new or casual partner.

Megan, who had started the pill at age 14 for a non-contraceptive reason, had always struggled with its routine. This increased her pregnancy fear, and here she describes how she became more worried about this as the time for her period approached:

“I think, see if it comes up to the time for my period, I start to worry. I’m thinking right... ‘did I definitely take it that day, and I know that that night we never used a condom’ and then when you get it, you’re like... when you get your periods, you’re like ‘why do I worry so much?’.” (Megan, complex career).

This increased worry, and the frequency of it, led to her discontinuation of the pill. Just as those who experienced condom failure changed method because condoms had become an

ineffective pregnancy prevention method for them (see Section 6.4.2), Megan stopped using the pill because it had become an ineffective pregnancy prevention method for her. Megan's experience of changing to the injection will be discussed in the next chapter.

However, for the most part, the young women would struggle on with taking the pill, so again this pull factor rarely applied. Some adopted novel strategies to remember it, such as asking friends or boyfriends to remind them, or even using mobile phone reminders, which two young women had done:

“I sat and put... all the reminders on my phone for like 5 to 8, so just before I left the house I knew if I hadn't taken it and [boyfriend] was always helping me out as well. “Remember the pill”, was like “oh yeah, thanks”.” (Megan, complex career).

This was particularly important for Megan, because having tried and disliked an alternative, it became even more important for her to cope with the routine.

Running out of the pill altogether was less common. When it happened most would change back to condom use until they had obtained a new pill supply; so this only involved a temporary method change. Only one young woman did not try to obtain a new supply when she ran out, and, unlike the rest, she did not change back to condoms either. Instead, Debbie had unprotected sex and her experience of this will be discussed further in Chapter Nine.

### **7.4.3 Not Having Sex**

Given that pill use was a particular feature of the young women's relationships with boyfriends, and primarily used for pregnancy prevention, they might have been expected to stop using it when these relationships ended and they stopped having sex. This was not the case for most, so again this pull factor only occasionally applied. Only two said that they had stopped using it solely because their relationships had ended. Here Milly describes her experience of this:

“...so I went on the pill. Em, but then we sort of started to get a bit rocky and everything like that and broke up and I just went off it, cos I thought there's no point in staying on it cos, eh, you hear all this stuff about being on it for too long and how it can have detrimental effects and everything, so I just came off it then. Em, cos I didn't see the point in staying on it, if I wasn't having sex or anything...” (Milly, complex career).

This was Milly's first sexual relationship and it is apparent that her pill use was tied to it. So, when it ended and she stopped having sex, she stopped using the pill. She had originally been using condoms and only started the pill on the advice of her mother for additional protection from pregnancy. Therefore when pregnancy prevention was no longer necessary there was no need to continue taking it. However, it was her concerns about the possible long term effects of use that were the basis of this decision.

Abby also stopped taking the pill when her relationships ended:

“...I used to take it when I wis going out with somebody then if I wasnae, I just didnae bother. Cos the way- the pill makes me put on weight tae, so I just used tae, if I wasnae, I didnae hae a boyfriend, I just used to come off it...” (Abby, chaotic career).

While she used not having sex as the reason for stopping pill use, it was her concern over weight gain that encouraged her to do so. Both Milly and Abby were talking about their early sexual relationships, and when older they did continue to take the pill when their relationships ended. In fact, most of those who had stopped taking the pill at some point, had started it again. Simply not having sex was rarely the only reason for stopping the pill. Instead, it was combined with the other pull factors, which centred on problems with the method itself. For the rest of the young women, not having problems with the pill meant that they had not had to change method, particularly when it became a routine part of their lives.

## 7.5 Summary

All but one of the young women had used the pill at some point. While only three had used the pill when they first had sex, use increased over time and over half were using it by the time they were interviewed.

Most of the young women changed from condom use to pill use because they were dissatisfied with condoms. As condom use decreased, pill use increased, particularly in relationships with boyfriends, when STI risk was no longer thought to be an issue. The greater efficacy and safety of the pill and the non-contraceptive reasons for use combined to set it apart from other available methods. While the pill was perceived to be a relatively inaccessible method when the young women first started having sex, it later came to be regarded as easily accessible, and most found access to the pill straightforward. The

additional benefit of having regular periods as a reassurance of not being pregnant encouraged continued use. The pill was synonymous with pregnancy prevention in a way that no other method was. Indeed for many, continued use was further supported by the fact that the pill became an accepted, routine part of everyday life.

The reasons for stopping the pill, which centred on not having sex, forgetting to take or running out of it, or the experience of side effects, actually rarely applied. While the young women may have been expected to stop pill use when their relationships ended this was not the case. This generally only happened when they experienced problems with use of the method. The end of a relationship with a boyfriend allowed the young women to stop using the pill if they were struggling with the routine. Being in a relationship provided the incentive to persevere with use, and some employed novel strategies to help them remember to take the pill. Finally, the experience of side effects, while uncommon, meant that a few young women had to stop using the pill on the advice of health professionals. However, for most of the young women, the absence of these factors, or the ability to manage them without method change, combined with the perception of the pill as the optimal method of pregnancy prevention, meant that they had not had to consider further method change beyond their occasional return to condom use, when they judged that circumstances required.

## **8 Chapter Eight**

### **Alternative Contraceptive Methods**

#### **8.1 Introduction**

In the previous two chapters I examined the young women's use of condoms and the pill, and their reasons for change to and from these. In this chapter I will explore their use of other, alternative, contraceptive methods. Only four of the young women had used alternatives, and all discontinued use within one year. The following questions will be addressed: why had these four young women used alternative methods; why had all four discontinued use; and why had no others tried these?

#### **8.2 Alternative Contraceptive Method Use**

While a range of alternatives to the pill and condoms are available, only two had been used: the injection and the progestogen-only pill.

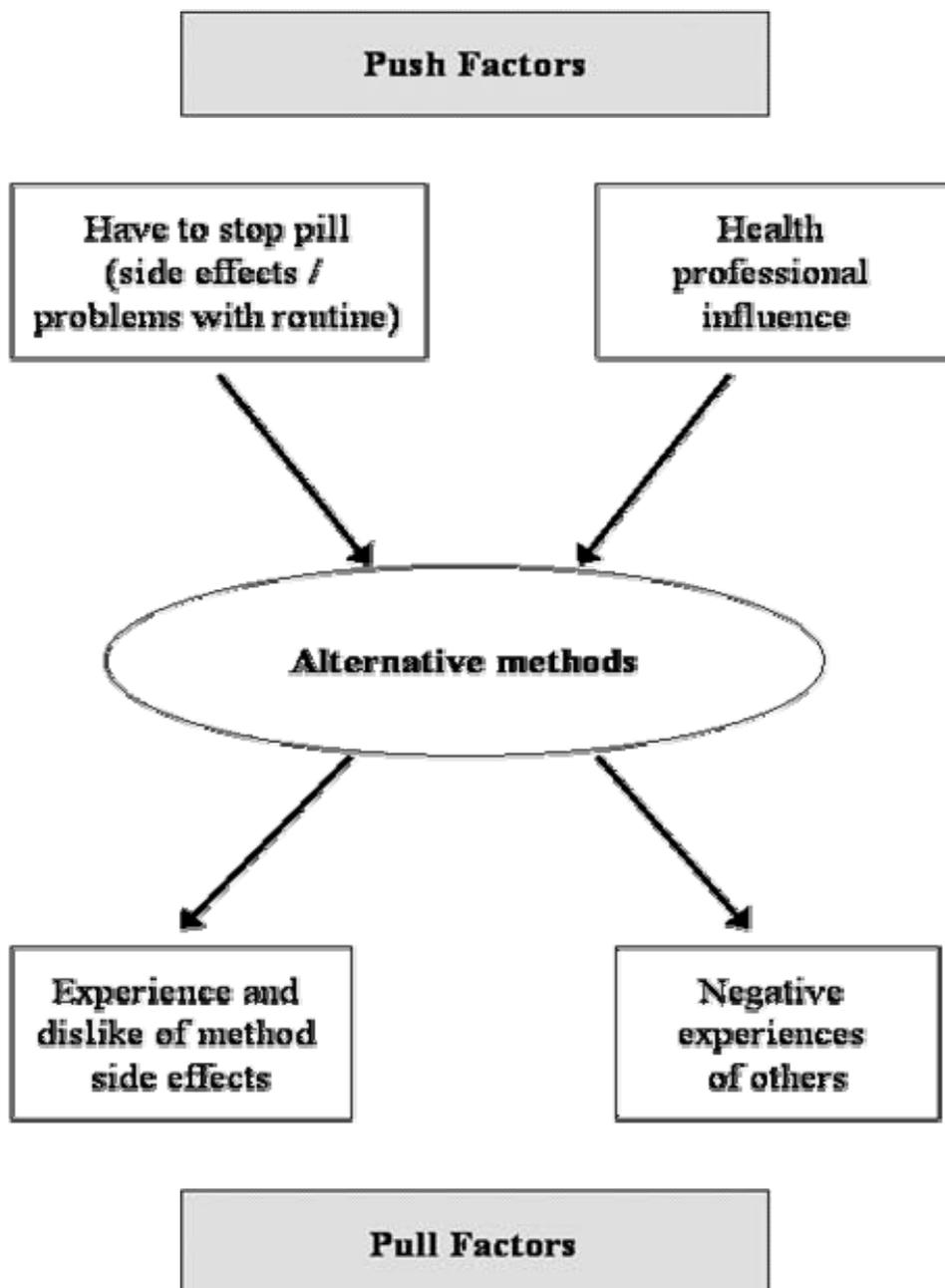
##### **8.2.1 Injection**

Two young women had used the injection. Margaret changed from the pill to the injection at age 17. She used condoms when she first had sex at age 15 before starting the pill, just before she was 16, in order to regulate her periods. At this point she stopped using condoms because her boyfriend (her one sexual partner) disliked them. After almost two years of using the pill she experienced side effects (feeling sick) and changed to the injection at the suggestion of her doctor. After using the injection for one year she stopped use because of weight gain. Megan changed from the pill to the injection at age 18. She also started the pill to regulate her periods, at age 14, prior to first having sex. When she did have sex, she also used condoms and had used both methods with all her partners until her current boyfriend. With him, Megan stopped using condoms after they had been together for a year but often forgot to take the pill and would then use condoms on occasion. She changed to the injection because of this, again at the suggestion of her doctor. She used it for nine months before also discontinuing use because of weight gain. Both Margaret and Megan changed back to the pill.

### **8.2.2 Progestogen-only Pill**

Two young women had used the progestogen-only pill. Abby, who had one of the more erratic patterns of contraceptive use, changed to this method at age 19. She had used condoms when she first had sex at age 14 and started the pill within a year. However, she stopped using the pill each time a relationship ended and started it again when a new one began (maintaining condom use with casual partners). She started the pill for the third time at age 17 and stopped using condoms with her boyfriend. However she often had sex when she knew she had not taken her pill, and then became pregnant. Abby started the pill again after having her child but had high blood pressure so her GP advised her to stop the method. She changed to the progestogen-only pill, but stopped using it after just three months because she disliked not having a monthly period. At the time of interview, she had yet to start using another contraceptive method. Fiona also changed to the progestogen-only pill at age 17. She had used condoms when she first had sex at age 15 but changed to the pill and stopped condom use soon after the start of a relationship with a boyfriend. As described in the previous chapter, she began to experience headaches and her GP advised her to stop the pill as a result. She also only used the progestogen-only pill for three months and discontinued for the same reason as Abby. Since then, Fiona had used condoms or had unprotected sex.

From the brief descriptions of these young women's experiences of alternative method use, it is apparent that particular push and pull factors were influential and these are shown in the diagram in Figure 8.1. Push factors are having to stop the pill because of side effects or problems with the routine, and health professional influence. The pull factors are the experience and dislike of method side effects, and the negative experiences of others.



*Figure 8.1: Push and Pull Factors for Alternative Contraceptive Methods*

### **8.3 Push Factors – Reasons for Use of Alternative Contraceptive Methods**

The need to change to an alternative contraceptive method originated from the side effects or difficulties with the routine of the pill, which some of the young women experienced. These were discussed in detail in the previous chapter. However, these were experienced by a number of young women, only four of whom changed to an alternative method. Here I will examine why this was the case.

### **8.3.1 Having to Stop the Pill (Side Effects / Problems with Routine)**

As discussed in the previous chapter, none of the young women were given alternative methods when they originally contacted a health service for contraception (see section 7.3.4). The pill (and often one particular brand) is what is offered, and what is expected:

“Cos I think they put everyone on the same one to start with unless you've got like a medical history or anything like that. And then if you have, cos they only give you one month, no three months I think, when you start it, to see if it's okay, and then you go back and if you've had any side effects they would put you on a different one.” (Kate, consistent career).

Alternatives were only offered when problems were experienced with the pill. Again, an alternative was necessary because pregnancy prevention, which underpinned all their contraceptive decisions, was still required. While experience of problems with the pill routine was common, Megan was the only one who changed to an alternative method because of it. However, it did appear that forgetting to take the pill was a particular problem for her, making it an ineffective pregnancy prevention method and leading to the need to find an alternative (see Section 7.4.2).

Three of the young women changed to an alternative method after experiencing side effects with the pill. Only one other young woman had experienced such side effects and not changed to an alternative (instead taking a break from the pill and using condoms before changing to a different pill brand). Here she describes why she chose to do this:

“...em, it just seemed like the sensible thing to do, obviously just because, em, ah, well, just because we hadn't been using condoms up until the point when I came off the pill, didn't mean that we were suddenly going to stop, like not use anything. Em, so they really... I just had to use them to bridge the gap between one pill and the other pill...” (Milly, complex career).

So why did those who changed to an alternative method not revert to condom use? All three were all with boyfriends at the time, had discontinued condom use in these relationships, and appeared to have particularly strong expectation of *not* using condoms in such relationships:

“I don't know [why stopped using condoms], I just... didnae feel we needed them. [...] Ken you're totally in love wi this guy, you dinnae think that he could possibly have anything wrong wi him. So as long as you're on the Pill

you're no gointae fa' pregnant. You dinnae think aboot catching anything else. So, get rid o the condoms." (Fiona, chaotic career).

For Fiona, condoms were associated with STIs and she no longer thought this was a risk factor in a relationship with a boyfriend. The decision to stop using condoms was centred on trust of the partner, and reverting to condom use could have suggested they did not trust their partners. As such, it could have been that to revert to condom use with a boyfriend was difficult for these young women. In contrast Milly, who was in a similar relationship when she had to stop the pill, did not have this expectation to the same extent, and had only stopped using condoms with her current boyfriend after being tested for STIs (see Section 6.4.3). Furthermore, the young women who changed to an alternative method had also said they disliked using condoms, while Milly had not.

While the young women who changed to alternative methods did not appear to be that different from those who experienced these problems but did not change to alternatives, there was one factor that did differ: the extent of health professional influence.

### **8.3.2 Health Professional Influence**

All of the young women who had changed to an alternative said that it had been suggested by their GP or clinic doctor. In the previous chapter I described how the young women had made the choice to go to a health service to start the pill, even if they described being 'put on' the pill rather than having chosen to go on it (see Section 7.3.4). Conversely, the decision to change to an alternative method appeared to be taken for them, giving the health professionals greater influence and control over this change than any other of the young women's reproductive choices. This was particularly the case when the young women experienced side effects, which they rarely actually equated with their pill use. However, it is important to note that they had, at the very least, reported their side effects to their doctor.

Milly, who had experienced side effects but who had not changed method, was given the option of a break in pill use followed by use of a different brand:

"...it was just that I started getting headaches and they weren't sure if it was that, they just said that it [pill] could be a cause of it, so they took me off it and I think it could have been cos they stopped soon as I stopped taking it pretty much, so. [...] Cos they recommended three or four months gap, although you

can go straight on, it was just cos I'd had side effects that they said that, so.”  
(Milly, complex career).

So for Milly, the suggested option was a break and then initiation of a different pill. Fiona also talked of being advised to take a break from the pill:

“Em... and they told me stay off it [pill] for a wee while, and then maybe try another one, in a few months.” (Fiona, chaotic career).

While the advice she received was similar to Milly's, Fiona did not start another pill after this break. Here she describes what happened when she went back to her GP:

Fiona: “So I went back to the doctor but they says ‘We don't really know what to put you on so we'll refer you to the family planning clinic’. So the doctor was awright for a, if you were on it the... you could get a prescription. But they werenae really very good at, starting you on the pill or anything like that. It was mainly the family planning clinic that done everything.”

LW: “So what happened when you went to the family planning clinic?”

Fiona: “I went and they told me all the different things that I could go on. Em I chose the- I think it's the mini-pill.” (Fiona, chaotic career).

So the change to an alternative method rather than change to an alternative brand was at the suggestion of the clinic staff. However, changing to a different pill brand did not always appear to have been presented as an option. Indeed, when Margaret later wanted to change back from the injection and was offered a different pill brand, she could not understand why this had not been offered to her in the first place:

“...they turned round and said ‘the only other thing is the injection’, whereas now the pill that I'm on, they could have put me on that straight from that one.”  
(Margaret, complex career).

For Megan, the decision to change to the injection was also at the suggestion of the family planning clinic:

“I went in and just spoke to the woman... in the family planning clinic and she said that like that would probably be the best thing if I was forgetting it all the time, would be to take... get the jag and then all you need to remember is your three month appointment.” (Megan, complex career).

The fact that Megan sought out this information further differentiated her from the rest of the young women who struggled with the pill routine but did not change method. Having not sought out this information, such alternatives had not been offered to them.

The push factors for alternative method use together explain why so few of the young women had used these. However, all four went on to discontinue use, and I will now address why this was the case. To recap, the pull factors, for those who had used the method, are the experience and dislike of side effects (Figure 8.1).

## **8.4 Pull Factors – Reasons for Discontinuing Alternative Methods**

### ***8.4.1 Experience and Dislike of Method Side Effects***

All four of the young women who used alternatives talked about their side effects and their dislike of these. Both who used the injection said that they gained substantial weight while using it:

“...I’d put on a lot of weight while I’d been on the injection and... it was like somebody else had said oh, they’d put on quite a bit of weight from it as well. [...] ...it was quite scary how much weight I’d put on... put on about two stone.” (Megan, complex career).

Five young women also experienced weight gain with the pill but talked about it in a very different way. They mentioned it in passing and talked of gaining only “a bit” of weight. This suggests that the weight gain with the injection really was more extreme. Slight weight gain could be outweighed by the other, perceived benefits of the pill. Only Abby said weight gain with the pill was a reason to discontinue use, but only used this as a secondary reason for why she stopped using the pill when her relationships ended (see Section 7.4.3). Furthermore, it did not stop her from starting the pill again when she started a new relationship. Excessive weight gain with the injection was a different matter, caused strong dislike of the method, and led to discontinuation of it. For Megan, this meant changing back to the pill, a method she knew she struggled with. Her difficulties with the pill were outweighed by her dislike of her experience of the injection.

The absence of the monthly withdrawal bleed was talked about as a side effect of the progestogen-only pill by Abby and Fiona. Previously this had been their reassurance they were not pregnant, and it reinforced their trust in the pill. Without it, they could not have the same trust in the progestogen-only pill:

“I think it was just the whole bit about no getting your periods I didnae like. It made you wonder has it worked and are you pregnant and kinda there was nae really point in it. You were still worrying every month when you never got your period. I like your period to be there cos you ken like...” (Fiona, chaotic career).

However, withdrawal bleed suppression was not thought to be negative by everyone. Megan talked of it as one aspect of the injection she actually liked. This is important because it shows that it was not just the experience of side effects that was a factor. It was also the young women’s perceptions, and in particular their dislike, of these.

These side effects were non-contraceptive and therefore not the same as the medical contraindications that for most had resulted in change to the method in the first place. As a result, there was not the same health professional influence in respect of discontinuation of alternative methods as there had been over their uptake. Stopping the alternative method was the young women’s own choice. While the alternatives were effective contraceptives, and provided the necessary pregnancy prevention which was central to the young women’s method choices, the non-contraceptive costs involved with use were a stronger pull away from the method. In contrast, in the previous chapter, I described how non-contraceptive benefits were a major push towards pill use.

## **8.5 Reasons for not Trying Alternative Methods**

As only four of the young women had used alternatives, it is important to consider why the rest had not done so. For the most part, this was simply because they had not experienced the push factors for alternative method use. The pill provided the pregnancy prevention they required, and those who had not experienced side effects with the pill had no reason to change method. While struggling with the routine of the pill was common, most of the young women did not change method as a result. A small minority only stopped using it when they did not need it (i.e. when relationships ended), while the rest persevered with use. The final pull factor in Figure 8.1, the negative experiences of others, helps to explain why this was the case.

### **8.5.1 Negative Experiences of Others**

While change to alternatives had generally been unnecessary for most of the young women, some had also been put off by the negative experiences of their friends. Negative stories were recounted in relation to the injection, the implant and the IUD. For the injection, these were particularly associated with weight gain. Abby, who had tried the progestogen-only pill and was now looking for another alternative, talked not just of her friend's negative experience of the injection, but also of the IUD:

“...see the lassie I telt you about that haud the implant and that haud the injection, she put on loads of weight? Well, she's got a coil [IUD] and see when she has her periods, she says it's agony.” (Abby, chaotic career).

While she had discussed this with her GP, it was her friend's experience that was most salient:

“Aye, [GP] says to me, he says it's like aboot one in ten women, he says maybe get pain, he says, ‘So you'll probably likely that you willnae’ but... she was really bad... So that kinda put me off it. [...] Hearing that I was like that ‘Ohh that sounds a bit saire [sore]’. Cos I dinnae usually get pain or anything and I wasnae wanting to start getting it (laughs).” (Abby, chaotic career).

Friends were seen as an important source of information because their advice was based on their own experiences. Obviously Abby was one of the few young women who had used an alternative and as such, could have been more conscious of the need for these, and therefore more likely to have discussed it with her friends. Friends' negative experiences of the pill did not have the same off-putting effect as their experiences of alternative methods. As was discussed in the previous chapter, the young women often blamed their friends' negative experiences of the pill on their friends as users rather than on the pill itself. The negative experiences of alternative methods were different because they involved side effects rather than user efficacy. A negative experience that was the result of the contraceptive method had more influence than a negative experience that was the result of the user.

## **8.6 Summary**

Only four young women had used alternative contraceptive methods, specifically the injection and the progestogen-only pill. It is possible that experiences of alternative

method use would be different for others and this should be kept in mind when interpreting the findings of this chapter. Even so, that only four had used alternatives, and all four had then discontinued use within a year, is of interest in understanding the young women's contraceptive careers.

The young women who used alternative methods only did so after experiencing problems with the pill; specifically problems that could not be managed within continued use. Three had experienced side effects and one had struggled with the routine of taking it. These were the factors which pushed them towards alternatives. They were further reinforced by their unwillingness to change back to condoms because of their particular expectations of not using condoms in relationships, and their personal dislike of that method. However, all changed method on the advice or direction of a health professional. This was an additional control over method change, which was not so apparent with other changes in the young women's contraceptive careers. However, in each case, discontinuation of the alternative method was then the result of the experience and dislike of side effects, despite the methods being effective contraceptives. Discontinuation was based on excessive weight gain for the injection, and on the absence of the monthly withdrawal bleed for the progestogen-only pill, which was of particular importance for the two young women involved who both relied on this.

The same factors help to explain why use of alternative contraceptive methods was limited among the rest of the young women. Change to alternatives was unnecessary for most, given that they had not experienced side effects nor had problems with the pill, which could not be managed. Where they had considered alternatives, they were often dissuaded by the negative experiences of their friends; choosing instead to persevere with their original methods.

## 9 Chapter Nine

# Unprotected Sex and Emergency Contraception

### 9.1 Introduction

So far I have examined the young women's use of condoms and the pill, and their limited use of alternative contraceptive methods. In this chapter I will explore non-use of contraception (i.e. unprotected sex) and use of emergency contraception (EC). Non-use or unprotected sex refers here to sex when no contraception was used rather than when it failed, regardless of whether EC was used afterwards. While conventional wisdom would often associate EC use with unprotected sex, among the young women I interviewed it was more often the result of contraceptive failure. This in itself is important in understanding the young women's contraceptive careers and is why these two features have been included together in this chapter.

Firstly, in relation to non-use, the following questions will be addressed: why did some young women have unprotected sex; why did others not; and what subsequently led to the adoption of contraceptive use? Then, in relation to EC use: when did the young women use EC; why did they do so; and when, and why, did they not do so?

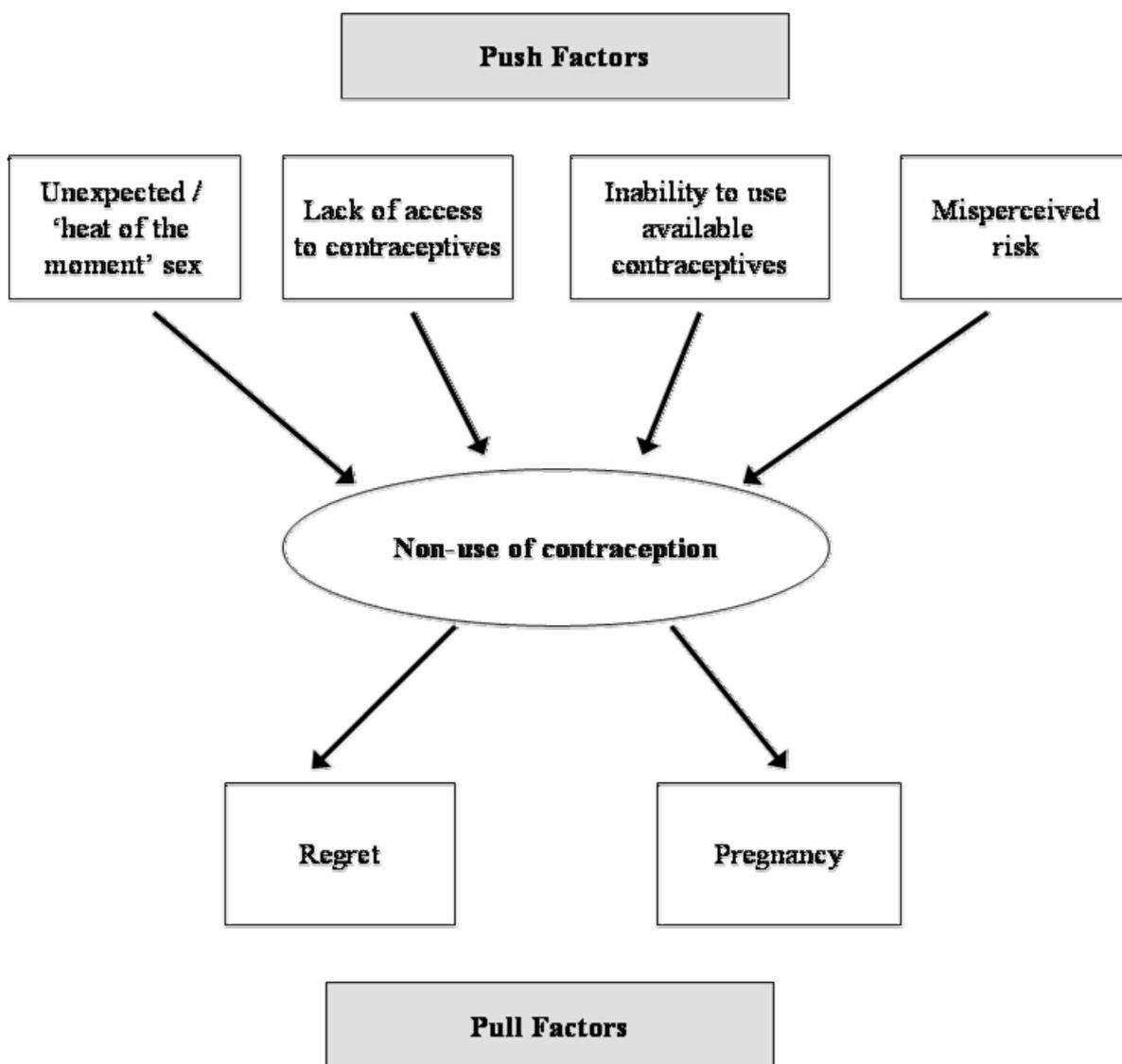
### 9.2 Unprotected Sex

Half of the young women had had unprotected sex at least once, seven of whom were from socially disadvantaged backgrounds. The same seven young women reported frequent non-use of contraception, where having unprotected sex became the normal behaviour. All seven also experienced pregnancy. Of these, only Mary said that she had stopped using contraception because she wanted to get pregnant. The rest of those who had unprotected sex reported only one-off, unintended events of non-use, and these young women were from relatively more advantaged backgrounds. One-off events of unprotected sex were, by definition, followed by contraceptive use when the young women next had sex. In this sense, non-use was a mistake, a break from normal behaviour. These represented two very different patterns of unprotected sex and the experiences of two young women are firstly described by way of example.

Debbie was one of the young women who frequently had unprotected sex. She used condoms when she first had sex at age 14 and started the pill soon after, using both methods for a few months before stopping condoms. When after one year that relationship ended, she continued to take the pill and used it with her next two boyfriends. She moved town to live with the second of these, and when she ran out of the pill she did not go for a new supply because she had not registered with a GP. She and her boyfriend instead had unprotected sex and while Debbie was aware of the pregnancy risk, she did not use EC. She simply did not think pregnancy would happen to her, but it soon did, and she had a child at age 17. After this, she and her boyfriend started using condoms. Debbie was particularly worried about becoming pregnant again, so when a condom split, and she had to use EC, she decided to start the pill again. She continued to take it when that relationship ended; combining it with condoms for casual partners and relying on it alone with boyfriends.

Kim, on the other hand, reported only one occasion of non-use, which was when she first had sex at age 16. She had not planned her first sex and it happened with a boy she knew, when she was drunk at a party. While she said she did not think about contraception at the time, she did think about it the next day. She knew she should have used it, and was worried she could be pregnant, so obtained and took EC. For Kim, this was a critical event, after which contraception was something she always used and discussed with her partners. She used condoms with her next boyfriend and while she thought about starting the pill, he said he would continue to use condoms, so she did not see the point. She also used condoms with her subsequent casual partners and then, at age 19, she changed from condoms to the pill once in another relationship with a boyfriend. She continued to take the pill after the relationship ended.

It is apparent that the young women who reported unprotected sex experienced particular push and pull factors for non-use and these are shown in the diagram in Figure 9.1. The push factors are having unexpected 'heat of the moment' sex, lack of access to contraceptives, inability to use available contraceptives, and misperceived risk. The factors that then pulled young women away from non-use centre on regret and pregnancy.



*Figure 9.1: Push and Pull Factors for Non-use of Contraception*

## 9.3 Push Factors – Reasons for having Unprotected Sex

### 9.3.1 Unexpected / 'Heat of the Moment' Sex

The extent to which the young women had planned, or expected, to have sex was important in understanding their non-use of contraception. This was particularly related to one-off events of non-use. There were three possible explanations for this: sex was with a casual partner, as a result of getting carried away, and/or the young woman was drunk. All of the one-off events of non-use happened with casual partners, and as such sex could have been unexpected. However, many of the young women had sex with casual partners and, as described in Chapter Six, they used condoms, feeling this was just what you should do

with casual partners. So what distinguished unprotected casual sex from safer casual sex? Those who had unprotected sex all described having sex without thinking of, or forgetting about, contraception. That is they got carried away in the 'heat of the moment':

“...we were messing around and it got a bit carried away, [...] ...we were just messing about and suddenly I thought, you know, I really just finished my period like last day, like, two or three days ago and I thought fuck, fuck, fuck, and I've not taken my the pill and like what am I doing, what am I doing? [...] Em... so basically I didn't have, didn't... take, I didn't think about it and I thought you know, there's always a condom in my purse or whatever and em... but didn't think about it, got a bit, it got a bit too playful and, eh, we ended up having sex...” (Neela, chaotic career).

This was the second time Neela reported having unprotected sex and both events could be described as unexpected. She is of particular interest because there was a clear contradiction between her risk taking behaviour and the expectations of her (Asian) culture, which she also talked about:

“...it's like not only am I a girl but I'm an Asian girl, so not only have I got to think about what... my own personal health... I need to think about the fact that if, if anything happens, God forbid, then not only am I, not only am I just, like... I'll be on my own from my family, I'll be alone from my society...” (Neela, chaotic career).

Neela refers to the shame that would be involved if she was to get pregnant before she was married, and yet she still had unprotected sex. With such potentially negative implications, this is perhaps surprising, but the unexpected nature of these episodes of unprotected sex could have meant that Neela was simply unprepared for them.

For some, another feature of this unexpected sex was that they were drunk at the time. Abby, who went on to have frequent unprotected sex with her boyfriend, reported a one-off event with a casual partner when drunk. In fact, she was actually unsure if he had used a condom or not because she had been so drunk:

“I can mind him haein' a condom on it, yin [I know] that. And then I can mind him no haein' it on, so I cannae mind if I had sex wi' it on or no. But I... oh, I was too drunk even to 'hink about it that night...” (Abby, chaotic career).

However, it should not be presumed that being drunk had to lead to such non-use, as some young women talked of being drunk when they had sex, but still used contraception. Lindsay and Michelle had been drunk when they first had sex but had used condoms

because their partners had these and initiated use. None of those who reported having unprotected sex said that their partners had tried to initiate condom use, so this sheds further light on why they had not used contraception on those occasions.

Lack of planning appears to stem from the combination of unexpected sex with casual partners, getting carried away in the 'heat of the moment', and being drunk, explaining why the young women who reported only one-off occasions of non-use had unprotected sex. However, it does not explain why for others non-use became frequent, normal behaviour.

### **9.3.2 Lack of Access to Contraceptives**

In previous chapters I have described the importance of access to contraceptives, and here it is apparent that lack of access is a reason for having unprotected sex. It often occurred when the young women ran out of or forgot to take the pill, or did not have condoms available.

Some of the one-off events of unprotected sex happened when the young women forgot they had stopped taking the pill. Kathy stopped the pill because she was not having sex, and then had unprotected sex when she got together with someone. Although the sex was unplanned (and she was drunk), she did not use contraception because she forgot that she was not on the pill, rather than because the sex was unexpected. For most of the young women, not being on the pill at this point would not have been a problem as they would have insisted on condom use with such casual partners. This was not the case for Kathy, who strongly disliked, and so rarely used condoms. However, for her, not using any contraception had been a mistake and she used EC, and then started the pill again. This is an important distinction between the one-off and frequent non-users.

All of the frequent non-users relied on their boyfriends to supply condoms, so if this did not happen, condoms would not be used. None carried their own condoms. Melissa reported frequent non-use with her first boyfriend, and while they had used a condom when they first had sex, they then only used condoms if he had them. This was the case even though she was aware of her pregnancy risk, and her need to address it:

“Em, we used eh, condoms every now and then, but then half the time... I ken it sounds really stupid eh but, half the time we wouldnae use them eh? And eh,

I was maist [mostly]... I was working all the time as well so... [...] So there wasnae any time for going up to the doctor's surgery or, anything..." (Melissa, complex career).

Melissa describes being unable to access contraceptives because she had not been able to get to her GP. As previously discussed, many of the young women had such expectations of discontinuing condom use with boyfriends. However, most did not have unprotected sex because they had chosen to access alternatives, specifically the pill, prior to discontinuing condoms.

### **9.3.3 Inability to Use Available Contraceptives**

While those who reported one-off events of non-use had not used condoms because they had been drunk or did not have them available, it appeared that frequent non-users had been unable to use contraceptives, or, more accurately, to get their partners to do so, even when it was available. This is in part explained by relationship differences. One-off non-use was with casual partners, however, frequent non-use was mostly with boyfriends, and the young women who reported frequent non-use with these partners were those who reported having coercive or negative relationship experiences. Again, they were also those from the more socially disadvantaged backgrounds. Here, Louise describes her experience of trying, and failing, to get her boyfriend to use a condom:

"I tried tae, well I tried to talk to him but it was like talking to a brick wa'. He just like had a way roon' me where he could just talk tae me and be aw nice and then he'd just get roond me. I was like, then I'd be like, I'm stupid. I didnae even think aboot going for the morning eftir pill cos I thought nah, never happen and it [pregnancy] did." (Louise, chaotic career).

Louise had a difficult relationship with this partner (see Section 5.3.3.4), and while she had insisted on condom use with previous partners, she struggled to do so with this one, and frequently had unprotected sex as a result. Conversely, this pattern of non-use was not apparent among the young women who reported only egalitarian or positive sexual relationships.

It is important to note that the young women's partners were, at the very least, complicit in this unprotected sex. When interviewed, Fiona had recently found out she was pregnant, and described how she had wanted her boyfriend to use condoms, but he had not done so:

“...he knew I wasnae on the Pill, he was gonnae wear a condom and everything was all planned and... But when it happens it disnae always go to plan. He never got tested or used a condom.” (Fiona, chaotic career).

Only Heather frequently had unprotected sex with boyfriends and casual partners. This occurred even though she carried her own supply of condoms. Heather said she carried these because she was aware of expectations of condom use. She thought that she *should* use them, but was often unable to do so. She did not want to ask her partners to use condoms because she was scared they would reject her:

“I mean I do think ‘I should use contraception’ and stuff but you, the majority of the people that I’ve had sex with I haven’t used contraception with. Em..., I think it’s just a thing that I, I don’t want to say to them cause I don’t want them not to, I don’t want them to say ‘right, I’m not having sex with you’. And I think that’s stupid but that’s me. I just don’t like rejection so.” (Heather, chaotic career).

She had had unprotected sex when she first had sex, and then continued to do so, only using condoms when her partners introduced them. It is important to note that this was despite being aware of the risk in her choice of non-use. Heather’s fears over her partners’ reactions outweighed her pregnancy fears, even though she had experienced pregnancy. This will be discussed further in Section 9.4.2.

### **9.3.4 Misperceived Risk**

The final push factor, misperceived risk, further explains how frequent unprotected sex became normal behaviour for some, distinguishing this group from the rest of the young women. Only one (Heather) of the seven young women who had frequent unprotected sex, did so with casual partners. For the rest, it was a behaviour that developed in relationships with boyfriends. While sex may have originally been unplanned, or access to contraceptives problematic, the fact that they continued to knowingly have unprotected sex suggests that their choice became more about their risk perceptions, than about issues of planning or access.

Frequent non-users did not think that pregnancy would happen to them:

“And I knew... I knew it was stupid, that I knew there was a lot of risks involved, pregnancy and stuff. But I wasn’t actually that bothered. I thought, ‘oh it’ll no happen to me’.” (Debbie, chaotic career).

Debbie also talked of being rebellious, and this was important in understanding her account of stopping the pill:

“Cos I was rebellious at that time as well, so I wasnae really bothered about, stuff like that. I wasnae... When we first met I was sixteen so it wasn't really like... We werenae... Well I know that I had been on the Pill since I was fourteen and stuff but, once I ran out the pill, I just didn't bother taking it again.” (Debbie, chaotic career).

She met the boyfriend she describes in this quote at age 16, after which she left school and moved town to live with him. Stopping the pill could have been the extension of her rebellion; contraception was not something she needed to worry about because pregnancy *could not*, never mind *would not*, happen to her.

It was not that these young women were entirely unaware of pregnancy risk, just that they perceived their own risk as low. Fiona was aware that she was at risk of pregnancy, and she had planned to start the pill but had not got round to doing so:

“Cos we just, obviously knew that we couldnae go on, for, I don't know how long I'm going to be with him, but we couldnae go on much longer risking it. Obviously there could be a chance that I could fall pregnant em, and I just... I'd obviously... one o us had to do something so I was going to start the Pill. I just left it a bit late. I should have really went on it to begin wi. Actually I did. I made an appointment and I missed it. I don't know why I missed it, but I did. Em so I made another one, and it was too late.” (Fiona, chaotic career).

There was also a sense that she simply did not think pregnancy would happen to her:

“Obviously it wisnae that big a shock cos I knew that obviously, there was a chance I could fall pregnant wi having unprotected sex. But you never think its gonnae happen to you. You never think it. But it does.” (Fiona, chaotic career).

However, it is worth noting that just before this relationship started, Fiona had had chlamydia, and was very worried about getting it again. When she was treated she was told that chlamydia could affect her fertility, which concerned Fiona because she said that she wanted to have children at some point. It is possible that by having unprotected sex, Fiona was actually testing her fertility.

The misperception that pregnancy simply would not happen to them was used as a justification for their unprotected sex, and for the continuation of this behaviour. It is also

important to note, as discussed in Chapter Five, that these were the young women from the more socially disadvantaged backgrounds and who lacked career-orientated future aspirations (see Section 5.3.4). This was very different from the perceptions of the rest of the young women, who, with higher levels of pregnancy fear and often more career-orientated aspirations, appeared to have greater motivation to use contraception.

Misperceived risk was further reinforced by successful risk taking. That is, by not becoming pregnant. Abby had sex with her boyfriend when she knew she had not taken her pill:

“I just always used to say to him, ‘I’ve no taken ma pill the night so just dinnae come inside me’ and then he would always would anyway. So then I was like that, that’s no fair if I’ve no telt him to dae that, and he always would. But then it got to the point that it was always alright, so I just didnae used to bother.” (Abby, chaotic career).

While she worried about this to begin with, the very fact that she had not become pregnant reinforced her misperception that she was not at risk. This allowed her to continue with this behaviour, until, of course, she did become pregnant.

Abby’s pattern of non-use started with a request to her boyfriend to withdraw before he ejaculated, a request he refused, highlighting his role in her pregnancy risk. Withdrawal as a contraceptive method was uncommon among this sample, with only two others reporting its use, both of whom also had unprotected sex. Mary used withdrawal when she and her partner stopped using condoms, before then progressing to unprotected sex (although she did say that she was not bothered about getting pregnant). Most young women recognised withdrawal as a potentially ineffective contraceptive strategy, so its use here suggests further misperceptions of pregnancy risk. Neela’s use of withdrawal was different, initiated by her Asian partners when they did not have condoms, regardless of whether she was on the pill at the time or not. She explained that there was a cultural expectation of this:

“...the actual friends that I have that I used to, em, get in touch with for, em... casually, basically they’re all Asian so the Asian, the basic the whole Asian perspective on family planning is withdrawal, right? So basically they all knew that and our, because of the fact I’ve never... with an Asian person before I got freaked out the first time. I was like... ‘where are you going?’ (laughs), ‘You’re not in me this time’ and you know, obviously I didn’t say anything at that point but you know, I asked him earlier, I asked him later on, you know, and he was like, you know, it’s the way that... the way that eh...

you know, 'that's the way I know and that's the way that's certainly been written in all those books about our religion and things'. I was like 'yeah, well, you know, you don't do anything else in reference to your religion but this is what you do?'. But I was like you know, 'it shows, I respect you for knowing that' and I did some research myself. I was like, well... I suppose it's OK" (Neela, chaotic career).

Unprotected sex happened when sex was unexpected, or when the young women did not have access to, or were unable to use available, contraceptives. Frequent unprotected sex became possible through the combination of misperceived risk and the reinforcement of this through successful risk taking that allowed unprotected sex to become normal behaviour for these young women.

The young women who did not have unprotected sex appeared to have avoided this even when they had casual sex, which by its very nature is unplanned. They had maintained access to contraception, appeared better able to use it, and had more accurate perceptions of their pregnancy risk. However, even frequent non-use was not a behaviour often maintained in the long term and I will now address the question of what led to change from non-use to (or back to) contraceptive use.

## **9.4 Pull Factors – Reasons for not having Unprotected Sex**

### **9.4.1 Regret**

The young women who reported one-off events of unprotected sex talked of their regret of these. For most it was their non-use of contraception that they regretted, although this was often set within the context of regret of the event itself. This is apparent in Kim's description of how she felt:

"...the next day when I woke up and I remembered and I was like, the first thing that came in my head was 'God, you know, he never used a condom, I could be pregnant or anything'. And erm, and then I did actually wait quite a while after that before I had sex again. And condoms were like first on the agenda. Cos I just felt really crap the next day and used and cheap really, and I didn't want to feel like that again." (Kim, complex career).

Generally, regret was combined with the realisation that they had put themselves at risk of pregnancy:

“Cos I did have to take the morning after pill once, but it’s not, you know, I think it’s actually been more luck on several occasions though, because I have you know, sometimes been really close to doing something very silly like not taking my pill properly or having stomach upsets and then forgetting that I should take a pill again. But erm, you know, it’s been luck on several occasions, but at the same time not anymore. That was kind of, I think everyone goes through a stage of being really silly and really irresponsible with everything. It’s kind of like ‘oh it doesn’t matter, you know, I’ll just get an abortion, I’m 17 years old and I’m quite stupid’. But the older you get you kind of think ‘no, I think I’ll just be careful instead’ (laughs).” (Kathy, complex career).

These episodes of non-use were a critical event and regret led to increased contraceptive vigilance. While those who reported one-off events of unprotected sex regretted it, frequent non-users did not regret it until they experienced pregnancy.

### **9.4.2 Experience of Pregnancy**

All of the young women who were frequent non-users became pregnant. It took this event to change their contraceptive behaviour. Earlier I described how Abby’s misperceived risk was reinforced by the fact she had not become pregnant. When she finally did become pregnant she struggled to believe it:

“Well right, I always used to take ma pill, right? And then if I was staying at [boyfriend’s house], I didnae... if I didnae hae it wi’ me, I didnae used to bother. So it kind of went... that went on for months and months and nothing had ever happened before, and then yin day I started bleeding, right, and it was just like a wee bit and this went on for o’er a week. [...] I was like that, I says, ‘I’m no pregnant’ cos I had actually hardly had sex wi’ [boyfriend] the month before. I’m no kidding, I only must have had sex about two or three times so I was like that, ‘I cannae be pregnant’. She [boyfriend’s sister] says ‘Dae a pregnancy test’. I says, ‘I cannae!’. [...] So I can mind sitting on her toilet, I was like that, ‘Right’. Ken, I wasnae bothered because I... in masel’ I kent [knew] that I wasnae going to be pregnant. And then I pee-ed on it, I was like that... and it came up and I was like that, ‘oh my God!’.” (Abby, chaotic career).

Pregnancy was the critical event for the frequent non-users. They found themselves in a situation they did not want to repeat. Their contraceptive vigilance increased, and they started to use contraception as a result. Frequent non-use had been possible while they thought pregnancy would not happen, but after it had, they recognised the risk and realised that pregnancy could indeed happen to them. However, this was not always straightforward. Even with increased contraceptive vigilance some of these young women continued to struggle with contraception. This was apparent for Abby who started the pill

after having her child but had to stop using it because of side effects. As described in the previous chapter, she went on to encounter problems with the alternative progestogen-only pill, and was still struggling to find a suitable contraceptive method.

Only one of these young women did not start using contraception after her pregnancy. Heather continued to have unprotected sex after having a miscarriage. She said that while she thought the experience should have affected her contraceptive use, it had not. This was, in part, because her fear that partners would reject her if she suggested condom use, as described in Section 9.3.3, outweighed any pregnancy fear she had. The outcome of the pregnancy also appeared to be important, as it was having had a child that changed the other young women's lives, and the desire to avoid having another that led to contraceptive use. However, since Heather had miscarried, it is possible that she did not experience this or feel the same need to avoid it. Indeed, it is also possible that because she had miscarried she was, on some conscious or unconscious level, keen to become pregnant again, so continued to have unprotected sex.

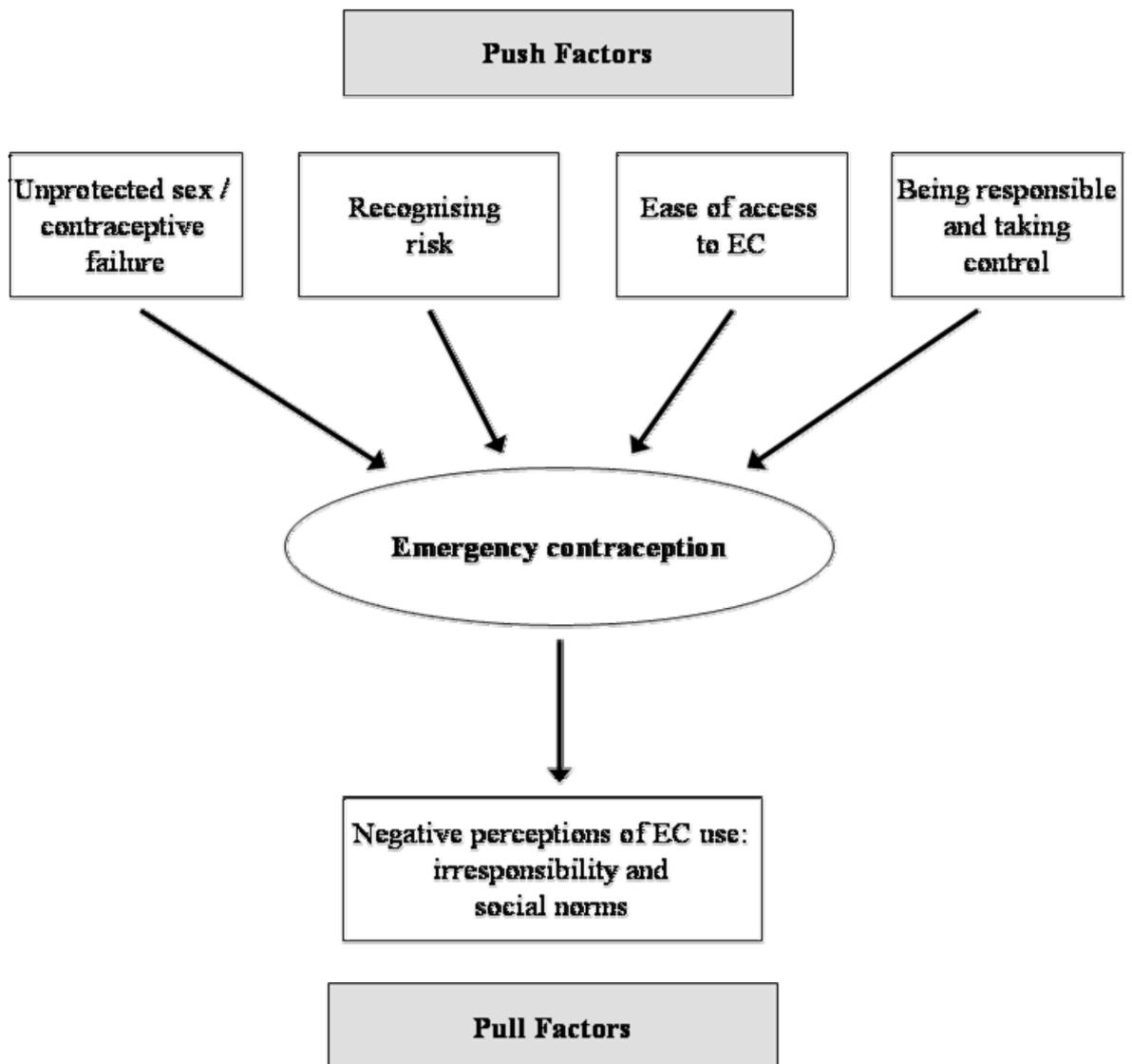
In examining these young women's patterns of contraceptive non-use it was apparent that some used EC and others did not. As I noted earlier, while EC is commonly associated with unprotected sex, among the young women I interviewed, EC use was more likely to follow on from contraceptive failure. In the second half of this chapter I will now examine their use of this method and address the questions of when they used EC, and why they did so.

## **9.5 Emergency Contraception**

Most (16) of the young women had used EC at some point. Only four had used it as a result of having unprotected sex, while the rest used it as a result of a condom failure or forgetting to take the pill (three of whom were, from a public health point of view, probably being over cautious but used EC just to be safe).

Debbie and Kim's experiences of EC use were described at the start of the chapter. Debbie did not use EC despite frequent episodes of unprotected sex but did use it when she later experienced condom failure. Kim, who reported only one occasion of unprotected sex, had used EC at that time. So why was EC used on some occasions and not others? Again, I use the concept of push and pull factors to describe my findings. The push factors for EC

use are unprotected sex and contraceptive failure, recognising risk, ease of access to EC, and being responsible and taking control, while the pull factor is the negative perceptions of EC use (Figure 9.2). Again, these factors are underpinned by the need to prevent pregnancy.



*Figure 9.2: Push and Pull Factors for Emergency Contraception Use*

## **9.6 Push Factors – Reasons for Emergency Contraception Use**

### ***9.6.1 Unprotected Sex and Contraceptive Failure***

All of the young women who had a one-off event of unprotected sex used EC (although two also did not use it when they had unprotected sex on another occasion). In comparison, none of those who frequently had unprotected sex used EC. All of the young women who experienced condom failure used EC as did those who had sex and then realised they had missed their pill. It is important to note that young women from both advantaged and disadvantaged backgrounds used EC when they experienced contraceptive failures. It would appear that EC was regarded as a back-up to regular contraceptive methods, rather than a method in itself. Indeed, in Chapter 5, I described how, even though 16 of the young women had used EC, only one named it as a contraceptive method (see Section 5.3.8). The perception of EC as a back-up method is further reinforced by the sense of using EC ‘just in case’, which was predominant among the young women who had used it:

“...so I was on the pill by that point and we used a condom too. But it split and so I went to the doctor and just got the morning after pill just to be on the safe side.” (Milly, complex career).

Non-use of contraception and contraceptive failure were the actions that required EC use, and while they demonstrate why and when the young women needed EC, not all used it. To understand this requires examination of the other reasons for use.

### ***9.6.2 Recognising Risk***

Acknowledging the need to use EC requires recognition of pregnancy risk. Those using EC after experiencing contraceptive failure were aware of their pregnancy risk and EC was required as a back-up. All of the young women who experienced condom failures used EC, which suggests that the visible, physical failure of their contraceptive method was a particular push towards EC use. For most who used EC when they had forgotten to take the pill, there was also the physical reminder of the untaken pill.

On the other hand, those who had frequent unprotected sex did not use EC, but this is not surprising, given their misperceived risk. For example, Abby did not use EC when she had not taken her pill. She misperceived her pregnancy risk to be low, and without risk, there was no need to use EC. However, she used EC when a condom split because she recognised the pregnancy risk this involved. On another occasion, Abby also had unprotected sex with a casual partner and had not used EC then either. This could possibly have been because she was drunk at the time and unsure if they had used a condom, so she could not completely recognise the risk. Furthermore, Abby regretted having unprotected sex with this particular person:

“And see that guy tae, that one that I telt you about, that one night stand guy, he’s been with about 40 lassies, so I didnae want to really sleep wi’ him without a condom. An’ that’s what I says, I think he did, I think he did. But I cannae mind cos I was gassed [very drunk].” (Abby, chaotic career).

Using EC at that time would have made her acknowledge the risk, and that she had indeed had unprotected sex with this person; something she did not want to do.

While it was important for the young women to recognise risk if they were to use EC, three were, it seemed from their accounts, being over cautious when they used it. Milly used EC when a condom split even though she was on the pill. With particularly strong pregnancy fear, she felt the need to use it as an additional reassurance. As she was only aged 16 at the time, she put this down to her young age:

“I mean I was pr- thinking about it now... I probably wouldn’t have done it, got... if I was this age, I probably wouldn’t have gone for the morning after pill now, knowing like that I was on the pill and that I’d been taking it steadily and all that sort of stuff but it was just sort of a wee panic.” (Milly, complex career).

In each case there had been a condom failure or there was a perception that they had not been entirely safe, but, as they all reported using the pill at the time, they were actually very unlikely to have become pregnant. What was important though was that they thought they were at risk and this is why they used EC.

### 9.6.3 *Ease of Access to EC*

Most of the young women who used EC had accessed it through health services. It is important to note that they had all been willing to access EC, even though they were slightly embarrassed about needing it in the first place:

LW: “How did you find that experience of going to get the morning after pill?”

Lindsay: “Kinda embarrassing cos I was still quite young then so...”

LW: “What age were you then?”

Lindsay: “Probably just 16... I’d only have been 16. I was embarrassed and... felt stupid as well, cos it shouldn’t have happened.” (Lindsay, consistent career).

While, overall, access was unproblematic, some did report more negative experiences, and this will be discussed further in Section 9.7.1.

Two young women had been given an advance supply of EC, and Lucy had subsequently used all of it:

“I did take the morning after pill as well. I did get them from the [clinic], em, but they were quite funny because at that time they gave me one for there but they gave you, like, five to take away just in case it ever happened again, which made you quite rely on it just in case it did...” (Lucy, complex career).

Lucy was given this supply of EC at age 16 and took it whenever she missed a pill or was taking antibiotics. It should be noted that Lucy was the only one who never used condoms again after starting the pill and it is possible that this was a further incentive to use EC. In doing so it is possible that she avoided having to use condoms when she had problems with the pill. It is also possible that having this supply of EC reinforced her perception that she did not need to use condoms.

Only four of the young women had bought EC from a pharmacy. Here Kathy describes her experience:

“But luckily enough you know I knew that next morning, I knew that the chemist sold them so I just went ‘hmm £25, a small price to pay for no babies’. So I went and got the morning after pill and you know, I decided after I took it,

it was like it was kind of a bad feeling and I don't think I want to do that again." (Kathy, complex career).

While Kathy did not find the price prohibitive, Kim complained about the cost (although this did not stop her from purchasing it). She had previously obtained EC from a clinic, but when she next needed it was aware she could get it from a pharmacy, and saw this as the easier option:

"Em, I think I had it [EC] once, a few, a few years ago now. Em, it was actually after like the first time I'd had sex and it was unprotected. And, em, I went for it. I don't know how I first ever, ever found out about it. I dunno, I can't remember. I just knew about it. And I'd went and got it at the family planning clinic that time. And then, I'd actually read in a magazine that they were starting to sell it over the counter and stuff. So I just thought 'och you know, it's easier, I'll just go and buy it from Boots'. So I did. [...] Em but I actually, I went and bought it, which I wish I hadn't done cos it cost 22 quid (laughs)." (Kim, complex career).

Therefore, the availability of EC over the counter presented an alternative for some young women, but accessing EC in this manner was uncommon.

#### **9.6.4 Being Responsible and Taking Control**

There was a sense that using EC was the responsible choice, and 10 of the 16 young women who had used EC talked of how it was better to use it, to be safe, that to risk not doing so:

"...so it was just to be on the safe side, just in case... anything did happen... I was just taking it just to make sure, that it wouldn't... that wouldn't happen." (Debbie, chaotic career).

Neela had used EC when she most recently had unprotected sex but not when she first did so. Here she describes not using EC at the first event and what had changed by the second:

"Cos I was at that age were I was just like... I'll be fine, I'll be fine, I'll be fine. And then obviously you've got your thing, you know, when you've lived in the world long enough you just think any of it, if you aren't going, if you don't take it into your own hands, then no-one else is gonna do it for you." (Neela, chaotic career).

In this quote from Neela, the sense of taking responsibility for herself is apparent. The first unprotected sex was completely unexpected, and deeply regretted, but the second was seen

as just a slip-up. With increasing age, and experience, it appeared it was something she was better able to deal with. Indeed, overall she appeared generally more prepared:

“...he was like... I think, this is just the general take that guys do ‘oh, I think we’d better be careful’. I was like... em... ‘there’s packets over there, I’ve got pills in my bag and I’ve also got, eh, 24 quid for like two tiny Tic Tacs [EC] em, anything else?’ and he just burst out laughing, like ‘yeah, I know it’s funny but yeah, we do have to be careful’ and... it’s not in a si... it’s not like we were in a situation to even discuss kids...” (Neela, chaotic career).

By being responsible in taking action to avoid pregnancy, there was a sense that the young women were taking control by using EC. It was more responsible to use it than to take the chance of being pregnant.

So, while having unprotected sex or a contraceptive failure were the events that meant the young women required EC, it was a combination of recognising their pregnancy risk, having easy access to EC (from a range of sources), and their perceptions of it being the responsible choice that encouraged them to use it.

## **9.7 Pull Factors – Reasons for Not Using Emergency Contraception**

### ***9.7.1 Negative Perceptions of EC Use: Irresponsibility and Social Norms***

Given that most of the young women had used EC, and thought they were responsible for doing so, it is first of all important to note that, in most cases, negative perceptions did not actually prevent EC use. Indeed, the only young woman in the sample who thought that using EC was wrong was Heather, who was possibly mixing it up with the ‘abortion pill’ used for early medical abortions:

“I got offered the morning after pill when I knew I was pregnant but I didnae want it cause I think that’s the same as having an abortion.” (Heather, chaotic career).

However, there was a contradiction between the young women’s feelings of responsibility in using EC and their perceptions of being irresponsible for needing it in the first place. For example Megan says:

“...but I feel a lot of people are ashamed to go for the morning after pill cos they feel like they’ve done something really bad. [...] I mean, I’ve had to go for it. And you do, sitting in that room, you think you’ve totally mucked up and... [...] I think because you hear all these things about people falling pregnant and... I kinda felt och, I’d never think I would be doing this.”  
(Megan, complex career).

Even with her perhaps over-cautious use of EC (she was on the pill at the time), Megan still had this feeling that she was irresponsible. The young women had to recognise their own pregnancy risk to use EC, and in doing so they had to acknowledge this risk to others when they went to get it. To do this meant that they must acknowledge having unprotected sex, even when this was the result of contraceptive failure rather than actual non-use. It would appear that the social norms around unprotected sex label such behaviour as bad, and the association between EC and unprotected sex therefore labels the need for EC as bad. The young women seemed to be aware of this perception, even though they had been willing to access EC.

It appeared that it was important for the young women’s own feelings of responsibility, and the sense that they were in control, to outweigh those of being irresponsible for needing EC. Only a minority actually reported negative experiences of obtaining EC or talked about being made to feel irresponsible by the health care provider they visited:

“I think it was maybe the Monday morning I had to go to the doctors. And I just told her what had happened, ken, that I’d obviously had sex and it wasnae protected, because the condom had split, and she gave me the morning after pill. But it was a locum doctor that was on and she says to me, ‘Em, oh, this is careless’ and everything. She was giein’ me a big lecture about it. And, eh, she says to me, ‘I’ll give you a packet, like a big box o’ them’. [...] I was like that with them... Ken it’s no ma fault! But I thought cheeky bitch.” (Abby, chaotic career).

Abby’s experience particularly highlights the contradiction between feeling responsible for seeking EC and the perceived irresponsibility of needing it in the first place. As Abby felt she was being judged as irresponsible, she was confused when the doctor gave her a supply of EC to take away for future use. This was a mixed message, which she found difficult to process. I have already discussed Abby’s use of EC at this event, but her failure to use it at subsequent events of unprotected sex. It is important to note that her failure to use EC occurred despite having been provided with this supply. While her misperceptions of pregnancy risk were important in understanding her non-use of EC, it is possible that she was further discouraged by her perception of how the doctor had received her. This is in

direct contrast to Lucy's experience, for whom the very act of being given an advance supply reinforced her perception of responsibility and subsequent frequent use of EC (see Section 9.6.3).

Whether negative perceptions of EC use could have dissuaded the young women from using EC again in the future is difficult to determine as most had only used it once. Only three reported using it more than three times. However, while Lucy had been happy to use it that often, there was a perception among the others that it was wrong to do so. For Fiona, who had used EC five times, this centred on her concern about the effect of frequent use:

“But I started to panic, I thought if I have to take this any mair, I'm gointae, something's gonnae happen to me, it cannae be right taking it that many times.” (Fiona, chaotic career).

For Louise, it centred on the perception of irresponsibility from others:

“I'd used [clinic] for that tae, for the morning after pill a couple o' times. Cos I'm thinking the doctors might be thinking 'How many times do you need to take it? Should you no be a bit mair careful?'. Even though they had split, I mean these things happen.” (Louise, chaotic career).

Although the reception she got from her GP was fine, she was worried what he would think of her when she needed to take it again, but rather than not use EC, she managed this by changing providers. Finally, it is important to note that all who reported such negative experiences were from more socially disadvantaged backgrounds.

## 9.8 Summary

Half of the young women had had unprotected sex and most had used EC at some point. While these two factors were related, they did not necessarily follow on from each other, particularly as most EC use was the result of contraceptive failure rather than non-use.

Among those who had unprotected sex, most reported frequent non-use of contraception, and all who did so were from socially disadvantaged backgrounds. A further few reporting only one-off, unintended events, of which lack of planning, or not expecting sex to happen, were common features. One-off events centred on simply getting carried away in the 'heat of the moment' or being drunk at the time. For these young women, non-use was a

mistake, a break from normal behaviour. However, the same could not be said of those who reported frequent non-use, where having unprotected sex became the norm. As a result, while one-off non-users simply neglected to think about contraceptive use, frequent non-users appeared unable to use contraceptives, or to get their partners to use them, even when they had been available. This pattern of non-use was most frequently reported with boyfriends, and it is important to note that their partners were often, at the very least, complicit in the decision not to use contraceptives. Frequent non-use was made possible through misperceived risk, which was further reinforced by successful risk taking when the young women did not become pregnant. In comparison, the young women who had not had unprotected sex had avoided these factors, and appeared to have more accurate perceptions of their pregnancy risk.

Among those who reported one-off events of non-use, it was apparent that this episode was a critical event. They regretted it, and as a result all used contraception when they next had sex. On the other hand, frequent non-users did not change their behaviour until they experienced pregnancy. It was only then that their non-use could no longer be supported by misperceived risk. For both, this resulted in increased contraceptive vigilance, which pulled them away from non-use and pushed them towards more effective use of contraception.

The young women who reported one-off events used EC, but none of those who frequently had unprotected sex did so. Use of EC required recognition of pregnancy risk, which those who frequently had unprotected sex were unlikely to do because of their risk misperceptions. EC use was most commonly the result of contraceptive failure and in these cases did not appear to be related to social background. Recognition of risk was combined with having easy access to EC, and a sense that using EC was the responsible choice. As such, it was apparent that this was the young women's attempt to regain control when something went wrong. EC remained a temporary, back-up method rather than a regular contraceptive. However, this was contradicted by a perception of irresponsibility for needing EC in the first place. While this had not stopped the young women from accessing EC, it was apparent that negative experiences of access had the potential to discourage future use.

## 10 Chapter Ten

### Discussion

#### 10.1 Introduction

The previous five chapters presented the findings of the qualitative research I conducted. Here, these findings, and how they relate to the literature, are discussed. Firstly a summary of the findings is presented, and then the reasons for contraceptive method use and non-use are explored under four, broad, overarching headings. Where appropriate, reference is also made to the findings of the quantitative analyses presented in Chapter Three. The final part of the chapter examines the young women's patterns of contraceptive use within the construct of the contraceptive career. It will address how and why these are similar to or different from other studies on patterns of contraceptive use in the literature.

#### 10.2 The Young Women's Contraceptive Use

All of the young women had changed their contraceptive method at least once, although most had only used two or three different methods. All had used condoms and all but one reported oral contraceptive use. Most change was between these two particular methods. Only three young women had used condoms consistently, and while the rest changed mainly to the pill, they typically went back to using condoms occasionally. While only three had used the pill when they first had sex, use increased over time and over half were using it by the time they were interviewed. Very few had used alternative methods (and all who had, went on to discontinue use of these), but half had had unprotected sex (without any contraception), and most had used emergency contraception (EC) at some point. Pregnancy fear was the main motivation for contraceptive use and the need for pregnancy prevention underpinned all of the young women's contraceptive choices, but beyond this there were specific reasons for using specific methods.

Condoms were talked about as the most readily available contraceptive method, and the relative ease of accessing them, combined with the young women's ingrained expectations of use, meant that they were most often the first contraceptive method used. However for most, as they got older, more mature, and more sexually experienced, social norms of use

centred only on their new or casual partners, with whom not using condoms would be irresponsible. Many reported negative experiences with condom use. Condom dislike was common among both the young women and their partners, and the experience of condom failure lessened trust in the method. While condoms were recognised as being both contraceptives and prophylactics, STI prevention was always secondary to pregnancy prevention, and, as the perceived risks of STIs lessened in relationships with boyfriends, so did condom use. Change was pre-empted by negative experiences of use, but it was being in a relationship with a boyfriend that allowed the change to take place.

As condom use decreased, pill use increased; mirroring the pattern observed in the quantitative data presented in Chapter Three. When the young women first has sex the pill was perceived to be a relatively inaccessible method, but over time it came to be regarded as easily accessible. The greater perceived efficacy and safety of the pill, and the non-contraceptive reasons for its use, combined to set it apart from other available methods. These and the additional benefit of having regular periods as a reassurance of not being pregnant encouraged continued use. The reasons the young women gave for stopping the pill were not having sex, forgetting to take or running out of it, and/or the experience of side effects. However, these rarely applied. A relationship ending allowed a young woman to stop using the pill if she was struggling with the routine, but being in a relationship provided the incentive to persevere with use. For most, the absence of these factors, or the ability to manage them without method change, meant that they did not consider further method change beyond their occasional return to condom use, when circumstances required.

Only four young women had used alternative methods, and this appeared to be a last resort for them after they had experienced unmanageable problems with the pill. All changed method on the advice or direction of a health professional; an additional control over method change, which was not so apparent with other changes in the young women's contraceptive careers. However, in each case, the alternative method was associated with dislike of its side effects, which resulted in discontinuation, despite the methods in question being effective contraceptives.

Half of the young women also reported unprotected sex (non-use), and most had used EC at some point. In the quantitative data, reports of unprotected sex were lower at around one in seven but remained consistent across the three episodes of sexual intercourse which

were examined (although only one third of those who reported non-use at first sex reported it at all three events). Among those I interviewed who reported one-off events, lack of planning was often a feature of unprotected sex. For these young women, non-use was a mistake, a break from normal behaviour. However, the same could not be said of those who reported frequent non-use, where having unprotected sex became the norm. These young women appeared unable to use contraceptives even when they had been available, and their partners were often, at the very least, complicit in the decision not to use contraceptives. Frequent non-users did not think pregnancy would happen to them; a situation further reinforced by successful risk taking when they did not become pregnant (although all did, eventually, become pregnant). Unprotected sex was a critical event, characterised by regret; regret of the event itself for those reporting one-off events, and of the pregnancy for frequent non-users. For all, this resulted in increased contraceptive vigilance, which pulled them away from non-use and pushed them towards more effective use of contraception.

Use of EC was more commonly the result of contraceptive failure than unprotected sex. It required recognising pregnancy risk, which those who frequently had unprotected sex were unlikely to do because of their risk misperceptions. Recognition of risk was combined with easy access to EC, and with a sense that using it was the responsible choice. EC remained a temporary, back-up method rather than a regular contraceptive and, as such, it was apparent that its use was the young women's attempt to regain control when something went wrong. While perceptions of irresponsibility for needing EC in the first place had not stopped the young women from using EC, negative experiences had the potential to discourage future use.

Overall, change occurred within and between relationships, and while the young women's relationships defined the parameters of change, their own experiences of use were generally more salient than the influence of their partners or others around them.

### **10.3 Reasons for Contraceptive Method Use**

I identified individual push and pull factors in the young women's accounts which encouraged use of, and change between, different contraceptive methods. These individual factors will be discussed under four broader, interrelated headings: social norms, relationships, access, and efficacy (of method and user). Each is considered in turn.

Reference will be made to the literature, which was introduced in Chapter Two, and similarities and differences between my findings and those from the existing literature are highlighted throughout.

### **10.3.1 Social Norms**

Social norms around sexuality have influence on young women's contraceptive use. In recent years, even though a vocal minority would prefer otherwise, the policy focus has been less on the avoidance of sex and more on the avoidance of its potential negative consequences, particularly in relation to teenage pregnancy and parenthood (Department of Health 2001; Hoggart 2006; Scottish Executive 2005). The emphasis on these negative consequences, and the definition of teenage pregnancy as a social problem (Greene 2003), reinforces norms of contraceptive use. It was apparent that the young women I interviewed thought they should be using contraception (whether or not they actually managed to do so). Additional community consequences heighten this perception among young people from Black and Minority Ethnic backgrounds (French et al. 2005; Hennink et al. 1999), as was the case for the young Asian woman in my study. What was then surprising was that she reported risk-taking behaviour that contradicted this. While the potential consequences may have been greater for her, she faced many of the same struggles to avoid risks as the other young women with erratic patterns of contraceptive use.

#### **10.3.1.1 Dominant Discourses of Sexuality**

Norms that encourage contraceptive use can be contrary to expectations of young women's sexuality, and this is an important consideration in understanding their contraceptive use. The dominant discourse of female sexuality is centred on love, romance and femininity, framed within a patriarchal society's expectation of monogamy:

“The normativity of romantic love inevitably serves to uphold the ideologies that sustain heterosexual monogamy and patriarchal forms of marriage and family.” (Warr, 2001, page 245).

Masculinity is privileged over femininity, and the dominant discourse of heterosexuality defines sex as penile-vaginal penetration, prioritising male sexual pleasure (Holland et al. 1998). The male partner is active and in control, while the female is passive and responsive; it is up to the man to initiate sex and the woman to respond (Allen 2003a;

Gavey and McPhillips 1999; Holland et al. 1998). Also inherent in this is a double standard, which congratulates the sexually active male but denigrates the sexually active female, and young women must protect themselves from the threat of a negative sexual reputation (Holland et al. 1998; Jackson and Cram 2003; Kitzinger 1995; Lees 1993; Milnes 2004; Stewart 1999b; Tolman 1994). Reputations are governed as strongly by females as males (Holland et al. 1998; Kitzinger 1995; Lees 1993), and protected by having only steady boyfriends (Holland et al. 1998; Lees 1993). Holland et al. argue that:

“To be conventionally feminine is to appear sexually unknowing, to aspire to a relationship, to let sex ‘happen’, to trust to love, and to make men happy.”  
(Holland et al., 1998, page 6).

This suggests that young women should not plan or prepare for, or even appear to want, sex. They cannot have sex outwith the confines of socially sanctioned ‘steady’ relationships, or consider their own sexual desires or pleasure. The young women I interviewed, however, did not appear to be behaving according to these rules. Indeed, many reported having casual sex partners and some described initiating, or seeking, sex for fun. I would argue that this difference might be explained by changes in social norms, and the proliferation of alternatives to this limited discourse of female sexuality.

In the last couple of decades there have been marked changes in the social, cultural and economic context of young women’s lives. The proportion of women in employment has increased markedly and the pay gap between men and women has narrowed. Women now occupy two fifths of professional jobs, compared with around one tenth in the 1970s, girls gain more qualifications than boys (in 2003/04, 59% of girls and 49% of boys achieved five or more A\*-C GCSEs or equivalent), and girls are slightly more likely to go on to further or higher education. However, gender segregation in higher education remains marked (women account for 82% of education undergraduates but only 11% of those on engineering and technology courses) (Equal Opportunities Commission 2006).

Furthermore, marriage has decreased while cohabitation and divorce have increased, and women’s average age at marriage has increased from 25 in 1971 to 32 in 2001 (Office for National Statistics 2004). Such economic and social change has also been accompanied by cultural change. Strong female roles in both television and film are increasingly apparent, particularly since the 1990s (e.g. Lara Croft: Tomb Raider, Alias) (Harris 2007; Inness 1999; Inness 2004). This adds to the increased visibility of women in our society, challenges their subordination, and offers an alternative to traditional, married life.

These changes suggest that young women might now have very different expectations for their lives. As McRobbie concluded in the second edition of "Feminism and Youth Culture":

"Completely gone is the kind of fatalism that used to exist, that women's lives would follow a predictable path, that this must inevitably evolve round husbands and children, and that women must subordinate themselves to fulfilling this role." (McRobbie, 2000, page 210).

Therefore, women are no longer so constrained by the associated discourses of sexuality which reinforced such subordination and made this traditional "path" the only reputable one available to them. This dominant discourse was in the past reinforced by (formal and informal) sex education, through the media and popular culture (Fine 1988; Holland et al. 1998; McRobbie 1981; McRobbie 2000; Thomson and Scott 1991; West 1999). Now alternatives are reinforced in the same way through positive media representations of female sexuality outwith the romantic discourse, such as in the television programme 'Sex and the City' (Milnes 2004). However, this should be qualified with the note that, in the final episode of this particular series, the most promiscuous character found (and gave in to) true love, so reinforcing the romantic discourse once again. Indeed, a recent content analysis found that while 'Sex and the City' contained more sexual content, it was actually more likely to depict sex between established, as opposed to casual, partners than television in general (Jensen and Jensen 2007).

Even if the romantic discourse has not been completely usurped, it is important to recognise that not all of young people's relationships fit into this framework (Allen 2004). Jackson and Cram (2003) argue that the young women they interviewed had three constructions of sex, only one of which was based on the romantic discourse. Within this construct, sex was special, but in the other two sex was physically driven or for fun and therefore construed as casual or incidental. The authors argue that:

"Constructions of sex as casual or incidental may be fashioned from a permissive discourse of sexuality, specifically the notion that women, as much as men, have the right to express their sexuality and seek sexual pleasure." (Jackson and Cram, 2003, pages 122-123).

I am not suggesting that romance, or romantic love, was not important to the young women I interviewed, but nearly all also talked of having casual relationships, which were defined as what they were; 'one-off' sexual encounters or 'one night stands'. These are not defined

by a search for love or romance, and exist alongside more traditional, romance-based, boyfriend relationships. Romance is just one of their discourses of sexuality.

Alternative sexual strategies, which challenge the norms of heterosexuality, have become more apparent, and these allow young women to prioritise their own pleasure and reject the passive, responsive role normally associated with female sexuality (Allen 2003a; Allen 2004; Gavey and McPhillips 1999; Jackson and Cram 2003; Milnes 2004; Stewart 1999a). For Stewart, these strategies include "...initiation of sex, their planned loss of virginity, the stating of conditional terms for relationships, their participation in casual sex, their efforts to ensure their own sexual pleasure is catered for and, finally, their refusal of unwanted sex and their amendment of behaviour accordingly." (Stewart, 1999a, page 277). These strategies were also apparent among some of the young women I interviewed, who appeared as active participants rather than passive in their sexual relationships. However, challenging the dominant discourses of sexuality is not straightforward, and in the studies above such resistance is often the exception rather than the rule. As Jackson and Cram state:

"...we found resistance to be somewhat tenuous and fragile, a fragment of possibility... ..it was not strident voices of opposition to the sexual double standard that arose in the young women's talk but murmurs that denigrated male sexual promiscuity, that subverted the term 'stud', that engaged with the possibility of sexual desire..." (Jackson and Cram, 2003, page 123).

Indeed, in my study, it was the confident young women who were most likely to appear to challenge the social norms and adopt alternative sexual strategies, while others, who lacked such confidence, were often still subject to the more powerful influences of their partners (this will be discussed further later in the chapter).

Much of the early work in this area highlighted the contradiction between the dominant discourse of romance and planning to have sex and use contraception (Finlay 1996; Holland et al. 1998; Lees 1993; Wight 1992). Young women have difficulty practising safer sex as a result of the romantic discourse within which the sexual encounter is placed (Gavey and McPhillips 1999; Kirkman et al. 1998; Stewart 1994). Women are unable to initiate condom use, even if their partner does not, because of the passive role they are expected to take in the sexual encounter. Young women are supposed to be looking for love and romance, not sex. Being prepared by having contraception contravenes this, and as such, initiating condom use, which demonstrates willingness to have sex, carries the risk

of the young women being labelled promiscuous or easy (Browne and Minichiello 1994; Finlay 1996; HEA 1999; Hillier et al. 1998; Holland et al. 1998; Kirkman et al. 1998; Kitzinger 1995; Lees 1993; Stewart 1999b; White 1999; Wight 1992). Such threats to sexual reputations are not confined to condom use. Kuiper et al. (1997) found similar perceptions related to use of the contraceptive implant (a situation made possible by the potential visibility of the implant in the user's arm).

The threat of a negative sexual reputation was apparent among the young women's narratives in my study. They were sometimes hesitant to reveal how many sexual partners they had had, and when describing their casual relationships expressed concern that they sounded "slutty". However, they did have casual sexual partners, so their concern was over the perception that others (i.e. myself) would have of their behaviour. Contrary to previous findings, most were willing to initiate use of condoms if their partners did not introduce them, and they did this without fear for their reputations. None linked carrying condoms to a negative reputation.

While Holland et al. (1998) argue that introducing condoms is unfeminine, I would suggest that this is no longer the case. Through the adoption of alternative sexual strategies, young women have a more active role in their sexual relationships (Allen 2003a; Allen 2004; Gavey and McPhillips 1999; Jackson and Cram 2003; Milnes 2004; Stewart 1999a). As such, their contraceptive use is within their own control. In fact, contraception has been highlighted as one of the areas over which young women have most control in their relationships, in that it becomes a means for them to act out their agency (Allen 2003a). The very embodied nature of most contraceptive methods allows this to be the case (Lowe 2005a). For the young women I interviewed, condom use appeared to be much more their decision than their partner's, or at the very least, it was a joint decision. They did not appear to be governed by norms which said they must strive for romance or be passive in their sexual relationships. They were aware of, and sought, alternatives to romantic relationships. These alternatives required different contraceptive strategies, including the need to initiate condom use to ensure their own sexual safety. The social, cultural and economic changes of the last few decades have facilitated this, and have been further accompanied by a shift in the social norms of condom use.

### 10.3.1.2 The Normalisation of Condom Use

Expectations that condoms must be used were common among the young women I interviewed. This was particularly the case with casual partners, and there was a real sense that non-use of condoms was irresponsible. It should be noted that for many, condom use really had become the perceived social norm amongst their age group. I do not mean to imply that condom use is always straightforward – the difficulties of negotiating condom use will be discussed further later in the chapter – but here it is important to note that the young women's expectations of condom use transcended these issues. Previous research has shown that belief in positive social norms of condom use, particularly within the peer group, can encourage use of the method (HEA 1999; Schaalma et al. 1993).

Such changing social norms around unprotected sex and condom use could stem from the fact that this generation have grown up in the era of HIV/AIDS. Despite this, most of the young women in my study did not think they were personally at risk of STIs; the risk of pregnancy remained a far greater concern. Invulnerability to STIs, and the salience of pregnancy over concerns about STIs, have been reported among young men and women elsewhere (Abel and Brunton 2005; de Visser 2005; Flood 2003; Hatherall et al. 2005; Hillier et al. 1998; Lear 1995; White 1999). In a qualitative study, de Visser (2005) found that this was because the young people he interviewed thought STIs had minor, treatable, consequences, while pregnancy had major, disruptive, ones, as also appeared to be the case among the young women I interviewed. At the very least, it is often only a general risk of STIs that young people report, rather than a perception of personal susceptibility (Abel and Brunton 2005; Hatherall et al. 2005). STI testing is generally low among young people (Lear 1995), but it is worth noting that the number of young women I interviewed who had had an STI test (nine out of twenty) was considerably more than I had expected. This has also been reported in other recent studies (Hatherall et al. 2005; Hoggart 2006), and suggests that there has also been a shift towards the normalisation of this behaviour.

Previous research has found that the association of condoms with STIs rather than pregnancy is a reason for not introducing them, since it suggests the partner poses an STI risk, contradicting the trust implicit in a sexual relationship and in the romantic discourse of sexuality (Coleman and Ingham 1999b; Holland et al. 1998; Kirkman et al. 1998). In my study, however, the young women were willing to introduce condoms with casual partners for this very reason. Trust was not an issue in these situations. This directly

contradicts earlier findings and strongly supports changing social norms of condom use (and the changing discourse of acceptable female sexuality). In my study, while the risk of STIs was general rather than personal, it was real, and all the young women were aware of STIs. Lear has previously reported that condoms had become “a fact of modern sexual life” for the Californian students she interviewed (Lear, 1995, page 1318). I would argue that this has also become the case for young Scottish women.

### **10.3.2 Relationships**

Previous studies have reported that young women are unwilling to have (or report) casual sexual relationships (Holland et al. 1998; Maxwell 2006; Moore and Rosenthal 1992), but this does not mean to say they do not actually have them. Research in the 1980/90s argued that casual sex was seen as a threat to young women’s reputations, and only sex within a ‘steady’ relationship with a boyfriend was regarded (by both men and women) as legitimate (Holland et al. 1998; Lees 1993). However, more recent research has shown that young people’s relationships are complex and varied (Allen 2004), and greater participation in casual sex has been argued to represent a rejection of the traditional discourses of female sexuality (Stewart 1999a). Most of the young women I interviewed reported casual partners as well as boyfriends. While there could be repeat encounters with casual partners, and relationships with boyfriends could be relatively short, there were particular contraceptive expectations within each. These centred on using condoms with casual partners, but stopping their use and changing to other methods, mainly the pill, in relationships with boyfriends.

#### **10.3.2.1 Insistence on Condom Use with Casual Partners**

Generally, condom use is more commonly reported with new or casual partners, for protection from STIs, as well as pregnancy (Bauman and Berman 2005; Crosby et al. 2000; Ford 1991; Fortenberry et al. 2002; Hatherall et al. 2005; Lear 1995; Plichta et al. 1992; Poppen and Reisen 1999; Woodsong and Koo 1999). However, women’s difficulties in requesting use with casual partners have also been reported (Gavey et al. 2001). Almost all of the young women I interviewed used condoms with their casual partners without question, and it is important to note that in these cases condom use was insisted on. I would argue that this insistence on condom use has become more common and represents changing social norms, and the normalisation of condom use just discussed. This

circumvents the difficulties inherent in communicating about safer sex (Wight 1992). Discussing contraception means that young people have to indicate their intent to have sex, which some find difficult to do (Coleman and Ingham 1999b), particularly when they have not established if this is also their partner's intent (Mitchell and Wellings 2002). The insistence on condom use with casual partners, made possible through the normalisation of condom use, allows their introduction to be delayed until sexual intent has been established.

### **10.3.2.2 Contraceptive Use with Boyfriends – Love, Trust and Negotiation**

However, it is also apparent in the literature that condom use becomes less likely in non-casual relationships with boyfriends, as the perceived STI risk lessens (Crosby et al. 2000; Ford 1991; Schaalma et al. 1993). So, the very definition of condoms as a method of STI prevention becomes a negative feature in regular relationships or with known partners (Hammer et al. 1996; Lear 1995; White 1999). The importance placed on love, trust and romance in relationships with boyfriends affects young women's expectations and in turn influences contraceptive use. Change from reliance on condoms to the pill (or injection/implant) in (longer-term) relationships with boyfriends has been widely reported, and represents the seriousness or commitment of these relationships (Bauman and Berman 2005; Hammer et al. 1996; Hirsch and Zelnik 1985; Holland et al. 1998; Lear 1995; Reisen and Poppen 1995; Thomas 1991; Woodsong and Koo 1999). Condom use can be justified at the start of such relationships for pregnancy prevention. Once other methods, such as the pill, are initiated, continued condom use, which is then for STI prevention, becomes impossible (Holland et al. 1998; Kirkman et al. 1998). Discontinuation of condom use is seen as a demonstration of trust; trust that the partner does not pose an STI risk and will not be unfaithful (Bauman and Berman 2005; Hammer et al. 1996; Holland et al. 1998; Woodsong and Koo 1999). This perception of trust in relationships, and its basis for the discontinuation of condoms, has become dominant, and is also supported by studies among young men (Flood 2003).

Change from condoms to the pill within relationships was indeed common among the young women I interviewed, and the basis for this change was the trust the young women had in their partners. In this sense, their relationship experiences were not greatly different from those previously described in the literature. The inability to maintain STI prevention

in relationships with boyfriends once trust had been established remains important. Only one young woman and her partner had been tested for STIs before they stopped using condoms. However, only one young woman changed from condoms to the pill simply because she was in a relationship. For the rest, change was encouraged by further issues related to efficacy. Moreover, the decision to change method within the relationship was often mutual and the negative gendered power relations widely described in the literature were not so apparent.

### **10.3.2.3 Gendered Power Relations**

Unequal gendered power relations have been a feature of research in this area for some time. These are argued to allow male partners to dominate young women, negatively impacting on their contraceptive choices (Browne and Minichiello 1994; de Visser 2005; Holland et al. 1998; Kirkman et al. 1998; Kuiper et al. 1997; Pollock 1983; White 1999). Condom use particularly can become less likely when male decision making is prioritised in relationships (Buysse and VanOost 1997; Crosby et al. 2000; Plichta et al. 1992). Traditionally, gendered power relations have been argued to stem from men's authority over women in society, women's disadvantaged economic (i.e. earning power) and social (i.e. restricted mobility) position, and the prioritisation of male sexual pleasure (Wight 1992). As such, there is overlap here with the issues discussed in relation to the dominant discourses of sexuality (see Section 10.3.1.1), but while the previous section was concerned with the general implications of these issues, this section deals with the specific (i.e. what actually happens in relationships).

Much of the literature in this area is over ten years old, and I would argue that things have changed in that time. As I discussed earlier, changes have occurred in the economic and social context of many women's lives, so lessening their disadvantaged economic and social positions. While I would not argue that men and women are completely equal in today's society, the perception that men have authority over women has lessened. This means that the young women I interviewed could have had a different outlook on their position in society than those studied in the late 1980s and early 1990s. This translates into different expectations for their lives, different discourses of acceptable female sexuality, and, partly as a result of these, different experiences of relationships.

However, the prioritisation of male sexual pleasure does remain salient, given that penetrative vaginal intercourse remains the norm. Indeed, after first having sex, few of the

young women reported having subsequent relationships that did not involve sexual intercourse, and those who did reported that this was because they found they were not compatible and the relationships did not develop to that stage. Greater emphasis on female sexual pleasure is one element of a rejection of traditional discourses of female sexuality (Allen 2003a; Jackson and Cram 2003; Stewart 1999a), but accounts of sexual pleasure or desire are often absent from young women's descriptions of their sexual experiences (Holland et al. 1998; Lees 1993). It has been argued that this is not surprising, given that it is difficult to think about pleasure and desire when the sexual act involves multiple fears over pregnancy, STIs, reputation, and ruined futures (Jackson and Cram 2003; Tolman 1994). Or perhaps this is something that young women just do not talk about.

Holland et al. (1998) argue that the inability of young women to focus on, or even talk about, their own sexual pleasure, limits the possibilities of their empowerment in their sexual relationships with men. The young women I interviewed did not talk in detail of their sexual pleasure or desires, but reference to it could be inferred in two ways. Firstly, unlike those in the Holland et al. study, many of the young women I interviewed had, and talked of, casual sexual relationships. These encounters were about sex, rather than being about finding a boyfriend. The very fact that they had these casual partners demonstrates a greater emphasis on their own sexual desires, and indeed, some talked of having sex just for fun or because they wanted to. Secondly, the young women acknowledged the role of their own sexual pleasure in their contraceptive decisions. They talked of their dislike of condoms because of the effect these had on their enjoyment of sex (this will be discussed further later in the chapter). So while male sexual pleasure remains dominant, female sexual pleasure is not completely absent.

More egalitarian relationships, through which young women have more control, have also been reported in the literature (Allen 2003b; Chung 2005; Holland et al. 1998; Lamanna 1999; Sharpe 2001; Stewart 1999a; Thompson 1995; Tschann et al. 2002; White 1999), although these are often the exception rather than the norm. As such, they have been argued to do little to challenge gendered power relations (Chung 2005; Holland et al. 1998). Holland et al. argue that it is possible to challenge the dominant norms of heterosexuality, from which male power and unequal power relations are derived, but noted that few young women in their study did so. Resistance and empowerment are often temporary and context-specific. Therefore, it takes a particular type of young woman, in a particular situation, to challenge male power, and, as such, a young woman's

empowerment is “not ‘hers’ to take from one relationship to another.” (Holland et al., 1998, page 131). I would argue that this is not necessarily the case as there were some young women in my study who were empowered in all their relationships. Similarly, Allen (2003b) argues:

“...that while male power is pervasive in some form, it is simultaneously contested and negotiated in ways which afford women a measure of agency.” (Allen, 2003b, page 235).

In her study, male coercive power was apparent, but young women’s descriptions of decision making also demonstrated relationships based on equality (power was shared with male partners) and mediation (male power was assented to). She suggests:

“...that within heterosexual relations male power by its nature operates so as to always offer spaces for female agency the potential extent of which is constantly shifting. This potential is governed by multifarious factors such as a person’s social location (including their access to particular discursive resources) and the material and historical conditions in which they live.” (Allen, 2003b, page 243).

The changing social, cultural and economic context of young women’s lives is reflected in their expectations and experiences of relationships.

I do not mean to discount the well recognised, detrimental effects of negative sexual pressure and coercion on the lives of young women (Allen 2003b; Chung 2005; Gavey 1991; Gavey et al. 2001; Hird 2000; Holland et al. 1998; Maxwell 2006; Thompson 1995; White 1999), or that these are an exertion of male power, characteristic of the dominant discourse of heterosexuality and constructions of masculinity (Chung 2005; Hird and Jackson 2001; Holland et al. 1998; Tolman et al. 2003). Indeed, some of the young women I interviewed did report negative sexual and relationship experiences, including coercion, abuse and rape. It was apparent that these young women also experienced considerable difficulty with contraception. Such coercion is also often more common among the most vulnerable (Maxwell 2006), which was also the case among the young women I interviewed. Rather, it was the more general accounts of unequal power relations, in relation to contraceptive use, that were absent from the accounts of the young women in my study. Furthermore, descriptions of positive relationship experiences were more common than those of negative.

Unequal power relations in relationships affect contraceptive use in two ways (Holland et al. 1998). Firstly, the subordination of young women and the construction of their sexuality within the confines of femininity mean that they are unable to request or negotiate contraceptive use (to ensure they do not appear sexually knowledgeable and to protect their reputation). Secondly, the prioritisation of male sexual pleasure within sexual encounters or relationships leads to the non-use or discontinuation of condom use to enhance the male sexual experience. However, among many of the young women I interviewed, this was really not the case. Their contraceptive decisions were not subordinate to, or governed by, the desires of their male sexual partners. I would argue that young women are now more able to control their contraceptive use because of the changes in the social norms I have already discussed. Greater emphasis on alternatives to romance and the acceptance of casual sex removes the threat to reputation of appearing sexually knowledgeable. This allows young women to move beyond the confines of femininity and take greater control over their own sexual safety. This is combined with the normalisation of condom use, through which non-use has become unacceptable. The insistence on use with casual partners in particular has changed the power relations of these encounters, removing the need for, and the difficulties encountered in, condom negotiations.

On the other hand, discontinuation of condoms, and change to the pill, was common within relationships among the young women I interviewed. While it could be argued that this is more representative of male desire to change method than of female, only one young woman changed method in a relationship solely because of being in that relationship. For the rest, relationships defined the parameters of their contraceptive method change, but there were further factors, around issues of access and efficacy, which affected method change. These were entirely separate from their relationships.

The way in which the young women I interviewed talked about their contraceptive choices was much more focused on the influence of these factors than on that of their relationships. In Chapter Three, the quantitative results also suggest there was more contraceptive method change between relationships than within them. Furthermore, in the analyses of the factors associated with contraceptive use, individual characteristics (social background and contraceptive planning) were significant predictors of contraceptive use at both first and most recent sexual intercourse. Similar findings have been reported elsewhere among an older age-group of women (over 30 years), who, by the very embodied nature of it,

regarded contraception as their choice (Lowe 2005a). While the women in Lowe's study did not specifically negotiate use, it was apparent that they considered what their partners would want, and Lowe argues that, as such, men were an "absent-presence" in the women's accounts. This is a considerable difference from the relationships governed by unequal power relations and dominated by the desires and choices of male partners. Lowe argues that there is a contradiction between women's desire to control their own bodies and their desire for equality within their relationships. I would further argue that the changing expectations that young women have of their relationships, as a result of changing social norms, have allowed greater emphasis on issues outwith their relationships to emerge in the accounts of their contraceptive experiences.

### **10.3.3 Access**

In this study, the young women's access to contraception was an important determinant of their method use. Here I will discuss their access to information, that is, where they learned about contraception and who they could turn to for advice, and access to condoms and health services (for other contraceptive methods), together with the implications of the trust and control implicit in their contact with health professionals.

#### **10.3.3.1 Access to Information**

How and what young women learn about contraception is an important determinant of its use, but the young women I interviewed struggled to identify the specific sources of their contraceptive knowledge. They referred to school sex education as their main knowledge source, but were vague as to exactly what they had, and had not, been taught. The lack of detailed reference to school sex education in their narratives may simply reflect the difficulty in recalling such detail a few years after leaving school. Also, it should be noted that it was not a specific focus of the interview schedule. However, there could be discrepancies between what is taught and what young people actually want to, or need to, know (Abel and Fitzgerald 2006; Fine 1988; Forrest et al. 2004; HEA 1999; Holland et al. 1998; Thomson and Scott 1991; West 1999), with sex education that young women see as relevant to themselves, and which provides the detailed information about contraception that they want to know, being more positively evaluated (Buston and Wight 2002). School-based sex education is important, and programmes can improve sexual behaviour and health outcomes (Kirby et al. 2007), although their impact is often limited (DiCenso et

al. 2002; Stephenson et al. 2004; Wight et al. 2002). Many young people report some level of dissatisfaction with their school sex education (Abel and Fitzgerald 2006; Buston and Wight 2002; HEA 1999; Holland et al. 1998; Lear 1995; Thomson and Scott 1991; West 1999). Further, it is just one of many influences on their sexual health knowledge.

Another often cited information source is the media, but, again, the young women in this study found it difficult to detail how this specifically affected their contraceptive use. The limit of the media's influence has previously been reported, centring on difficulties arising from the complexity of the issues, and the relative lack of explicit focus on contraceptive use (Batchelor et al. 2004; Bostock and Leathar 1982). The exception to this is teen magazines, which do appear to be an important source of information (Batchelor et al. 2004; Buston and Wight 2002; HEA 1999; Thomson and Scott 1991). Again, among the young women I interviewed, the media appeared to have limited influence.

While studies have reported that parental involvement is positively associated with young women's contraceptive use (Miller et al. 2001; Whitaker et al. 1999; Wight et al. 2006), it is also important to recognise some limitations of this. Discussions between parents and their teenage children are often limited, and only effective if parents are open and comfortable with the topics under discussion (Lear 1995; Whitaker et al. 1999). However, many young people are embarrassed and resistant to the idea of talking to their parents about sex and contraception (HEA 1999; Thomson and Scott 1991). Few of the young women I interviewed reported talking with their mothers about contraception, and only one had talked with her father. As such, parents appeared to have limited direct influence over this area of their daughters' lives. Young people can be reluctant to acknowledge their sexual activity to their parents, and as this is often implicit in discussions about contraception, it continues to limit the extent to which they are willing to have such discussions with their parents (Sharpe 1987; West 1999). Holland et al. (1998) argue that this difficulty arises from the protective discourse inherent in the approach parents take to their daughters' sex education. This is particularly apparent if we note that the things the young women in my study were willing to talk to their mothers about were the aspects of contraception that could be separated from sexual activity (i.e. side effects and non-contraceptive benefits).

On the other hand, friends are an important, and often more salient, information source for young women (Buston and Wight 2002; HEA 1999; Holland et al. 1998). Peer norms are

of particular importance (Shoveller et al. 2004), and norms of contraceptive and condom use, are often reinforced by peer support (Harper et al. 2004; HEA 1999; Lear 1995; Lindsay et al. 1999). However, friends' perceptions and experiences of side effects can also have a more negative influence on young women's contraceptive decisions (Cheung and Free 2005; Gilliam et al. 2004; Kuiper et al. 1997). The stories and personal experiences they share become an important determinant of the young women's own contraceptive choices. The young women in my study often reported friends' negative experiences with contraceptive methods such as the injection as the reason they would not try these. In a qualitative study of adolescent females' views of the contraceptive implant, Kuiper et al. (1997) found that the social dynamics of peer networks had the same influence over contraceptive choice as they would have over more mundane lifestyle choices. Selecting a contraceptive was subject to the same influence as selecting the right thing to wear. This became particularly important when peer perceptions were negative, as Kuiper et al. found was often the case with the implant, and it was difficult for young women to select a method that was contrary to the expectations of their peers. It is important to note that many of the stories from peers are negative, the facts are blurred, myths are reinforced, and misinformation is common (Gilliam et al. 2004; HEA 1999; Kuiper et al. 1997; Sharpe 1987; Thomson and Scott 1991). This is further reinforced by the lack of positive stories from peers. Positive experiences, which contradict the dominant peer perception, are often withheld (Kuiper et al. 1997).

### **10.3.3.2 Access to Condoms**

Condoms were the method most of the young women in my study used when they first had sex, and for many, it was the partner who supplied them. The role of young men in supplying condoms at (even unplanned) first sexual intercourse has previously been highlighted in the literature (Mitchell and Wellings 1998). Furthermore, the ability to obtain condoms from alternative sources is important for those who are unwilling to access health services (Morrison et al. 1997; Stone and Ingham 2003).

While communication about sex and contraception is recognised to be difficult (Holland et al. 1998; Wight 1992), the verbal and non-verbal (i.e. simply producing a condom) strategies young people use to initiate condom use have been described in the literature (Bird et al. 2001; Coleman and Ingham 1999a). Bird et al. found that both men and

women used non-verbal strategies but Coleman and Ingham reported that non-verbal strategies were more often the practice of men.

However, while less explicitly reported, it was apparent that some of the young women interviewed by Coleman and Ingham had carried, and initiated use of (through verbal strategies), their own supply of condoms. Most of the young women I interviewed also carried their own supply of condoms. This is an important finding because it is contrary to much of the previous literature. A meta-analysis of the psychosocial correlates of condom use found that carrying condoms was one of the strongest predictors of use (Sheeran et al. 1999). However, the analysis was not gender specific, so whether this explicitly applied to women was not addressed. Numerous studies have found that carrying condoms is difficult for young women because of the possible adverse effects on their sexual reputation (Browne and Minichiello 1994; Finlay 1996; HEA 1999; Hillier et al. 1998; Holland et al. 1998; Kirkman et al. 1998; Lees 1993; Stewart 1999b; White 1999; Wight 1992).

The young women I interviewed carried condoms without fear for their reputations, and while some expressed concerns over negative sexual reputations, none suggested that carrying condoms was associated with this. I would argue that this was directly the result of the change in the social norms of female sexuality and the normalisation of condom use. As discussed earlier, the young women I interviewed were able to carry condoms, and to initiate their use. Also, the normalisation of condom use, in that use is simply expected, further enables young women to access and introduce the method. Interviews with young men have found that they also report their female partners have become an important source of condoms, even when young women themselves are unwilling to admit to carrying them (HEA 1999).

### **10.3.3.3 Access to Health Services**

In order to start using the pill, young women have to have access to health services and be willing to use them. Use of sexual health services (either GP or clinic based) has been linked to knowledge of services, accessibility (including opening times), physical proximity of clinics, attitudes of service providers, user willingness or comfort talking about sex, and anonymity (Aten et al. 1996; Jaccard 1996; Morrison et al. 1997; Parkes et al. 2004; West 1999). While negative perceptions of these can discourage use, other barriers to service use include fears over confidentiality and embarrassment (Burack 2000;

Churchhill et al. 2000; Donovan et al. 1997; HEA 1999; Jaccard 1996; Stone and Ingham 2003; West 1999). All but one of the young women I interviewed had accessed health services, and access to the pill was straightforward for most, but experiences varied, and negative reports of service use were not uncommon. Jewell et al. (2000) found that young women from disadvantaged backgrounds experienced more problems accessing services and as a consequence were often unable to maintain contraceptive use. Similarly, among the young women I interviewed, negative experiences of use were more common among those from socially disadvantaged backgrounds.

It is also important to consider access to contraception within the social context. It has long been recognised that the provision of contraception is never purely medical, and falls within certain social constructions and expectations of what is acceptable for young women, in terms of both sexual and contraceptive behaviour (Foster 1995; Hawkes 1995; Pollock 1989; Oakley 1993; Thomas 1985; Turner 1987). It has also been argued that the push to control fertility is as much about constraint as it is about control (Granzow 2007). In this sense, contraceptive use becomes a responsibility or an obligation rather than a choice, and the acceptance of the pill as the norm (by young women and their partners) reinforces this. Indeed, change to alternatives was further discouraged by the negative perceptions and experiences of their friends. So, when they experience problems with condom use, young women have to change to the pill. Once they had started the pill, few discontinue, but this becomes problematic when women do experience difficulties with side effects or unmanageable problems with use. Failure to use the pill puts young women in a contradictory position to the norm (Granzow 2007). This is particularly the case when unintended pregnancy is consistently presented as a failure (Department of Health 2001; Greene 2003; Hoggart 2006; Scottish Executive 2005).

While the provision of contraception is a tenet of the national sexual health strategies (Department of Health 2001; Scottish Executive 2005), social constructions of acceptable behaviour are still apparent, and this was particularly the case in relation to EC use. Most of the young women I interviewed thought that using EC was the responsible choice. It was their attempt to regain control when something had gone wrong with contraception. Despite this, there was still also some embarrassment about accessing EC, as also reported elsewhere (Ellertson et al. 2000). However, it is important to note that this did not stop the young women I interviewed from accessing EC. Free et al. (2002) report that the young women they interviewed often felt they were being scolded during their EC consultations.

These authors argue that such young women were aware of the contraceptive risk they had taken, and health professionals dwelling on this had a negative effect, making the young women less likely to return. This contrasts starkly with health professionals' perceptions of the EC encounter as an opportunity to reinforce contraceptive behaviour (Ziebland et al. 1998; Ziebland 1999). The perception of irresponsibility that some health professionals have of EC use and users, and their difficulty in prescribing the method as a result, has been widely reported (Barrett and Harper 2000; Bissell and Anderson 2003; Fairhurst et al. 2004; Gold et al. 1997; Simonds and Ellertson 2004; Ziebland et al. 1998; Ziebland 1999). This directly contradicts the young women's feelings of responsibility and may create problems. While the young women I interviewed had found it easy to access EC, it was apparent that negative experiences had the potential to discourage future use.

Advance or pharmacy provision of EC has become more common. Reducing embarrassment is recognised as one of the benefits of having access to an advance supply (Ziebland et al. 2005), and studies have shown that providing advance supplies of EC can increase use (Bissell and Anderson 2003; Glasier and Baird 1998; Glasier et al. 2004; Gold et al. 2004; Jackson et al. 2003; Raine et al. 2000; Raine et al. 2005). When EC was made available without prescription in the UK, overall use of the method did not increase, but fewer women were found to have accessed it through traditional GP or clinic locations (Marston et al. 2005). Few of the young women I interviewed had bought EC in a pharmacy, although they were aware it was available there. This is surprising given that some reported negative experiences of accessing it through health services. However, most had only used EC once so it was not possible to determine if negative experiences would affect future use. It is also possible that the £20-£25 cost of purchasing EC over the counter, which one young woman did comment on, could make it prohibitive. Other studies have also found this to be the case (Blanchard et al. 2003; Folkes et al. 2001). As such, health professionals continue to have considerable influence over young women's access to, and use of, EC.

#### **10.3.3.4 Health Professionals – Trust and Control**

The power that health professionals have over access to contraceptives is important, and trust and control are particular features of this. In my study, while the young women who went to their GP or clinic had done so to access the pill, some described being "put on" it, rather than choosing it themselves. It was as though they deferred control of the decision

to the health professional. The extent of control that health professionals had over the young women was particularly apparent during the change from the pill to alternative contraceptive methods, when the decision to change method was taken for them. However, the young women had considerable trust in the decisions of their GPs and clinic doctors. This is an important feature of the doctor/patient encounter, and has been widely discussed in the literature (Fisher and Todd 1986; Lowe 2005b; Lupton 1996; Lupton 1997; Möllering 2001).

Lupton (1996) argues that trust is based on communication, uncertainty and dependency, and strongly influenced by perceptions of 'good' and 'bad' doctors, with trust in doctors challenged by bad experiences (Lupton 1997). Almost all the young women I interviewed trusted their GP and clinic doctors, and positive descriptions of service use were common. The only exceptions were those who had had to change from the pill to an alternative method. In Lowe's study of women in their 30s, she argued that trust was gendered. Greater trust was placed on the embodied knowledge more apparent in the (predominantly female orientated) family planning clinic than the GP surgery (Lowe 2005b). Lowe also argued that the family planning clinics presented women with greater method choice, but this was not the case for the young women I interviewed. Indeed, most were only offered the pill when they first went to clinics or their GPs. Similarly, a recent survey of GPs in the UK found that the pill remained the main method they would prescribe for contraception, and while 81% thought that LARC methods had an important role in teenage pregnancy prevention, just under half said that these would not be their first choice to prescribe (Wellings et al. 2007). In Lowe's study, doctors were not considered to be experts in the field of contraception and the women she interviewed (who were older than those I interviewed) expected to make their own decisions over their method use. The conflict between what women want when they access contraceptives and what the (family planning) provider thinks is appropriate for them has also been recognised elsewhere (Candlin and Lucas 1986; Fisher and Todd 1986). Lowe argues:

“...contraception is constructed as distinct from 'medical matters' and thus when doctors deny women's requests they are considered to be exerting illegitimate power.” (Lowe, 2005b, page 374).

This is somewhat contrary to the experiences of the young women I interviewed. I would argue that this is because they were in a particularly subordinate position by being young, inexperienced, and female. They were not yet in a position to challenge the health

professionals' authority in the way Lowe's interviewees were. The trust of the young women I interviewed is a particular representation of the power doctors had over them as young women, and their weak position in the power relation of the doctor/patient interaction (Fisher and Todd 1986; Möllering 2001; Todd 1984). Health professionals' power was legitimate because the young women did not have enough experience to question it. It was only when these decisions caused further problems for the young women that this trust and acceptance of power was broken and rebelled against. While the decision to change from the pill to an alternative method was taken by the health professional, the decision to discontinue the alternative when side effects were experienced was taken by the young women. Their negative experiences of the alternative methods made them question the decision the health professional made.

#### **10.3.4 Efficacy**

Efficacy refers to efficacy of method and efficacy of user, both of which were important, even though they may conflict. The search for a suitable contraceptive method is partly determined by the perceived efficacy of each method in preventing pregnancy. This process has been described as trying to find the "least worst" option (Walsh 1997). Method efficacy is about selecting the safest method, while user efficacy is about being the best contraceptive user.

##### **10.3.4.1 Condom Failure**

Studies have reported that condom failure is a feature of young women's experiences of use (Crosby, DiClemente et al. 2005; Crosby, Yarber et al. 2005; Hatherall et al. 2005; Loxley 1996; Sanders et al. 2003), and is associated with method discontinuation (Bracher and Santow 1992; Hammerslough 1984; Hatherall et al. 2005). This was the case among the young women I interviewed. While, as I discussed earlier, the social norms of condom use encourage use, particularly with new or casual partners, the experience of failure reduces the young women's trust in the method. This results in increased uncertainty and pregnancy fear and leads them to look for alternatives, within the context of their more established relationships.

#### 10.3.4.2 Condom Dislike

Fear of condom failure was just one feature of the young women's personal dislike of condoms. Dislike also centred on the detrimental effect the method had on their enjoyment of sex. It is important to note that many of the young women in my study talked of this. Female dislike of condoms has not often been reported in the literature (Crosby, Yarber et al. 2005; Gavey et al. 2001; Hammer et al. 1996; HEA 1999; Lowe 2005a), with the focus generally in terms of male sexual pleasure (Browne and Minichiello 1994; Holland et al. 1998; Measor 2006). Holland et al. argued that the young women's negative descriptions of condom use in their study reflected the experiences of their male partners, and thus demonstrated their powerlessness in their relationships:

“Although these perceptions were not necessarily presented as male, they nevertheless serve to privilege male sexual pleasure.” (Holland et al., 1998, page 40).

In her paper “Condom use: a culture of resistance”, Measor (2006) interviewed young women, but she actually used their accounts to focus on their male sexual partners' dislike of condoms. Even though some of the quotes used in the paper demonstrate the detrimental effect of condom use on the young *women's* sexual enjoyment, the young *men's* experiences are prioritised. The evidence of young women's dislike is only briefly commented on towards the end of the paper (Measor 2006). This is unfortunate when the interviews were with young women, and adds to the continuing emphasis of male dislike in the literature.

The descriptions of condom dislike among those I interviewed were similar to those used by men, and centred on how condoms reduced sensations, ruined the moment, and were difficult to use (Flood 2003). However, it is important to note the young women were talking about their own sexual pleasure, and their own enjoyment or sensations during sex, not their partners'. In a recent study of condom discomfort and failure among US College students, Crosby, Yarber et al. (2005) found that, when asked the reasons for condom discomfort, the most common reason given by the women was vaginal irritation. Gavey et al. (2001), in a qualitative study with an older age group (22-43 years) of women, also highlighted the effect of condom dislike on female sexual pleasure. The rejection of the discourse of female sexuality which limited young women to a passive role in sexual encounters allows young women to move beyond this, and to consider their own sexual pleasure as well as their partners'.

In my study, the experience of condom failure and personal dislike of the method encouraged the young women to find alternatives. For most this involved change to the contraceptive pill, which was thought to be a more effective pregnancy prevention method than condoms. This was particularly important to the young women given that all of their contraceptive choices were underpinned by the need to prevent pregnancy.

#### **10.3.4.3 Changing to the Pill – Gaining Greater Control**

Changing to the pill from condoms is often argued to represent male power in relationships, but change to the pill or other hormonal methods can actually give young women more control. Kuiper et al. (1997) argued that implant users felt that use of this particular method gave them control over themselves. It acted as a defence from, and contradicted, the negative control their partners had over them. The contradiction between control of self and the control of partners is important. Among the young women I interviewed, the change from condoms to the pill gave them more control because they did not have to rely on partners to use condoms. However, there is a second element of control, which relates to the control over their own bodies that methods such as the pill provide.

I have already discussed how use of the pill in serious relationships signifies trust and commitment and, as such, it has been argued that pill use, in particular, is relationship-specific. That is, women will start the pill at the beginning of their relationships and stop use at the end (Skinner 1986; Thomas 1991). This was not the case for many of the young women I interviewed, as they continued to take the pill outwith their serious relationships for non-contraceptive reasons, particularly for menstrual regulation. It was this element of pill use in particular that gave them control over their own bodies. The presence of the regular, monthly period was often recognised as a reassurance, a way of checking they were not pregnant, regardless of the fact that the withdrawal bleed is not a proper period. However, the change to hormonal methods presented new problems for some of the young women, in relation to the flipside of this popular non-contraceptive benefit, menstrual irregularities, and the experience of other side effects.

#### **10.3.4.4 Hormonal Contraceptives and the Experience of Side Effects**

Side effects of hormonal contraceptives are often cited as a reason for method discontinuation (Balassone 1989; Berenson et al. 1997; Bracher and Santow 1992; Clark et

al. 2004; Davidson et al. 1997; Emans et al. 1987; Hatherall et al. 2005; Kalmuss et al. 1996; Lakha and Glasier 2006b; Paul et al. 1997; Polaneczky et al. 1996; Rai et al. 2004; Rosenberg and Waugh 1998; Sanders et al. 2001; Sivin et al. 1998; Smith and Reuter 2002; Stevens-Simon and Kelly 1998; Suman et al. 1998; Walsh 1997). It should be noted that discontinuation often occurs when side effects are multiple or found to be intolerable (Berenson and Wiemann 1993; Rosenberg et al. 1995; Sangi-Haghpeykar et al. 1996), and otherwise they can be outweighed by the (stronger) desire to avoid pregnancy (Cheung and Free 2005). While the experience of side effects was relatively uncommon among the young women I interviewed, it is important to note that stopping the pill was inevitable when side effects were identified as pill-related. Furthermore, all four who used alternative methods (injection or progestogen-only pill) also discontinued use of these methods because of side effects. There are two particular side effects I want to discuss in more detail: menstrual irregularities, and weight gain.

Menstrual irregularities are the most commonly cited side effect of hormonal contraceptives in the studies listed above. The role of the pill in regulating menstruation was a popular feature of the method for many of the young women I interviewed, as has also been reported elsewhere (Cheung and Free 2005; Johnston-Robledo et al. 2003; Weisman et al. 1991). In contrast, two stopped taking the progestogen-only pill because they did not have a monthly withdrawal bleed with this method. Cheung and Free (2005) found that some young women wanted to suppress menstruation altogether, but in other studies amenorrhea led to doubts about method efficacy and increased pregnancy fear (Clark et al. 2006; Hatherall et al. 2005). This was similar to my own findings. A number of recent (quantitative) studies have argued that there is no clinical need for the withdrawal bleed, reporting that women are more open to the use of methods that would suppress menstruation (Andrist, Arias et al. 2004; Andrist, Hoyt et al. 2004; Archer 2006; den Tonkelaar and Oddens 1999; Glasier et al. 2003; Thomas and Ellertson 2000). While methods such as the injection can suppress menstruation, they can also result in inter-menstrual bleeding, which when excessive and ongoing, is unacceptable to young women and can lead to method change (Cheung and Free 2005; Clark et al. 2006; Gilliam et al. 2004). Qualitative studies of young women continue to highlight menstrual irregularity, including suppression, as a concern (Cheung and Free 2005; Clark et al. 2006; Gilliam et al. 2004; Gold and Coupey 1998; Johnston-Robledo et al. 2003; Kuiper et al. 1997). The potential of this as a reason for method discontinuation has to be recognised.

Few of the young women talked about experiencing weight gain with the pill, and this factor was, anyway, usually outweighed by other perceived benefits of the method. Only one young woman said she stopped using the pill specifically because of her perceived weight gain, and she only stopped using it temporarily. On the other hand, weight gain was cited as the reason for stopping the injection by both of the young women who used it. Weight gain with the injection has been reported in some trials (Bonny et al. 2006; Clark et al. 2005; Risser et al. 1999), but refuted in others (Moore et al. 1995; Pelkman et al. 2001; Pelkman 2002). Similarly, the link between the pill and weight gain is unproven (Gupta 2000). However, in studies of women's attitudes and experiences of both methods, weight gain is regularly reported as a side effect (Berenson and Wiemann 1993; Brown et al. 2007; Bryden and Fletcher 2001; Davidson et al. 1997; Gilliam et al. 2004; Paul et al. 1997; Polaneczky et al. 1996; Rosenberg et al. 1998; Sangi-Haghpeykar et al. 1996). The young women I interviewed perceived their weight gain to result directly from their use of the pill or more significantly, the injection, regardless of scientific evidence to the contrary. Their perceptions may be more important than the reality in explaining their discontinuation of the injection.

Conflicting information on pill side effects leads to confusion for women, particularly when symptoms are discounted as unimportant or as unrelated to pill use (Fisher and Todd 1986; Pollock 1989). This does little to reassure women or help them to manage their contraceptive use. However, even accurate information from health professionals may be superseded by the stories of friends. It was apparent among some of the young women I interviewed that advice from friends was more salient than that of health professionals. Information received from health professionals is often discounted in favour of that from friends (Gilliam et al. 2004; Sharpe 1987). So again, the perceptions that young women have of the side effects of particular contraceptive methods, and the implications of these, could be more important than the reality.

#### **10.3.4.5 User Efficacy – Being the Best**

While method efficacy was important to the young women I interviewed, their own efficacy as users of these methods was also significant. This was particularly apparent once they had initiated pill use. While for some this was unproblematic, others struggled with the routine, and pregnancy risk increased significantly among those who struggled most.

Quantitative studies have focused on the role of contraceptive or sexual self-efficacy and self-esteem in contraceptive use (Adler and Rosengard 1996; Gebhardt et al. 2003; Johnson and Green 1993; Longmore et al. 2003; Salazar et al. 2005; Seal et al. 1997; Sheeran et al. 1999; Speier et al. 1997; Tschann and Adler 1997). Being comfortable and confident talking about contraception has also previously been shown to influence consistent use (Stone and Ingham 2002; Tschann and Adler 1997). Conversely, it is often those with lower self-esteem, less confidence, and who are unwilling to plan or talk about contraception who are less likely to use contraception, and as a result are at greater risk of pregnancy (HEA 1999). A lack of self-esteem can negatively impact on a young woman's ability to initiate condom use (Lees 1993). This was also the case among the young women I interviewed. Communication with partners is one of the strongest predictors of contraceptive use (Edgar et al. 1992; Harden and Ogden 1999; Henderson et al. 2002; Manlove et al. 2003; Sheeran et al. 1999; Stone and Ingham 2002), a finding supported by the quantitative analyses I presented in Chapter Three.

Communication about, and use of, contraception is often reported to be more likely in boyfriend relationships (Coleman and Ingham 1999b). In another, qualitative study of young peoples' condom use intentions and actual behaviour, Coleman (2001) compared intended use, as reported in a first interview, with actual use, reported at a second interview. Self-efficacy, confidence, the ability to plan, communicate and negotiate, and intentions of use, combined to determine consistency of condom use (Coleman 2001). Those lacking in self-efficacy did not use condoms all the time, as was also the case among the young women I interviewed. In my study, one of those who struggled most with her contraceptive use was particularly lacking in confidence. In fact, while she was acutely aware of the norm that she should use condoms, she struggled to do so because she did not want to ask her partners to use them. In this sense, her accounts of condom use were more similar to those of the women in the previous literature, whose condom use was constrained by the dominant discourses of romance and passive female sexuality (Gavey and McPhillips 1999). Furthermore, the young women who frequently had unprotected sex were those who reported negative or coercive relationship experiences and their partners were often, at the very least, complicit in the decision not to use contraceptives. This highlights the importance of confidence and self-efficacy in moving beyond these constraints. However, in Coleman's study, the one (male) participant who never used condoms did not lack this confidence, which suggests that this factor alone does not fully explain use. There could also be interesting gender differences here. Indeed, Coleman

argues that excessive risk taking may be more likely among men, but I found some young women were also repeat risk takers (i.e. they frequently had unprotected sex), so I would argue that this is not exclusively the domain of young men.

#### **10.3.4.6 Life Aspirations, Socio-economic Status and Social Disadvantage**

Among the young women I interviewed, the most consistent contraceptive users were those with the most career-orientated future aspirations; again consistent with findings elsewhere (Bracher and Santow 1992; Chacko et al. 1999; Emans et al. 1987; HEA 1999; Kuiper et al. 1997; Woodsong and Koo 1999). These were the young women who thought they had the most to lose, and therefore the most to fear, from pregnancy (Lamanna 1999). Indeed, environments that promote educational attainment have also been associated with the avoidance of negative sexual and reproductive health outcomes (Maxwell 2006). On the other hand, young women without such career-orientated aspirations, and those with low educational expectations, are less likely to use contraception, and also tend to be from more socially disadvantaged backgrounds (Arai 2003; Bonell et al. 2003; Bonell et al. 2005; HEA 1999; Young et al. 2004). This was also the case among the young women I interviewed. Furthermore, in the quantitative analyses in Chapter Three, aspirations and expectations were significantly associated with contraceptive use at both first and most recent sexual intercourse, with pregnancy fear, and not aspiring to have a child in the near future, increasing use. Conversely, young women from socially disadvantaged backgrounds were less likely to have used contraception at both first and most recent sexual intercourse. Studies of contraceptive discontinuation have also reported that lower socio-economic status, poverty and lower education levels are associated with this (Bracher and Santow 1992; Emans et al. 1987; Grady et al. 1983; Grady et al. 1988; Grady et al. 2002; Hammerslough 1984; Ramstrom et al. 1992; Rosenberg et al. 1995; Trussell and Vaughan 1999).

#### **10.3.4.7 Struggling with the Contraceptive Pill Routine**

Studies have shown that up to half of pill users will forget to take a pill during the monthly cycle (Fox et al. 2003; Lachowsky and Levy-Toledamo 2002; Rosenberg et al. 1998; Wahab and Killick 1997), and this has been linked to discontinuation of the method (Balassone 1989; Berenson et al. 1997; Breheny and Stephens 2004), and to the experience of pregnancy (Breheny and Stephens 2004). Some of the young women I interviewed only

occasionally forgot to take the pill, but it was a frequent event for others. Since these interviews were conducted, missed pill guidelines have changed (Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit 2005). While missing one pill is no longer regarded a pregnancy risk, the new guidelines are not exactly straightforward (they are different for 20 and 30-35 microgram ethinylestradiol pills) and it remains to be seen what effect these could have on young women's management of their pill use. Regardless, strategies to manage use remain necessary for those who struggle with the pill use routine. A few initiated novel strategies, such as setting mobile phone reminders, to remember to take the pill, and there is potential for such technology-based reminders being useful for those who struggle most with this (Fox et al. 2003; Lachowsky and Levy-Toledano 2002). LARC methods, such as the implant and the injection, circumvent this problem and young women have reported that not having to remember to take these is a positive benefit (Berenson and Wiemann 1993; Kuiper et al. 1997). However, it is striking that no one in my sample reported sustained use of the injection or implant.

#### **10.3.4.8 User Failure – Pregnancy and Misperceptions of Risk**

While method efficacy was an important determinant of method use, it is important to note that method failure did not result in pregnancy for any of the young women I interviewed. This was because they used EC when this happened, and I will discuss this further in the next section. In contrast, Arai (2003) found that most of the teenage mothers she interviewed reported using contraception when they became pregnant, although she did comment that it was not clear if they had been using it properly. Some studies have reported that ambivalence to, or positive perceptions of, pregnancy are associated with less consistent contraceptive use (Adler and Rosengard 1996; Breheny and Stephens 2004; Bruckner et al. 2004; Crosby et al. 2002; Hoggart 2006; Jaccard et al. 2003; Stevens-Simon et al. 1996; Zabin et al. 1993). Even a pregnancy that is not actively planned can be viewed positively and very much wanted (Greene 2003).

It has been argued that the absence of future aspirations or career-orientated expectations, combined with low educational expectations, and the lack of alternative aspirations make having a child a more attractive option (Arai 2003; Bonell et al. 2003; Bonell et al. 2005; Coleman and Cater 2006; HEA 1999; Hoggart 2006; Jewell et al. 2000; Lamanna 1999; Stevens-Simon et al. 2005; Thompson 1995; White 1999; Young et al. 2004). Indeed,

within the context of visible local circumstances and community norms “...parenthood provides a certain path to the accumulation of experience and authority – a concrete and local vision of the future that was consistent with their values.” (Thomson, 2000, page 423). Martyn and Hutchinson (Martyn and Hutchinson 2001) argue that when being raised in poor communities where teenage motherhood is common, young women can feel pressurised to conform to these norms, but this outcome could actively be avoided through the awareness of alternatives, knowledge of positive role models, and the self-esteem and desire to do so. It was apparent that the young women who became pregnant had less career-orientated future aspirations than the rest of those I interviewed. Pregnancy can be a rational choice through the lack of desirable, or achievable, alternatives (Arai 2003; Coleman and Cater 2006; Thomson 2000), and ‘planned’ pregnancy among young women has been suggested to represent an opportunity to “change direction in life” (Coleman and Cater, 2006, page 601). However, while some young women may indeed ‘plan’ to become pregnant (Coleman and Cater 2006; Greene 2003), only one of the eight young women I interviewed who had experienced pregnancy said that she had wanted to become pregnant. So was there something else about these young women that put them at risk of pregnancy?

Although characteristics of the specific sexual event, particularly alcohol use, may be important (Coleman and Cater 2005; Hoggart 2006), this was not always the case here. Being drunk will not inevitably lead to having risky sex or to non-use of condoms (Coleman and Cater 2005; Gavey et al. 2001), and the relationship between alcohol and unprotected sex has been found to vary by the context of the relationship at the time (Cooper 2002; Leigh 2002). Although being drunk decreased the likelihood of contraceptive use in the quantitative analyses presented in Chapter Three, the role of event-specific factors such as this was limited in the qualitative findings by the fact that the young women who became pregnant were mainly those who frequently had unprotected sex over an extended period of time rather than those who ‘forgot’ to use contraception in the ‘heat of the moment’. Only one became pregnant after a one-off occasion of not using a condom when drunk. Furthermore, some of the young women I interviewed avoided non-use when they were under the influence of alcohol because their partners initiated condom use. Such insistence from partners can protect young women from unintended pregnancy (Martyn et al. 2002). However, it is often in more established relationships with boyfriends that young women are most at risk of pregnancy (Finlay 1996; Hoggart 2006; Lamanna 1999; Sharpe 1987; Thompson 1995); an argument in part supported by my own findings. For most of the young women who had become pregnant, the decision to not use

contraception had been their own, but it is important to note the role their partners played in this. For example, when she forgot her pill, one asked her boyfriend to withdraw before he ejaculated but he did not, demonstrating the limits of her negotiation and the greater power he had in this situation.

So was it simply then that these young women did not think they would get pregnant? Those who became pregnant did indeed have misperceptions of pregnancy risk. They did not think pregnancy would happen to them. This resulted in their failure to use contraception effectively and, eventually, in pregnancy. This is supported by findings elsewhere (Breheny and Stephens 2004; Finlay 1996; HEA 1999; Jones et al. 2002; Lamanna 1999; Larsson et al. 2002; Sharpe 1987). It is also important to note that these young women had all previously been contraceptive users. This was also the case among the adolescent mothers interviewed by Breheny and Stephens (2004), who had used contraception, but often did so inconsistently, again because they did not think they would get pregnant. In my study, the risk misperceptions of the young women who eventually became pregnant were reinforced when they successfully took risks, that is, when they had sex without contraception and did not become pregnant. This is further supported by the quantitative analyses in Chapter Three, which found that almost half of the young women who reported non-use at first intercourse also reported this at most recent, and a third reported it at all three of the reported episodes of sexual intercourse, suggesting that non-use could have been the normal behaviour for a minority of young women. Recognising the personal risk of getting pregnant, and the particular risk involved with individual contraceptive methods or non-use, is part of the contraceptive decision making process (Miller 1986). Conversely, the perceived benefits of unprotected sex (excitement, pleasure and connection to partner) have been associated with sexual risk behaviours (Parsons et al. 2000), although there was no evidence that this was the case among the young women I interviewed.

The experience of pregnancy was a critical event, which increased contraceptive vigilance and led to more effective use. Interestingly, this was also apparent in Coleman's study; although the critical event was a pregnancy scare rather than an actual pregnancy (Coleman 2001). Contraceptive use commonly increases after the experience of pregnancy, but does not always continue in the long term (Hewell and Andrews 1996; Kershaw, Niccolai, Ickovics et al. 2003; Lamanna 1999; Orcutt and Cooper 1997; Paukku et al. 2003). Indeed, previous pregnancy has been associated with contraceptive

discontinuation (Chacko et al. 1999; Stevens-Simon and Kelly 1998; Suman et al. 1998), and a recent systematic review of US studies found that teen pregnancy was associated with future sexual and contraceptive risk (Meade and Ickovics 2005).

In my study, contraceptive use did increase among those with experience of pregnancy. However, some continued to struggle with use, and as a result risked repeat pregnancy. Indeed, at the time of interview, one young woman had stopped using the progestogen-only pill and commented that she had not had a period for over three months. So for her, being pregnant again was a distinct possibility. Meade and Ickovics (2005) also found that the outcome of the pregnancy affected future risk, with previous birth associated with use of long term contraceptives such as the injection, but previous miscarriage or abortion associated with inconsistent contraceptive use and repeat pregnancy. This is consistent with the behaviour of one of the young women in my study who had experienced a miscarriage. She had not adopted more consistent contraceptive use, unlike the rest of the young women who had experienced a birth. Although traumatic, life probably does not change much following a miscarriage or abortion, in the way that it invariably does after having a child. However, Coleman and Cater (2006) found that previous miscarriage, and the disappointment associated with this, led to a subsequent 'planned' pregnancy for some. This is another plausible explanation for the lack of contraceptive use following miscarriage.

#### **10.3.4.9 Taking Control – Use of Emergency Contraception**

I have argued that use of EC was the young women's attempt to regain control when things went wrong, so it is interesting to note that those who reported frequent unprotected sex, and subsequent pregnancy, did not use EC. Using EC requires both knowledge of the method and recognition of pregnancy risk (Free et al. 2002; Free and Ogden 2005; Goulard et al. 2006; Sørensen et al. 2000; Ziebland et al. 2005). Those reporting frequent unprotected sex did not recognise the risks inherent in this, and as such, it is not surprising that they did not use EC. However, EC use is also more common among young women from advantaged backgrounds, with those from disadvantaged backgrounds replacing EC use with a 'wait and see' approach to the possibility of pregnancy (Jewell et al. 2000). This is in direct contrast to the 'just in case' approach of many of the young women who do use EC (Ziebland et al. 2005). This is also supported by my own findings, and it appeared, in both the quantitative and qualitative analyses, that some young women use EC

even when their risk of pregnancy was probably low (i.e. they were using the pill and condoms at the time). Free et al. (2002) found that those who used EC had stronger future education, career, travel or lifestyle aspirations, with which pregnancy would be incompatible. This is similar to the aspirations of the young women who are more likely to use contraception in general, so the characteristics that distinguish contraceptive users and non-users can also distinguish between EC users and non-users.

I found that EC use was more commonly the result of contraceptive failure than of unprotected sex, which also supports findings from elsewhere (Free et al. 2002; Ziebland et al. 2005). I would argue that this distinction is strongly related to the social norms of EC use, and, as discussed earlier, the perception of irresponsibility attached to the method. Some studies have found that EC use after contraceptive failure is perceived to be more socially acceptable than use after unprotected sex (Bissell and Anderson 2003; Ziebland et al. 2005), and trials of advance EC provision have found that many women will still not use EC when they have unprotected sex, even if they have an advance supply (Glasier et al. 2004; Jackson et al. 2003; Raine et al. 2005). Concerns over excessive use were also apparent among the young women in my study. There remains considerable fear that greater availability will lead to misuse; even though there is no evidence to support this (Ellertson et al. 2000). Indeed, all of the young women in my study who had used EC saw it as a back-up rather than a regular contraceptive method.

#### **10.3.4.10 The Distinction between Method and User Failure**

I have argued that there is an important distinction between user and method failure, with each having a different effect on the young women's contraceptive use. User failure (e.g. forgetting to take the pill) was something the young women could control, but method failure (e.g. condom failure) was something they could do little about. User problems with pill use can be dealt with and are also often outweighed by the non-contraceptive benefits of the method (Cheung and Free 2005). Hatherall et al. (2005) also argue that young women could adjust for pill failures when these happened in advance of having sex, but could not prepare for the unpredictability of condoms, which lessened their control over the method. Throughout the young women's accounts of their contraceptive use in my study, it was apparent that instances of method failure, such as condoms bursting, or the experience of side effects, such as weight gain or irregular periods, led to contraceptive changes. On the other hand, instances of user failure, such as forgetting to take the pill,

only led to method change when they became unmanageable. The distinction between user and method failure also extended to the influence of others, and as was discussed earlier, friends' experiences were often the most salient. Among the young women I interviewed, it was apparent that friends' negative experiences with alternatives were considered to be the result of side effects, which were outwith their control (method failure), but their negative experiences such as pregnancy while using the pill, were considered to be the result of not taking the pill correctly (user failure). Friends' experiences with alternative methods discouraged use, but their negative experiences with pill use did not have the same effect. Indeed, it is striking how little effect negative experiences of the pill, either friends' or own, had on the young women. I have already described how they changed to the pill because of its perceived greater efficacy (see Section 10.3.4.3), and it was apparent that their belief in the method, even when it went wrong, was almost unshakable. Their attribution of pill problems to the user rather than the method reinforced what was almost the 'cult' of the pill.

The process of selecting a contraceptive has been described as trying to find the 'least worst' option (Walsh 1997), and this description is apt for the young women I interviewed. The social norms around contraceptive use encouraged their use in general, and then their relationship, access and efficacy experiences led to changes between different methods. They progressed from method to method, assessing the efficacy of each. However, their choices were essentially limited to condoms or the pill. Non-use, while relatively common, was not a behaviour that could be maintained over time. Few had used alternative methods; a fact also noted elsewhere (Hatherall et al. 2005). This is important in understanding the development of their patterns of contraceptive use.

## **10.4 Young Women's Contraceptive Careers**

At the start of this thesis I set out the research questions of the study, which centred on describing young women's patterns of contraceptive use, whether they have contraceptive careers, and their reasons for use and non-use of different contraceptive methods. So far in this chapter I have addressed the last of these three questions, but now I will turn to the first two: what are their patterns of use and do they have particular contraceptive careers?

### **10.4.1      *Patterns of Contraceptive Use***

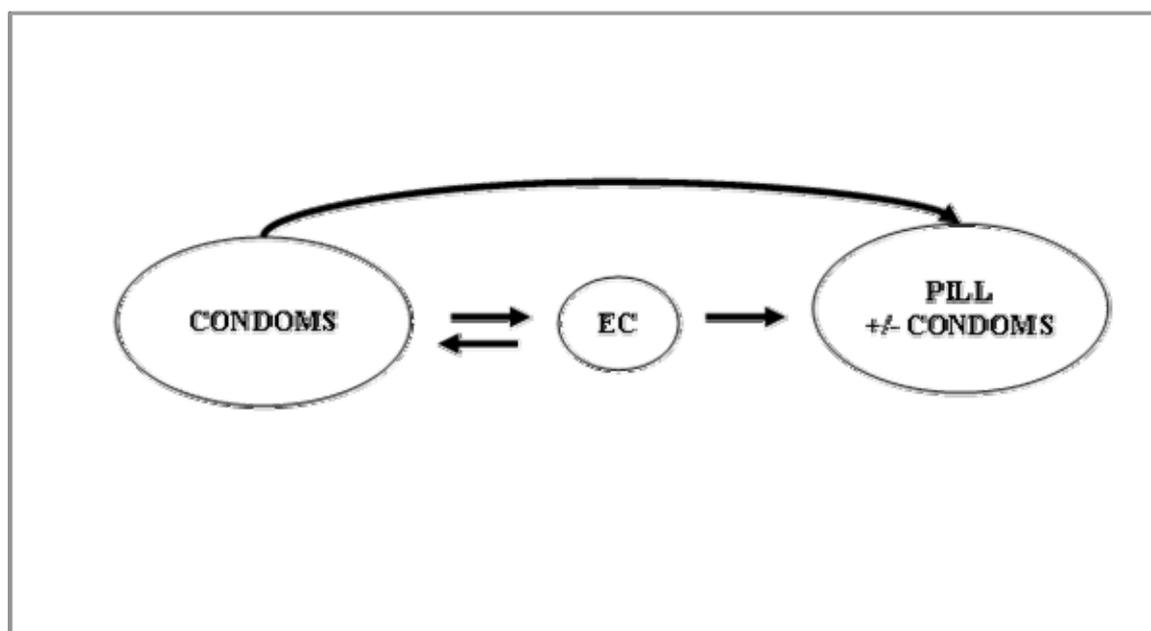
Each of the young women I interviewed had her own specific pattern of contraceptive use. The quantitative studies of contraceptive consistency and discontinuation suggested that around a third of young women switch or discontinue method use (Balassone 1989; Chacko et al. 1999; Emans et al. 1987; Fletcher et al. 2001; Gleib 1999; Grady et al. 1983; Manlove et al. 2003; Manlove et al. 2004; Manlove and Terry-Humen 2007; Ramstrom et al. 2002; Rosenberg and Waugh 1998; Trussell and Vaughan 1999), although all of these studies focused on a limited time period, such as one year or one relationship. Here change was more common. In the quantitative analyses in Chapter Three, only half of the young women in the SHARE sample reported use of the same method at both first and most recent sexual intercourse, while the remainder switched to a different method (or to non-use). Among the 447 young women who reported on contraceptive use at three episodes of sexual intercourse (first, first with most recent partner, and most recent sexual intercourse), there were 122 different patterns of contraceptive use. All of the young women I interviewed had changed contraceptive method at least once, and the number of changes they made ranged from one to fourteen, although most had only used two or three different methods. Individual patterns of contraceptive use have previously been reported in the major studies in this area (Lindemann 1974; Matteson and Hawkins 1993; Matteson 1995; Matteson and Hawkins 1997; Miller 1976). Matteson and Hawkins (1993) found that 14-19 year olds and 20-25 year olds had changed method up to six and nine times respectively. So to find varied patterns of use and numerous contraceptive changes was not entirely unexpected.

### **10.4.2      *Contraceptive Careers***

As most change was between condoms and the pill, and other changes were mainly peripheral to these, commonalities within the individual experiences of the young women were apparent and could be categorised into three contraceptive careers: consistent, complex and chaotic. Consistent contraceptive careers were characterised by uniform and regular use over time; complex by manageable change depending on relationships, partner type, and experiences of use; and chaotic by frequent method changes and multiple experiences of contraceptive failure. In this chapter I have discussed how social norms, relationships, access, and efficacy affected use and non-use of contraceptives, and here I

will demonstrate how the experience of these differed for each of the career types. The process for each career type is described in the following diagrams.

The young women with consistent careers had the most straightforward patterns of contraceptive use (Figure 10.1). Their method use was limited to condoms and the pill, with some EC use. They started out using condoms, and used EC when they experienced condom failure, after which they changed to the pill for greater protection. However, most also continued to use condoms. This pattern was maintained across relationships, with casual and regular partners. Essentially, contraceptive use was unproblematic, determined by strong belief in the positive social norms of condom use, and consideration of method efficacy. These were the most advantaged young women, mainly from non-manual backgrounds, at university, and with good career prospects. They felt they had much to lose from pregnancy.



*Figure 10.1: The Process of the Consistent Contraceptive Career*

Complex contraceptive careers were characterised by greater change and variability, but the main method changes were still between condoms, the pill and EC (Figure 10.2). Young women with complex careers also used alternative methods (the injection), and reported unprotected sex (non-use), but these were not part of the core career. Most started out with condoms, used EC for condom failure or problems with pill use, and changed to the pill for greater protection. The change to the pill was accompanied by an expectation of pill use, and condom discontinuation, in relationships. As a result, further change from the pill back to condoms was possible when relationships ended. Non-use was infrequent

and a critical event, always followed by condom or pill use. Change from the pill to an alternative method (the injection) was necessary when side effects or problems with use became intolerable, and was always suggested by a health professional. Change back to the pill followed because of the side effects of the alternative. Use was determined by the social norms of condom use (in relation to new or casual partners), expectations in relationships, consideration of method efficacy, and the role of user efficacy. These young women had, perhaps, the most traditional, relationship-specific, patterns of contraceptive use. However, changes were never just about their relationships, but were also accompanied by considerations of access, and method and user efficacy.

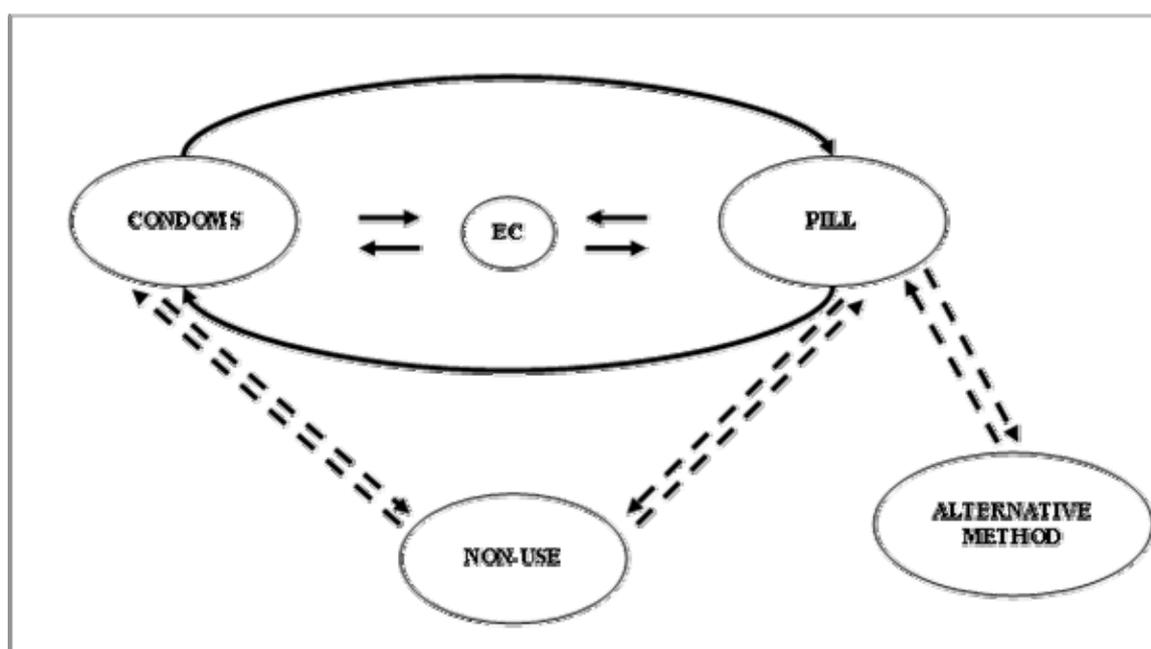


Figure 10.2: The Process of the Complex Contraceptive Career

Finally, for young women with chaotic contraceptive careers, the use of condoms and the pill remained central, but non-use also became part of the core pattern (Figure 10.3). Their use of condoms and the pill followed the same pattern as those with complex careers, as did their use of alternatives, but problems with alternative methods led to non-use rather than pill use, and their EC use was limited. Discontinuation of pill use was often followed by non-use rather than condom use, and non-use became part of their core pattern as a result of risk misperceptions. All but one in this group experienced pregnancy. Use was less often determined by the social norms of condom use (even in relation to new or casual partners), but rather by expectations of not using condoms in relationships, user (in)efficacy, and only some consideration of method efficacy. These young women had the most chaotic lifestyles, and it appeared that contraceptive use became just another thing

they had difficulty coping with in their relatively disordered lives. It is also important to note that these were also often the young women from more disadvantaged backgrounds, with less career-orientated future expectations.

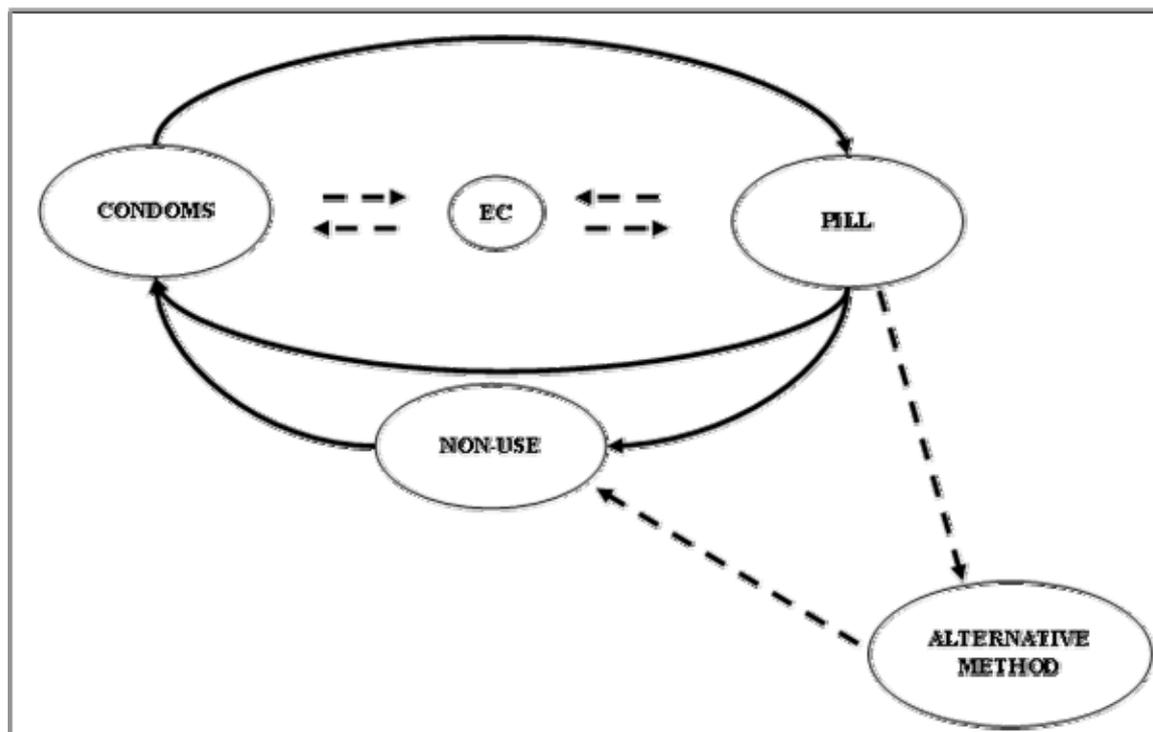


Figure 10.3: *The Process of the Chaotic Contraceptive Career*

The number of method changes increased with each career type; from one to two changes for consistent careers, four to eight for complex and nine to sixteen for chaotic. I have shown that the contraceptive careers varied because the young women adopted different strategies for managing their contraceptive use, had varying ability to manage use of particular methods, and different experience of method discontinuation and contraceptive risks. The few changes the young women with consistent careers made were towards more effective methods and, as such, they experienced few problems with method change. Those with complex careers made more changes and often used different methods with different partners, but these young women were managing their contraceptive risks by maintaining their pregnancy protection and adding STI protection when thought (not always accurately) necessary. Those with chaotic careers made frequent and erratic method changes, often to less effective methods. This left them at increased risk of pregnancy and STIs. They were the only ones who chose to have frequent unprotected sex.

The link between number of changes and method efficacy is also supported by the findings of the quantitative analyses in Chapter Three. Change was less likely among those using more effective methods (condoms, pill, dual method use), and those who reported initial use of the more effective contraceptive methods were more likely to be consistent in their use of these or to change to other effective methods as opposed to less effective ones. However, change from more to less effective methods was also apparent across the three episodes of sexual intercourse reported in the quantitative data. While just over half the young women in the SHARE sample had consistently used an effective contraceptive method at all three episodes of sexual intercourse reported in the data, the remainder had taken a contraceptive risk at some point.

### ***10.4.3 How are Contraceptive Careers Different from other Models of Contraceptive Use?***

I identified five qualitative studies, which had specifically examined patterns of contraceptive use (Free et al. 2005; Lindemann 1974; Luker 1975; Matteson 1995; Miller 1976). Here I will address the similarities and differences between these and my own findings, in relation to the patterns and the process of contraceptive use.

#### **10.4.3.1 Similarities and Differences in Patterns of Contraceptive Use**

Two of the studies described linear patterns of contraceptive use (Lindemann 1974; Miller 1976). In these, young women progressed from non-use (or withdrawal/rhythm), to use of coitus-dependent methods (such as condoms), to use of prescription methods (such as the pill). The patterns of contraceptive use among the young women I interviewed were not linear and did not follow these three stages. In fact, only one young woman followed the three stage pattern exactly, from non-use to condoms to the pill. In the quantitative analyses of contraceptive patterns in Chapter Three, there was also only one young woman who followed this pattern (although it is possible that more did follow this pattern, just that it was not evident over the three specific time points in the analysis). For Miller, use of the pill was relationship-specific, and this was also the case among some of the young women I interviewed. In this sense, the linear models, with some back-tracking, are most like the experiences of those in my study who had complex contraceptive careers.

However, among the young women I interviewed, method change was rarely just the result of a relationship ending. Furthermore, many continued to use the pill outwith their relationships because of the non-contraceptive benefits of the method. These factors are not addressed by Lindemann and Miller. Neither can the simple, linear models account for the more complicated patterns of those with chaotic careers. They reported frequent unprotected sex later in their career, after they had previously been using contraception, including methods such as the pill. A linear pattern fails to take account of the method problems and side effects that young women encounter. While these were an important feature for some in my study, they did not appear to be so in the studies of Lindemann and Miller. I would argue that it is these that lead to greater variation in contraceptive use patterns.

For most of the young women in my study, the non-use stage was skipped, and their contraceptive careers began with condom use. Only three started their contraceptive career with non-use, and only one continued to have unprotected sex after this first event. Lindemann and Miller report a constant move towards medical or prescription methods (i.e. the pill), and this was apparent among the young women I interviewed. For Lindemann, those who exactly followed the linear pattern, or started at the third stage (use of prescription methods such as the pill) remained there, consistently using this method. Similarly in my study, when pill use was unproblematic, there was little need to make further contraceptive changes (other than temporary change back to condoms). However, condoms remained of continuing importance, particularly for STI prevention (in addition to pregnancy prevention). This did not appear to be a factor for the young women in the studies by Lindemann and Miller, and this difference represents a significant temporal change in the social norms concerning unprotected sex and condom use.

These studies were conducted in the 1970s prior to the advent of HIV/AIDS. As I have argued in this chapter, the young women in my study have grown up within this context. Changing social norms and the normalisation of condom use have made use important for STI as well as pregnancy prevention. This was not evident in the studies of Lindemann and Miller. What is striking though is that even though they are 30 years apart, mine, as well as their studies found that young women's choices are essentially limited to a small number of contraceptive methods. This was the case in my study even though new methods have, in theory, become available to young women.

### **10.4.3.2 Similarities and Differences in the Process of Contraceptive Use**

The extent of method change among the young women I interviewed suggests that their patterns of use are more like the dynamic models of contraceptive use described in the other three qualitative studies I identified (Free et al. 2005; Luker 1975; Matteson 1995). In each of these models, women's patterns are more varied, as they go through a process of constantly assessing their contraceptive needs based on their circumstances and perceptions of personal pregnancy risk. The continual and cyclical nature of the process means that change is always possible, resulting in individual patterns of contraceptive use. There are similarities and differences between these studies and my own, which are worth considering. To do so, I will return to the four themes I introduced earlier: social norms, relationships, access and efficacy.

Earlier in the chapter I discussed in detail the changing economic and social context of young women's lives and the impact of this on the social norms of sexuality and contraceptive use for young women. This is combined with a change in the norms of condom use since the advent of HIV/AIDS, which has made condoms an important feature of young women's contraceptive decisions, for prophylactic (i.e. non-contraceptive) reasons. This is where differences between my findings and the earlier studies are most apparent (Luker 1975; Matteson 1995). For Luker, women had to consider the social norms of contraceptive use, and use was limited by the fact that they were not supposed to plan for, or appear to want, sex. I have argued that this is no longer the case for young women, or, at least not to the same extent. The young women I interviewed did not appear to be governed by norms of passivity in their sexual relationships, and they were willing to initiate contraceptive use to ensure their own sexual safety. This has been facilitated by the social, cultural and economic changes of the last few decades. The social costs of contraceptive use are very different for young women in Scotland in the 2000s than they were for young women in the US in the 1970s. Indeed, with greater emphasis on the avoidance of the negative consequences of sex rather than of sex itself, particularly in relation to teenage pregnancy and parenthood (Department of Health 2001; Hoggart 2006; Scottish Executive 2005), the norms of contraceptive use have been reinforced.

As a result of the norms of sexual passivity, the earlier studies also argued that women were in a position of relative powerlessness, in which it was difficult to get partners to continue to use contraception, particularly condoms (Luker 1975; Matteson 1995).

Matteson argued that women would make contraceptive choices to please their partners rather than themselves and Luker suggested that women found it difficult to get their partners to use condoms. Again I have argued that this is no longer necessarily the case. Greater emphasis on alternatives to romance and the acceptance of casual sex remove the threat to reputation of appearing sexually knowledgeable. This allows young women to move beyond traditional confines of femininity and take greater control over their own sexual safety. The normalisation of condom use has made it easier for some young women to insist on this. On the other hand, contraceptive change within relationships, from condoms to the pill, was still relatively common among the young women I interviewed. So there were still some similarities between the relationship experiences of the young women I interviewed and those in these earlier studies.

The findings of Free et al. (2005) in relation to social norms and relationships were more similar to my own. This is perhaps not surprising given the two studies are UK-based and conducted only a few years apart. For Free et al., avoiding a negative sexual reputation remained important, but using contraception was seen as responsible because of this, rather than something to avoid. Indeed, contraceptive use was linked to a positive perception of female sexuality and the young women sought to have positive sexual experiences. These were similar to my own findings and support my argument of changing social norms.

While highlighting recognition of the young women's own sexual pleasure, Free et al. argued that their male partners' sexual pleasure remained the priority and, if necessary, contraception would be changed to maintain this. However, I would argue that relationships only define the parameters of contraceptive method change. There are further factors, around issues of access and efficacy, and the way in which the young women I interviewed talked about their contraceptive choices was much more focused on these.

Access to contraceptives was also an important feature of all three dynamic models. In each, the embarrassment involved in accessing contraceptives, the costs of contraceptives, and negative experiences with health professionals were barriers to access (Free et al. 2005; Luker 1975; Matteson 1995). Embarrassment, especially in relation to acknowledging sexual activity, is a particular issue for young women (Luker 1975). For Matteson, the paternalistic model of health care forces women to accept contraceptive decisions, which may not be what they themselves want. This is similar to the role of health professional control I discussed earlier, and I would argue that this is a particular

issue for young women, who may not have the experience or confidence to challenge the unwanted contraceptive decisions health professionals make on their behalf. The need to access a health service to start the pill, and willingness to do so, remain important determinants of change to this method.

In relation to access, there was no discussion of whether the young women would carry their own condoms in these three studies. The women in Luker's study rarely, if ever, used condoms, and struggled to suggest use to their partners, never mind carry their own. Twenty years later, Matteson found women were more likely to use condoms, particularly in relation to STI prevention, but relied on their male partners to supply these. Even more recently, Free et al reported that unplanned sex could mean condoms were unavailable, but they do not discuss whether young women were willing to carry condoms. I found that many of the young women I interviewed were, indeed, willing to do so. I would argue that this is further evidence of the changing social norms of use and of acceptable female sexuality.

However, it is also apparent that new options exist for young women. Luker (1975) found that the likelihood of being able to get an abortion if pregnancy occurred was central to women's risk taking decisions. However, young women now have the option of using EC if a contraceptive risk has occurred. Free et al. and I both found that this to be an important feature of young women's contraceptive patterns, and a means of regaining control when something had gone wrong. It is possible that the availability of this 'back-up' method has changed patterns of risk taking behaviour. However, it should be noted that I found EC use was more often the result of contraceptive failure than unprotected sex. Interestingly, unprotected sex rarely led to EC use because the young women who frequently reported this misperceived their risk of pregnancy. The introduction of new contraceptive methods can further complicate patterns of contraceptive use. While the studies by Luker and Matteson were conducted before the injection and implant became widely available, some of the young women in the study by Free et al. did report use of the injection. The authors did not report on their specific experiences of these, but they did find that maintaining regular menstruation and avoiding menstrual irregularities were important to their interviewees. As I found, this could be particularly important in relation to use of such alternative methods.

The perception of pregnancy risk is central to all three dynamic models of contraceptive use (Free et al. 2005; Luker 1975; Matteson 1995), and my findings support this. It is apparent contraceptive risks are most likely when the perceived level of pregnancy risk is low or non-existent. I have argued that this is part of the young women's own efficacy as contraceptive users. Also related to this is the extent to which pregnancy is a desirable option. For Luker, a benefit of pregnancy was that it could infer a particular status and the role of motherhood could become attractive when alternatives were unavailable. Similarly, Matteson and Free et al. found that those who had alternatives, that is, strong career aspirations or the like, were most likely to want to avoid pregnancy. Again, this is similar to my own findings.

The actual experience of using contraceptives is an incredibly important part of the contraceptive use process. All three studies found the experience of side effects, contraceptive failure, and problems with method use were a central feature of the process. However, while male dislike of condoms was commented on in all three studies, female dislike was only referred to in the study by Free et al. This could be because condoms were less commonly used by the women in the studies by Luker and Matteson. As condom use has become more important for STI prevention, it could be that problems of use have become more salient to young women. Hence, there is now greater emphasis on young women's own dislike of the method.

In each of these studies the dynamic nature of the contraceptive process meant that individual women would have individual patterns of use. None of these studies describe what the resulting patterns of use would actually be, only the process. I was able to focus on actual patterns of use, and it is a particular strength of my study, because it has enabled me to differentiate between those who will find contraceptive use unproblematic and those who will struggle with use. The importance of this will be discussed further in the next chapter.

## **10.5 Summary**

In this chapter I have examined young women's reasons for contraceptive use and non-use, their patterns of use, and the process of the contraceptive career. I have discussed these in relation to the literature and highlighted the similarities and differences between my findings and those of others. The differences that exist are mainly the result of temporal

change, particularly in relation to the social norms of contraceptive use and female sexuality. The changing economic and social context of young women's lives, and the normalisation of condom use since the advent of HIV/AIDS, has changed the experience of contraceptive use for young women. However, familiar patterns of social disadvantage and inequalities remain. In the next chapter I will consider the conclusions that can be drawn from this research.

# 11 Chapter Eleven

## Conclusions and Recommendations

### 11.1 Introduction

This final chapter presents the conclusions that can be drawn from this research, within the context of the original research questions, and the policy implications of these. I will also discuss the strengths and weaknesses of the study, before finishing with recommendations for future research.

### 11.2 Aims of the Study

To recap, the aims of the study were to examine contraceptive use, to assess patterns of use, and to explore the concept of contraceptive careers among a sample of young women in the East of Scotland in the early 2000s.

The research questions were:

- What were the patterns of contraceptive use among these young women?
- Did these young women have contraceptive careers?
- What were the reasons for use and non-use of different contraceptive methods?
- What were the sexual and reproductive health implications of young women's contraceptive patterns?

To begin with I conducted quantitative analyses of data collected as part of the SHARE sex education trial evaluation. These analyses were conducted to set the context for the qualitative interviews I then conducted with 20 young women from the SHARE sample. The main conclusions that can be drawn from the findings of this study are presented below for each of the research questions.

## 11.3 Main Conclusions

### 11.3.1 *What were the patterns of contraceptive use among these young women?*

This thesis demonstrates the complexity of young women's contraceptive use. The quantitative analyses of the SHARE data suggested that young women's contraceptive use was complex, change could be considerable, and multiple patterns of use could be expected. This was supported by the qualitative findings. Indeed, each of the 20 young women I interviewed had her own specific pattern of contraceptive use.

Although a range of contraceptive methods are available to young women, most, even those who report multiple method changes, only use condoms or the pill, and occasionally EC.

- The classic pattern of non-use to condom use to pill use, suggested in the early literature, was rare, although contraceptive change within relationships, from condoms to the pill, was relatively common.
- Almost all of the young women had taken a contraceptive risk at some point, and a considerable proportion reported having unprotected sex.
- It is striking that all of the young women I interviewed who had tried alternatives had discontinued use of these, and none had consistently used LARC methods.
- Many of the young women reported using EC, more commonly as a result of a contraceptive failure than after unprotected sex; as such EC appeared to be considered a back-up, rather than a contraceptive method in itself.

### 11.3.2 *Did these young women have contraceptive careers?*

While there was not a specific pattern that all the young women followed, my findings demonstrate they do have contraceptive careers. Here, career is used in the sense of a process rather than a set path. There were three contraceptive career types: consistent, complex and chaotic. Consistent contraceptive careers were characterised by uniform and

regular use of effective methods over time, complex by manageable change depending on relationships, partner type, and their experiences of use, and chaotic by frequent method changes, often to less effective methods, and multiple experiences of contraceptive failure.

- The young women with consistent, complex and chaotic careers had different strategies for managing their contraceptive use, and had different experience of method discontinuation and contraceptive risks.
- There was a link between career type and both method and user efficacy, with those with consistent careers displaying the greatest efficacy.
- The young women with chaotic careers tended to be those from the most socially disadvantaged backgrounds, and had less career-orientated future aspirations or expectations.

### **11.3.3 *What were the reasons for use and non-use of different contraceptive methods?***

This thesis argues that young women's contraceptive patterns are determined by the social norms around use, and the access they have to different methods. Patterns develop as they move through different relationships and have different experiences of both method and user efficacy. My findings suggest the following:

- Pregnancy fear is the main motivation for contraceptive use, and while there are specific reasons for using specific methods, use is underpinned by the need to prevent pregnancy.
- Given changes in the social, cultural and economic context of their lives in recent years, young women appear to be less limited by a romantic discourse (which meant they were constrained in planning, preparing for, and/or seeking to enjoy sex).
- Condom use has become normalised, and many now think it irresponsible to not use condoms, particularly with new or casual partners.

- Love, trust and romance in relationships with boyfriends remain important, and these relationships often define the parameters of contraceptive change, but are just one of a number of influences.
- The negative gendered power relations of previous research are less evident, even if it is not possible for every young woman to attain equality in every relationship.
- Many rely on their partners to supply condoms when they first have sex, but most go on to carry their own supply of condoms, and do so without fear for their sexual reputations.
- Condom dislike is not exclusive to men; young women dislike condoms because they have a detrimental effect on their own enjoyment of sex.
- When young women look for an alternative to condoms, they change to the pill because it is perceived to be more effective, and gives them greater control over their contraception (and their own bodies).
- Use of the pill is often maintained for non-contraceptive reasons, particularly menstrual regulation, and for some, having a regular monthly period remains an important reassurance of not being pregnant.
- The belief in the superior efficacy of the pill is ingrained and maintained even when knowledge, or experience, of failure suggests otherwise.
- The reproductive choices available to young women are socially constructed, and the acceptance of the pill as the norm by young women, their health care providers, and society as a whole, reinforces this. As a result, few discontinue use of the pill once started, and in the absence of side effects or unmanageable problems with use, there is no need to change from the pill to an alternative.
- The young women who cope best with contraception are often those with greatest confidence, with career-orientated future aspirations, and from socially advantaged backgrounds.

### **11.3.4 What were the sexual and reproductive health implications of young women's contraceptive patterns?**

A number of different sexual and reproductive health implications were apparent within the data, and the young women were most at risk when they experienced problems with method use. However, it is striking that most had taken a contraceptive risk at some point. The young women who struggle with contraception, and are at greatest risk of unplanned pregnancy or other negative sexual and reproductive health outcomes, are often those with least confidence, less developed career-orientated future aspirations, and from socially disadvantaged backgrounds. My findings suggest:

- Condom failure is the most common method problem, and experience of this lessens trust in the method, and can lead to discontinuation.
- Problems with the routine of taking the pill are also common, but only lead to method change when they become unmanageable.
- The presence of the regular, monthly withdrawal bleed with the pill is used as a way of checking against pregnancy. Methods, particularly alternatives to the pill such as the injection, which disrupt the menstrual pattern which young women regard as 'normal', or result in perceived, excessive, weight gain, are unacceptable to some and can lead to discontinuation.
- For many, EC use is thought to be the responsible choice, and is an attempt to regain control when something has gone wrong.
- Most who experienced pregnancy simply did not think it would happen to them, but these were also often the young women who lacked confidence, had low or non-career orientated aspirations for their futures, and were from more disadvantaged backgrounds.

## **11.4 Policy Implications and Recommendations**

It is striking that young women from socially disadvantaged backgrounds continue to be those most at risk of negative sexual and reproductive health outcomes. These are the

young women who experience the greatest difficulties with contraceptive use, and as a result, are most at risk of unintended pregnancy. With chaotic and disordered lives, contraceptive use becomes just another thing they have difficulty coping with. They come from more deprived areas, have more complicated or problematic family backgrounds, and low, or at least non-career orientated, expectations of what their futures will hold. They also often have low self-esteem and lack confidence in their contraceptive use and sexual safety. Pregnancy could be seen as a positive outcome in these situations (Arai 2003; Coleman and Cater 2006; Greene 2003; Hoggart 2006; Thomson 2000). Recognising that such young women are likely to attempt to use contraception, but struggle greatly with it, offers the opportunity for specific intervention. Addressing this has the opportunity to improve the sexual and reproductive health outcomes of young women from the more disadvantaged and vulnerable groups.

This research study has highlighted the importance of contraceptive method choice to young women. One size does not fit all. While a range of methods should be offered, it is important to recognise that pill use can be unproblematic if managed well. Provision of the pill should be accompanied by guidance on coping with the routine of use, including advocating use of technology-based reminders (e.g. mobile phone alerts). The impact of the new, less straightforward missed pill guidelines also remains to be seen. However, the pill does not suit everyone, and it is important that real choice of method is available. The contraceptive consultation should include consideration of what might really suit each individual young woman, based on their lifestyle and their contraceptive experiences until that point.

Recently, greater use of LARC methods, such as the implant, has been advocated as a means of reducing unintended pregnancies (National Institute for Health and Clinical Excellence 2005). In some situations, these methods are being targeted at young women, but the use of methods that suppress menstruation could be inappropriate for those who rely on their monthly period as evidence of not being pregnant. There has been a move towards such methods in recent years, and in May 2007 the US Food and Drug Administration licensed the first contraceptive designed to be taken every day to eliminate periods indefinitely (Garavelli 2007). In the debate around this new pill much has been said about the need for women to have periods, the safety of menstrual suppression, and even whether it is morally right or wrong to do so (Garavelli 2007). However, nothing is said of the importance to some of menstruation as a means of checking that they are not

pregnant. Originally the contraceptive pill was designed with seven pill free days to encourage the perception that the method did not interfere with the normal menstrual cycle, to make it more socially acceptable to women, health care providers and the Catholic Church (Archer 2006; Connell 1999). There is no clinical need for the contraceptive pill's monthly withdrawal bleed, but young women may rely on it regardless. Conversely, menstrual irregularities (i.e. breakthrough bleeding) are frequently reported to be side effects of LARC methods, particularly among young women. The promotion and provision of any method requires adequate presentation and consideration of the side effects, which it could involve. Otherwise the risk of discontinuation, and hence unintended pregnancy, will be high.

On the whole, young women want to avoid pregnancy and therefore some consider using EC when something has gone wrong to be the responsible choice. It is their means of regaining control. However, often they are treated as irresponsible for needing it in the first place, and this could be a barrier to future EC use. Concerns that greater availability of EC will lead to excessive use are unfounded (Ellertson et al. 2000), and even trials of advance EC provision have found many women will still not use EC when they have unprotected sex (Glasier et al. 2004; Jackson et al. 2003; Raine et al. 2005). I would argue that this is partly because of the enduring image of irresponsibility attached to it. Efforts are needed to reiterate EC use, and its users, as responsible.

In recent years, rates of common STIs have increased among young women, and in 2005 16-24 year olds accounted for over half of new diagnoses of chlamydia, gonorrhoea, and genital warts in the female population (The UK Collaborative Group for HIV and STI Surveillance 2006). Therefore, the promotion of condom use for STI prevention remains as important as the promotion of effective contraceptive methods. In my study, there was evidence of a normalisation of condom use, but frequently this was limited to new or casual partners. The promotion of condoms for STI prevention alone fails to consider the wider influences (of pregnancy, partner and method) on young women's use of the method, and the role of their negative experiences has yet to be addressed. Encouraging condom use among young women has been a major component of HIV prevention efforts, and currently much focus is given to the development of condom negotiation skills, but this alone will not address these issues. Condom dislike was common, and it is important to recognise this is an issue for young women as well as men. Interventions to counter this and the limits of the normalisation of condom use should to be included in STI prevention

efforts. It is also important to address the issue of condom failure. Imperfect use has been associated with a lack of confidence in using condoms (Hatherall et al. 2007), and greater promotion of condom use skills should become a focus at distribution points.

Some STIs, such as chlamydia and Human Papilloma Virus (HPV), have more than immediate, unpleasant consequences, and present significant future health risks in the form of infertility, pelvic inflammatory disease, and cervical cancer. The Joint Committee of Vaccination and Immunisation recently recommended the introduction of the HPV vaccine for girls aged 12-13 years (subject to independent review of the cost benefit analysis), and the proposal of the Scottish Executive to introduce this in 2008 could have major impact on young women's risk of cervical cancer (Scottish Executive 2007). Although the focus is on cancer prevention, the introduction of the HPV vaccine may be contentious because the virus is sexually transmitted (Kahn 2007; Kaufmann and Schneider 2007; Lo 2006). Regardless, it will be important that its introduction is framed in such a way that does not negate from the continued need for condom use to prevent HPV and other STIs.

It was apparent in my study that many young women still rely on trust of their partner, rather than STI testing, when they decide to stop using condoms. Locally, more young couples are attending genitourinary medicine clinics for STI testing, but it has been noted that these tend to be from middle class backgrounds and generally at lower risk of actually having STIs (Dr Gordon Scott, Lothian GUM Consultant, personal communication). Young women from socially disadvantaged backgrounds could be more at risk, given my findings suggest they are more at risk of having unprotected sex. More work has to be done to promote STI testing among this group.

While general accounts of gendered power relations were largely absent and most were having positive relationship experiences, the incidence of sexual pressure and coercion, including rape, violent assault and abuse is of concern. Such findings have also been reported elsewhere (Allen 2003b; Chung 2005; Gavey 1991; Gavey et al. 2001; Hird 2000; Holland et al. 1998; Maxwell 2006; Thompson 1995; Tolman et al. 2003; White 1999). The detrimental effects of these negative experiences on the lives, and contraceptive careers, of these young women should not be ignored. For young women to experience this is unacceptable. This requires targeted prevention efforts with young men and women.

## 11.5 Strengths and Weaknesses of the Study

A particular strength of this study is that I was able to examine both the process and the patterns of young women's contraceptive use to gain a fuller understanding of their experiences. Often the research in this area has only addressed one or the other. This is the first UK study to describe young women's patterns of contraceptive use, and, as such, is an important starting point for future research.

In Chapter Four, I described the research methods used in this study and the issues around reliability, validity and generalizability associated with this approach. It is important to bear in mind that the findings are based on the young women's own narratives and representations of their experiences, and the data generated are a product of the interaction between the interviewee and me, the researcher. Any interview study such as this is reliant on the participants' own representations of self and this has to be accepted, to the extent to which it can be checked within the individual interview situation. With one-off interviews, it was not possible to check this further.

As a result of recruitment difficulties and the time constraints of this part-time PhD study, the findings are based on interviews with 20 young women, who may represent a specific risk group. Only seven interviewees first had sex between age 16 and 18, while the remainder had done so by age 16. It is possible that further studies of young women outwith this risk group may find less complicated contraceptive careers to be more common. Furthermore, although the sample contacted was selected randomly, all of the young women who took part in the study chose to do so, and it is possible that they are different from those who declined. However, in comparing the characteristics of the interviewees and those who declined or did not reply, it appeared that those who did not reply were quite similar to those who were interviewed. Those who declined had similar social class backgrounds, but did appear to be more sexually experienced, had gained more credit level standard grades, and were less likely to live in the main city. However, when compared with the rest of the SHARE sample (at age 18) and other national samples (at age 20-24), the interviewees were very similar to other young women in terms of contraceptive use.

Indeed, one of the strengths of my study is that the qualitative interviewees were selected from the SHARE sample, and the findings could be set in the context of those from the

quantitative analyses presented in Chapter Three. There were some limitations to the quantitative data to bear in mind. The predetermined list of contraceptive methods in the SHARE questionnaire could have led to under-reporting of newer methods such as the injection or implant and the inclusion of only three episodes of contraceptive use limited the patterns I could examine. Furthermore, the lack of data on user efficacy or reasons for use meant that these could not be assessed. However, there were similarities between the results of the quantitative and qualitative parts of the thesis that support the findings of both, and these were highlighted throughout the discussion in Chapter Ten. Furthermore, the qualitative analysis was able to build on the recognised limitations of the quantitative data by collecting data on complete sexual histories and examining the specific reasons for use of particular methods at particular times.

However, the interview sample was not large. Only four of the young women I interviewed had used alternative contraceptive methods, and it is possible that other young women would have different experiences of use of these methods. However, perhaps the small number of alternative method users is not surprising given my findings that few are offered such alternatives and change is ultimately unnecessary when there are no, or only manageable, problems with the pill. Even in the wider SHARE sample, injection use was low (around 1% and not reported by any of the young women in the sub-sample used to assess patterns of contraceptive use across the three episodes of sexual intercourse). However, as noted above, use could have been under-reported.

There were also certain things the young women did not talk about to a great extent, which is important in the interpretation of the findings. Sexual pleasure and desire were at best alluded to, and never discussed in detail. It is possible that this is something they found difficult to talk about. They were not directly questioned on this either, and it is something that should have been addressed further in the interviews. However, perhaps it was too difficult for me too, as a new qualitative researcher, still learning how to raise and prompt on the most sensitive topics. The young women also said little of where they learned about contraception but this was not for want of questioning. Even when asked directly about where they learned about different contraceptive methods and services, they struggled to identify these. Some of my findings suggest that the young women's personality types could have had bearing on their contraceptive use, particularly in relation to their confidence levels, but again this is something I did not have specific data on so could not explore further. By interviewing young women from the two cohorts of the SHARE

sample, I was able to consider themes which emerged from the first round of interviews, and address these in the second. In hindsight, it would have been useful to conduct more interviews to address these further themes that arose, but for which the data were limited.

Finally, the findings focus only on the experiences and stories of the young women I interviewed. While it was not possible as part of this study, it could have been useful to interview their partners and health care providers as well to get another viewpoint.

## **11.6 Recommendations for Future Research**

During the course of this study, a number of research gaps became apparent. This is the first UK study to describe young women's patterns of contraceptive use, and these qualitative findings should be further explored with other groups of women throughout the UK, using both qualitative and quantitative research. In particular, it would be useful to examine the emerging issues around LARC use, sexual pleasure and desire, sources of contraceptive knowledge, and personality, highlighted above. This would provide a more comprehensive understanding of the role of contraceptive discontinuation and method switching in women's lives in the UK, which could aid the development of appropriate sexual and reproductive health interventions.

Many of the issues that affected these young women's contraceptive careers were specific to the fact that they were 'young'. Indeed, there were differences between my findings and those of Lowe (2005a, 2005b), who conducted a similar study with women aged over 30 years. Further research should be undertaken to investigate the contraceptive careers of this older age group of women, particularly in terms of how they change as women get older and plan to have children. Specific issues around method discontinuation, such as the fertility implications of the injection (Kaunitz 1998), may not be important to young women who have no immediate plans to become pregnant. However, they could be much more relevant, and have different implications, for women in their 30s who plan to stop contraceptive use with the intention of becoming pregnant. Further triangulation, through interviews with health care providers would also be worthwhile.

My findings suggest there have been considerable changes in the contraceptive experiences of young women in recent years, and many of these centre on the changing use, and importance of condoms. It would be interesting to explore young men's experiences to see

if they support these findings. Issues of particular interest include do young men carry condoms or expect their female partners to, how do they perceive their own, and young women's, sexual reputations, and what role do gendered power relations have in young men's descriptions of their relationships. Are young people's relationships really more equal now than they were 15 years ago? Further research should consider interviewing couples to compare their accounts. Indeed, a recent study that interviewed young women and their partners, both as a couple and separately, found differences in the reports of their relationships between these interviews (Allen 2003b).

Many of the young women I interviewed strove to be effective contraceptive users. This was even the case among those who had taken significant risks and experienced pregnancy. However, some continued to struggle with contraceptive use and were at considerable risk of repeat pregnancy. There is extensive literature on repeat pregnancy in the US, but even there it is limited by a lack of comparability between studies (Meade and Ickovics 2005). In the UK, there is little literature in this area and it remains an issue worthy of further research. Similarly, the literature on contraceptive side effects is often contradictory, and many of these (quantitative) studies base their findings on quite basic univariate statistical analyses. A systematic review or meta-analysis on this topic is warranted, particularly when these findings are being used to inform policy (National Institute for Health and Clinical Excellence 2005). More definitive research on this issue is necessary.

In this thesis I have demonstrated that a young woman's contraceptive career is about employing an effective strategy to manage and cope with changing needs and circumstances. In the UK, young women have access to safe and effective methods of fertility control, but use of particular methods at particular times is governed by a complex mix of further factors based on social norms, relationships, and experiences of method and user efficacy. For some, use is straightforward, but for others it remains a constant struggle, and challenges to improving young women's sexual and reproductive health remain. Recognising and understanding the complexity of contraceptive use, and the ways in which young women seek to manage this, will aid in this endeavour.

## Appendices

- Appendix A: Factors associated with contraceptive use at first and most recent sexual intercourse (unadjusted odds ratios)
- Appendix B: Pattern of contraceptive use at first and most recent sexual intercourse by contraceptive method
- Appendix C: Contraceptive patterns flowcharts
- Appendix D: Pilot interview schedule
- Appendix E: Main interview schedule
- Appendix F: Interview request letter
- Appendix G: Study information sheet
- Appendix H: Study consent form
- Appendix I: Thematic framework index for qualitative analysis
- Appendix J: Descriptive maps of the young women's individual patterns of contraceptive use

## Appendix A: Factors associated with contraceptive use at first and most recent sexual intercourse (unadjusted odds ratios)

	Sexual intercourse			
	First (N=1098)		Most recent (N=993)	
	OR	95% CI	OR	95% CI
<b>Structural</b>				
Non-manual social class – mother	1.55	1.12-2.14	1.49	1.06-2.10
Non-manual social class – father	1.70	1.19-2.44	1.58	1.09-2.29
Mother's qualifications – further/higher education level	1.49	1.11-2.00	1.50	1.09-2.07
Father's qualifications – further/higher education level	1.61	1.19-2.18	1.86	1.33-2.61
Non-white ethnicity	0.43	0.19-0.96	1.60	0.46-5.51
Religiosity – age 14 (5 point scale: very religious – not at all religious)	0.85	0.73-0.99	0.94	0.80-1.10
Religiosity – age 16 (5 point scale: very religious – not at all religious)	0.72	0.61-0.86	0.87	0.73-1.04
Live with both parents	1.41	1.05-1.88	1.27	0.93-1.72
High parental monitoring – age 14	1.55	1.15-2.07	1.63	1.20-2.22
High parental monitoring – age 16	1.20	0.89-1.62	1.63	1.16-2.28
Mother's age – less than 40	0.68	0.50-0.91	0.87	0.64-1.19
Housing – privately owned	1.62	1.19-2.20	1.64	1.19-2.27
Standard grades – credit level	2.00	1.46-2.73	2.12	1.50-3.00
Proportion of friends left school – age 16 (5 point scale: none – all)	0.85	0.74-0.99	0.77	0.66-0.89
Proportion of friends who smoke – age 16				
None	1		1	
A few	0.82	0.39-1.75	0.88	0.39-1.98
Half	0.45	0.20-0.98	0.64	0.27-1.49
Most/All	0.36	0.17-0.74	0.45	0.21-0.98
Talked to friends about using contraception in the last year	1.23	0.85-1.79	2.02	1.35-3.01
Proportion of 16 year old girls who have had sex (7 point scale: all – none)	1.30	1.14-1.49	1.33	1.15-1.54
Proportion of 16 year old boys who have had sex (7 point scale: all – none)	1.26	1.13-1.42	1.28	1.13-1.46
Friends would use condoms when having sex with someone for the first time				
Disagree	1		1	
Unsure	1.44	0.88-2.34	1.14	0.66-1.96
Agree	4.94	3.20-7.65	2.61	1.63-4.20
Friends would want you to use condoms when having sex with someone for the first time – agree	2.13	1.48-3.08	2.50	1.69-3.70

	Sexual intercourse			
	First (N=1098)		Most recent (N=993)	
	OR	95% CI	OR	95% CI
<b>Social / Psychological / Individual</b>				
Self esteem – age 14 (mean score : 4 point scale – high to low)	0.76	0.58-0.999	0.55	0.42-0.73
Self esteem – age 16 (mean score : 4 point scale – high to low)	0.85	0.64-1.13	0.64	0.47-0.87
Future aspirations (unlikely to be doing the following in 2 years time; 5 point scale very likely to very unlikely) – age 14				
Be living with a boyfriend / husband	1.24	1.06-1.44	1.23	1.05-1.44
Have a child / children	1.24	1.09-1.41	1.33	1.17-1.52
Be at college / university	0.76	0.65-0.88	0.72	0.62-0.84
Future aspirations (unlikely to be doing the following in 2 years time; 5 point scale very likely to very unlikely) – age 16				
Be in a steady relationship	0.84	0.71-1.01	0.69	0.57-0.83
Have a child / children	1.33	1.16-1.53	1.60	1.38-1.85
Be at college / university	0.85	0.75-0.96	0.77	0.67-0.88
Be in a training scheme	1.09	0.94-1.27	1.18	1.00-1.39
Got drunk in the last 12 months – age 14				
Never / once or twice a year	1		1	
About once a month	0.62	0.44-0.89	0.90	0.62-1.31
Once a week or more	0.54	0.38-0.77	0.77	0.53-1.10
Got drunk in the last 12 months – age 16				
Never / once or twice a year	1		1	
About once a month	0.91	0.58-1.43	0.91	0.55-1.53
Once a week or more	0.55	0.36-0.84	0.46	0.29-0.74
Smoke cigarettes – age 14				
Use regularly	1		1	
Use occasionally	1.30	0.84-2.02	1.62	0.99-2.64
Tried	1.61	1.12-2.31	1.31	0.91-1.89
Never tried	1.57	0.998-2.46	1.58	0.97-2.56
Smoke cigarettes – age 16				
Use regularly	1		1	
Use occasionally	2.30	1.42-3.73	1.69	1.02-2.80
Tried	2.01	1.42-2.84	1.64	1.13-2.38
Never tried	1.28	0.74-2.22	1.82	0.90-3.71
Ever tried drugs – age 14	0.59	0.44-0.79	0.74	0.55-1.01
Ever tried drugs – age 16	0.60	0.42-0.88	0.71	0.47-1.06
Drunk or stoned at first intercourse	0.52	0.39-0.69	0.53	0.38-0.73

	Sexual intercourse			
	First (N=1098)		Most recent (N=993)	
	OR	95% CI	OR	95% CI
Drunk or stoned at last intercourse			0.39	0.28-0.55
3 or more sex partners	0.52	0.38-0.70	0.51	0.37-0.70
It's important to plan how you will protect yourself from unwanted pregnancy before you have sex (4 point scale: disagree – strongly agree)	1.54	1.22-1.93	2.36	1.83-3.05
It's important to plan how you will protect yourself from sexually transmitted diseases before you have sex (4 point scale: disagree – strongly agree)	1.51	1.21-1.87	2.14	1.68-2.73
Talked to mother about sex – age 14				
Comfortable	1		1	
In between	0.81	0.57-1.14	0.77	0.54-1.11
Uncomfortable	0.54	0.36-0.80	0.67	0.44-1.03
Never have / does not apply	0.53	0.31-0.91	0.64	0.36-1.13
Talked to boyfriend about sex – age 14				
Comfortable	1		1	
In between	0.90	0.62-1.31	0.75	0.51-1.12
Uncomfortable	0.84	0.50-1.43	0.50	0.29-0.85
Never have / does not apply	1.12	0.76-1.65	0.78	0.52-1.18
Talked to boyfriend about sex – age 16				
Comfortable	1		1	
In between	0.63	0.41-0.97	0.38	0.24-0.60
Uncomfortable	0.42	0.18-0.97	0.20	0.08-0.49
Never have / does not apply	0.73	0.47-1.14	0.59	0.36-0.97
Comfortable talking to best friend about sex – age 14	1.43	0.96-2.13	1.61	1.05-2.45
Talk openly about sex with a boyfriend – age 14 (5 point scale: very difficult – very easy)	1.06	0.90-1.24	1.39	1.18-1.64
Talk openly about sex with a boyfriend – age 16 (5 point scale: very difficult – very easy)	1.18	0.99-1.41	1.57	1.30-1.91
Using condoms would be embarrassing – age 14 (5 point scale: strongly agree – strongly disagree)	1.18	1.01-1.39	1.33	1.12-1.57
Using condoms would be embarrassing – age 16 (5 point scale: strongly agree – strongly disagree)	1.60	1.34-1.90	1.88	1.54-2.29
Regret at first intercourse	0.46	0.34-0.62	0.84	0.61-1.16
I would be really nervous if I got into a sexual relationship with someone – age 16 (5 point scale: strongly agree – strongly disagree)	1.15	1.00-1.32	1.05	0.90-1.23
Sexual fantasies are healthy – age 14 (5 point scale: strongly agree – strongly disagree)	0.76	0.62-0.94	0.76	0.61-0.94
I really like the idea of being touched sexually – age 14	0.82	0.68-0.99	0.93	0.76-1.12

	Sexual intercourse			
	First (N=1098)		Most recent (N=993)	
	OR	95% CI	OR	95% CI
(5 point scale: strongly agree – strongly disagree)				
<b>Relationships</b>				
Number of sex partners in last year (range 0-20)	0.88	0.81-0.96	0.80	0.73-0.88
Forced to do something sexual which did not want to do	0.50	0.33-0.78	0.48	0.30-0.75
Age first time kissed using tongues	1.11	1.01-1.22	1.15	1.04-1.27
Age first time experienced heavy petting	1.18	1.04-1.33	1.24	1.09-1.42
Age first time experienced oral sex	1.15	0.98-1.34	1.25	1.05-1.48
Had boyfriend at time of interview	1.51	1.12-2.02	1.53	1.12-2.10
Could discuss using contraception with boyfriend	1.32	0.63-2.76	3.30	1.71-6.34
Could discuss using condoms with boyfriend	1.79	0.89-3.60	3.08	1.58-5.98
Boyfriend knows exactly how feel about him	1.81	1.20-2.74	1.49	0.95-2.32
Age at first sexual intercourse	1.45	1.25-1.67	1.22	1.05-1.43
Age of partner at first intercourse	1.05	1.00-1.11	1.07	1.01-1.14
Pressure at first intercourse				
No pressure	1		1	
Pressured by partner	0.47	0.34-0.66	0.90	0.62-1.32
Put pressure on partner	0.56	0.21-1.47	1.01	0.33-3.09
Talked with partner about protecting ourselves before first intercourse				
No	1		1	
Yes, just before	8.90	5.22-15.2	2.95	1.87-4.65
Yes, well before	38.1	16.6-87.6	7.86	4.69-13.2
Planning first sex intercourse				
It was completely unexpected	1		1	
It just happened on the spur of the moment	1.06	0.72-1.56	0.81	0.52-1.29
I expected it to happen soon, but was not sure when	3.32	2.18-5.07	1.61	1.02-2.55
We planned it together beforehand	12.1	5.64-26.1	3.01	1.66-5.44
Person first had sex with was boyfriend	3.28	2.43-4.43	2.51	1.80-3.49
How long went out with him before sex				
Less than 1 month	1		1	
1 – 3 months	1.46	0.89-2.39	1.39	0.81-2.37
3 – 6 months	2.44	1.37-4.35	1.74	0.98-3.08
More than 6 months	1.78	1.01-3.13	1.67	0.92-3.04
Have had sex with more than one person			0.47	0.32-0.68
Person last had sex with was boyfriend (including if this was only indicated at first sex coz of routing)			2.59	1.83-3.69
How long went out with him before first had sex				
Less than 1 month			1	

	Sexual intercourse			
	First (N=1098)		Most recent (N=993)	
	OR	95% CI	OR	95% CI
1 – 3 months			2.11	1.30-3.43
3 – 6 months			2.29	1.32-3.98
More than 6 months			2.38	1.33-4.28
Used contraception at first intercourse			5.26	3.72-7.44
Had sex with most recent partner more than once			1.57	1.05-2.33
<b>Medical</b>				
Pregnancy	0.36	0.23-0.58	0.61	0.38-0.97
Wanted to become pregnant	0.23	0.04-1.23	0.05	0.01-0.42
One of the things I fear most is becoming pregnant – age 14 (5 point scale: strongly disagree – strongly agree)	1.18	1.04-1.34	1.16	1.01-1.33
One of the things I fear most is becoming pregnant – age 16 (5 point scale: strongly disagree – strongly agree)	1.36	1.20-1.53	1.38	1.21-1.58
Easy to use a condom properly – age 14 (5 point scale: very difficult – very easy)	0.94	0.78-1.13	1.29	1.07-1.57
Easy to use a condom properly – age 16 (5 point scale: very difficult – very easy)	1.66	1.37-2.01	1.60	1.30-1.96
It is likely that I will get a sexually transmitted disease in the next 10 years unless I use condoms – age 14 (5 point scale: strongly disagree – strongly agree)	1.23	1.05-1.44	1.10	0.93-1.31
It is likely that I will get a sexually transmitted disease in the next 10 years unless I use condoms – age 16 (5 point scale: strongly disagree – strongly agree)	1.16	1.02-1.33	1.11	0.96-1.28
It is important to think about STDs when you choose a contraceptive (5 point scale: strongly disagree – strongly agree)	1.27	1.04-1.55	1.51	1.22-1.87
The contraceptive pill is effective in preventing pregnancy – age 16 (5 point scale: strongly disagree – strongly agree)	1.30	1.09-1.54	1.34	1.11-1.62
The condom is a good way of preventing pregnancy (5 point scale: strongly disagree – strongly agree)	1.10	0.93-1.26	1.32	1.11-1.57
Condoms are very effective in preventing HIV/AIDS – age 16 (5 point scale: strongly disagree – strongly agree)	1.15	0.98-1.35	1.29	1.09-1.54
Know that emergency contraception has to be used within 72 hours – age 14	1.47	1.03-2.10	1.45	0.99-2.13
Know that emergency contraception has to be used within 72 hours – age 16	1.59	1.18-2.15	1.52	1.09-2.13
Know that a girl can get pregnant if she has sex standing up – age 14	1.21	0.89-1.63	1.43	1.04-1.96
Know that a girl can get pregnant if she has sex standing up	1.64	1.08-2.50	1.66	1.04-2.66

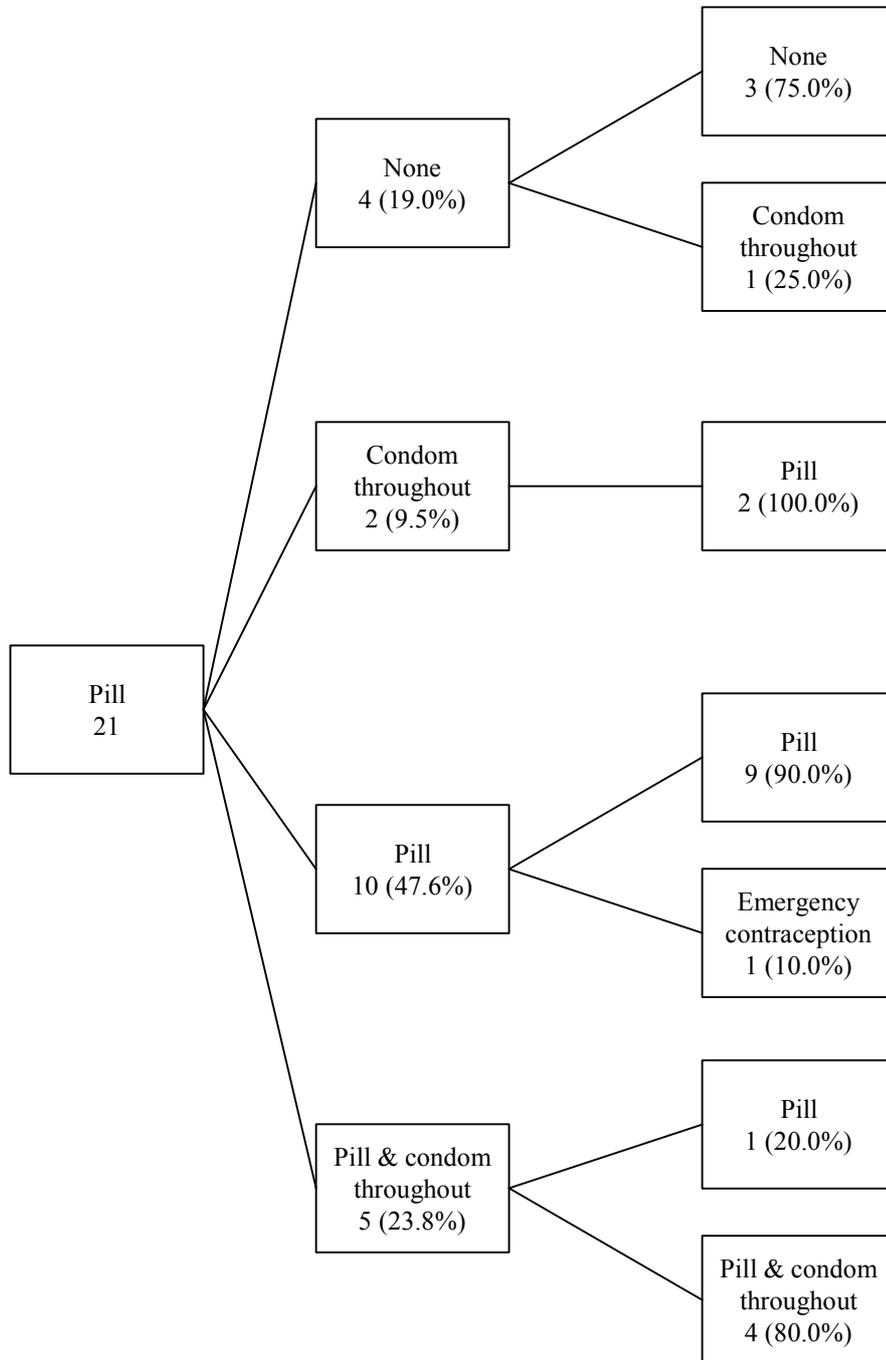
	Sexual intercourse			
	First (N=1098)		Most recent (N=993)	
	OR	95% CI	OR	95% CI
– age 16				
Know that a girl can get pregnant if the man / boy withdraws before ejaculation / coming – age 14	1.17	0.85-1.60	1.42	1.01-2.00
Know that a girl can get pregnant if the man / boy withdraws before ejaculation / coming – age 16	1.60	1.18-2.16	2.05	1.47-2.87
<b>Availability and access</b>				
In sex education, how to use condoms properly was covered				
– age 16				
Not well	1		1	
Okay	2.33	1.44-3.78	1.09	0.65-1.82
Well	1.44	0.99-2.10	0.95	0.61-1.48
Sex education made me feel more able to discuss sexual matters (5 point scale: strongly disagree – strongly agree)	1.20	1.02-1.41	1.04	0.87-1.25
Sex education made me more confident about getting condoms (5 point scale: strongly disagree – strongly agree)	1.28	1.12-1.47	1.14	0.98-1.33
Sex education made me more confident about using condoms properly (5 point scale: strongly disagree – strongly agree)	1.38	1.20-1.58	1.13	0.97-1.31
Bought condoms in the last year	2.00	1.45-2.76	1.95	1.38-2.76
Went to a health service in the last two years for condoms	1.50	1.10-2.04	1.10	0.79-1.52
Went to a health service in the last two years for advice about being pregnant	0.62	0.45-0.85	0.61	0.43-0.87
Know where can be prescribed contraception	1.87	1.15-3.04	2.80	1.64-4.79
Get a condom – age 16 (5 point scale: very difficult – very easy)	1.34	1.08-1.66	1.52	1.20-1.93
Make an appointment at a clinic or with a doctor to go on the pill – age 16 (5 point scale: very difficult – very easy)	1.03	0.89-1.20	0.83	0.71-0.97
City A – Edinburgh school	1.91	1.31-2.76	1.62	1.12-2.36

## Appendix B: Pattern of contraceptive use at first and most recent sexual intercourse by contraceptive method

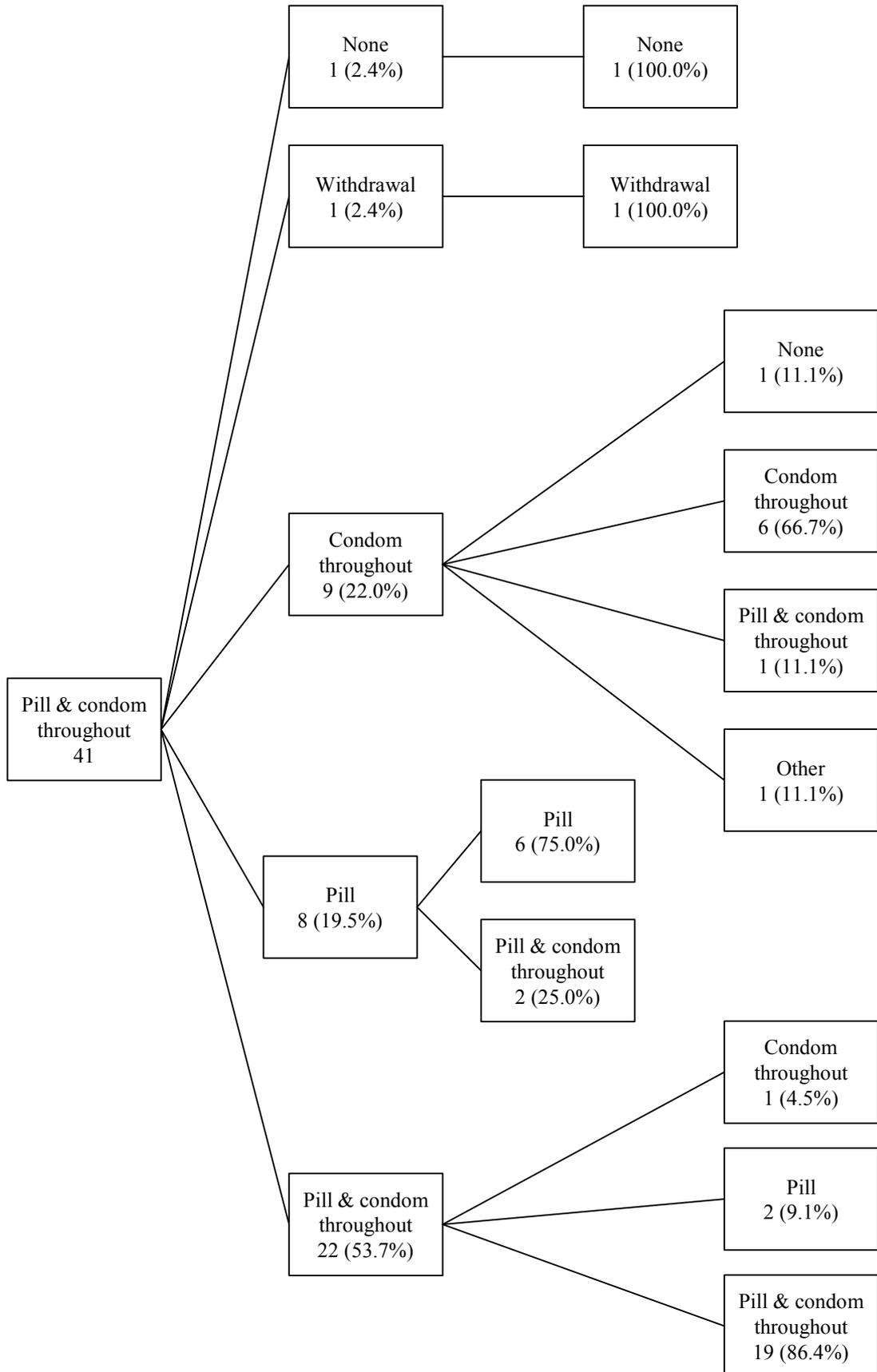
First intercourse	Most recent intercourse											Total
	None	Withdrawal	Condom before coming	Condom throughout	Pill	Pill & condom throughout	Emergency contraception	Condom / pill/ emergency contraception	Injection	Other	Don't know	
None	59 (47.2%)	6 (4.8%)	1 (0.8%)	26 (20.8%)	23 (18.4%)	6 (4.8%)	2 (1.6%)	1 (0.8%)	1 (0.8%)			125 (100.0%)
Withdrawal	13 (18.8%)	15 (21.7%)	1 (1.4%)	24 (34.8%)	8 (11.6%)	3 (4.3%)	2 (2.9%)	1 (1.4%)	1 (1.4%)	1 (1.4%)		69 (100.0%)
Condom before coming	1 (7.7%)	1 (7.7%)	5 (38.5%)	4 (30.8%)	1 (7.7%)						1 (7.7%)	13 (100.0%)
Condom throughout	49 (9.4%)	26 (5.0%)	7 (1.3%)	291 (56.1%)	83 (16.0%)	40 (7.7%)	10 (1.9%)	6 (1.2%)	5 (1.0%)	1 (0.2%)	1 (0.2%)	519 (100%)
Pill	4 (9.8%)	2 (4.9%)		2 (4.9%)	23 (56.1%)	9 (22.0%)	1 (2.4%)					41 (100.0%)
Pill & condom throughout	4 (4.8%)	2 (2.4%)		10 (12.0%)	16 (19.3%)	48 (57.8%)	1 (1.2%)		1 (1.2%)	1 (1.2%)		83 (100.0%)
Emergency contraception	6 (15.0%)	4 (10.0%)		14 (35.0%)	5 (12.5%)	4 (10.0%)	6 (15.0%)		1 (2.5%)			40 (100.0%)
Condom throughout/ pill/ emergency contraception	1 (4.8%)	2 (9.5%)		9 (42.9%)	5 (23.8%)	2 (9.5%)		2 (9.5%)				21 (100.0%)
Injection									2 (100%)			2 (100%)
Other	1 (33.3%)			1 (33.3%)	1 (33.3%)							3 (100.0%)
Don't know				2 (40.0%)	1 (20.0%)	1 (20.0%)	1 (20.0%)				1 (20.0%)	5 (100.0%)
Total	138 (15.0%)	58 (6.3%)	14 (1.5%)	383 (41.6%)	166 (18.0%)	113 (12.3%)	22 (2.4%)	10 (1.1%)	11 (1.2%)	3 (0.3%)	3 (0.3%)	921 (100.0%)

### Appendix C: Contraceptive patterns flowcharts

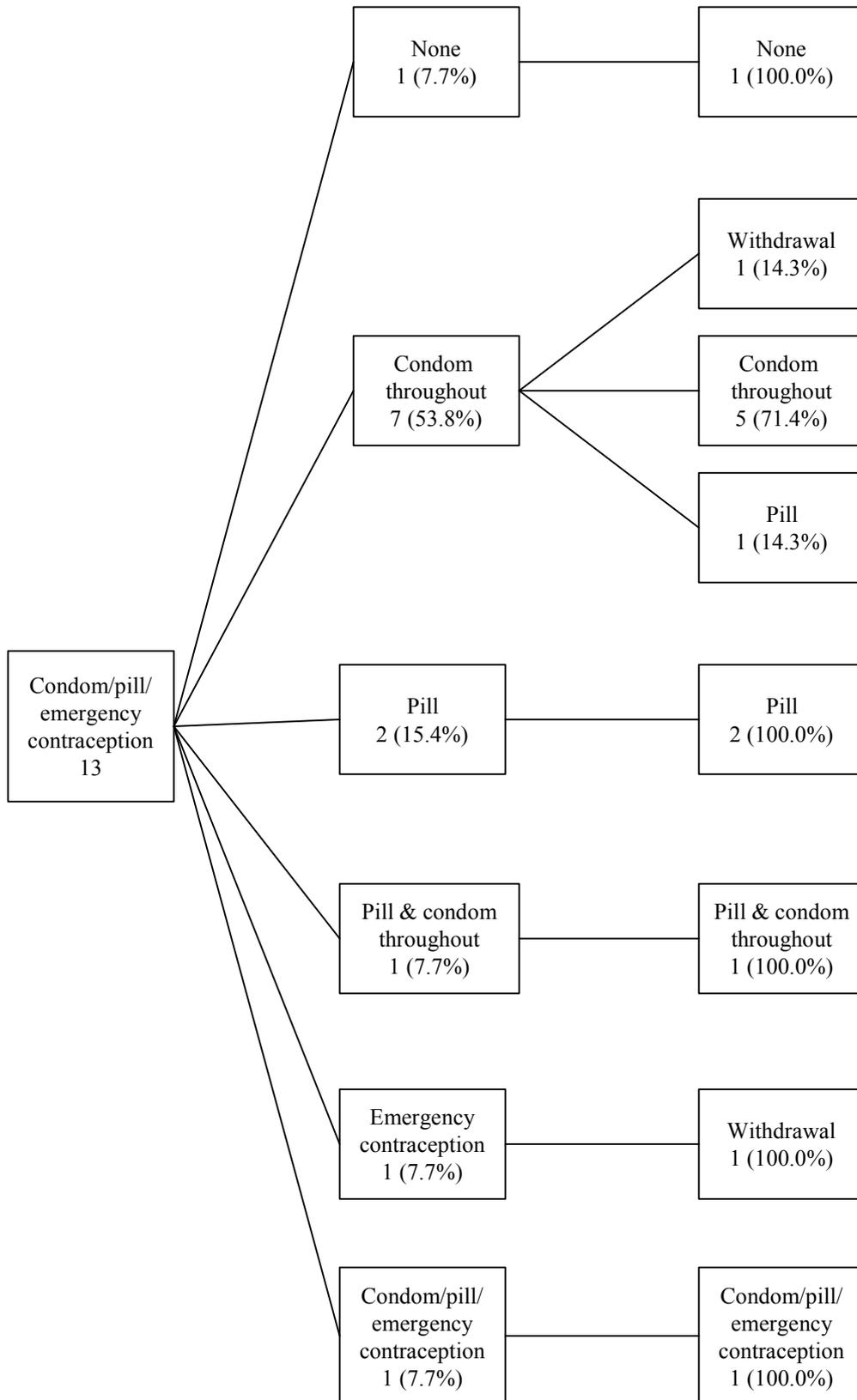
Flowcharts of contraceptive patterns between first intercourse, first intercourse with most recent sexual partner, and most recent sexual intercourse (by initial contraceptive method)



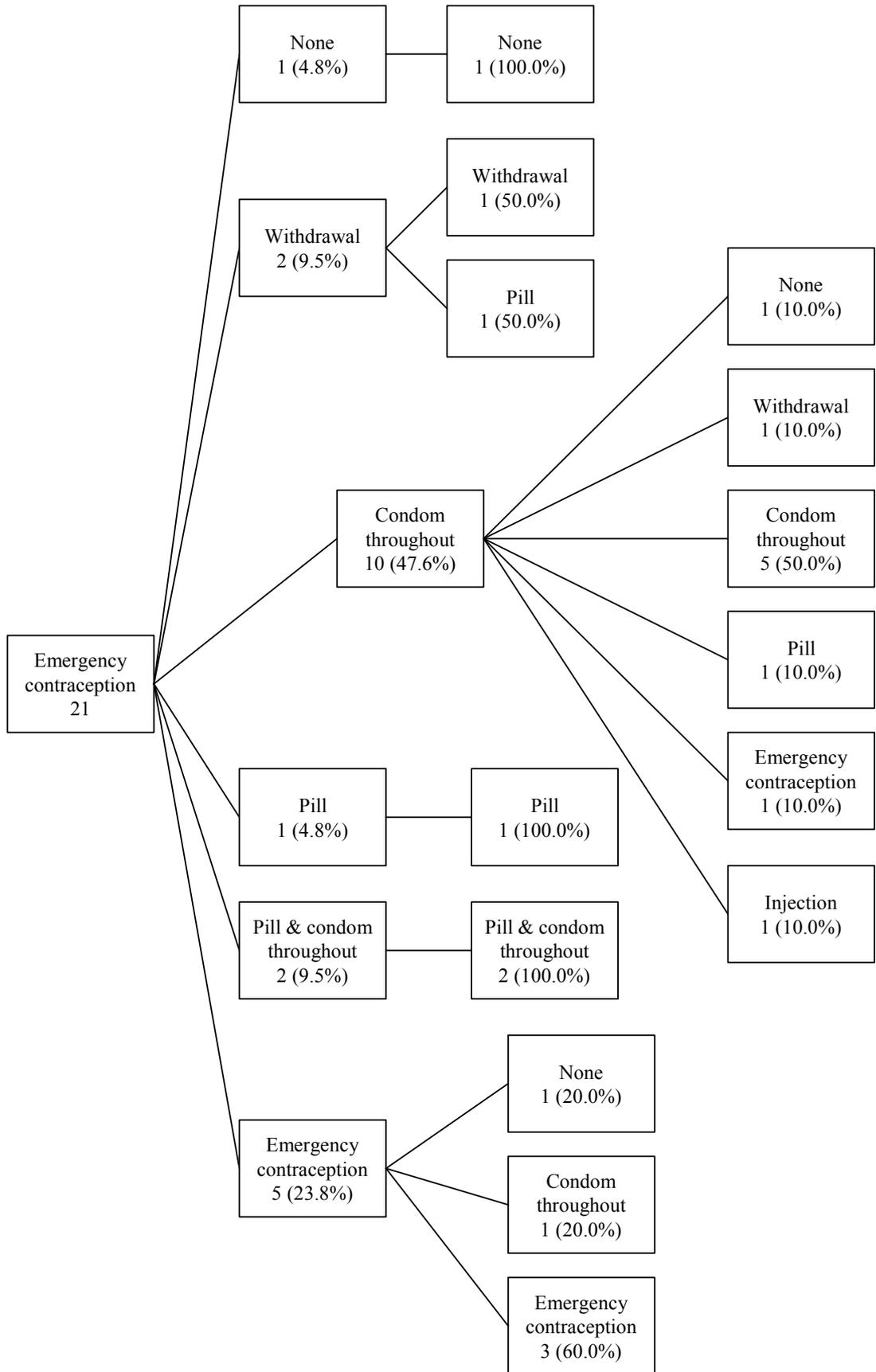
Flowchart of contraceptive pattern between first, first with most recent partner, and most recent sexual intercourse (pill use at first intercourse)



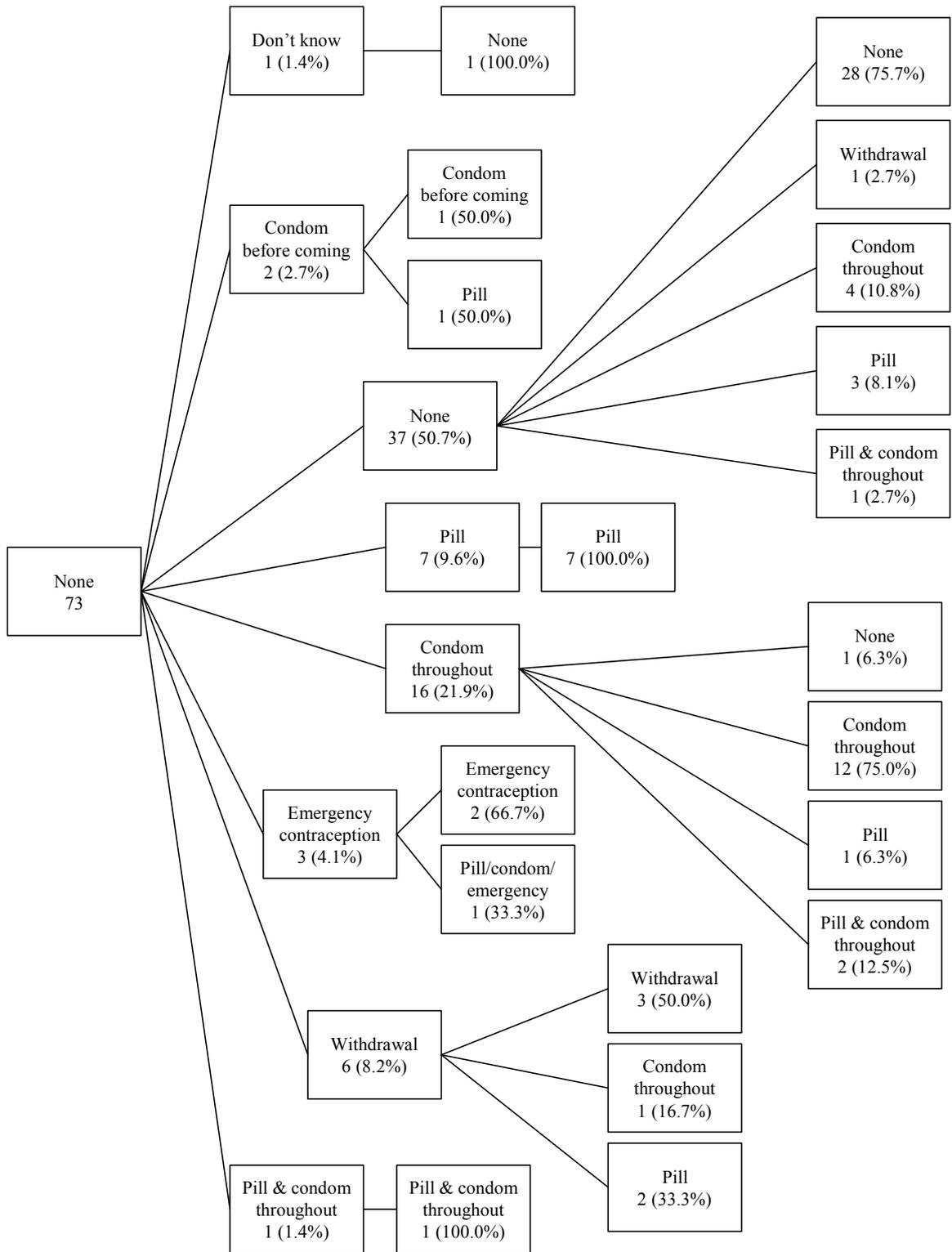
Flowchart of contraceptive pattern between first, first with most recent partner, and most recent sexual intercourse (pill and condom use at first intercourse)



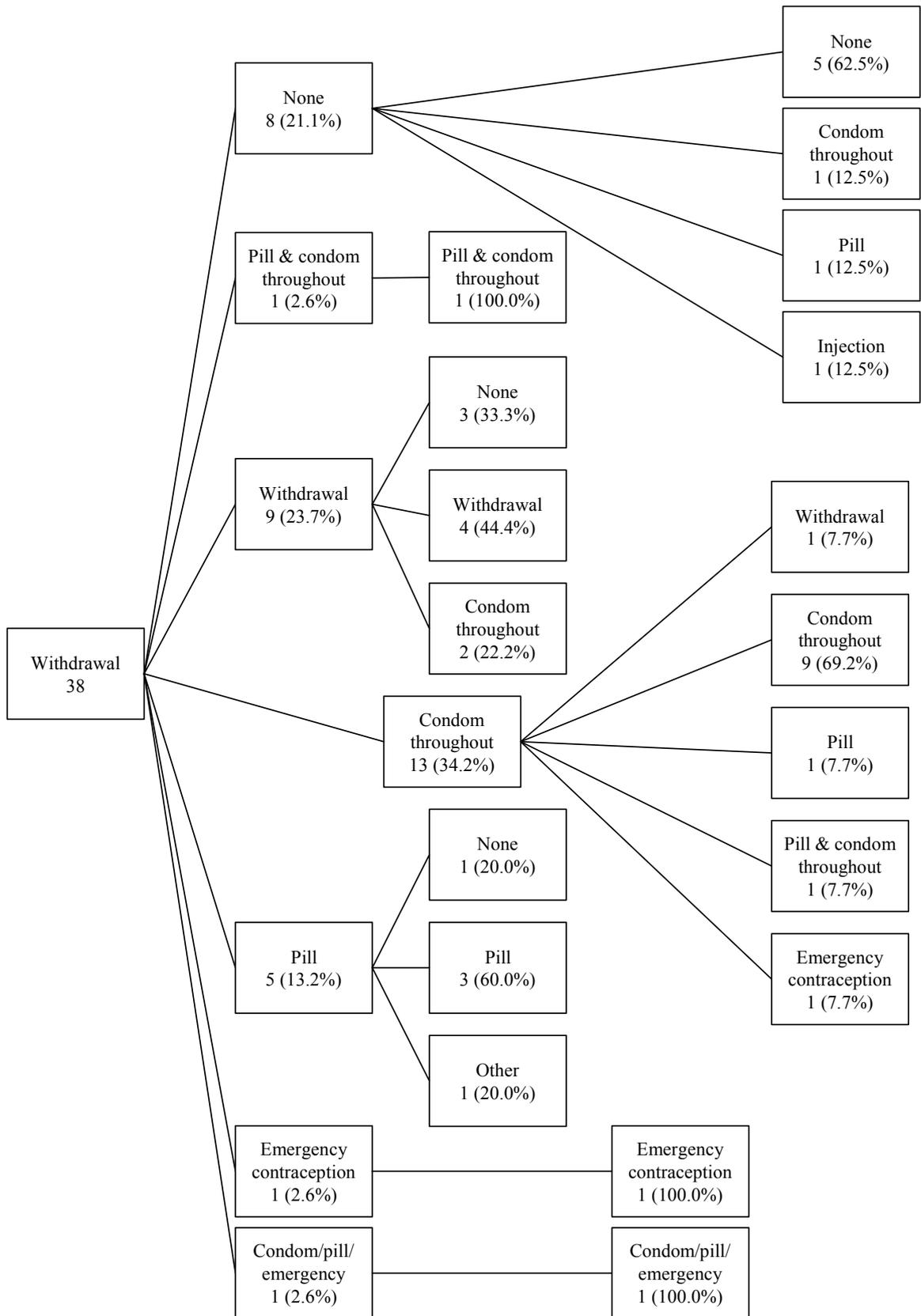
Flowchart of contraceptive pattern between first, first with most recent partner, and most recent sexual intercourse (pill, condom and emergency contraception use at first intercourse)



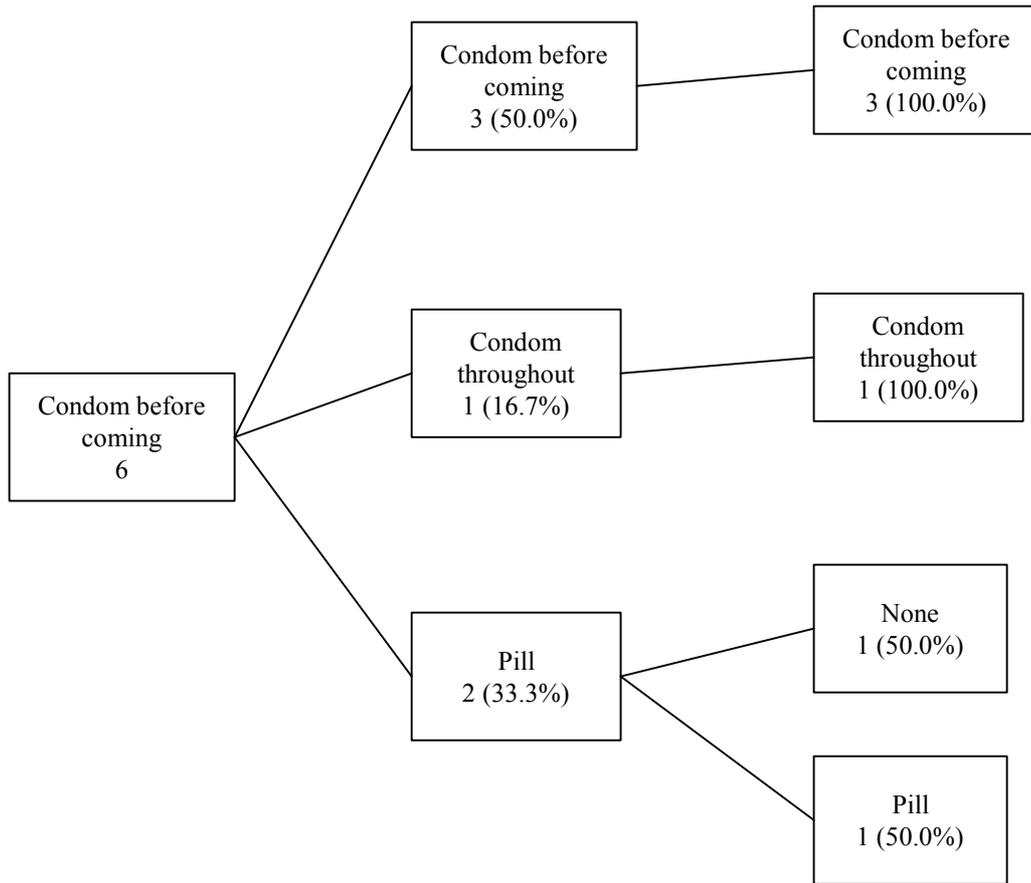
Flowchart of contraceptive pattern between first, first with most recent partner, and most recent sexual intercourse (emergency contraception use at first intercourse)



Flowchart of contraceptive pattern between first, first with most recent partner, and most recent sexual intercourse (non-use at first intercourse)



Flowchart of contraceptive pattern between first, first with most recent partner, and most recent sexual intercourse (withdrawal at first intercourse)



Flowchart of contraceptive pattern between first, first with most recent partner, and most recent sexual intercourse (condom put on before ejaculation at first intercourse)

## Appendix D: Pilot interview schedule

### General introduction

- Ask to say a bit about self
- Live in Glasgow? Is that why come to this clinic?

### General knowledge of contraception

- Knowledge of different methods
- Access to methods
- How learned about these methods?
- Personal use of contraceptives
- Experience of use – all methods tried
- Access – use of services and what think of these
- Influences
- What think about methods tried?
- Particular likes and dislikes

### Relationships and patterns

- Start with current relationship (or most recent) (or most recent sex experience?)
- Background – how long, how met, how it is going?
- Sex
- Contraceptive use in the relationship
- What use currently?
- Always used the method?
- Did you start using it with this boyfriend?
- What other methods have you used with this boyfriend?
- Whys?
- Influence of partner
- Other influences
- First sexual intercourse
- Story of this
- Was contraception used?
- Why was it used (or not used)?
- Who was the partner?
- Influences
- Other relationships / sexual encounters
- Fill in between first and most recent
- Background – how long, how met, how it is going?
- Sex
- Contraceptive use
- What use currently?
- Always used the method?
- Did you start using it with this boyfriend?
- What other methods have you used with this boyfriend?
- Whys?
- Influence of partner
- Other influences

### Future

- Happy or not with current contraception? Why? (if not using any – how feel about it)
- Plan to change contraception in the future?
- What happens if relationship comes to an end?
- Do you think there is a pattern to your use of contraception?

### Interview Experience

- Is there anything you would like to add?
- How did you feel being interviewed?
- Were the questions asked ok?
- Was anything missed out?
- Is there anything you think should be changed?
- What did you think of the terms used (e.g. sex, boyfriend etc)?

## Appendix E: Main interview schedule

### General background

- Ask to say a bit about self
- Family
- Friends
- Hobbies / going out / media

### General knowledge of contraception

- Knowledge of different methods
- Access to methods
- How learned about these methods?

### Current or most recent relationship

- Start with current relationship (or most recent) (or most recent sex experience?)
- Background – tell me about him – how long, how met, how it is going?
- Sex
- When first had sex? – story
- Contraceptive use – why?
- Influence of partner
- Other influences – family, friends, school, media
- How often have sex now?
- Contraceptive use in the relationship
- What use currently?
- Always used the method?
- Did you start using it with this boyfriend?
- What other methods have you used with this boyfriend?
- Why?
- Influence of partner
- Other influences – family, friends, school, media

### First sexual intercourse

- Story of this
- Was contraception used?
- Why was it used (or not used)?
- Who was the partner? Background as above (how met etc).
- Influence of partner
- Other influences – family, friends, school, media

### Other relationships / sexual encounters

- Fill in between first and most recent
- Background – as above
- Sex
- When first had sex? – story
- Contraceptive use – why?
- Influence of partner
- Other influences – family, friends, school, media
- How often had sex?
- Contraceptive use in the relationship
- What method used?
- Always used the method?

- Did you start using it with this boyfriend?
- What other methods have you used with this boyfriend?
- Why?
- Influence of partner
- Other influences – family, friends, school, media

#### Other relationships

- Non-sexual relationships
- Background – tell me about him – how long, how met etc?
- Timeline – before, during and after sex experience?
- Why?

#### PROMPT CARD HERE (LIST OF CONTRACEPTIVE METHODS)

#### Personal use of contraceptives

- Experience of use – list all methods tried
- Access – use of services and what think of these
- Particular likes and dislikes
- Benefits and risks of contraception
- Withdrawal/fertility awareness
- Experience of pregnancy – ever worried about? & ever been? personal and among friends/siblings etc
- Ever done pregnancy test?
- Emergency contraception use
- If emergency contraception not mentioned in list at start of interview ask why
- Trust of methods
- Pressure to use methods
- Regret of using methods

#### STIs

- Ever worried about infection?
- Why?
- Use of services – GUM/GP/other
- Ever had infection? – experience

#### Future

- Happy or not with current contraception? Why? (if not using any – how feel about it)
- Plan to change contraception in the future?
- What happens about contraceptive use if relationship comes to an end?

#### Importance of contraception

- Think about it often?
- Important to you?
- Major part of life or affects life in general?

Repeat their pattern of use to them – ask if it is a fair representation?

Some people see a pattern in their contraceptive use – do you?

Is there anything you would like to add?

## Appendix F: Interview request letter



Social and Public Health Sciences Unit  
University of Glasgow  
4 Lilybank Gardens  
Glasgow  
G12 8RZ

Telephone +44 (0) 141-357 3949  
Fax +44 (0) 141-337 2389  
Web [www.msoc-mrc.gla.ac.uk](http://www.msoc-mrc.gla.ac.uk)  
E-mail [lisa@msoc.mrc.gla.ac.uk](mailto:lisa@msoc.mrc.gla.ac.uk)

Dear,

### YOUNG WOMEN'S ATTITUDES AND EXPERIENCES OF CONTRACEPTION

My name is Lisa Williamson and I'm a researcher at the Medical Research Council in Glasgow. I'm currently studying young women's contraceptive use. I want to interview young women about attitudes to, and/or experiences of contraceptives such as condoms or the pill. I know you have previously completed questionnaires for the SHARE study and have told us you don't mind continuing to take part in this research.

So how would you feel about being interviewed?

Please complete the enclosed postcard and return it to me in the envelope provided (no stamp required). Or you can send an email to [LISA@MSOC.MRC.GLA.AC.UK](mailto:LISA@MSOC.MRC.GLA.AC.UK). Please remember to include a telephone number, mobile or email address, so I can contact you.

Once I receive the postcard or email I'll get in touch to give you more information about the interview and you can decide if you want to take part. We can then arrange the interview for a time and place that suits you. I can come and interview you at your home or in another suitable location. If you would prefer, you can come to Glasgow, and your travel expenses will be paid for. As a thank you for taking part you'll be given a £20 gift voucher.

If you have any questions before then you can contact me at the address above.

Thank you for your time.

Yours sincerely,

Lisa Williamson.

## Appendix G: Study information sheet



Social and Public Health Sciences Unit  
University of Glasgow  
4 Lilybank Gardens  
Glasgow  
G12 8RZ

### YOUNG WOMEN'S CONTRACEPTIVE USE

#### Information Sheet

***Why carry out this study?***

To collect information on the contraceptive use of young women in Scotland.

***Who funds the study?***

The study is funded by the Medical Research Council.

***What is involved?***

The interview may take up to an hour.

You don't have to take part if you don't want to.

The information you give me is confidential. I will not use your name or reveal that you were interviewed.

If you agree, the interview will be recorded. Interview tapes will be securely stored in the MRC unit. They will be kept for ten years.

***What questions will be asked?***

I'll ask about your experience of contraceptive use, your relationships, and your use of health services.

If there is a question you do not want to answer you can say so.

***What will be done with the information?***

The interview will be written up and compared with the experiences of other young women. Your comments will be made anonymous and I will not use your name at any time. The findings of the study will be written up in a report and may be published in research journals.

I hope the information you give me will help me to understand patterns of contraceptive use, and in turn to make recommendations on future contraceptive and sexual health services available to young women in Scotland.

***What happens after the interview?***

I only want to interview you once, but if you later think of a question or a comment you can contact me: Tel: 0141 357 3949 or Email: [lisa@msoc.mrc.gla.ac.uk](mailto:lisa@msoc.mrc.gla.ac.uk)

**Appendix H: Study consent form**

Social and Public Health Sciences Unit  
University of Glasgow  
4 Lilybank Gardens  
Glasgow  
G12 8RZ

**YOUNG WOMEN'S CONTRACEPTIVE USE****CONSENT FORM**

I have read and understood the information sheet for the Young Women's Contraceptive Use study.

- I realise that I do not have to answer a question if I do not want to.
- I understand that all the information I give is confidential and that my name will not be used.
- I understand that the findings of the study will be written up in a report and may be published in research journals.
- I am willing to take part in an interview.
- I agree that the interview can be recorded.

NAME (block capitals) \_\_\_\_\_

SIGNED \_\_\_\_\_

DATE \_\_\_\_\_

## **Appendix I: Thematic framework index for qualitative analysis**

1. Contraception – use, access, choice and change
  1. contraceptive use
  2. contraceptive access
  3. contraceptive choice
  4. contraceptive change
  5. contraceptive knowledge
  6. contraceptive likes
  7. future contraceptive use
  8. importance of contraception
  9. contraceptive patterns
  
2. Contraception – failures, first sex, non-contraceptive reasons and motivations
  1. contraceptive failures
  2. contraceptive use at first sex
  3. non-contraceptive reasons
  4. trust of contraceptive methods
  5. motivation – pregnancy fear
  6. motivation – STI fear
  
3. Contraceptive methods – use, access, choice and change
  1. condom use
  2. condom likes and dislikes
  3. pill use
  4. pill likes and dislikes
  5. injection use
  6. injection likes and dislikes
  7. dual method use
  8. emergency contraception

#### 4. Influences on contraceptive use, choice and change

1. boyfriends
2. boyfriend direct influence on contraceptive use
3. casual partners
4. parental influence
5. other family influence
6. peer influence
7. school influence
8. media influence
9. health services
10. pregnancy experiences of others
11. pressure
12. social norms
13. talking about contraception

#### 5. Risks related to contraceptive use, choice and change

1. contraceptive risks
2. contraceptive crises
3. non-use of contraception
4. experience of pregnancy
5. experience of STIs
6. contraceptive regret

**Appendix J: Descriptive maps of the young women’s individual patterns of contraceptive use**

Abby – Chaotic Contraceptive Career

Abby lived with her parents and her child and was working full-time. She was on her local council waiting list for her own house. At the time of interview, she had split with her boyfriend, who she had been with for 3 ½ years (although they had split up 3 or 4 times during the relationship). She had had a similar on/off relationship with another boyfriend from she was 14 to 16 and had also had four casual partners.

Abby used a condom when she first had sex. She started the pill at age 15 and combined this with condoms but stopped taking the pill when she split up with her boyfriend. She then used condoms only but had unprotected sex with one casual partner. With her next boyfriend she used condoms until one split and she started the pill. She stopped using condoms when she started the pill but did use a condom with a casual partner she met on holiday (she had split up with her boyfriend at that time). Abby often forgot to take the pill but would still have sex and became pregnant. After her pregnancy she started the pill again but had to stop taking it because of high blood pressure. She started the progestogen-only pill but stopped this because she did not like it.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes							
Manual	Credit	14	6	4	4	14							
<u>Contraceptive Pattern</u>													
		First sex (boyfriend)	Casual partner	Boyfriend	Casual partner	Casual	Boyfriend (3½ yrs)	Boyfriend (no sex)	Casual	Boyfriend (3½ yrs)	Pregnancy (had child)		
Events		↓	↓	↓	↓	↓	↓	↓	↓	↓	↓		
Contraceptives		↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	
		Condom	Pill & condom	Condoms & condom	Pill & condom	Condom	Condom (& none)	EC Pill & condom	Pill	None	Pill	Mini-pill	
Age		14	15	16	16	16	17	17	18	18	18	19	20
													Stopped mini-pill

- Contraceptive methods used: condoms, the pill (combined and progestogen-only) and emergency contraception.

Debbie – Chaotic Contraceptive Career

Debbie lived with her child and was a full-time mother. She had had four longer term relationships (boyfriends), which lasted from 7 months to 2 years and four casual partners. The boyfriend she had from age 16 to 18 had been physically abusive to her. She had been with her current boyfriend for two months.

Debbie used a condom when she first had sex but stopped using these when she started the pill a few months later. She only used the pill with her next two partners. Debbie stopped taking the pill when she ran out and did not have access to a GP or clinic to get more. She had unprotected sex with her partner and became pregnant. After her pregnancy, she used condoms and used emergency contraception when one split. She started the pill again because of this. She used condoms and the pill with her casual partners and only used the pill with her boyfriends.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes
Manual	General/foundation	14	9	6	3	8

<u>Contraceptive Pattern</u>								
	First sex (boyfriend 1 year)	Boyfriend (7 months)	Boyfriend (2 years)	Pregnancy (had child)	Boyfriend (no sex)	Casual (x4)	Boyfriend (7 months)	Current boyfriend
Events	↓	↓	↓	↓	↓	↓	↓	↓
Contraceptives	↑	↑	↑	↑	↑	↑	↑	↑
	Condom	Pill & condoms	Stop pill	None	EC Condom	Pill (& condoms for casual)	Pill	Pill
Age	14	15	16	17	18	19	20	

- Contraceptive methods used: condoms, the pill and emergency contraception.

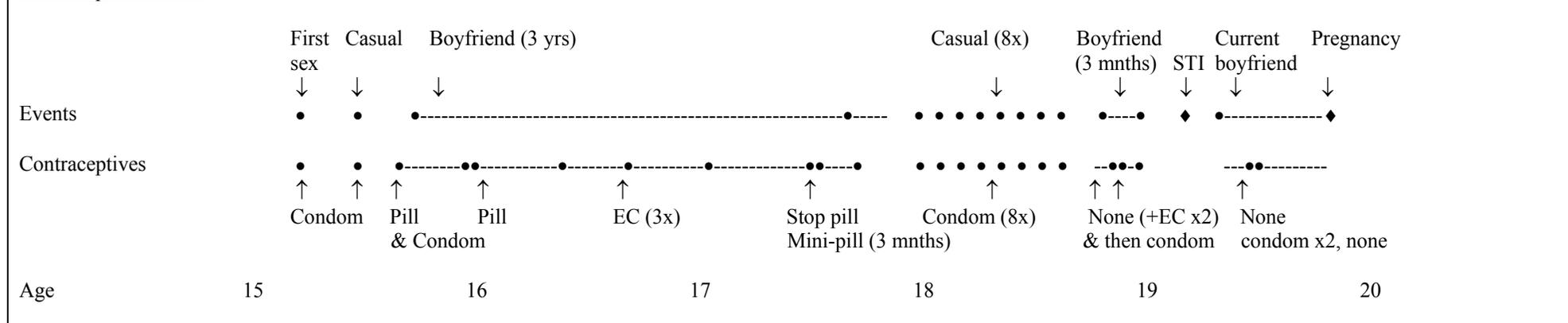
Fiona – Chaotic Contraceptive Career

Fiona lived with her mother (her parents were separated) and was working part-time. She was 3 months pregnant at the time of interview and had been with her boyfriend for 4 months. She had previously had two boyfriends (of 3 years and 3 months respectively) and ten casual partners. Fiona had had chlamydia.

Fiona used a condom when she first had sex and with her next casual partner. She then started a relationship with her boyfriend of 3 years and started the pill before they first had sex. They used the pill and condoms for the first 3 months and then stopped using condoms. During that relationship Fiona used emergency contraception three times when she forgot to take her pill. She stopped the pill because of a side effect (headaches) and started the progestogen-only pill but stopped this after 3 months because she did not like it. Fiona used condoms with her next partners with the exception of a boyfriend with whom she had unprotected sex and used emergency contraception twice. They then used condoms. Fiona had unprotected sex with her current boyfriend but was worried about getting chlamydia so used condoms a couple of times before again having unprotected sex.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes
Non-manual	General/foundation	15	13	5	4	11

Contraceptive Pattern



- Contraceptive methods used: condoms, the pill (combined and progestogen-only) and emergency contraception. She also had unprotected sex.

Heather – Chaotic Contraceptive Career

Heather lived with her parents and was working part-time. From age 14, she had regularly had sex with two young men; a situation which she described as being used for sex. After this she had a boyfriend of one year and then a casual partner. She had become pregnant while in the relationship with her boyfriend and had a miscarriage.

Heather did not use contraception when she first had sex and for the next year continued to do so, only occasionally using condoms if they had them available. She started the pill to regulate her periods and as a treatment for acne. She took the pill for 3 ½ years but stopped because she was forgetting to take it. She then had unprotected sex with her boyfriend and became pregnant. Since then, she had continued to have unprotected sex, even though she did carry condoms. Heather did not want to ask her partners to use condoms because she was worried they would reject her.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes	
Non-manual	General/foundation	14	4	6	2	6	
<u>Contraceptive Pattern</u>							
	First Sex (regular sex with two young men for 3 yrs)			Boyfriend (just over 1yr)	Pregnancy (miscarriage)	Sex with ex-boyfriend	Casual
Events	↓ ↓			↓	↓	↓	↓
Contraceptives	• •	•			•	-	-
	↑ ↑	↑			↑ ↑	↑	↑
	None (intermittent condom)	Pill (non-contraceptive reason)			Stop pill None pill	None	None
Age	14	15	16	17	18	19	20

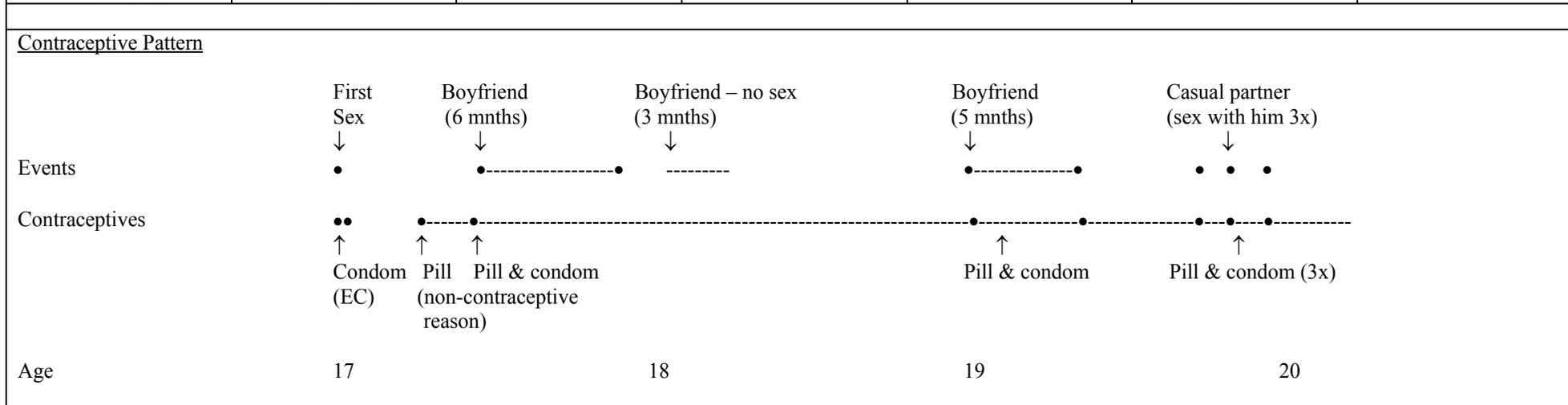
- Contraceptive methods used: the condom and the pill. She also had unprotected sex.

Kate – Consistent Contraceptive Career

Kate lived with her parents, was at university and worked part-time. She did not have a current partner and had had a series of short term boyfriends (all less than 1 year) and one recent casual partner.

Kate used a condom when she first had sex but the condom split and she used emergency contraception. She later started the pill to regulate her periods and then used condoms and the pill with all her sexual partners.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes
Non-manual	Credit	17	4	6	3	1



- Contraceptive methods used: condom, pill, emergency contraception.

### Kathy – Complex Contraceptive Career

Kathy lived in student accommodation and was in her second year at university, having recently changed course and university. After breaking up with her long-term boyfriend when she was 17, she had 14 casual partners, which were one night stands or lasted for a few weeks. She had been with her current boyfriend for 2/3 months at the time of interview.

Kathy used a condom when she first had sex. After she started the pill to regulate her periods and as a treatment for acne, she only used condoms intermittently when she forgot to take the pill or had to use other methods while taking antibiotics. She stopped taking the pill when she was not in a relationship but then had unprotected sex and used emergency contraception. After this, she started the pill again, repeating her pattern of intermittent condom use. Kathy had recently changed pill brand. She was tested for STIs and then only used the pill with her current boyfriend.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes
Non-manual	Credit	14	16	9	4	6

<u>Contraceptive Pattern</u>								
		First sex (boyfriend 4 yrs)		Casual (3 mths) (start concurrent with first)	Casual (x13)	STI screen	Current boyfriend	
Events		↓		↓	↓	↓	↓	
Contraceptives		●	●	●	●	●	●	
		↑	↑	↑	↑	↑	↑	
		Condoms	Pill	Condoms (intermittent)	Stop pill (EC)	None (EC)	Pill	
Age	13	14	15	16	17	18	19	20

- Contraceptive methods used: condoms, the pill, emergency contraception and withdrawal (although she was on the pill at the time).

### Kim – Complex Contraceptive Career

Kim lived with her parents and was at college. She had had 6 sexual partners, 4 of whom were casual and 2 were boyfriends. She had also had 3 boyfriends she had not had sex with. She had been with her current boyfriend for a few weeks and had not had sex with him.

Kim did not use contraception when she first had sex and used emergency contraception as a result. She then used condoms with her next 5 partners. She started the pill and stopped using condoms with her boyfriend when she was 19. When she had sex with him and realised she had forgotten to take her pill, she used emergency contraception. She continued to take the pill when the relationship with her boyfriend ended.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes		
Manual	General/foundation	16	6	5	3	2		
<u>Contraceptive Pattern</u>								
		First Sex	Boyfriend (1 year)	Boyfriend (1 mnth) no sex	Casual (3x)	Boyfriend (1 mnth) no sex	Boyfriend (3 mnths)	Boyfriend no sex
Events		↓	↓	↓	↓	↓	↓	↓
Contraceptives		•	•-----•	•	•	•	•-----•	•-----•
		↑	↑		↑		↑	↑
		None (EC)	Condoms		Condom (3x)		Condom Pill EC Pill	
Age	16	17	18		19		20	

- Contraceptive methods used: condom, pill, emergency contraception. Also had unprotected sex.

Lindsay – Consistent Contraceptive Career

Lindsay lived with her parents and was working full-time (although she was planning to go to college). She had recently split from her fiancé, whom she was with for 4 ½ years and had a new boyfriend.

Lindsay used a condom when she first had sex and continued doing so until she experienced a condom split and had to use emergency contraception. After this she started the pill and continued to use condoms as well.

Social background	class	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes
Non-manual		General/foundation	14	4	4	3	1

<u>Contraceptive Pattern</u>							
	Boyfriend (3 mnths) first sex	Boyfriend (2 weeks) no sex	Boyfriend (1 yr)	Boyfriend (4½ yrs)			Current boyfriend
Events	↓	↓	↓	↓	-----	-----	↓
Contraceptives	•	•	•	•	•	•	•
	↑ Condom	↑ Condom	↑ Condom	↑ EC	↑ Pill & Condom		↑ Pill & condom
Age	14	15	16	17	18	19	20

- Contraceptive methods used: condom, pill, emergency contraception.

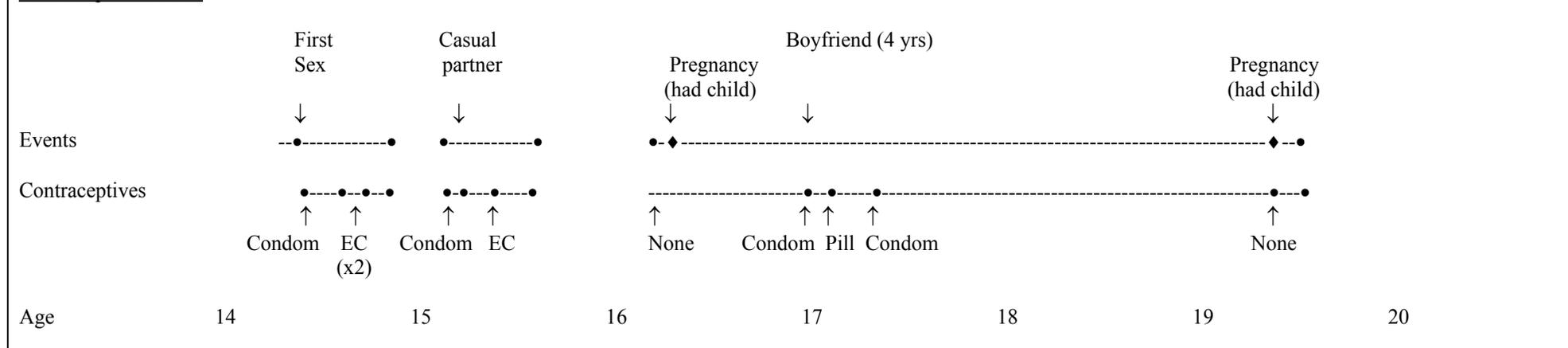
### Louise – Chaotic Contraceptive Career

Louise lived with her two children and was a full-time mother. Her boyfriend of 4 years had left her just before the birth of their second child. She had previously had two short-term relationships, which she classed as casual.

Louise used a condom when she first had sex and continued to use these with her first two partners. She experienced condoms splitting three times and on each occasion used emergency contraception. When she first had sex with her boyfriend, Louise had unprotected sex and became pregnant. After the pregnancy they used condoms. Louise started the pill but felt that it affected her moods so stopped taking it and again used condoms. One night when Louise and her boyfriend were drunk, they had unprotected sex and she became pregnant with their second child.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes
Manual	General/foundation	14	3	6	3	5

### Contraceptive Pattern



- Contraceptive methods used: condoms, the pill and emergency contraception. She also had unprotected sex.

### Lucy – Complex Contraceptive Career

Lucy lived with her partner and was working full-time. She had been with her current boyfriend since she was 18. She had previously had 3 long-term boyfriends, some short-term boyfriends, she was with for a few weeks at a time and casual partners, which were one night stands or partners she met while on holiday.

Lucy used a condom when she first had sex and started the pill soon after this. She did not use condoms again with any of her partners after starting the pill. She used emergency contraception when she forgot to take her pill or when she was on antibiotics. When she went for emergency contraception she was given an advance supply for future use, all of which she had used.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes			
Manual	Credit	12	12	4	3	1 + 6 EC			
<u>Contraceptive Pattern</u>									
	First sex (boyfriend 1 year)	Casual (holiday)	Boyfriends (short-term) (x3)	Casual (x3)	Boyfriend (2 years)	Casual (holiday)	Boyfriend (1 year)	Current boyfriend	
Events	↓	↓	↓ ↓ ↓	↓	↓	↓	↓	↓	
Contraceptives	•	•	•••••	•••••	•••••	•••••	•	•	
	↑	↑					↑		
	Condoms	Pill					EC (advance supply of 6 packs given and used from this time)		
Age	12	13	14	15	16	17	18	19	20

- Contraceptive methods used: condom, pill, emergency contraception.

### Margaret – Complex Contraceptive Career

Margaret lived with her parents and was working full-time. She had been with her current boyfriend since she was 15 and he was her only sexual partner.

Margaret used a condom when she first had sex. She started the pill to regulate her periods just before she was 16 and stopped using condoms at that time. When she had sex and realised she had forgotten to take her pill, she used emergency contraception. While she was on the pill she became pregnant and had a miscarriage (she did not know she was pregnant until she miscarried). At age 17, Margaret changed to the injection because she was experiencing side effects with the pill. She used the injection for 1 year but stopped the method because she gained weight while on it, instead starting a different brand of pill, which she had used since then.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes
Manual	General/foundation	15	1	6	4	4

<u>Contraceptive Pattern</u>						
Events		Current boyfriend First sex ↓		Pregnancy (miscarriage) ↓		
Contraceptives		•	•	•	•	•
		↑	↑	↑	↑	↑
		Condom	Pill (non-contraceptive reason)	EC	Injection	Pill
Age	15	16	17	18	19	20

- Contraceptive methods used: condoms, the pill, the contraceptive injection and emergency contraception.

Mary – Complex Contraceptive Career

Mary lived with her parents and was working part-time. She was 7 months pregnant at the time of interview. She had recently split up with her boyfriend and planned to bring the baby up on her own. She had had 1 other long-term boyfriend and 3 casual partners.

Mary used a condom when she first had sex and continued to use condoms until changing method with her most recent boyfriend. She stopped using condoms and used the withdrawal method instead and then started using condoms again for a short time. They then stopped using condoms and had unprotected sex. Mary said she had not been bothered about getting pregnant.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes	
Manual	General/foundation	15	5	3	2	3	
<u>Contraceptive Pattern</u>							
		Boyfriend (1 year) First sex ↓		Casual (3x) ↓		Boyfriend (1 year) ↓	Pregnancy ↓
Events		•-----•	•	•	•	•-----•	◆-----•
Contraceptives		•-----• ↑ Condom	•	• ↑ Condom (3x)	•	•-----• ↑ Condom	•-----• ↑ Withdrawal
Age	15	16	17	18	19	20	

- Contraceptive methods used: condoms and withdrawal.

### Megan – Complex Contraceptive Career

Megan lived with her parents and was working full-time. She had recently split up with her boyfriend of 3 years but was hopeful that they would get back together. Previous to this she had a 1 ½ year relationship with a boyfriend from age 15 and had had 8 casual partners before starting the relationship with her most recent boyfriend.

Megan started the pill to regulate her painful periods, before she first had sex. When she did first have sex she used a condom as well as the pill. In her first relationship she only had sex without a condom once. She used condoms and the pill with her casual partners and used emergency contraception on with one of these partners when she thought it had not been 100% safe. She used condoms and the pill with her most recent boyfriend and then stopped using condoms after almost a year. She used condoms if she missed a pill or was taking antibiotics. Megan changed from the pill to the injection because she frequently forgot to take the pill. She used the injection for 1 year but discontinued because she put weight on and changed back to the pill.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes
Non-manual	General/foundation	16	10	4	4	6

<u>Contraceptive Pattern</u>						
		First sex (boyfriend 1½ years)		Casual (x8)		Boyfriend (3 years)
Events		↓		↓		↓
Contraceptives	•	•	••	••••••••	•	••
	↑	↑	↑↑	↑	↑	↑↑
	Pill (non-contraceptive reason)	Pill & condom	Pill Pill & condom	Pill & condom (EC)	Pill	stop Pill Injection
						Stop Pill Injection
Age	14	15	16	17	18	19
						20

- Contraceptive methods used: condoms, the pill, the injection and emergency contraception.

Melanie – Complex Contraceptive Career

Melanie lived with her partner and was working full-time. She had been with her current boyfriend since she was 19, and previous to that had three relationships with boyfriends, which lasted for just under 1 year, and 2 casual partners.

Melanie started the pill before she first had sex to regulate her periods and also because she thought that she should start taking it before she first had sex. She used a condom and the pill when she first had sex and with her next partner. She did not use condoms with her next partner and he asked her to use emergency contraception (although she was on the pill at the time). She used the pill and condoms with her next partners but stopped using condoms with her boyfriend after 6 months. They then split up and got back together and Melanie insisted that they again use condoms. They did so for a short time before discontinuing condom use again. Melanie had only used the pill with her current partner.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes
Manual	Credit	16	6	4	3	6
<p>Contraceptive Pattern</p> <p>The diagram illustrates the contraceptive pattern from age 16 to 20. It shows a timeline with various relationship types and contraceptive methods used. Key events include 'First sex' at age 16, and several periods of being with a 'Boyfriend' (9 months, 8 months, 8 months) and 'Casual' partners. A 'Break' of 2 months occurs between the third boyfriend and the 'Current boyfriend'. Contraceptive methods used include 'Pill (throughout)', 'Pill &amp; condom', 'Pill &amp; condom (+EC)', and 'Pill &amp; condom'.</p>						
Events						
Contraceptives						
Age	16	17	18	19	20	

- Contraceptive methods used: condoms, the pill and emergency contraception.

Melissa – Complex Contraceptive Career

Melissa lived with her daughter and worked part-time. She had recently split up with a short-term boyfriend. Previous to this she had two long-term partners. She became pregnant and had a child with her first boyfriend, whom she was with for 2 years. She had been raped when she was 18.

Melissa used a condom when she first had sex but then only used condoms occasionally when her or her partner had them and otherwise had unprotected sex. She became pregnant and had the child. In her next relationship she used condoms and then started the pill after having a pregnancy scare (late period). When she started the pill, they used condoms occasionally. She used emergency contraception when she forgot to take her pill and realised she had actually run out. She stopped taking the pill when the relationship ended and used condoms with her next partner.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes		
Manual	General/foundation	16	3	4	3	7		
<u>Contraceptive Pattern</u>								
Events		Boyfriend (2 years) First sex	Pregnancy (had child)	Rape	Boyfriend (1 year)	Pregnancy scare	Boyfriend (2 months)	
Contraceptives		Condom	None (intermittent condom use)	Condom	Pill	EC	Stop (condoms pill occasionally)	Condom
Age	16	17	18	19	19	19	20	

- Contraceptive methods used: condoms, the pill and emergency contraception.



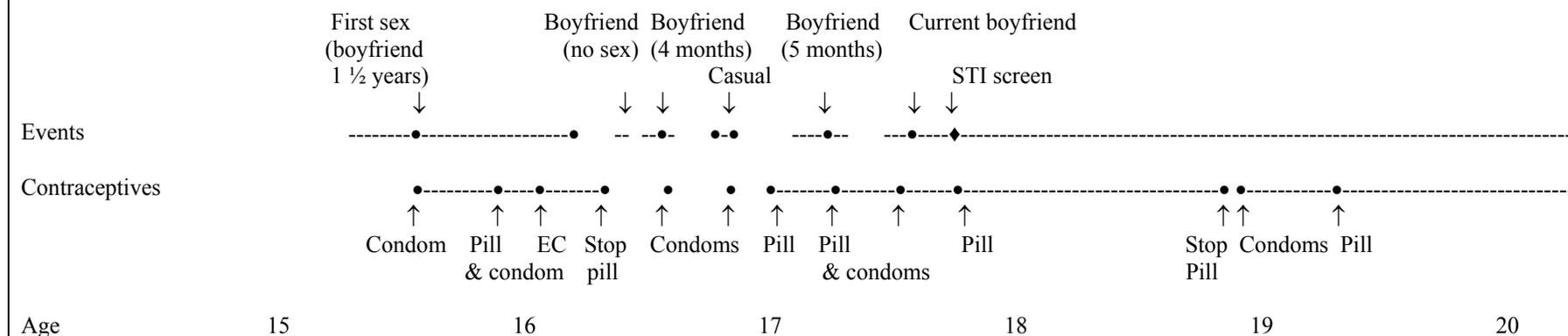
### Milly – Complex Contraceptive Career

Milly was at university and lived in student accommodation. She had been with her current boyfriend for 3 years and they were engaged. She had had a long-term boyfriend (1 ½ years) when she was 15, and then three shorter relationships and a casual partner she met while on holiday.

Milly used a condom when she first had sex and then started the pill after her parents found out she was having sex and advised her to. She continued to use condoms as well and used emergency contraception when one split (even though she was on the pill at the time). She stopped the pill when the relationship ended and used condoms with her next two partners. At age 17, she started the pill again to regulate her periods after having glandular fever. She used the pill and condoms with her next partners. Milly and her fiancé stopped using condoms after they had both been tested for STIs. At age 19, she had to stop the pill when she experienced a side effect (headaches) and they used condoms until she started a different pill brand 4 months later.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes
Manual	Credit	15	4	9	3	8

### Contraceptive Pattern



- Contraceptive methods used: condoms, the pill and emergency contraception.

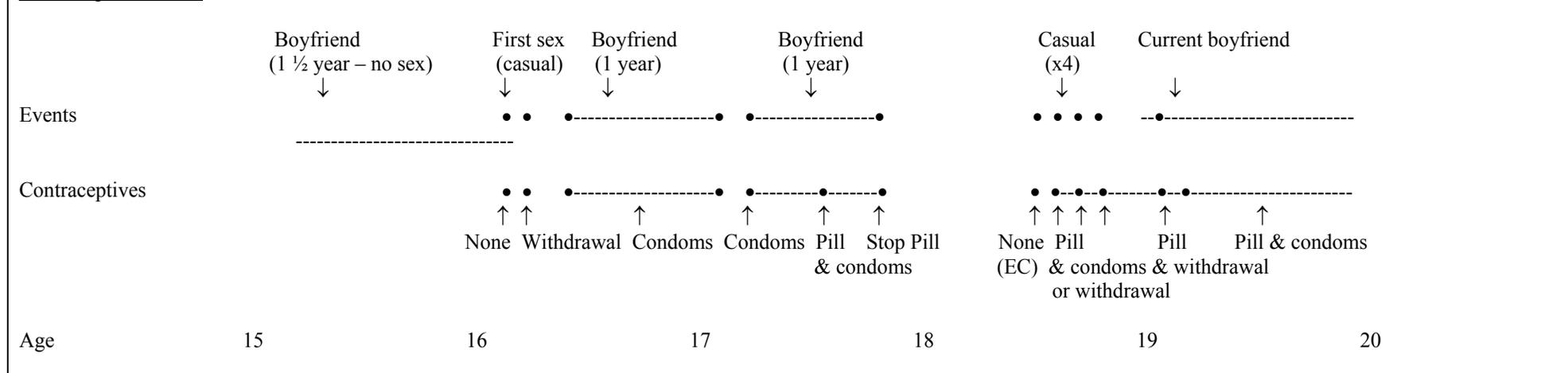
Neela – Chaotic Contraceptive Career

Neela lived with her parents and was working full-time. She had been with her current boyfriend for just under a year and had three previous long-term boyfriends. She had also had five casual partners, who were friends she knew and had casual sex with rather than one-night-stands.

Neela did not use contraception when she first had sex, and the next time she had sex (with the same partner) they used withdrawal. She then used condoms with her next two partners. Neela started the pill to regulate her periods and continued to use condoms. She stopped taking the pill when her relationship ended. When she next had sex, she forgot that she was not on the pill and had unprotected sex so used emergency contraception. She started the pill again after this and used it with condoms, or with withdrawal when she did not have condoms.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes
Non-manual	Credit	16	8	8	4	8

Contraceptive Pattern



- Contraceptive methods used: condoms, the pill, emergency contraception and withdrawal. She also had unprotected sex.



Vicky – Consistent Contraceptive Career

Vicky lived with her parents and was at university. She had one sexual partner, her boyfriend whom she had been with since she was 17.

Vicky used a condom when she first had sex, then started the pill a few months later. She always used the pill and condoms.

Social class background	Educational attainment ('S' grades)	Age at first sexual intercourse	No. of sex partners	No. of contraceptive methods known	No. of contraceptive methods used	No. of contraceptive method changes
Non-manual	Credit	17	1	5	2	1

<u>Contraceptive Pattern</u>						
Events			Current Boyfriend First sex ↓			
Contraceptives						
Age	17			18	19	20

- Contraceptive methods used: condom, pill.

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