NEGOTIATING HEALTHY SEXUALITY: FACTORS INFLUENCING DUAL CONTRACEPTIVE USE BY FEMALE UNIVERSITY STUDENTS IN NORTHERN ONTARIO

BY

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ABSTRACT

In spite of the rising rates of sexually transmitted diseases among young women in Canada (and particularly in the North), the factors affecting the use of dual contraception to prevent both pregnancy and STDs remain an under-researched issue. This thesis examines dual contraceptive use and decision making among a group of university women aged 18 to 25 in Northern Ontario. Utilizing fifteen in-depth interviews, I explore how women negotiate healthy sexuality and contraceptive use during heterosexual sexual relationships.

Though the women recognize dual contraceptive use as important for healthy sexuality, their own narratives suggest that it is not commonly practiced, particularly in relationships which are presumed to be monogamous or last more than a few months. Key factors influencing their decision making are: 1) the complexities of negotiating trust with their male partners; 2) social influences such as schools, parents, and peers; and 3) social stigma about active female sexuality which makes assertiveness in sexual encounters difficult for women.

This study is the first of its nature in Northern Ontario and it has provided an opportunity to hear women's own perspectives on factors influencing dual contraceptive use. This research also contributes to the growing body of literature on women's reproductive health among young women in Northern Ontario.

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CHAPTER 1- INTRODUCTION

INTRODUCTION

This thesis is an examination of the factors that influence the use of dual contraceptives among a sample of 15 female university students aged 18 to 25 in Northern Ontario. Based on the primary data collected through in-depth interviews and my review of secondary material on women's health and sexuality, I argue that, even though these women are conscious of the risks associated with not using condoms to protect against STDs, dual contraceptive use is not common in their relationships, particularly those which last more than a few months. The reasons for their lack of dual contraceptive use are multi-factorial. The three main factors that became evident in the research are: 1) how women negotiate trust in a relationship; 2) social influences such as parents, peers, schools, and 3) the social construction of female morality.

1] WHAT IS DUAL CONTRACEPTION?

Dual contraception is defined as the "concurrent use of two contraceptive methods for two purposes – protection against pregnancy and protection against STIs/HIV" (Woodsong and Koo, 1999:568). The condom is the only form of contraceptive available today that is effective in preventing a sexually transmitted disease[1] (Hacker, Amare, Strunk, and Horst, 2000:280). When combined with another form of contraceptive that is systematically used

[1] The term sexually transmitted infections (STIs) is often used interchangeably with the term sexually transmitted diseases (STDs).

to prevent pregnancy, dual contraception is achieved. An example of dual contraception would be the use of both a condom and the birth control pill during heterosexual sexual intercourse. Variations would be to combine condom use with another method of contraception used to prevent pregnancy such as an IUD, Depo-Provera, a diaphragm, spermicidal cream and so on.

In 1997, according to Everett, Warren, Santelli, Kann, Collins and Kolbe, almost half of high school students in the United States reported being sexually active (2001:112). When contraceptives are not used correctly, or if dual use of contraceptives does not happen, young women face the risk of pregnancy and contracting sexually transmitted diseases. Pregnancy rates have diminished in the United States in recent years. Yet, this decline in the pregnancy rate is coupled with a higher rate of acquisition of sexually transmitted diseases by young women. Of the estimated 15 million new STD cases diagnosed annually in the United States, adolescents represent one fourth of this total (Bearinger and Resnick, 2003:341).

In Canada, young women's pregnancy rates have also fallen over the years. The problem lies in the fact that young Canadian women are now facing higher rates of sexually transmitted infections. The rates of STDs such as chlamydia and gonorrhoea have significantly risen among Canadian women in the past few years and there is little evidence of their use of dual contraceptives (Maticka-Tyndale, 2001:Figure 4). Tschann, Adler, Millstein, Gurvey, and Ellen conclude that even though 58% of students in the United States say they use contraceptives regularly, the percentage is much lower

once every incidence of sexual intercourse is factored in (2002:17). Hacker et al.'s study found that 65% of females were not using any form of contraceptive consistently during sexual intercourse, even though 54% were sexually active on a regular basis (2000:279). Poppen and Reisen state that in a national study conducted in the United States, 7% of the women used dual contraception within the last month while engaging in sexual intercourse (1999:54). The presence of such strong evidence makes it important to conduct research on dual contraceptive use in order to understand the underlying issues that influence dual contraceptive choices for young women.

Even though existing secondary literature addresses factors that influence use of dual contraceptives, there has been no specific literature that looks at contraceptive use in Northern Ontario. Recent data suggests that STIs are on the increase here and substantially higher than other parts of the province (Northern Health Information Partnership, 2003:Figure 26). However, there have been no studies conducted on dual contraceptive use in Northern Ontario to date.

2] SEXUAL HEALTH IN NORTHERN ONTARIO

Northern Ontario consists of 89% of the land mass of Ontario[2] (Southcott, 2004:3; See map of Northern Ontario in Appendix D). Northern Ontario was chosen as the geographical location to conduct this study on

[2] The federal government's definition of Northern Ontario includes the municipalities of Greater Sudbury Division, Sudbury, Kenora, Rainy River, Thunder Bay, Algoma, Cochrane, Manitoulin, Nippising, Parry Sound and Timiskaming. Muskoka district municipality was included into the definition of Northern Ontario in 2000 and is currently a part of the region too.

dual contraception for multiple reasons. As stated above, one of the reasons is the higher pregnancy/STD rates in Northern Ontario.

In Ontario, the provincial rate of teenage pregnancy in 1996 was 44.9 per 1000 women. Thunder Bay (the city where the study was conducted) alone had a teenage pregnancy rate of 54.4 pregnancies per 1000 women (Pauluik, Little and Sieswerda, 2001:4). According to Pauluik et al., Thunder Bay's rate of teenage pregnancy was higher than the total for Northern Ontario as a whole, which had a teenage pregnancy rate of 50.6 per 1000 women (2001: 4). Northern Ontario also has the highest rate of teenagers who report having had sex without condoms the last time they engaged in sexual intercourse (Stewart, Cheung, Ferris, Hyman, Cohen and Williams, 2002:62).

Northern Ontario also has a high rate of STDs among its youth population. Chlamydia was the most frequently treated sexually transmitted disease diagnosed among women in Northern Ontario (Northern Health Information Partnership, 2003:Figure 26). The incidence of chlamydia in 10 - 19 year olds from 1997 to 2001 was 363.5 cases per 100,000 compared to the provincial rate of 260.3 per 100,000. Among females, the incidence of gonorrhoea is 15.9 per 100,000 in the province of Ontario (Rostam and Gucciardi, 2002:54). Gonorrhoea had an incidence rate of 9.8 per 100,000 in Northern Ontario, which is slightly lower than the provincial average (Northern Health Information Partnership, 2003:Figure 26).

Another compelling reason why Northern Ontario was chosen to conduct this study is because of the presence of a large Aboriginal population in this part of the province. Aboriginal people make up 1.4% of Ontario's population according to data collected in 2000. Almost half of this population is under 24 years of age. In 1996, there were 408,100 Aboriginal women in Canada (M.Stout, Kipling and R.Stout, 2001:10). Aboriginal peoples form about 2.4% of the population of the province of Ontario and the majority live in regions of Northern Ontario (Glenn, 1995:2).

Aboriginal people's rate of sexually transmitted diseases is estimated to be four times higher than the Canadian national average. Northern Ontario has extremely high rates of sexually transmitted diseases in certain areas. The rate of gonorrhoea in some areas of the Sioux Lookout Zone in Northern Ontario is reported to be almost 10 times the Canadian average (Ontario Aboriginal HIV/AIDS Strategy, 1996:24). A study conducted by Ontario First Nations AIDS and Healthy Lifestyle Survey (OFNAHLS) in 1993, found that over 40% of First Nations respondents in Northern Ontario had never heard of AIDS. Aboriginal women also represent a higher population of diagnosed HIV/AIDS cases compared to their non-Aboriginal counterparts, 18% as compared to 6% (M.Stout, Kipling and R.Stout, 2001:13).

Calzavara, Burchell, Myers, Bullock, Escobar and Cockerill (1998) conducted their study on condom use among Aboriginal people in the province of Ontario. Their study included 658 participants from eleven reserves located in rural parts of Ontario. Almost 60% of their sample

consisted of young men and women between the ages of 15 and 29 (1998: 273). The majority of their participants (61%) had not used condoms in the previous 12 months while engaging in sexual intercourse. The potential for STD transmission remained high because 40% of males in their sample had multiple sex partners during this period, but only 8% always used condoms (Calzavara et al., 1998:277). Women who did not have multiple sex partners themselves were still being placed at risk of an STD by their male partners. Calzavara's study pointed out that unless Aboriginal women possessed in depth knowledge about STDs, they did not have positive attitudes towards using condoms. Dual contraception was a term unheard of by many Aboriginal youth.

The Aboriginal community also faces problems of being under-researched when it comes to health care issues (Stout, M., Kipling and Stout, R., 2001:17). Education, knowledge about contraception, availability and accessibility of contraceptives and condoms all remain major problems for the Aboriginal population when trying to prevent unplanned pregnancy and STDs.

Another reason for choosing Northern Ontario is because of predominance of the ideology of masculinity. Masculinity and power are also very important in contributing to ideas about condom use while engaging in heterosexual sexual encounters. The ethos of working class masculinity found in regions like Northern Ontario is important in shaping the context in which the use of dual contraception is negatively viewed. Wakewich and

Parker talk about the links between masculinity and sexuality in the region of Northern Ontario (2002: 11). They say,

> Given the primary resource history of the region (Northern Ontario) and the high value placed on masculinity it would be reasonable to assume that attitudes about sexuality and safe sex practices would be heavily influenced by cultural and regional values. Women's ability to control decision making about the use of safe sex practices may be compromised (2002: 11)

As discussed by Wakewich and Parker (2002), these cultural values may compromise women's decision-making power on healthy sexuality. Power of the partners involved remains a key factor in women's ability to negotiate use of dual contraception during heterosexual sexual encounters. Secondary literature supports the idea that hegemonic power differentials between the sexes also make it difficult for a woman to negotiate dual contraception with her male partner in a society where the working man's masculinity is the norm.

Bowd and Loos conducted a major study on the topic of sexual health in Northern Ontario. Bowd and Loos (1995) examined gender differences in adopting AIDS preventive behaviours at the campus of Lakehead University in Thunder Bay. First year students were the sample used in this study. The results showed that men expressed more negative attitudes towards condom use than women. Seventy-one percent of men responded negatively to the question, "Do you enjoy putting on a condom?" In contrast, only 42% of females responded negatively to the same question (1995:24).

In the study conducted by Oncale and King on undergraduate students in an urban state university in the United States, 16.9% of the 307 male participants who were sexually experienced had tried to dissuade a female partner from using condoms (2001: 383). In this same study, only 13.6% of the female participants who were sexually experienced had tried to dissuade a male partner from using a condom. The most common excuse given by men (36.9% of the sample) who tried to dissuade the female partner was that sex feels better without a condom (Oncale and King, 2001:383). The above studies are also indicative that men are more likely to carry these attitudes than women in university settings.

An additional factor identified in the literature which may influence women's contraceptive choices is the lack of health care professionals in the region. People living in Northern Ontario often face a shortage of family physicians. This shortage of family physicians is felt strongly especially by the female residents and influences their ability to obtain a doctor's appointment to acquire a prescription to access a particular form of birth control (Wakewich and Parker, 2000: 21). In their study on dual contraception, Bull and Shlay (2005) clearly stated that access to health care providers such as physicians is very important to promote positive ideas about dual contraceptive use among females. To encourage women to see physicians for these needs, they suggest giving women money for transportation and making physician services available at work places (Bull and Shlay, 2005:6). This demonstrates

the importance of seeing a health care practitioner[3] regularly to discuss contraceptive choices, needs, and healthy sexuality.

It is often argued that adolescents living in smaller communities in Northern Ontario are more reluctant to purchase condoms at their local pharmacies. The main reasons for this are being noticed by someone they know, or someone their parents know. Even though other forms of contraceptive such as birth control pills are more discretely placed in a pharmacy compared to condoms, the issues of confidentiality and privacy remain a major problem for many youngsters (Shroff and Clow, 2003:28). All of the factors mentioned above make Northern Ontario an interesting location to research the use of dual contraceptives among young women.

3] PARAMETERS AND SIGNIFICANCE OF THE STUDY

This study explored the factors that influence use of dual contraceptives through in-depth interviews with a sample of young women in Northern Ontario. As will be discussed in more detail in Chapter Three, the participants of the study were women who were born and/or raised in Northern Ontario. The women who participated were also between the ages of 18 to 25 and students at Lakehead University in Thunder Bay. Fifteen in-depth interviews were conducted to obtain a better understanding of factors that influenced women's use of dual contraceptives. This study was conducted from a feminist sociological perspective. The study was designed

[3] In Ontario, birth control pills are prescribed by a physician.

to learn about women's perspective and experiences in contrast to many conventional health studies which are done from an androcentric frame.

The study also addressed a rural region of Ontario. It was significant in understanding differential access to resources available for women who live in these areas. It is evident from the previous section on Northern Ontario that there are high rates of STDs in this region compared to the rest of the province of Ontario. Northern Ontario also has a higher rate of Aboriginal population than the rest of the province. Since this study looked at some factors that are unique to this region, it is a significant one in understanding women's perspectives on dual contraceptive use in these areas.

4] PLAN OF THE THESIS

In order to identify key themes for the interviews, a review of the existing literature was conducted. As will be discussed in Chapter Two, numerous factors influencing use of contraceptives among young women were identified in the literature. The key factors were: power of the partners involved; spontaneity of sexual intercourse; length of the relationship; nature of sexual health education; parental involvement; peer attitudes and religiosity.

Chapter Three provides an overview of the design of the thesis including the choice of a feminist qualitative methodology for conducting this study. Open-ended interviews were used to examine the factors that influence the use of dual contraception among young women in Northern Ontario. A

synopsis of the development of the interview questionnaire forms a part of this chapter. This chapter also provides information on the demographics of the sample and how the sample was selected for the research. Problems faced during the sample selection and the interviews are also discussed.

Chapter Four outlines the main themes that emerged from the interviews. These themes fall under categories of issues of trust, social influences, and the social construction of female morality. One of the major themes that emerged was the importance of trust when women tried to negotiate use of dual contraceptives. I argue that trust plays multiple vital roles when women try to negotiate dual contraceptive use during heterosexual sexual encounters. Trust affects whether women are able to ask their male sexual partners questions about their sexual history, or if they have undergone STD testing. I argue that dual contraceptive use is virtually non-existent in relationships that women perceive to be long term and monogamous. The interviews also revealed that the nature of sexual health education is problematic because of its focus on the anatomy and the biology of sexual intercourse, rather than the interpersonal dynamics that occur during heterosexual sexual encounters. The interviews have also led me to conclude that parental education has not been focused on educating the female about sexually transmitted diseases but rather, on the shame and fear of an unplanned pregnancy. The stigma of an unplanned pregnancy has led women to rely on systematic forms of birth control such as the pill rather, than condom use which prevent STDs. The issue of stigma along with the negative

social construction of female morality is a recurring theme in many of the interviews. Other relationships between the themes such as peer involvement, sexual health education, religion, social class and dual contraceptive use are also explored in this chapter.

In Chapter Five, I provide a summation of the arguments presented in my thesis and draw connections between the primary and secondary sources in more detail. I discuss the implications of factors affecting the use of dual contraception among young women in Northern Ontario from a feminist sociological perspective while suggesting directions for future research.

CHAPTER 2 – REVIEW OF THE LITERATURE

A review of existing studies on contraceptive use among young heterosexual women was completed to identify the factors that influenced their use of dual contraceptives. The key determinants identified were power of the partners involved, spontaneity of sexual intercourse, length of the relationship, sexual health education, parental involvement, peer attitudes, religion, culture and ethnicity. Each of these is discussed below to give an overview of current understanding of the dynamics of sexual decision making in the secondary literature which were then utilized to develop my research frame.

i) POWER OF THE PARTNERS INVOLVED

Power in relationships is defined as the ability of one person to influence another person's attitudes or behaviour (Tschann, et al., 2002:18). Emotional intimacy leading to sexual intercourse among adolescents is an important arena of power. Feelings of emotional intimacy with the male partner after sexual intercourse are often high among young women. Usually, male partners are less involved emotionally in the relationship. This provides them with more power over the female which often can shape decision-making about contraceptive use (Tschann et al, 2002:19). When this imbalance in power occurs, men tend to make decisions on how contraceptives should be used, when they should be used, or if they should be used at all. This leaves many women, who have less emotional power

over their sexual partners, at the risk of acceding to their male partner's wishes and not using contraceptives at all, or limiting their use, during sexual activity (Tschann et al, 2002:22).

The issue of sexual power in a relationship is also discussed by Woodsong and Koo (1999). Woodsong and Koo discuss women's lack of power and their unequal status with men in relationships that are sexual in nature, and attribute this unequal status to women's need to comply with social norms. Their study defined social norms as rules that pose a challenge for women when they try to insist upon the use of a contraceptive for men, such as condoms (Woodsong and Koo, 1999:570). Kelly and Bazzini (2001) discuss women's disadvantage when trying to negotiate contraceptive use with men because of the conservative attitudes about sexuality women are expected to hold. Women are encouraged to comply with the norms of femininity that frown upon sexual assertiveness and sexual control. Control and assertiveness are seen as masculine characteristics. Kelly and Bazzini argue that women are supposed to resist sex rather than initiate it, which makes proactively discussing dual contraceptive use problematic (2001:786).

From their study of first year undergraduates at an American university, Oncale and King report that young men were more likely to dissuade young women from protected sex by using excuses such as suggestions to their female partners that they will not get pregnant or catch a sexually transmitted disease (2001:379). Bearinger and Resnick note that dual contraceptive use is quite consistent among young people when the

male partner complies with the practice even when the female may have originally requested it. The men who report dual use hold the belief that they are somewhat responsible for contraception while engaging in sexual intercourse (Bearinger and Resnick, 2003:343).

ii) SPONTANEITY OF SEXUAL INTERCOURSE

The timing of sexual intercourse and its relationship to using dual contraception is discussed in detail in the work of Oncale and King (2001). One of the reasons that condoms are often neglected during sexual intercourse is due to the lack of availability when individuals are 'in the mood to have sex'. About 13.1% of the men said there were no condoms available during sexual intercourse as it was a spontaneous action. Spontaneity of intercourse made it acceptable to avoid usage of condoms even though it was in people's best interest to avoid the sexual activity rather than continue it (Oncale and King, 2001:383).

According to Henderson, Wight, Raab, Abraham, Buston, Hart, and Scott (2002) in their study of heterosexual risk behaviour among teenagers, 32% of the sample said sexual intercourse happened at the spur of the moment and 20% stated that it was an unexpected action (Henderson et al., 2002:486). This makes the factor of timing a crucial one in obtaining a contraceptive like a condom, or even having the time to discuss dual contraceptive use and safe sex. Hacker, et al. state that when their research sample was asked about not using condoms, the largest proportion of respondents (approximately 11%) answered that they did not expect to have

sexual intercourse and that condoms were not readily available at the time of the intercourse (2000:285). Even though condoms were not present, sexual activity continued without a condom. Spontaneity of sexual intercourse was one of the most common factors listed by the participants in the research conducted by Oncale and King for sexual activity without condoms even if the female was on the birth control pill (Oncale and King, 2001:383).

Rhodes and Cusick's (2002) qualitative study of young people whose partners were diagnosed with STDs such as HIV/AIDS reported the numerous reasons provided to them about why the timing of sexual intercourse prevented the use of any form of condoms. Sexual activity and desire were labelled as natural events that could not be altered once initiated according to the young women in their sample. The most common reasons given for not using a contraceptive were 'getting carried away at the moment and it becomes difficult to discuss birth control', 'the heat of the moment', 'weakness felt at the moment during sexual intercourse to discuss this issue' and 'just wanted to have sex' (Rhodes and Cusick , 2002: 218). Among these participants, spontaneity of sexual activity is indicated as a very important factor influencing dual contraceptive use. This suggests that it is not simply the absence of condoms that prevents dual contraception. The discomfort and reluctance to discuss condom use during sexual activity is a key deciding factor.

iii) LENGTH OF THE RELATIONSHIP

Other research indicates that use of dual contraception and the choice of the contraceptives used are connected to the length of a couple's relationship. For example, a qualitative study conducted on young women's contraceptive choices and how they are influenced by the length and nature of the relationship was conducted by Woodsong and Koo. Some of the participants talked about using condoms at the beginning of their relationship, and then moving to non-use of condoms as the relationship with their partners developed. The birth control pill became the main choice of contraception as the relationship evolved. These women indicated concern about unwanted pregnancy, yet they also admitted to using the birth control pill inconsistently, and occasionally not using it at all thus leaving them with no form contraception at certain points in their relationship inspite of ongoing sexual activity (Woodsong and Koo, 1999:574).

Serial monogamy and lack of dual contraception are also linked according to a study by Everett et al. (2000). They found that among high school students, condom use declined if women believed they were in a monogamous relationship, even though the belief might be inaccurate. The couple usually resorted to other forms of contraception or occasional use of contraception at this point of their relationship. The most troubling discovery to the authors was that in the period of their presumed monogamous relationship, 46% of the students were actually involved in sexual activity with another partner (Everett et al., 2000:117). Poppen and Reisen similarly state

that women use dual contraception early on in relationships, but neglect condoms as soon as the relationship becomes committed (1999:63).

Saygeh, Fortenberry, Anderson and Orr (2005) looked at the rates of chlamydia among young women. Their work indicates that condom use is neglected in relationships that are perceived to be monogamous for numerous reasons. When partners establish trust with each other, condoms are seen as unnecessary in their sexual encounters. Stopping condom use is also seen as a signifier that the two people are having sex exclusively with each other (Saygeh et al., 2005:167). Dual contraception is thus seen as a practice for relationships where two partners are not exclusive with each other and there is no trust. Equating dual contraceptive use with mistrust is very problematic as this behaviour clearly puts both partners at risk of STDs, especially when there are acts of infidelity by one partner.

Social influences also play a very important role in influencing women's use of dual contraceptives. Some of the key social influences are the nature of sexual health education, parental involvement, and peer attitudes. The literature that has been collected on the nature of sexual health education is discussed in the following section.

iv) NATURE OF SEXUAL HEALTH EDUCATION

According to Crosby and Yarber, correct condom use was the topic least covered in sexual education classes in the United States, with only 37% of the instructors providing instructions on condom use (2001:416). Dual contraception was a topic that was rarely touched upon in many schools in

Canada too, as will be discussed below. Crosby and Yarber examine the quality of sex education in their large longitudinal study of 16,677 young men and women in the United States. Their report stated that even though 91% of high school students receive some form of sex education, the quality of education received about contraceptives varied greatly (Crosby and Yarber, 2001:415). The majority of their sample believed they could benefit from education on how to use contraceptives, including the condom, correctly. Sexual health education is shown to have a positive effect on the use of contraception. Dilorio, Dudley, Kelly, Soet, Mbwara, and Potter (2001:209) state that adolescents who attended public sexual health clinics viewed condoms favourably and also used them consistently.

In many cities in Ontario, local health units are actively involved in promoting sexual health education, programs and services (Orton and Rosenblatt, 1993:109). Yet, Orton and Rosenblatt's study found that only 11% of the Ontario public school boards reported having condom dispensers in their high schools (1993:113). Oral contraceptives, when sold at Public Health Units, usually cost five dollars for a package. IUDs are not available from many health units and 57% of health units in Ontario reported that diaphragms were not available (Orton and Rosenblatt, 1993:114).

According to the Ontario's Ministry of Education and Training curriculum, topics on healthy sexuality and contraceptive use are introduced once in grade nine, and are not discussed for the remainder of the student's high school education (1999:3). The availability of sexual health education

greatly varies in the province of Ontario The grade nine health and physical education program is divided into four major strands with sexual health education falling under the 'Healthy living' strand. Even though the curriculum discusses that sexuality should be taught under this strand, teachers are left to their discretion as to the amount of time that can be devoted to this topic (Ontario Secondary School Curriculum, 1999:11). The topics covered vary within schools and among teachers. There are no mandatory rules to teach units on contraception, sexually transmitted diseases, types of contraception, and so on.

v) PARENTAL INVOLVEMENT

Orton and Rosenblatt investigated the roles of parents in providing sexual education to children (1993:159). Their research recommends that if the parents do not have the education to provide knowledge to their children about safe sex practices and contraceptive use, they should attend classes to obtain the knowledge to impart it to their children. Bull and Shlay found in their study of dual contraception that three-quarters of their sample did not talk about healthy sexuality with their parents (2005:75). Many of the women interviewed considered their parents not to be open-minded enough to discuss sexuality with them. Some of the women also thought that their parents would judge them harshly (Bull and Shlay, 2005:75). Those women who talked to their mothers about healthy sexuality found them to be a helpful source. They note that when young women are not speaking to their parents

about their sexual activities, the parental involvement tends to be minimal in this aspect of their lives.

Hacker et al. argue that parental involvement is highly correlated with an adolescent making healthy contraceptive choices and engaging in safe sexual intercourse (Hacker et al., 2000:286). Lack of communication about contraception between the parent and the child was shown to cause the child to make poor contraceptive choices in the future.

vi) PEER ATTITUDES

Peers and friends are a very influential group for young women and men in the 18 to 25 age range. Many young adults turn to their friends for information on contraceptive use. According to Hacker et al. (2000:283), 14% of their sample received knowledge about contraceptives from their friends. Friends and peers influence each other in numerous ways, including how they think about sexual activities and contraceptive use.

In a study conducted on dual contraception at two college campuses in the United States, Poppen and Reisen (1999:11) note that women who had friends who viewed dual contraception positively tended to use dual contraception more frequently. Bull and Shlay state that 73% of their sample talked about sexuality and contraception with their peers (2005:76). One of the problems with peer groups is that friends also convey incorrect information about contraceptives to their peers (Dilorio et al, 2001: 214). Dilorio et al.'s study on adolescents found that the behaviour of peers made a huge impact on how the adolescents made sexual choices for themselves. If

their peers held negative attitudes towards condoms, the adolescents themselves held those negative attitudes (Dilorio et al., 2001:214). This makes peers an influential, but unreliable, group that individuals might depend on for information about contraceptive choices.

vii) RELIGION, CULTURE, AND ETHNICITY

Tschann et al.'s study was conducted among an ethnically diverse adolescent sample in San Francisco. Their study found no direct relationship between ethnicity and a woman requesting that her partner wear a condom (Tschann et al., 2002:22). Oncale and King conducted their study on condom use among 954 undergraduate students in an urban university in the United States. Fifty-five percent of their sample identified themselves as Catholic while almost 20% of the sample identified themselves as Protestants. Fifty-four percent of the sample identified themselves as Caucasian and 28% of the sample identified themselves as African-American (2001:380). This study also found no significant differences among ethnic and religious groups with regards to decision making about condom use or actual practice of condom use (Oncale and King, 2001:383). Though it is not possible to generalize from only two recent studies, these findings suggest that religious denomination and ethnicity might not be influential factors in using condoms during sexual intercourse. However, research does show that religiosity can be a factor in women using the birth control pill to prevent pregnancy during sexual intercourse.

Miller and Gur conducted a study on sexual responsibility among adolescent girls from an ethnically diverse sample. Fifty-nine point four percent of their sample was Euro-American, 23.3% African-American, 6.0% Hispanic, and 11.4% were from other ethnic backgrounds (2002:401). Their study did not show a connection between ethnicity and use of contraception per se. Interestingly however, religiosity was shown to be linked with a woman's choice to use contraception. Miller and Gur stated that young women who attend some religious events had greater knowledge about the suffering associated with an unplanned pregnancy or HIV (2002:404). Fear of suffering an unplanned pregnancy encouraged these women to use a systematic form of contraception, such as the birth control pill. This insight was formed from their religiosity, which discouraged risk-taking behaviours such as engaging in sexual intercourse if there was a chance of them getting pregnant along with encouraging more self-restraint. These women were also more likely to visit birth control clinics to obtain prescriptions of the birth control pill. The use of condoms by these women in order to prevent STDs was not mentioned in this study.

Everett, et al. who studied high school students in the United States argue that the usage of the pill is greater among Caucasians than African-Americans or Hispanics (2000: 115). Among their sample of sexually active participants, 20.6% of the white students in their sample were using the birth control pill compared to 11.9% of black students and only 9.6% Hispanic students. However, their study did not show ethnicity or religion influencing

use of condoms. The authors suggested that women are trying to prevent unwanted pregnancies rather than STDs by using the pill without condoms. Their study concluded that young women were replacing condom use with birth control pill use to prevent pregnancy. This held serious implications for the rising STD rates in the United States among young women.

The most striking work done on ethnicity in Ontario was done by Calzavara et al (1998). Six hundred and fifty-eight out of 6100 Aboriginal youth from First Nation reserves of Ontario took part in this study (Calzavara et al., 1998:272). The researchers found that fear of pregnancy was the only factor that predicted condom use. Fear of STDs did not have any effect on the participants' condom use (Calzavara et al., 1998:278). Sixty one percent of this sample also did not use condoms when engaging in heterosexual sexual intercourse. Therefore, the use of condoms was not very common among the youth surveyed.

The *Ontario Aboriginal HIV/AIDS Strategy* reports that the rates of teenage pregnancy are very high among Aboriginal women in Canada (Ontario Aboriginal HIV/AIDS Strategy, 1996:24). In the United States, the rates of teenage pregnancy are very high among African-American women compared to Euro-American women. Twenty-five percent of all the black children in the United States are to born to teenage mothers. Among different ethnic groups, Caucasian women were more likely to use systematic methods of contraception to prevent unwanted pregnancies (Carataga, 1999:106). Orton stated that women who attended church were more likely to prevent

unwanted teenage pregnancy because of the emphasis on sexual responsibility. However, prevention of STDs was not mentioned in this understanding of sexual responsibility (Orton, 1999:128).

It is noticeable that role of religious beliefs is limited to encouraging the prevention of pregnancy. Class is also a very significant factor in prevention of pregnancy. Orton says that teenage pregnancy is more common in women who are from families of lower socio-economic status. She says,

> The proportion of teenage women reporting a pregnancy in the previous years was 18 percent for those in a household with income below $30,000, more than four times higher than the 4 per cent reported in households with income above $30,000. Similarly, few sexually active teenagers in lower income households (below $30,000) reported that they always use birth control (54 percent vs. 68 percent in households with income above $50,000) or use condoms as protection against sexually transmitted diseases (18 per cent vs. 35 per cent) (Orton, 1999:128).

Henderson, et al. also note that sexual intercourse before the age of 16 along with pregnancy is often stigmatized and seen as a symbol of being from lower class (2002:484). Teenage parents are often viewed as being of lower class because of their financial inability to care for their child, lack of education, unemployment and poverty levels (Caragata, 1999:106). Having a child at a young age also has implications for a woman's ability to continue her education in order to attain better job prospects. Therefore, it is understandable that prevention of pregnancy is important for many women.

With so much emphasis on the prevention of pregnancy, it is interesting to note from the literature reviewed that prevention of STDs is largely being neglected. While ethnicity and race do not appear to be

influential factors in determining use of dual contraception according to this research, some level of religiosity, fear of unwanted pregnancy and social class remain important factors.

CONCLUSION

It is evident from the discussion above that numerous factors influence a woman's use of dual contraception while engaging in heterosexual sexual encounters. Power differentials along with the social construction of female morality is very important in influencing dual contraceptive use. Spontaneity of sexual intercourse and length of the relationship are also very important in determining if condoms are used at all during sexual intercourse. When sexual encounters become spontaneous, condoms are not used if they are not readily available. Additionally, studies suggest that in relationships perceived to be long-term and monogamous, condom use is neglected. Here partners are more focussed on preventing pregnancy through a systematic method of contraception.

Within the social circle, the nature of sexual health education, parents and peers remain key to developing attitudes about healthy sexuality for women. Even though culture and ethnicity may not play significant roles in influencing choices of contraception, some religions enforce a strong moral code about not becoming pregnant before marriage. The stigma of unwanted teenage pregnancies as a signifier of lower class families also provides

motivation for some women to use systematic methods of contraception to prevent pregnancy.

Drawing on these insights, the next chapter discusses in more detail the methodological concerns shaping this study and the way in which it was conducted. I discuss my sampling method, how the interview questionnaire was developed, and the rationale for choosing a feminist qualitative methodology for this study. Challenges faced during the interviews are also discussed. Chapter Three also provides details about the discussions held with key informants that played an important role in designing the questionnaire and the thematic analysis used to code the study results.

CHAPTER 3 - METHODOLOGY

This thesis draws on both primary and secondary sources. Primary sources include in-depth interviews with 15 university students between the ages of 18-25 who were born and/or raised in Northern Ontario. Ten of the participants were from the city of Thunder Bay. The remainder were from the regional communities of Rainy River, Sudbury, Sault Ste Marie, Longlac, and Dorion (See map- Appendix D). Secondary sources were drawn from literature on contraceptive use among young heterosexual women from the fields of Sociology and Women's Studies with a focus on women and sexuality, women's contraceptive use, decision making affecting women's contraceptive use, and health risks associated with not utilizing dual contraception. As discussed in Chapter Two, existing literature was used to identify the factors that are thought to influence use of dual contraceptives during sexual encounters. Three key informants knowledgeable about contraceptive use from the city of Thunder Bay were also contacted to obtain information that pertained specifically to this region.

As discussed in the previous chapter, the secondary sources suggested many key factors that shaped dual contraceptive decision making such as power differentials between the partners, spontaneity of sexual intercourse, length of the relationship, peer influences, and parental involvement in the woman's life. The findings from the literature search were

used to develop the key themes for the interviews (See Appendix A for full questionnaire).

1] QUALITATIVE METHODOLOGY INFORMED BY FEMINIST RESEARCH

This study utilized a qualitative methodology informed by feminist research. Most existing studies which look at the contraceptive choices made by males and females are quantitative in nature, relying on surveys and questionnaires (see for example, Poppen and Reisen, 1999; Crosby and Yarber, 2001; Dilorio et al, 2001; Bearinger and Resnick, 2003). To date, very few qualitative studies have been done on dual contraceptive use (Woodsong and Koo, 1999). A qualitative study employing feminist principles such as the one done by Bull and Shlay (2005) has many advantages for doing research on women's sexuality. One of the biggest benefits is that it gives an insider perspective. According to Hesse-Biber and Leavy, qualitative research provides detailed explanations of why certain social processes can occur. When informed by feminist methodology, qualitative research becomes crucial in uncovering women's experiences (2004:4). The quotation below from Anderson and Jack (1991) highlights the importance of listening to women's perspectives using qualitative feminist methodology.

> Where experience does not 'fit' dominant meanings, alternative concepts might not be readily available. To hear women's perspectives accurately, we have to learn to listen in stereo, receiving both the dominant and muted channels clearly and tuning into them carefully to understand the relationship between them (Anderson and Jack, 1991:11).

As discussed in Chapter One, there has been a significant body of quantitative data collected on the use of contraception. Two of the studies referred to in Chapter One, however, were conducted using a qualitative approach. Their findings have been particularly helpful for the design of my study. One of them is the study by Sheana Bull and Judith Shlay in Denver, Colorado (2005). This study involved in-depth interviews with 48 women from the ages of 13 and above. Their sample consisted of women who were already considered at high risk of unwanted pregnancies and STDs. One of the significant contributions of this study was that themes relating to trust and power dynamics that prevent use of dual contraception were discussed in detail by the participants. This provided the researchers with insight into why dual contraceptive use is neglected in many heterosexual relationships.

The other recent qualitative study that was done on dual contraceptive use was by Cynthia Woodsong and Helen Koo in Atlanta, Georgia (1999). Woodsong and Koo ran focus groups for African-American males and females in order to obtain their perspectives on the factors that influence the use of dual contraception. Woodsong and Koo's methodology was crucial in uncovering the experiences of women of colour and their perspectives on dual contraceptive use. Their qualitative data showed that numerous women are familiar with the benefits of dual contraceptive use, but are unable to negotiate the same while engaging in sexual encounters because of power related issues. The women they interviewed discussed issues such as power dynamics and issues of trust influencing dual contraceptive use in detail.

O'Neill criticizes quantitative research as one that silences the participants by treating them as objects (1995:332). There is a limited relationship between the researcher and the participants during quantitative research, resulting in more descriptive than interpretive findings. For my study, a clear relationship needed to be established between myself and the participants, because the topic warranted trust between the former and the latter. Building this trust was very vital to my study because the topic of sexuality and contraceptive use is a personal one for most women. Qualitative research using feminist principles such as subjectivity and reflexivity helps establish a closer relationship with the participant, which is very important while discussing sensitive issues such as contraception (Maynard and Purvis, 1995:7).

Charmaz (2004) talks about the building of rapport with interview participants in her work. She conducted interviews with women who suffered from chronic illnesses. Charmaz argues that an unexpected relationship is often built with the women who are being interviewed. She reached this conclusion when one of the women she interviewed, Karen, called her months after the interview. Karen wanted to help with Charmaz's study because Karen herself had gained a lot from the interview and wanted to give back something to the interviewer (2004:16). Even though this kind of relationship is not always possible to develop, it is important to establish meaningful relationships with participants who are being interviewed.

When potential participants were called for the telephone screening, I talked to them about their program of enrolment at the university, their interest in choosing the particular program, their favourite courses, as well as discussing the study with them. This helped to establish a minor, yet meaningful, channel of communication between the participant and myself. Since the issue being discussed was contraception, which is a sensitive topic, most participants wanted to have a more relaxed encounter, such as having a cup of coffee during the interview which we did. I also asked participants to choose the location of the study to make it more comfortable for them. Three participants chose their own homes and two chose the Gender Issues Centre at the University. The remainder of the interviews were conducted at my graduate office.

During the interviews some participants asked me personal questions about myself. They wanted to know about my cultural background, my interests, my reason for choosing this topic, my experiences of living in other cities, and so on. I shared some personal information in response to their requests to help build a rapport between us and in an effort to minimize the power differential between interviewer and interviewee. Their comfort and trust in me was very important in acquiring accurate information on both pregnancy and STD prevention.

In the literature, Kitzinger discusses the issue of sensitivity while conducting qualitative research. Kitzinger did her work on interviewing people for the HIV/AIDS media project using a focus group methodology. She talks

about the relevance of using methods such as focus groups and interviews, as they tend to be more interactive than non-qualitative methods. She argues that this kind of interaction is often better for addressing sensitive issues because of the possibility for dialogue and trust building (1994:2).

Feminist principles when applied to qualitative research address the issue of power between the participants and the researcher. During quantitative research, the participants are often asked questions in the language of the researcher, which may be very scientific and discipline oriented. In their study on young women's sexuality, Holland and Ramazangolu (1994) talk about the language that made it difficult for young people to understand the research questions.

> In our case, quite often young people did not have an appropriate language with which to discuss sexual matters. What was available was either the clinical/scientific, which is somewhat removed from their own vocabulary, or the obscene/crude, which they were often uncomfortable with in an interview (Holland and Ramazangolu, 1994:138).

Use of formal scientific language establishes an environment in which the researcher holds more power over the participant (Oakley, 1981:30). For my interviews, I made an effort to design my interview questionnaire using language and vocabulary that reflected the way women actually talk about their sexual health and other matters on this subject. To do so, I first conducted pilot interviews with three women on their views on contraception. During the pilot interviews, I asked the women if they would change anything

about the questions they were asked. The pilot interview participants did not suggest any needed changes to the interview questionnaire.

During the actual interviews for the study, every participant was asked at the end if there was something that needed to be improved on, changed, or included in the questionnaire. Some of the suggestions given by the participants were to ask more about demographics, to add more questions about the teenage pregnancy rates in Northern Ontario, and to include more on sexual health education in Northern Ontario. Modifications were consistently made to the interview schedule to incorporate these suggestions.

As the interviews progressed, I paid attention to the language used by my participants during the interview. The questionnaire was refined after each interview. My supervisor and I reviewed early interview transcripts together and changes in language and vocabulary were made throughout the interview process.

One such example was when we noticed that participants were reluctant to talk about their own experience with STDs in the initial interviews. I added the question 'have you ever asked a male sexual partner if he has had an STD test?' (See Appendix A for full questionnaire). Rather than initially asking directly about the participant's own sexual history, this question inquired about the male sexual partner's sexual history. After this question was added to the interview schedule, I noticed that when it was asked, the participants were more relaxed while talking about STDs as the discussion was not initially directed towards their own STD testing history. Interestingly

many did voluntarily share information about themselves afterwards. This question also opened up more discussion from participants on power differentials with their male partners and the problems they would face if they asked their male partners about having undergone STD testing in the past. Since this question was asked very early on in the interview, it helped to minimize any power of language that I unconsciously had over the participant being interviewed. Some participants instantly became comfortable talking about terms such as the 'norms of femininity' and 'social stigma' attached to being a sexually assertive female once this question was asked.

Bryman describes qualitative research as aiming to see through the eyes of the people being studied (2001:277). Using a qualitative feminist methodology helps a researcher, such as myself, to view the participants through their own experiences of using contraceptives. This is not to say that qualitative research is not without its limitations. One of the criticisms of qualitative research is that it may be difficult to replicate in another setting (Bryman, 2001:282). The interviewer becomes the main person who is collecting the data, asking the questions, and the questions follow an unstructured format depending on the answers given by each respondent (Hesse-Biber and Leavy, 2004:12). This could result in more variability in the method used.

For example, in my study, some participants tended to deviate a lot from the actual questions I posed. When asked about peer attitudes, one participant shared some thoughts on the negative relationship with her peers

now because she had just arrived at the interview after arguing with a group of good friends. This was not related to the interview question on peer attitudes influencing choices of dual contraception. Therefore, my conversation with this particular participant was left up to my discretion as to how to redirect and continue with the interview.

A small quantitative study also faces limitations of generalizability. As will be discussed in more detail later in this chapter, my sample consisted of 15 women between the ages of 18 to 25 who are currently attending Lakehead University in Thunder Bay. A university sample represents a group who have chosen the path of post-secondary education. Women who are attending university are able to afford to attend university, possibly because they come from families that have a higher socio-economic status. However, this may be less of a concern at Lakehead University given that a much greater proportion of students come from working-class or lower-middle class families in Northern Ontario. Almost half of the students who attended Lakehead University in 2004 came from Northern Ontario (Lakehead University Annual Report, 2003:1). This makes the sample of students chosen from Lakehead University for this study unique compared with the students attending universities in many other parts of Ontario.

Even though they could be from middle or working class backgrounds, a certain level of motivation exists for these women to remain in university, and this could be an influencing factor in preventing pregnancy or a sexually transmitted disease. The results obtained from this exclusive group of

university students would be hard to apply to a population of the same age group who are not currently obtaining any post-secondary education.

2] SAMPLING

Sampling was done through the distribution of flyers around the campus of Lakehead University explaining the nature of the research study and inviting women to participate. I also went into classrooms with the permission of instructors and provided a brief discussion of the study to recruit potential participants. Some of the classes I selected were in the disciplines of Sociology, English, Women's studies, Engineering, Biology, and Psychology. The study was also advertised through the Gender Issues Centre (GIC) at Lakehead University. A few participants heard about the study from peers and friends. They contacted the interviewer (me) through electronic mail or personal contacts.

Even though the sample was not random, steps were taken to ensure some variation among participants in terms of their ethnicity, educational background, religion, and family structure. The posting of flyers and canvassing of potential participants by going to classrooms spread the word of the research study at a larger scale. The people who contacted me after viewing the posters had no prior relationship with me. They were selected to be participants in the study after a telephone screening for age, city of birth, city of residence and whether they had ever engaged in heterosexual sexual intercourse. Two participants reported having children and were included in

the study. Even though participants were limited to the ages of 18 to 25, numerous participants above the age of 25 called and expressed interest in participating in the study. A limitation of the sample remains that the participants are self-selected – they are the ones who chose to respond to the flyers and the classroom canvassing.

Five additional participants were obtained through a snowball sample. The snowball technique is helpful when research is sensitive and needs some built-in trust between the interviewee and the interviewer. Snowball sampling has been defined as 'starting with one or two people and then using their connections, and their connections' connections, to generate a large sample' (Palys,1997:139). Since snowballing is established through a network of friends and acquaintances, it uses pre-established trust to the advantage of researching such a personal topic. It should also be understood that snowballing might bring in participants who socialize in the same social networks. Their opinions on issues such as dual contraception could be influenced by their social networks.

Although care was taken to ensure that the sample was varied, it remains a small sample. A majority of university students fall between the ages of eighteen and twenty-five. Since this research project deals with factors influencing young women's dual contraceptive practices, my rational in selecting university students lay in the notion that the university was a good location to contact single women who are involved in heterosexual sexual encounters or relationships. The chances of these women being single and

not having children were greater within a university setting than most other settings. The Lakehead University student body includes women from different ethnic and cultural backgrounds, including Aboriginal women. As a percentage of its enrolment, Lakehead has one of the highest Aboriginal student populations at a Canadian university (Lakehead University Annual Report, 2003:1). A considerable effort was made to include Aboriginal students in this study. I contacted the chair of Indigenous Studies at Lakehead University, who offered to inform the students in her classes about the study. Flyers about the study were also given to the professor mentioned above. I posted flyers at the Aboriginal students centre at Lakehead University, inviting their participation in the study. These efforts were made to obtain a representative sample of the student body of Lakehead University for the study.

3] METHOD

In-depth interviews were chosen for the research technique because, as explained above, they encourage a subjective account of the participants' experiences. As I am studying factors that influence dual contraceptive use, the interviews gave each participant a chance to provide me with rich detail on the factors that influence their use, or non-use, of dual contraceptives. The in-depth interviews consisted of open-ended questions that left room for discussion and personal reflections on factors affecting dual contraceptive use.

As mentioned previously, drawing on existing literature, the main themes the interview schedule covered were: demographic information such as age, education, race, ethnicity, religion; detailed questions on the factors that influence women's choices of using dual contraception in heterosexual sexual encounters such as power differentials between male and female partners; length of the relationship; spontaneity of the sexual intercourse; the influences exerted by parental involvement and peer attitudes; sexual health education received along with the emphasis placed on dual contraception during sexual health education; and any other areas participants' responses suggested. After building on the factors identified through the literature review, I added questions that focused on the specific circumstances and dynamics of sexuality in Northern Ontario. These questions were developed from the literature review and from the interviews with key informants. Demographic questions were included at the beginning of the interview schedule. The full interview schedule is included as appendix A.

The research by Woodsong and Koo focused on women's lack of power and their unequal status with men in relationships that are sexual in nature, and attribute it to women's need to comply with the norms of society (1999:571). To explore these power dynamics, in my interview the questions on power differentials ranged from "How do you negotiate the type of contraceptive to use with your male sexual partner?" to "If you use a contraceptive to prevent pregnancy, but your partner refuses to use a contraceptive to prevent STDs, do you still continue the relationship?"

Everett. et al. found that among undergraduate young students, condom use declined if they believed they were in monogamous relationships. The use of condoms was dependent on the length of the relationship in their study (2000:112). In my research, an example of a question that dealt with length of the relationship was "How long into your relationship did you reach the decision to use a certain type of contraceptive?" Questions were also asked on other factors that influence contraceptive use such as sexual health education, peer attitudes, parental involvement, cultural values, religious values, ethnicity, etc. The interviews ranged in length from one hour to two and half hours. The majority were an hour and half in length. With the respondents' permission, all of the interviews were tape-recorded and transcribed for later analysis.

4] PARTICIPANTS

The participants contacted the interviewer (myself) primarily by telephone. During each call, the purpose of the study was clearly explained to the participant. If the participant was interested in participating in the study, a time and place for the interview was scheduled. Before the interview started, the participants were given a cover letter explaining the study in detail and a consent form discussing this research project as per Lakehead University's research ethics guidelines. It was made clear in both the cover letter (See Appendix B) and the consent form (See Appendix C) that participation in the study was strictly voluntary and the information provided would be kept

completely confidential. Respondents were assured that they could withdraw from the study at any time and did not have to answer any questions they did not wish to. All the respondents did the interview in English. With the permission of the participants, interviews were tape-recorded and transcribed.

The mean age of the participants was 22 years. Seven of the 15 participants were born and raised in Thunder Bay. Two of the participants were born in Toronto and spent their early adulthood in Thunder Bay. Five participants were born and raised in the cities of Rainy River, Sudbury, Sault Ste Marie, Dorion, and Longlac. One participant was born in Nipigon, raised near Fort Frances until she was three and then moved to Thunder Bay. The parents of eight participants were still married. One person's mother died about four years ago. One participant did not want to discuss her family constitution. Five participants had parents who were divorced.

Even though the majority of the participants said they were not religious now, the family religion growing up was identified as Catholic (four participants), Lutheran (two participants), Presbyterian (one) and Anglican (two participants). The other participants identified no family religion growing up. Middle class was the most common class designation given by participants. Only one participant identified herself as upper class. Three participants identified themselves as not belonging to any ethnic group. One participant identified herself as Aboriginal. French, Scottish and English were the most common ethnic heritages mentioned by the majority of the

participants. For a detailed breakdown on demographics of the participants, please see Appendix E.

Some of the participants were more comfortable than others at the outset of the interview and others grew more comfortable as the interview progressed. All the participants were forthcoming about very personal aspects of their lives that included dual contraceptive use. Many of the participants also stated that they were aware of the high rates of teenage pregnancy in Thunder Bay and everyone was aware of the high rates of STDs in Thunder Bay.

The interviews were conducted between September 2005 and April, 2005. This was considered to be the best timeline because almost all students are on campus during these months. The parameters of the sample did not change, but two women with children were included in the study because they fit all of the necessary parameters of age and place of origin when they contacted me and expressed interest in participating. There was very little response to participate in the interviews during the first 2 months of the academic year, but the responses progressed rapidly after November.

There were no unexpected challenges from the interview sessions. Many participants expressed happiness that such a study was taking place in their community. Some also suggested that men should have been included in the study. They felt that they would it would be beneficial to know about male perspectives on the relationship between condom use and the high rates of STDs in Northern Ontario. As I note in the final chapter, a future study

looking at both male and female perspectives on this topic would be useful. In the future, I would also widen the age parameter so women in their thirties could also participate in this study. These women's perspectives as university students in the child-bearing age group would make them a potentially important group to interview.

5] KEY INFORMANTS

For additional insights, I also contacted three key informants who are knowledgeable about contraceptive use among young women in Northern Ontario. The three key informants chosen were an educator for the AIDS committee of Thunder Bay, a nurse practitioner with the Anishnawbe Mushkiki Aboriginal Health Access Centre, and a government employee at the First Nations Branch of Health Canada in Thunder Bay. After the interviews were completed, I re-contacted the nurse practitioner from the Anishnawbe Mushkiki Aboriginal Health Access Centre to discuss her perspective on some of the findings.

Esterberg describes key informants as individuals who are quite knowledgeable about a particular scene and are willing to share information and their expertise with the researcher (2002:70). For this study, discussions with key informants were used to aid in developing questions that were relevant to the sample being interviewed. The key informants provided me with valuable information on the specifics of sexually transmitted diseases in Northern Ontario, the trends of contraceptive use in Northern Ontario, the

problems surrounding the lack of use of condoms among students in Northern Ontario, and the high rates of teenage pregnancy in the region.

The educator from the AIDS committee of Thunder Bay provided insight and knowledge on dual contraceptive use in Thunder Bay to prevent AIDS and other STDs. As stated in a preliminary discussion with this key informant, prevention of STDs does not play a major role in casual heterosexual sexual encounters. Prevention of pregnancy is the key concern for many women engaging in heterosexual sexual intercourse. The key informant affirmed that power differentials in relationships between men and women, availability of condoms during sexual intercourse, length of the relationship and spontaneity of the intercourse were factors that led to dual contraception not being used. Thus, even though condom use is imperative to prevent STDs, many individuals in Thunder Bay are still engaging in casual sex even if the woman is on another form of contraceptive (i.e. birth control pill) to prevent pregnancy. This background information was used to help develop some questions for the initial interview questionnaire.

Informal discussions with the two other key informants provided perspectives on the issues surrounding dual contraceptive use among the Aboriginal population of Thunder Bay. It was important to include perspectives from the Aboriginal community because Aboriginal people's rates of sexually transmitted diseases are estimated to be almost four times higher than the Canadian national average. Aboriginal women also represent a higher population of diagnosed HIV/AIDS cases compared to their non-

Aboriginal counterparts - 18% as compared to 6% (Stout, M., Kipling and Stout, R., 2001:13).

The nurse practitioner with the Anishnawbe Mushkiki Aboriginal Health Access Centre shared knowledge about the high rates of STDs in the Aboriginal population, especially chlamydia and gonorrhoea. She discussed the Centre's services including distribution of free oral contraceptives, condoms, and IUDs. Power struggles during heterosexual sexual encounters, women's inability to negotiate condom use with men and multiple sexual partners were the main concern that she identified in the Aboriginal community. The last key informant worked at the First Nations Branch of Health Canada in Thunder Bay. Being a government employee, she was able to share some problems around lack of research and lack of statistics available on the health care of Aboriginal people. She also discussed the high rates of teenage pregnancy in the Aboriginal communities of Northern Ontario. Data from the key informant interviews were used to develop questions about growing up in the north, high rates of STDs in the north, and STD testing were then added in the interview schedule.

6] CODING THE DATA

A thematic analysis was used to code the data. The first approach was to narrow themes from the content of the interview. Themes are identified by "bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone' (Aronson, 1994:1). For instance;

did participants who say A also say B' Were there similarities or differences between these participants' Do some themes relate to each other more than other themes do" (Aronson, 1994:1). This did not rule out the fact that deviating patterns occurred among some themes. These patterns were also considered. An example of a theme that was identified during the research is the decline of condom use during long-term relationships. Excerpts from the that demonstrated these themes included 'when I was in my longest relationship, towards the end of it, we either wouldn't have condoms or we would' (interview #2), 'as the length of the relationship's time increased, condom use became more sporadic. Now, its just occasional.' (interview #1), and 'We were just like dazed at the point and realized we don't have condoms. Should we, should we not, what are the implications. Then me saying I am on the pill, the risks are low, so, yeah' (interview #3). After reviewing the interview transcripts, key themes were coded and cross-checked and the findings reviewed in relation to the secondary literature.

CONCLUSION

This chapter has focussed on the various aspects of methodology including method, sampling, collecting information from key informants, and coding of the results from the interviews. The next chapter outlines and analyzes the key themes that emerged from my interviews - those that corresponded to previous findings and those that were new For example, it became evident during the interviews that trust plays a vital role in negotiation

of dual contraception during heterosexual sexual encounters. Another key factor that emerged during the interviews, but was not discussed in the secondary literature, was the nature of sexual health education. During the interviews, numerous participants talked about the emphasis of sexual health education in their high schools as being purely focused on biology and anatomy rather than the interpersonal dynamics of sexual relationships. This was a concern for many of the participants. Themes that were present in the secondary sources along with themes that emerged from the interviews will be discussed in detail in chapter four.

CHAPTER 4 – NEGOTIATING TRUST, SOCIAL INFLUENCES AND SOCIAL CONSTRUCTION OF MORALITY IN DUAL CONTRACEPTIVE DECISION MAKING

This chapter is primarily descriptive in nature. I present the summaries of my interviews and give detailed accounts from the respondents to illustrate key themes arising from the interviews. I discuss how women's use of contraceptives is influenced by many factors, such as power, length of the relationship, nature of sexual health education, parental and peer attitudes, cultural, religious and ethnic values, and issues of anonymity in accessing contraceptives in Northern Ontario. I also discuss the emerging themes from the interviews such as trust between partners, and the nature of sexual health education. Before turning to a discussion of these key factors, I begin with an elaboration of participants' understandings of healthy sexuality. Their perspectives on sexuality were explored by asking them about their primary purpose in using a contraceptive, their thoughts on dual contraception and how they will teach their own children about contraception. The contrasts between the ideals they express and their actual contraceptive practices will be discussed later in this chapter.

1] PRIMARY PURPOSE FOR USING A CONTRACEPTIVE

All of the participants understood the meaning of the term 'dual contraception'. Of the 15 women interviewed, all said that their primary

purpose in using a contraceptive was to prevent pregnancy. When asked the question, "What is your primary purpose in using a contraceptive"? responses included:

> Leah: to not get pregnant (Interview #8)[4]
>
> Lynn: to prevent pregnancy (Interview #9)
>
> Joleen: partly to regulate my period and partly, because of my boyfriend, to prevent pregnancy (Interview #6)

Prevention of sexually transmitted diseases (STDs) was the secondary purpose for using protection while engaging in heterosexual sexual intercourse cited by most respondents as the following quotations illustrate.

> SN: Do you have any other purposes in using a contraceptive?
> Angela: Yes, to eliminate the transmission of STD's for sure. (Interview # 2)

> SN: Any other purposes in using contraceptives other than for prevention of pregnancy?
> Shanta: If it is a new partner, STDs. Just making sure. (Interview # 12)

The birth control pill was the favoured contraceptive for the women in my study. Its accessibility, availability, and high rate of effectiveness in preventing pregnancy were the reasons given for its use. Amy talked about the easy accessibility of the pill discussing how she was able to get it through the District Health Unit in Thunder Bay. She says, "I think that access to contraceptives is good in Thunder Bay. I went to the TBDHU when I was 15 or 16 to see the doctor, to go get the pill, because I know it works."(Interview # 1).

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[4] All the names used are pseudonyms to ensure confidentiality of the participants.

As will be discussed later, Amy is one of the few women in my study who commented on the accessibility and availability of the birth control pill compared to other methods of contraception.

2] PARTICIPANTS' VIEWS ON HEALTHY SEXUALITY

As noted above, when the term dual contraception was mentioned to the participants, everyone understood the meaning of the term. The cover letter (see appendix B) that the participants read before the interview also explained the term in detail. During the interview, all of the participants said they considered dual contraception to be the most effective technique of preventing pregnancy and STDs at the same time. When asked about how their views on contraception changed while growing up, everyone also acknowledged that their views had evolved as they obtained more sexual experience. One of the major changes was becoming more aware of the problems surrounding not using dual contraception such as contracting STDs and or becoming pregnant. The young women felt their knowledge of contraceptive use expanded with time and experience. As Marie says,

> When I was younger, I wasn't aware but now I'm older, I guess that it's more I have to [use contraception]. I know what the effects are. I've seen a couple of my friends get pregnant and get STDs. When I was younger, I was naive to it. Now I know what could happen if I don't. (Interview # 10)

Joleen also noted that she has become more knowledgeable about contraception. She added, "I did a lot of research on contraceptives". This research helped her to choose the right type of contraception for herself. She

felt that Depo-Provera was an unsafe contraceptive for health reasons and that the birth control pill had less long term side effects than Depo-Provera, so she switched to the birth control pill.

The participants were asked how they would teach their own children about contraception. Fourteen responded saying that they would be open and clear with their children while teaching them about contraceptives. All fifteen participants stated that they would advise their children about dual contraception as being the most effective method to concurrently prevent pregnancy and STDs. However, one of the major contradictions in their ideas becomes evident here. On the one hand, they feel strongly about the effectiveness of dual contraceptive use. They recognize the positive aspects of dual contraception and want to impart that knowledge to their future children. However, as will be discussed below, many of the participants themselves are not using dual contraception when engaging in heterosexual sexual encounters. This contradiction between knowledge/beliefs and behaviours was apparent throughout the study.

The majority of participants also stated that they would teach their daughters about contraception differently than their sons as they feel that pregnancy and STDs are a double-edged sword for women. Many recognized based on their own experiences that men might pressure women into having unprotected sexual intercourse. This was cited as a key reason to teach their daughters differently. Jen says,

> I'd teach a daughter from a point of stand up for yourself. I know it might be stereotypical but from a guy's perspective, respect a girl, her

> wishes. For a girl, I'd say you are going to grow up and you need to watch what happens because people will walk all over you. If you want to be on the birth control pill, go right ahead. (Interview # 5)

Ann and Leah said that they would impart more detail about the risk of pregnancy to their daughters. They also stated that they would teach their daughters to be more assertive about using contraceptives when engaging in sexual intercourse with men. Jane said that she would encourage her daughter to stand up for herself and to not succumb to pressure from men to have unprotected sexual intercourse with them. Jane agrees with Jen by saying,

> If its a girl, I'd say when you grow up, you will need to be careful as people will take advantage of you. (Interview # 13)

According to Leah, because pregnancy happens only to women, she would teach her daughter differently too.

> If I have a daughter, I will say you don't want to get pregnant at a young age as it makes your life incredibly difficult. (Interview # 8)

These quotations clearly indicate that the women are very concerned for their daughters because of the possibility of an unplanned pregnancy. These participants are also concerned about men taking advantage of their daughters and pressuring them to have unprotected sexual intercourse. As the women's comments reveal, there is a lot of responsibility placed on female children. The women recognize the importance of their daughters' ability to be assertive in saying 'no' to males who would try to engage them in unsafe or unprotected sexual intercourse.

When asked about how they would teach their sons, none of the participants mentioned the power differential that women face in heterosexual sexual encounters. The most common response of the participants was that they do not want their sons getting girls pregnant. When asked how they would prevent this, all of the participants responded that they would teach their sons about condom use to prevent pregnancy.

Interestingly, none of the participants brought up the topic of teaching their children about STD prevention and using dual contraception when asked about educating their children in the future. Their emphasis was exclusively on teaching their children about contraception to prevent pregnancy.

From the interviews quoted above, even though healthy sexuality is very important to all of the participants, they have distinct views on how to teach their children about contraceptive use. The participants recognized the risks that young women face with unplanned pregnancies. Even though the power dynamics between male and female sexual partners are understood by the participants, their views on healthy sexuality are driven by concerns about avoiding pregnancy. There was little focus on prevention of STDs.

3] KEY FACTORS INFLUENCING DUAL CONTRACEPTIVE USE

Three major themes emerged that influenced women's use of dual contraception during sexual encounters. The themes are: 1) how trust between partners influenced women's ability to negotiate dual contraception ; 2) social influences such as schools, parents, and peers; 3) and the negative

social construction of female morality. Each of these themes is important in the way it influences women's choices of dual contraception while engaging in heterosexual sexual encounters.

A] TRUST

Although prior literature did not emphasize the negotiation of trust in a relationship as a central theme influencing dual contraceptive use, this emerged as a central theme early in my interviews, particularly in relation to the discussion of power dynamics in contraceptive decision-making. Power differentials during heterosexual sexual encounters were studied in two ways. Participants were asked questions about how they negotiated contraception with their male sexual partner(s) and how they inquired about their male partner's sexual histories by asking questions about STD testing.

i) ROLE OF TRUST IN NEGOTIATION OF CONTRACEPTION

All of the participants indicated that they felt it was the responsibility of both sexual partners to use contraception. They said it was the job of the male to use a condom, and use it correctly, and the female to make sure she takes her birth control pill, or uses another method of contraception regularly. Even though this was the ideal view presented, it was acknowledged that men often do not want to wear a condom. Because of this, the women felt safer if they took responsibility for contraception into their own hands. Those

taking the birth control pill stated they were the only ones who could be trusted to take the pill daily.

Another concern that emerged during the interviews was that men could not be trusted to put on a condom correctly. Some women feared that men do not adjust the condom properly, or follow the instructions to use it safely, which might lead the condom to break during the act of penetration. This sentiment was expressed by Rose as follows:

> Yeah, the guy I dated, he was not an expert. He did not know to put a condom on because it did not fit. He said at first, it did not feel comfortable at all. He had to figure out by himself how to put it on, put it on, put it on. I would much rather do something I know how to do than try and fiddle with something I don't. (Interview # 11)

Even though all of the women initially said "both" when asked whose responsibility it was to use contraception, several later stated that it was primarily their responsibility, because of the risk of pregnancy. Hence, as depicted in the following examples, women always made sure that they were on some form of contraception:

> SN: Umm, ok, do you think it's your or your partner's responsibility to use contraception?
> Angela: Both. Definitely mine, I definitely make sure I'm on something for sure. (Interview # 2)

> SN: Do you think it's yours or your partner's responsibility to use contraception?
> Amy: Ummm, hmmm. Both. Mine, I guess. I mean, for myself, it'd be my responsibility. Like I'd never have unprotected sex with anyone. So...okay. (Interview # 1)

When asked to elaborate why they thought it was primarily women's responsibility, all of the women in my sample noted that condom negotiation with men was the hardest part of engaging in safe sexual intercourse. They said that it was always safer for the women to be on some form of birth control to prevent pregnancy. Some of the women noted with concern that female friends had been convinced by their male sexual partners that there was no need for condom usage during sexual intercourse.

The interviews clearly showed that many women feel pressured to negotiate condom use because of the objections raised by men. Two main reasons why male sexual partners did not want to use condoms became evident; either they did not like using condoms, or the comfort of skin on skin contact was important to the men and they felt that condoms interfered with this. Amy talks about one of her friends in this excerpt:

> Amy: Umm, yeah, I had a friend who wanted her partner to use a condom but he did not want to.
> SN: Do you know the reason why he didn't want to use a condom? Was it a long term relationship?
> Amy: No, it wasn't a long term relationship. It was sort of a one night stand.
> SN: So, do you know the excuse he gave?
> Amy: That he did not like using them. (Interview # 1)

Amy said that her female friend had sexual intercourse with the man because she was on the birth control pill. The issue of pregnancy seemed to have been dealt with. The man's dislike of condoms was accepted because the risk of pregnancy had been prevented by the birth control pill in this situation.

Similarly Shanta (Interview # 12) noted,

> I've heard past boyfriends say 'Oh ,we love the skin on skin' whatever. But, no one's ever said it has to be like that.
> SN: Is that an excuse?
> Shanta: It could be, for some guys. If they read Cosmo or anything, there's always articles on that [skin to skin pleasure].

Interestingly Shanta's comments also highlight the role that media plays in shaping an individual's notion of safe sexual intercourse and of pleasure. From her comment it is evident that the magazine might not only have shaped the male's notion of having sex without a condom, it has also shaped Shanta's expectations of what is influencing the man's expectations. It raises a significant concern that if other young women are also relying on information from forms of the media such as magazines, they are being placed at risk of engaging in unsafe sexual intercourse because of the cultivation of problematic ideas about male sexual pleasure versus safe sex.

When discussing issues of power in the bedroom, Kendra talked about her friends. Even though her friends knew that it was dangerous to engage in sexual activity without a condom, they often did not want to pressure their male partners to use condoms. The quotation below shows that women are afraid of being labelled too sexually active by men if they pressure men to use condoms. She states,

> I think they don't want to pressure a guy to wear a condom because of the stigma of doing it. So they are like 'just forget about it'. They don't want to be perceived as like sluts. (Interview # 7)

It is evident here that Kendra's friends think that pressuring a guy to wear a condom has a stigma attached to it because women don't want to be

seen as promiscuous ('sluts'), sexually controlling and assertive about sexual issues in the bedroom.

Jen stated that she was willing to engage in sexual intercourse without condoms if she knew the person well. Even though she may not be in a steady relationship with him, there was a willingness to not use a condom on her part. As stated by Jen,

> I guess if it comes to the guy using a condom and I am on birth control, if it's something we can work at, I can't say that we will not continue (the act of sexual intercourse). It will depend on how long I have known the person. (Interview # 5)

Jen did not elaborate further about why knowing the person for a period of time would be a contributing factor in her decision making process about contraception. However, it is evident that both partners (male and female) are more comfortable with sexual intercourse once the issue of pregnancy has been covered. The birth control pill plays a crucial role as the choice of contraception for many women because of its ability to prevent pregnancy. This line of thought might be the contributing factor to Jen's decision-making process about engaging in sexual intercourse without a condom as long as she is on the birth control pill.

All of the participants were asked about how the topic of contraception is first discussed within their relationships. It became very clear from the interviews that in many cases, there was rarely a discussion about contraception before the act of sexual intercourse was initiated. The majority of participants responded by saying that it was the last thing discussed and usually only came up in the bedroom.

> Angela: No, it usually comes up in the bedroom (laughs). It's one of those last minute things because it's hard to talk about for a lot of people, so it comes up when the need arises and the time for it comes up. (Interview # 2)

The responses of two other participants to the same question were:

> Cathy: Umm, ahmm. I don't know, I never really discuss it. (Interview # 4)

> Kendra: We'll usually have a small conversation about if I'm on the pill. Usually we talk about what the female partner is on for the prevention of pregnancy. You know, we never sit down to discuss what contraceptive to use to protect against STDs. Usually pregnancy issues are talked about first. Often it's not even a priority to talk about condoms. (Interview # 7)

These quotations illustrate that the couples did not talk about dual contraception, or any form of contraception before the relationship became sexual. Despite indicating possessing knowledge on the importance of dual contraception, the women did not seem to be taking the initiative to proactively discuss safe sexual intercourse with their male sexual partners. The clear divide between one's knowledge of safe sexual practices, versus their actual practice, is noticeable here.

As noted earlier, all of the women were very knowledgeable about the problems of STDs and what contributes to healthy sexuality. However, when it comes to their sexual well-being, the primary commitment is to avoid pregnancy. The commitment to engage in safe sexual intercourse using dual contraception to prevent STDs and pregnancy seems not to be of importance here. To further explore the role of trust in negotiating use of dual

contraceptives, the women were asked about their partner's having had STD tests in the past. This is discussed in further detail in the next section.

ii) ROLE OF TRUST WITH REGARDS TO INQUIRING ABOUT STD TESTING

Women's lack of power in heterosexual sexual encounters is evident through their problems negotiating safe sex with their male sexual partner(s). With sexually transmitted diseases being on the rise, women's inability to negotiate safe sex is further exacerbated by their reluctance to ask their male sexual partners about having had an STD test in the past. This reluctance was talked about by numerous participants during the interviews, suggesting that it is it a very important factor.

Surprisingly, none of the women in my sample asked their male partner(s) if they had ever had an STD test. Even though many of the women are familiar with their partner's sexual histories, they found asking about STD testing awkward, difficult, and 'unfeminine'. This was because the cultural construction of female sexuality requires women not to be explicitly sexual. One woman stated that she thought the guy would be offended if she brought up the topic of STD testing. According to Shanta,

> Because guys could be offended by that. They could be like woah, I have only slept with 2 other people and I'm clean, this and that. (Interview # 12)

Shanta's views suggest that in her experience, men are easily offended by being asked about their sexual past. Hence, she did not want to risk alienating them by asking about STD testing even though the information is important for her own health.

Another woman suggested there is a taboo in talking about STDs. She also noted the norm of masculinity makes it acceptable for men to be sexually promiscuous, while, the norm of femininity prevents women from making inquiries about men having undergone STD testing. This norm of femininity shapes a sense of women's morality. Women are supposed to be asexual and not sexually active. Men are allowed a certain degree of sexual freedom and sexual promiscuity that is considered inappropriate for women. As Joleen states,

> I think it is, yeah. I think there's still stigma around STDs even though a lot of people have them. It's a taboo topic. It's almost like offensive to ask someone, because they might take it hard. Having an STD has associations with it. The norms of femininity, Yeah probably it has a role. I think it's supposed to be acceptable for men to have whatever sex they want. I think for women to ask their partners is like they are ...hmm, not sure what to say. (Interview # 6)

Some women feared annoying men when asking them about having undergone STD testing. This prevented Jen from asking her male partners if they have had STD testing in the past. Jen says,

> I don't want to make them feel uncomfortable. I can see you asking and the men turning around and saying "what do you think" and getting all worked up. (Interview # 5)

Jen's feelings are similar to Shanta's. They both think that their male partners would be easily offended if asked about having an STD test done in the past. Jen's reluctance to ask a man about STD testing relates to the reaction she fears from him – he might take offence. This makes the topic problematic for her, and places her at risk of health concerns in the future.

Trust was the key factor that prevented some women in asking men about having STD testing in the past. For some of the participants, an STD test meant delving into the past of their partners, a negative past. It also meant questioning where he has been sexually, whether he always protected himself by using a condom, whether he has cheated on his previous partner(s) and so on. Questioning a man's sexual past may be seen as a challenge to his masculinity. Therefore, some participants choose to trust their male partners to have engaged only in safe sexual intercourse in the past rather than risk offending them by challenging him. As Rose explains below,

> SN: Did you ever ask the men 'have you had an STD test'?
> Rose: No, I think I did not ask men that as a societal thing.
> SN: Is there a reason why you haven't asked men that?
> Rose: Umm, I think that because my sense is that they were going to wear a condom anyways in the past. It's not an issue. (Interview # 11)

Power differentials between males and females often cause problems while negotiating contraception during heterosexual sexual encounters. The interviews here demonstrate that women have problems negotiating contraceptive responsibility, safe sexual intercourse, and issues such as STD tests that are core to healthy sexuality. While my sample consists of university educated women who are aware of the importance of practising safe sex, using condoms during sexual intercourse, and the importance of preventing STDs, it is evident from the interviews that the women are considerably more concerned about preventing pregnancy than preventing contraction of STDs.

Norms of asexual femininity make it hard for them to negotiate dual contraceptive use. While they are aware of the risks that come with unprotected sexual intercourse, many have problems asserting safe sexual intercourse with their male sexual partners.

Interestingly, the women seem to be more focussed on the man's feelings, such as him taking offence, or feeling uncomfortable, rather than protecting their own health. They also feel that feminine expectations of morality limit their ability as women to be explicit and assertive about sexuality. Asking a question about STD testing is viewed as a direct enquiry about a man's sexual history. The women were choosing to trust their partners to be STD free rather than to risk alienating them by exploring their sexual histories. The women are expected to have faith that their male partners have done the right thing in the past (always having used a condom in his prior sexual relationships). These cultural expectations (gender norms) make it very difficult for women to negotiate safe sexual intercourse and promote healthy sexuality in their daily lives. The contrast between women's beliefs of what constitutes healthy sexuality, and what they are practicing in terms of healthy sexuality, makes this an interesting and important factor shaping women's use of dual contraception in heterosexual sexual encounters.

iii) NEGOTIATING TRUST IN RELATION TO LENGTH OF THE RELATIONSHIP

All of the respondents stated that it is the responsibility of both sexual partners to use contraception. Yet, as was evident from the previous

discussion of power between partners involved, this is more of an ideal vision than a reality for these women. The women report taking complete responsibility for preventing pregnancy by using the birth control pill, but, are neglecting to use condoms to prevent STDs. One of the key factors mentioned by the women during interviews was the length of the relationship and how it affects contraceptive choices. Responses indicate that the types of contraception used when beginning a new sexual relationship are very different from the types of contraceptives being used as the relationship progresses. The length of the relationship between partners played a key role in influencing the use of dual contraception in heterosexual sexual encounters.

All 15 participants stated that when beginning a new sexual relationship, their preferred form of contraception was dual contraception. Male partners' used condoms while the women were on either the birth control pill or Depo-Provera. The participants also stated that the primary reason for using dual contraception was that they did not know the male sexual partner very well. It was a new relationship and they were not certain about it. Therefore, it was safer to engage in sexual intercourse using dual contraception. However, contraceptive use changed as their relationship progressed.

There was a clear change in contraceptive use when women felt like they were in a long-term relationship with their male partner. Condom use

declined as the relationship progressed. Prevention of pregnancy was revealed as the main ongoing concern for couples.

When asked about what factors would influence such changes, the most common answer was the increase of trust between the partners. Trust became established because it was defined as an ongoing/real relationship now, no longer merely a sexual encounter. If condoms were used at the beginning of the encounter, they were no longer being used once the relationship became established as dating relationship.

According to Amy, condom use became sporadic in her long-term relationship. When the supply of condoms ran out, no initiative was taken to purchase them. She thought of it as an unconscious change. Since pregnancy was not a concern because she was using the birth control pill, it became easier for her male partner to stop using condoms. Her partner also felt confident in stopping condom use. Amy who is dating a former co-worker had engaged in sexual intercourse with her partner the first time they went out after work. Amy stated that their relationship progressed to a dating relationship a few months after they started their sexual relationship and condoms were used for the first few months of their relationship. At this point the use of condoms became sporadic in their sexual encounters.

Kendra raised the same point about condom use just "disappearing". Yet, the transition was much faster in Kendra's relationship. Kendra had met her male partner at university and was friends with him for a while. They had started to engage in sexual encounters while out of town with a group of

friends. Once they had returned to the university campus, their dating relationship became established. At this point, condom use stopped. The time-frame for the dating relationship for Kendra and her partner was officially within two weeks of their first sexual encounter and condom use stopped at this point. Once again, the issue of pregnancy was taken care of because Kendra was on the birth control pill.

> SN: Why did you stop using condoms?
> Kendra: I don't know, we just thought we were going to be together for a long time and it was going to last. It plays a huge role and I was on the pill, so pregnancy is covered.
> SN: If you weren't on the pill, would you have thought differently?
> Kendra: Damn straight, I would have. (Interview # 7)

Kendra also stated that all of her female friends who are in long-term relationships are using the birth control pill and none use condoms currently. In Jane's 'long-term' relationship, condom use disappeared within a month. She was comfortable being on the pill because it prevented pregnancy. Her male partner felt the same way. As Jane states,

> Well, we knew that we would be together for a long times to come. But, we knew we did not want a child now. So, I just got on the pill and he was happy with it because we did not have to use condoms anymore. (Interview # 13)

Jane did not say why her partner was happy not to use condoms anymore. She felt that since she was taking care of pregnancy by being on the pill, both she and her partner felt safe as they were not ready for a child. Lou agrees that if you are in a long-term relationship, you should work

towards the prevention of pregnancy rather than STDs. She feels that pregnancy prevention should be the main concern. She says,

> If you are just with each other and the relationship is going places, why worry about STDs. But, if you don't want to have a child, you might as well take some precaution for that and when you are ready to have a child, you can always get off the pill or shot that you are on. (Interview # 15)

The lack of availability of condoms was another factor that became evident in some of the interviews. Jen talked about the lack of availability of condoms influencing her decision making on using them during sexual intercourse. She stated that if condoms were not available, they would engage in sexual intercourse without them. It was an 'unconscious' choice made by the couple. It took about a year and a half for dual contraceptive use to stop completely in Jen's relationship. Jen notes:

> I was on the birth control pill and at the beginning, we used condoms 100%. The odd time, I guess when you are somewhere and don't have one; you are not as hesitant to go ahead without a condom. It's understood that if we have them and it's available, we would use it. Not in a situation where we can't get them. (Interview # 5)

Ann talked about a relationship that lasted four years. She stated that they rarely used condoms and there were instances when she did not use the pill regularly either. About six months into the relationship, they completely stopped using condoms. She said that if condoms were unavailable, there was no effort made to acquire them. As Ann recalls,

> Condoms were not used all the time. There were occasions when we got pretty heated and there was none around. So, it was the pull out method. (Interview #14)

As noted above the time-frame for condom use to disappear varied for different couples. However, the common theme here is that once a woman felt secure with her male partner through the establishment of a dating relationship, condom use started to wane. The prevention of pregnancy, along with the security of a dating relationship that is thought to be monogamous led to the lack of use of dual contraceptive. The time frame in defining the relationship transition was often extremely short, only two weeks in Kendra's case and a month in Jane's case – too early to clearly rule out the risk of STDs.

For many women in this study, engaging in sexual intercourse without a condom meant that trust was a major factor in the relationship. The women were trusting that they were involved with a monogamous male partner and that their partner's fidelity was unquestionable.

It is interesting to note that many women stated that male partners also demonstrate trust in engaging in sexual intercourse without a condom. Men were trusting that their partner was taking the birth control pill regularly. However, it is important to recognize that the definition of trust varies here by gender. The women are trusting their male partner to be monogamous, faithful and loyal to them by not engaging in sexual encounters with other partners thus limiting the risks of STDs. The men, on the other hand, are presented as trusting their female partners to take the birth control pill regularly to prevent unwanted pregnancy even though they are frequently not

using condoms themselves to do so. They do not want to become fathers through unwanted pregnancies.

It also became clear from the interviews that reintroducing dual contraception into long-term relationships would challenge trust in the relationship as the following dialogue with Kendra illustrates:

> SN: If you brought condoms back into your relationship, would there be a problem?
> Kendra: It'd be like why more than anything. He'd be like ok, why now? He would protest it and not want to do it with the condom. It'd cause problems.
> SN: Do you think he'd think cheating?
> Kendra: Yeah, I can see that. He could get really really jealous. (Interview # 7)

Shanta affirms the same thing. She says it would be an issue because they have been involved in sexual intercourse without it. When asked if reintroducing condoms back into her relationship would be an issue, she answered,

> Umm, that's a good question because there is a difference with in and without. But I think if you are used to without, I think bringing it back might be an issue. (Interview # 12)

Lou supports the ideas put forth by Shanta and Kendra when she says, "I do know men who hate them and make a huge issue" (Interview # 15). Lou saw the idea of reintroducing condom use as a problem because her male partner hates using condoms, therefore, it would be forcing him to use something he dislikes.

This section clearly illustrates the role that dual contraception plays at the beginning of a relationship. Dual contraception is associated with a lack of

trust, lack of commitment, and a short time period of being together. Dual contraception is generally stopped when trust and commitment are defined as key aspects of the relationship. The relationship is thought to have progressed from just sexual to something substantial, monogamous and potentially long term. Regardless of the time passed, as soon as the relationship is defined in this way, condom usage stops not through active discussion and decision-making, but rather passively by not buying more condoms when the supply runs out. Yet these same individuals are committed to buying and using the birth control on a regular basis and few would engage in sexual encounters without it. This strongly suggests therefore, the commitment towards using dual contraception to prevent STDs is not very high in comparison with the commitment to pregnancy prevention.

B] SOCIAL INFLUENCES

To get a more complete understanding of where participants' beliefs and ideas about contraception and dual contraception came from, I asked a number of questions regarding the nature and impact of social influences on them. As their responses indicated, social influences played a key role in educating and shaping the women's perspectives on dual contraceptive choices and healthy sexuality - both negatively and positively. The major social influences they identified were schools (sexual health education received), parents, and peers.

i) THE LIMITED NATURE OF SEXUAL HEALTH EDUCATION IN SCHOOLS

Sexual health education in schools was described by my participants as very limited in focus and primarily concerned with the prevention of pregnancy, rather than dual contraception and prevention of STDs. All of the participants in my study were required to take Physical Education in grade nine and sexual health education was a part of the curriculum. Yet, very little time in the classes was actually devoted to this topic. Only one participant, Kendra, took physical education after grade nine. She continued in physical education to grade eleven. According to Kendra, sexual health education was not reintroduced in the curriculum after grade nine.

None of the participants who attended the grade nine sexual health education classes found them particularly enlightening or helpful. None recalled dual contraception ever being discussed in the classes. Methods of contraception were introduced and it was suggested that condom use prevents STDs and birth control prevents pregnancy. Yet, the use of dual contraception was not emphasized, or acknowledged as an important practice to prevent pregnancy and STDs concurrently.

Only three participants found the sexual health education in the schools satisfactory. Shanta, who went to high school in Rainy River[5], said her sexual class was more biologically based. The same comments were

[5] The population of Rainy River is 1,000. This information was obtained from their official site www.rainyriver.ca

made by Amy who went to high school in Thunder Bay and Rose who went to high school in Sudbury. As Amy recalls:

> Anyways, high school, grade 9, it was more biology based, I think. It was more on anatomy and physiology rather than issues like teen pregnancy, STDs and all that stuff. So it was more like anatomical sex-ed, I did not find it particularly helpful. Yeah, it was pretty bad. (Interview # 1)

Lynn complained that her sexual education classes used videos from the 1980s. She felt that these videos were irrelevant to today's youth. Lynn says,

> Most times they'd pop in a movie and it'd be from 1980, and, I don't think anybody could relate to it. (Interview #9)

In particular, she noted that her sex education classes did not talk about the feelings that led to sexual intercourse. Rose also had problems in that her sexual health education classes did not deal with the feelings or emotions experienced around sexuality. This is one of the major emerging themes from the interviews. While the secondary literature reviewed did not identify the limited biological orientation of sexual health education as a factor in shaping attitudes and perceptions of contraceptive use, my participants clearly noted this as a concern. Many of the women said that they would have liked to learn more about the interpersonal dynamics of sexuality in their sexual health education classes and that this might have helped them in negotiating healthy sexuality. Rose says,

> When we were talking about reproductive health stuff, it was very much anatomy. This is this, this is this, and little about how the egg reproduces, why you need the sperm and I think in grade 9, we discussed AIDS/HIV. We did just talk more about the myths and how

> you could get HIV. They were trying to clear that up because it has been so 'it could happen to you and I' in the media. Until then, we all in the class were like how it was called a gay disease. But, I'd have to say still more anatomy, still more biology, less on feelings in relationships that were connected to sex. (Interview # 11)

Another problem with the sexual health education received by the participants in my sample was the narrow orientation of the discussion of STD risk. As Rose explains, the discussion of STDs was focused almost exclusively on HIV/AIDS. Other STDs such as gonorrhea and chlamydia were rarely mentioned even though they are the most common STDs among youth in Northern Ontario.

All of the participants noted that prevention of pregnancy was the primary focus of their sexual health education classes and the message they took out of the classes was that pregnancy prevention was of more importance than the prevention of STDs. As Rose says:

> I think, I think that the major thing about growing up in Sudbury is that STDs were not a focal point of sexual education, of anything. It was pregnancy; I feel this is the 70s again, in the role that pregnancy is the bad thing that could happen from having sex. (Interview # 11)

This orientation in sexual health education is indicative of the ongoing stigma attached to unplanned pregnancy. For a young woman in high school becoming pregnant is viewed as a very immoral thing, or, "the bad thing that could happen from having sex" as Rose notes (Interview # 11).

Rose's observations about the gap in sexual health education may be helpful in understanding the dynamics of power discussed earlier in this chapter. Women often work towards controlling pregnancy in relationships rather than STDs as they are taught in their sexual health education classes

that pregnancy is the one thing that must be prevented before anything else. The immorality of an unwanted pregnancy is reinforced in the very basic institutions of society such as schools as well as in the wider society. Hence, it should come as no surprise that the women in my sample worked consciously to prevent pregnancy rather than preventing STDs in their current relationships.

When talking to Angela (Interview # 2) who went to a school in Thunder Bay, the conversation progressed as follows:

> SN: How did they talk about STDs?
> Angela: Oh, I can't even remember. Again, it'd have been really quick. It'd have been like ½ an hour max during the whole grade 9 curriculum.

Angela could not remember how they talked about STDs in her high school, but she did recall that there was only a very short period of time devoted to the topic. Marie who went to high school in Thunder Bay also says that pregnancy got more attention than STDs in her sexual health education classes. She recalls,

> Pregnancy. I'd say it got 70% of the attention in classes and STDs got about 30% of the attention in classes. (Interview # 10)

Ann who went to high school in Longlac says,

> Pregnancy was very emphasized. I remember, for one class, they brought in six single mothers to talk about how hard it is to be a single mom. STDs kind of took the back door. (Interview # 14)

The presentation by single moms in Ann's school emphasized the hardship pregnancy brought on for young women. Even though STDs are on

the rise in Northern Ontario, it is evident from the sexual health education at these schools that STDs are not being presented as a significant health risk stemming from unprotected sexual intercourse. Unplanned pregnancy in a young teenager seemed to be the primary problem that had to be controlled or prevented by the use of contraceptives such as the birth control pill.

Jane, who attended a Catholic school in Thunder Bay, also said that the sexual health education was very poor at her school. She said most of the class was biological in content and there was a very small project on STDs.

> They showed us how the sperm and the egg worked. It showed us the biology part of it rather than the humanistic part of it. They just discussed the different types of contraception. Nothing else. (Interview # 13)

When Jane talks about the humanistic part of sexual intercourse not being taught, she is referring to the non-biological dimensions of emotions and feelings involved in sexual relationships. The portrayal of sexual intercourse in sexual health education classes simply as the 'fertilization of the egg by a sperm' is a very limited perspective. When emphasizing merely the biology of the process, students are left in the dark about STD rates, causes of STDs, methods of prevention and obtaining help when an STD is contracted. Jane felt that students also need to be taught how to negotiate condom use, even when their emotions are involved during sexual encounters. They should also be encouraged to emphasize with their male sexual partner the importance of condom use even if he does not want to use them. Interestingly in contrast to much literature which asserts the need for

more sexual health education per se, the concern raised by my participants is in reference to the actual nature of the sexual health education, in particular the lack of attention to the interpersonal dynamics of healthy sexuality and how those influence power and decision making in contraceptive use.

The respondent's comments strongly suggest that in spite of the high rates of STDs in the North, current sexual health education classes are not devoting enough time to teaching their young students about STDs. Dual contraception is not being introduced in classrooms as the best way to prevent pregnancy and STDs at the same time. The limited nature of current sexual health education in the grade nine curriculum and the lack of sexual health education in subsequent years at the time when many young people are becoming sexually active seems to be a negative influence on healthy sexuality as noted by my participants.

ii) PARENTAL INVOLVEMENT

It became evident through the interviews that within the family, it was the role of the mother to talk to daughters about healthy sexuality and contraceptive use. Fathers were rarely involved in the process. Four participants stated that their parents never spoke to them about sex at all. In Kendra's case, she was uncertain why her parents, especially her mother, did not talk to her. Leah also said that no one in her family discussed contraception with her while growing up. Even though Carla came from a close- knit family, contraception and sexuality were never discussed. Jane said her family never had the time to talk to her about sexual health because

her mother was always working. Jane feels her mother should have talked to her, especially because her mother is a nurse. None of the women mentioned why they thought it was the mother's responsibility to talk to them about this issue. When asked to speculate on why their mothers did not talk to them about sexuality, Kendra and Carla said they did not know, but both wished they had done so.

There was some form of communication about contraception between the remainder of the participants and their mothers. However, not everyone was comfortable talking to their mothers about their contraceptive choices. One of the main issues that became apparent through the interviews was that mothers' conversations with their daughters about contraceptive choices were usually only initiated when they became aware that their daughters were sexually active. For some participants, it was years after they had become sexually active.

As Jen recalls, there was not much communication between she and her mother growing up. Things have changed and they are now friendlier and better able to discuss sexual issues. Jen has been in a long-term relationship with her male sexual partner for over a year now. In Jen's words,

> My mother talks to my older sister a lot. She knows what's going on in my life. I'll give her a call, let her know. That's starting to open up now. We're just living together now, the two of us. Growing up, there was not much communication. (Interview # 5)

The lack of communication between mother and daughter before being sexually active was also brought up by Amy. When asked about her parents'

communication with her about contraceptive choices when she was younger, Amy said that her comfort level with her mother was not adequate to talk about sexual behaviour. Her mother only became aware of her contraceptive choices after she had been with her male partner for about two years, as the following excerpt demonstrates:

> SN: Do your parents talk about it or did they discuss it at home? Was the comfort level high enough for that to happen at home?
> Amy: No, it wasn't high enough. The first time my mom and I talked about sex was when she found a condom in my garbage can. And I had been in a relationship with my boyfriend of about two years, and we had a sex talk on the way to gas up our truck. And she just asked me what I'm doing, how long I have been having sex for and how safe I am. She was comfortable I was using the pill and using the condom, so that was about it. She left it up to me to make these kinds of decisions but she did make her concerns, she did tell me her concerns, yeah. (Interview # 1)

Some mothers took the indirect approach in talking to their daughters. A few parents used the television as a medium to educate their children about choices in healthy sexuality. Angela's mother used to joke about sex with her. Lou's mother gave her a stack of books about sexuality when she was young. According to Lou, the books were very technical and anatomical, and had nothing to do with the feelings that led to sexual intercourse between two individuals.

It became clear during the interviews that when mothers began talking to their daughters about healthy sexuality, their main concern too was pregnancy prevention. Since the daughters had often already become sexually active by the time this conversation took place, mothers queried about what methods of contraception were being used to prevent pregnancy.

There was no mention of STDs in these parent-adolescent educational conversations,

Respondents suggested that their mothers viewed pregnancy as the primary risk to be avoided. Some women were encouraged by their mothers to use the birth control pill to avoid pregnancy at all costs. Rose's mother was adamant about talking about pregnancy rather than STDs. Joleen's mother encouraged her to stay on the birth control pill even though she was already using it to control her acne. When Joleen felt that her acne was no longer a concern, she wanted to stop using the pill. Her mom suggested that she might want to stay on it for the prevention of pregnancy. Kendra's parents were also concerned about their daughter becoming pregnant at a young age. Pregnancy was presented as a disruption of daily life by her parents. Kendra says, "If I became pregnant, I am sure my parents would be a little bit concerned about how I would finish school." (Interview #7). Lou's mother was very much against teenage pregnancy. According to Lou,

> She expressed the view that having children as a single person is not that desirable. She would have tried to get me to put the baby up for adoption. My mom was constantly putting those values in my face. (Interview # 15)

Respondents felt that most of their mothers thought it was safer to have their sexually active daughters on the birth control pill in order to prevent unwanted pregnancies. Angela's mother played a significant role in her acquiring the birth control pill by taking her to the health unit when she was in high school. Ann's mom also took her to the doctor to put her on the birth

control pill. She did not want Ann to have children when she was in school. Ann says,

> I was starting to sleep around and my mother couldn't stop it. So, she said 'you should go on the pill.' (Interview # 14)

As noted above, the risk of contracting a sexually transmitted disease was not addressed by any of the respondents' parents. Respondents were unsure why the topic of STDs was not important to their parents even though they were willing to discuss pregnancy with them. It was unclear if the parents themselves were aware of the high rates of STDs in Northern Ontario. This seems particularly surprising as some of the student participants' mothers are nurses, and a few others were university professors. What this may again underline is the overwhelming social stigma of unwanted pregnancy regardless of the career or the educational level of the parent. As noted above, it is evident in my sample that prevention of pregnancy is key within the circle of the family when safe sex is discussed. Unwanted pregnancy is viewed as a disruption of social aspects of life (like finishing school as Kendra's quotation points out).

The interviews also revealed that other social influences, such as peer attitudes shape the factors affecting use of dual contraception by young women.

iii) PEER ATTITUDES

Most of the respondents said that peer attitudes did have some influence on their views, or choices of contraception and that reciprocally,

they also influenced their peers. The ways and types of influence varied. Some participants tried to encourage their friends to use some type of birth control pill. Others shared contraceptive knowledge with their friends and talked about problems using certain types of contraception.

Carla started using the birth control pill after friends put pressure on her to do so because she was starting to become sexually active and had not used contraception regularly before. Her peers did not want her to get pregnant because they knew it would "ruin her life along with her hopes and dreams" (Interview # 3). In this instance, it can be seen that Carla's peers were a resource group helping one another to take contraceptive use seriously. However, there was no discussion of STD prevention among Carla and her friends.

A similar pattern was evident with Lou's friends. Lou stated that it was expected by her peers that a male must carry a condom, while the female was on the pill. Leah talked about going on the pill to prevent pregnancy, as some of her high school friends and peers were getting pregnant through unplanned pregnancies. She says,

> Most girl friends were 16 or 17 when they got pregnant. I couldn't believe it. It is really unfortunate, you know. They are not going to get anywhere in life. So, I just decided to get on the pill to avoid it.
> SN: How many girls got pregnant?
> Leah: About 5 or 6 out of 20 girls. (Interview #8)

Peers were considered a safe source of information for one another. Questions that could not be asked to figures of authority such as teachers, educators, doctors and parents, could be asked of peers. Many also felt that

they could provide valuable information on contraception to their own peers. For example, when asked if peers have influenced her choices of contraception, Jen replied by saying that:

> As a friend, I have been able to influence people. I think why not. I'm the first one in my friends to start something like that [the pill], everybody's following along. (Interview # 5)

Kendra also talked about the influence she had on her peers with regards to contraception here. She stated,

> I think I influenced them because I was the first one of us to lose our virginity. Therefore, they use that as a stepping stone. They come for relationship advice because we all have pretty good understanding on contraceptive use. We are all on the same kind of birth control, so, we trade the pill if someone runs out. (Interview #7)

Ann said that all her friends started becoming sexually active at the same age. They often discussed contraceptive methods. However, Ann's peer group did not always engage in safe sexual intercourse. In fact, Ann stated that she lost her virginity at age 12 during a sleepover at a friend's house. A few of Ann's peers have children through unplanned pregnancies. She says, "In high school, a lot of my friends were never regular with their contraceptive use." (Interview # 14). Ann herself now (23 years of age) has a child through an unplanned pregnancy.

While peers can be a source of valuable information, as noted above they may not be knowledgeable about or practicing safe sex themselves. Carla's friends were key role players in encouraging her to use the birth control pill to prevent pregnancy. Carla obtained valuable information through

peer pressure and started using the birth control pill. Even though she is only preventing pregnancy through the birth control pill, she gives credit to her peers for making her obtain a prescription.

Similarly, Lou's friends held the belief that it is the man's responsibility to carry a condom when the female was on the birth control pill. This was Lou's attitude too about healthy sexuality. Lou says during the interview,

> Well, my buddies thought that if the guy wants to have sex, he should have a condom with him. It's his job. But, I must take care of myself first, and, it is my job to be on the pill, take my prescription regularly, go for my doctor's appointments when it's scheduled and do my deed. None of my girlfriends carried condoms around because that's the man's duty. (Interview # 15)

However, one must keep in mind from the discussion in the earlier part of this chapter that this is not always the case. A male might not always carry a condom while a female is on the birth control pill. Therefore, these interviews demonstrate that while peers can be transmitters of valuable advice, they can also be a social network where problematic ideas about responsibility of contraceptive use and healthy sexuality begin.

C] SOCIAL CONSTRUCTION OF MORALITY

Social construction of morality was an important overarching theme influencing a woman's choice of using dual contraceptives. As discussed earlier, some evaluation of morality is important because the women did not want to have an unplanned pregnancy. Unwanted pregnancies are often

viewed as something that happens to immoral women. Influences shaping the social construction of morality for the respondents are discussed next.

i) RELIGIOUS, CULTURAL, AND ETHNIC VALUES

The cultural, religious, and ethnic backgrounds of the women interviewed were quite diverse and reflective of the overall ethnic makeup of North-western Ontario. One person identified herself as Aboriginal (Amy). Three people identified themselves as having Scottish ancestry. Angela's heritage is Norwegian, Scottish, and Aboriginal. Jen's family origin was a mix of British and Scottish. Marie's mother was French and Scottish, and her father was Icelandic. Ann is half French and half German. Lynn identified herself as of British heritage. Shanta's ethnic heritage was Swedish and German. One participant (Cathy) identified herself as being half Portuguese. Rose, identified herself as being Irish. Two people identified themselves as having a Finnish background. Leah was half Finnish. Jane's family were Ukrainian and Finnish. Four participants did not wish to identify themselves as belonging to any particular ethnic group.

While ethnicity and culture did not seem to play a significant role in the participant's views on dual contraception, religion did play a significant role in the factors that shaped contraceptive choices made by some of the participants. There was also a clear link between religion and parental attitudes about contraception and unwanted pregnancy. The only instance where ethnicity and culture significantly influenced parental and participant's attitudes was in the case of Amy. Amy's views on contraception were not

influenced by her religion as she identifies with no religious groups. However, her Aboriginal ancestry and culture influenced her views on contraceptive choices. As mentioned in the previous section on parental education, Amy's mother did not talk about sex with her until Amy was already sexually active. The comfort level was not high enough to discuss sex in the household. Amy attributes this discomfort to her Aboriginal culture. Amy says,

> So, in my mom's culture, sex is something they did not talk about, it is not mentioned. In my house, sex was not mentioned when we were growing up. Mostly, no one talks about it. It's just not talked about openly. (Interview # 1)

When asked about why she thinks it is uncommon to talk about sex in Aboriginal cultures, Amy said that it is what makes Aboriginal people different from Western society. In Western society, parents often give their children the 'sex talk'. However, in Aboriginal culture, it is not even thought about to do so. Amy notes:

> Amy: I don't know why, it's just one thing. They don't talk about it. I say, in Western society, people such as parents take their kids aside and give them the birds and the bees talk. That's just not done, it's just not done.
> SN: Is it frowned upon to do it?
> Amy: I don't know if it's frowned upon to do it, it's just not even thought of to do it. Maybe, I don't know, it's just not talked about, I don't know. (Interview # 1)

It is unclear if the trend is similar in other Aboriginal households, but Amy felt it was due to her ethnic and cultural background that sex was not discussed openly and choices of contraception were not addressed in her

household. [5] Amy is currently on the birth control pill and in a long term relationship with her male partner. Dual contraception is not used in their relationship at the present moment. Even though Amy's mother reluctantly talked to her about healthy sexuality, choices of contraception were not addressed by her mother. The talk only happened because her mother found a condom in Amy's garbage can.

Cathy, Jane and, Ann were raised in Roman Catholic families. Jane's family went to church every week, but were not strict about their views on contraception. Jane felt that being from the Catholic faith did not affect her decision making about sexuality. Even though Cathy's family had attended a Baptist church when she was nine years old, she still chose to identify herself as Roman Catholic because she was baptized Roman Catholic. Marie also identified herself as Catholic. The respondents who grew up with a Catholic background believed that premarital sex was a sin. Ann's grandmother was a strident Catholic. She was very unhappy that Ann was having premarital sexual intercourse.

> SN: How did your religion affect your views on contraception?
> Ann: I was raised Roman Catholic, but, it was practiced more by my grandmother than my mom. She did not know anything about my sexual life until I was about 15. She is kind of a closed person and did not talk much about it. I remember one time when I was 17; she was scratching her head and threw a bunch of condoms on the table. She just walked away. That was her sex talk.

Ann indicated that she is unsure why her grandmother gave her condoms, because her grandmother was not happy that she was engaging in

[5] In the subsequent chapter, the issue of culture and sexuality is discussed further in reference to my conversation with a key informant from the local Aboriginal health centre

pre-marital sexual intercourse. However, Ann thinks the condoms were thrown on the table by her grandmother to ensure that she would prevent any unwanted pregnancies.

When asked whether her religious values had affected her views or choices of contraception, Marie says,

> Yes and no. I think the responsibility is why I do what I do. But, if I were a true Catholic, I would not have premarital sex. (Interview # 10)

Cathy identified with the values of her church and said that its policy is 'no sex before marriage'. She said it was her religion rather than her Portuguese ethnic background that had most influenced her views about contraception.

> SN: Do your religious values affect your choices of contraception?
> Cathy: They did, when we went to the Baptist church. It was very much 'no sex before marriage.' (Interview # 4)

One participant, Rose, whose partner was Catholic indicated his religious views influenced their purchase of contraception because they feared his family would find out that he was engaging in pre-marital sex. She stated that her boyfriend had problems buying condoms because of his religious convictions. His family members were devoted Catholics and premarital sex was considered to be a sin. Therefore, he was worried that people might see him buying condoms. As Rose recalls,

> Mostly because it would get back to his parents. I don't think he was concerned about his friends seeing, but, it was any friends of his parents and then "ohhh, your son was buying condoms" and then that would be a really big problem in his family. (Interview # 11)

Ironically, though Rose's boyfriend was willing to engage in pre-marital sexual intercourse regardless of his religious beliefs and values. His concern is to avoid the stigma of his church or family finding out about his sexual activity. Therefore, the fundamental religious value of 'not engaging in pre-marital sexual intercourse' was not the subject of caution or concern for Rose or her boyfriend. Rather, it is the social and religious stigma of being seen as engaging in pre-marital sexual intercourse.

Marie and Cathy are concerned with the upkeep of their religious moral image by not getting pregnant before marriage and it is this anxiety about female morality which promotes their use of the birth control pill to prevent pregnancy. Once again, it should be noticed that there is no connection to dual contraceptive used here. While the women are using the birth control pill to prevent pregnancy and avoid stigma, condom use is being neglected.

The respondents who were members of the Protestant churches were Shanta and Angela (Lutheran), Lynn and Joleen (Anglican), and Jen (Presbyterian). These participants said that they were not actively religious growing up. They only visited the church on occasions or holidays. Shanta felt that religious beliefs had no effect on her use of contraceptives. Angela felt that her Lutheran religion did shape her use of contraceptives. She described the influence of church on her views of sexuality this way,

> Not contraceptive use, but frequency of use. Because I'm so not afraid to have sex or I'm not waiting till marriage. So it may be use of contraceptives versus no use at all because you have no need for it.

> So, to use it wisely. Versus someone who's like Catholic who doesn't have sex and has no need for contraceptives. (Interview # 2)

Angela explained that she was taught by her church to use contraceptives wisely if she is engaging in pre-marital sexual intercourse. She defined wisely as choosing the right kind of contraception, mainly, the one that helps to prevent pregnancy. Joleen who is Anglican shares similar views with Angela saying that religion helped her become positive about contraception. Joleen confirmed being positive as where contraceptive use was not discouraged like the Catholic religion, but, rather encouraged if you are sexually active. Lynn, who is also Anglican, says that religion had no positive or negative effect on her use/choices of contraceptives. Participants who were not religious clearly stated that religion did not influence their views about, or choices of, contraception at all.

It is interesting to note that two of the women said that their religious beliefs made them use contraception wisely. These women were also using contraception to prevent pregnancy rather than STDs. Joleen is using the birth control pill at the present moment and Angela is on Depo-Provera. It should be noted that all of their religions officially sanctioned pre-marital sexual intercourse. Whether Catholic, or Anglican, or Lutheran, the evidence here suggests that it is not the pressure to follow religious doctrine that is making these women use contraception. It is the fear of unwanted pregnancies which will reveal their pre-marital sexual behaviour that is the motivating factor to use contraceptive methods.

An unwanted pregnancy would be a more obvious infringement of religious values than contracting an STD which may not be publicly visible. In order to avoid the negative social repercussions of pregnancy outside of marriage, these young women feel the necessity to avoid pregnancy at all costs before marriage. This leads many women such as Angela into believing that they are using contraceptives responsibly. Their view of responsibility and healthy sexuality is tied to prevention of pregnancy, and not to prevention of STDs.

ii) CLASS

The issue of social class was also raised by some participants in the discussion of social stigma and unplanned pregnancy. The stereotypical view of unplanned pregnancy marking adolescent girls as low status, or from a lower class, was another deterrent to not getting pregnant.

For many of the respondents interviewed, unwanted pregnancy was viewed as something that happened to women of lower class parents. This influenced some of the women in my sample to use contraception to prevent pregnancy. Jen who did not see herself as influenced by religion or culture states,

> I'm not big on religion but just the idea of social norms like when you are 17; you are looked down if you have a child. I think seeing those people in society and the way they are treated because they might have a child just made me not want to have that burden from society upon me.
> SN: Is it a class issue?
> Jen: Yeah, yeah. (Interview # 5)

Similarly, Rose who had no family religion growing up affirmed saying,

> Ummm, I must say my mom insisted on not having children, teen pregnancy kind of thing. I can see it very much as a class issue. Yeah, she definitely did not want to be seen as the mother of that lower class pregnant daughter at 17, that kind of thing, so that's where her push for being on the pill and doing whatever you can for not getting pregnant came from most. (Interview # 11)

For both Jen and Rose their mother's attitudes about poverty and limited social opportunities for single mothers and the linking of unplanned teenage pregnancy as a lower class issue was an influential factor. Other mothers such as Lou's feared that an unwanted pregnancy would reduce her daughter's educational opportunities since she would have a child to take care of and this would ultimately limit her social mobility. Unwanted pregnancy along with the social repercussions faced by the individuals who had children before marriage were represented to the daughters as lower class problems, but also as a route to loss of class status for young women from the middle classes.

As all of the women in my sample are university students, the immediate goal in mind for many (and the expectation of the parents) is to complete their education and to obtain well paying jobs in their respective fields. An unwanted pregnancy would hinder this goal and make their futures risky. This point was reinforced by many of their parents in discussions about the risk of unplanned pregnancy.

iii) SEXUAL HEALTH IN NORTHERN ONTARIO

Geographical factors also played a role in influencing women's use of dual contraception. Rose's male partner had trouble purchasing condoms

from the nearby store in Sudbury. He was afraid of his confidentiality being violated. He was concerned that someone would let his parents know that he was buying condoms and they would find out that he was engaging in premarital sexual intercourse. Marie who lives in Thunder Bay agreed with Rose. She says,

> I think if you lived in a smaller city up north, it'd be harder to access contraception. If I was still living up there [talking about a small town where her parents are from], it's a small town of 150 to 200 people. Every family knows everyone. I think it'd be hard to buy condoms. There's only one store there and the person selling condoms would be a family member or friends of a family member. I think it'd be hard if you were trying to hide it or if you did not want anyone to know your business. (Interview # 10)

Marie still has family that lives in the smaller city mentioned above. Angela also discussed concerns with confidentiality when trying to purchase condoms in small northern communities. She noted that the person helping you at the counter could be a friend of the family or a friend's mother. This has made it embarrassing for her to purchase condoms many times. The problem of confidentiality plagued her even more because her parents work at the local university. They were reluctant to put her birth control pill purchase through their drug plan for fear of co-workers knowing that their daughter is sexually active. This also shows the moral dilemma perceived by her parents because their daughter is sexually active. As Angela states,

> Well, I remember when I went to first get the pill at the health unit, I asked my mom. They said, 'oh do you want a receipt, you can put it through the health plan.' I asked my mom to put it through the drug plan and she said, 'oh no, people I work with will see what is on the receipt, people will find out, I am not going to do that, besides I don't even know if its covered.' There was no attempt at that point to see if it was even covered because they didn't like the fact that I was on it

> knowing I was only 16. That was a young age for others to know that I was sexually active. They knew their coworkers really well, they are tight knit that way, they are also, I mean the jobs they are in, they both are Professors, and it'd be painful. Confidentiality, yeah. (Interview # 2)

Joleen who grew up in Sault Ste Marie talks about issues of confidentiality while purchasing condoms. She states that there were no condom dispensers in her high school. When asked about confidentiality issues while purchasing contraception in northern Ontario, Joleen replied,

> I can see the issues with small towns and being able to get condoms. I'd think like maybe the town where my parents grew up. There is only one drug store and you'd know the person who works there. And it will be like 'so and so's son or daughter came in.' (Interview # 6)

It was evident throughout my interviews that women I interviewed wanted to be seen as living a moral life. They worry about the consequences of purchasing condoms at the local store because of being perceived as immoral. Both men and women living in small towns face problems of confidentiality when purchasing condoms. However, as noted previously, many men are reluctant to wear condoms even when they are available arguing that their use inhibits pleasure. Problems of confidentiality when purchasing condoms become an additional factor in discouraging dual contraceptive use in and may contribute to the high rates of STDs in these areas.

Angela who obtained her first prescription for the birth control pill at the local District Health Unit (DHU) talked about the problem limited hours of service posed for teenagers trying to access birth control confidentially. Many students are unable to attend because the limited appointment hours (1:30

p.m. to 5 p.m.) overlap with high school classes and the location of the office is inconvenient for public transportation.

Amy, who is of Aboriginal heritage, does not understand the reason why there are such high rates of teenage pregnancy amongst the Aboriginal girls in Northern Ontario. She thinks it may be due to the problem of accessing contraception. She felt that it was hard for many Aboriginal girls who live in the reserve communities to come into town to obtain contraception during school hours, especially because of the limited transportation available from the reserve communities into the City of Thunder Bay.

As these comments indicate, young women also face problems of confidentiality and accessibility when they are trying to access dual contraceptives. Even though young women might be able to obtain a prescription for the birth control pill, those from smaller towns face stigma and embarrassment when trying to purchase condoms.

iv) HIGH RATES OF STDs IN NORTHERN ONTARIO

When asked if they knew about the high rates of STDs in Northern Ontario, all of my participants said "yes". Their awareness came through various media –advertisements in buses, information pamphlets, publications, and so on. I asked then to comment on why they thought the rates of STDs were higher in Northern Ontario than in other parts of the province. Some of the participants thought it was because of the tight bond among members of communities in Northern Ontario, making youth assume trust among other easily and quickly. A few thought it was due to the lack of sexual education in

Northern Ontario. Some attributed it to the boredom experienced by youngsters growing up in communities with few activities.

Many smaller communities in Northern Ontario are face-to-face and have close social networks. Interestingly the respondents indicated this affects the nature of sexual dynamics in these communities. Participants noted that in smaller communities, people usually know one another or one another's families and often believe they know each other's dating histories. They frequently assume that because of the nature of close social relations in the community people feel a responsibility to one another and will share information about having been diagnosed with an STD, rather than putting a partner at risk while engaging in sexual intercourse with them.

Rose and Angela agreed that the communities are very tight-knit in the north. This leads to a lack of fear of STDs when engaging in sexual intercourse with each other. Some participants suggested this built-in trust to lead to unsafe sexual intercourse, thus, leading to higher chances of contracting STDs. As Rose notes,

> And, I really don't think that a thought was put to STDs because, a lot of us did not see each other going anywhere outside the city and it was a kind of close knit community feeling, you know, my group of friends and the way we hung out. There just did not seem to be that kind of sleeping around, venturing out into unknown places where you'd bring back STDs into the group. (Interview # 11)

Rose felt that because people rarely left the community, there was a sense of security while dating. This sense of security lay in the false belief that STDs would only be present in people outside of the community. Women

from these face-to-face communities held the naive assumption about strangers and outsiders as the one's bringing STDs into their community. When asked about the built-in trust between people from Thunder Bay, Angela answered,

> Yeah, yeah. We were pretty close. We were bad; it's a tight community out there. The kids are into a number of things, they do a lot early. All the relationships were very short term though, it was very risky. It was something to talk about when they got back to school. It made them look cool. (Interview # 2)

It is apparent from Angela's and Rose's views that familiarity with a person is conflated with trust. Leah also talks about this kind of built-in trust in communities of Northern Ontario. According to her, trust is defined as if a person was ever diagnosed with an STD, they would convey it to their current sexual partner. However, the reality was much different. Since confidentiality is a big problem in northern Ontario, she said that it was ideal to keep something like an STD discreet. Leah speaks about the problems that plagued her high school with respect to STDs when she states that,

> Yes, everyone knew everything. You knew who was sleeping with who, who had the venereal diseases, who was likely to get them and it turned out that they did. The school had about 200 students. There was a group of people, everybody who slept with everybody. People thought if someone had something, they'd tell me. But, no, they won't because it's going to be all over the school. It's not the best idea. (Interview # 8)

It is evident from Leah's interview that there is an assumption of sharing information among sexual partners if someone has been diagnosed with an STD in the past. However, she also contradicts herself when she talks

about how people were aware of one another's personal lives, hence, they would not share such confidential information. Sharing would lead them to be ostracized and ridiculed at school. Cathy also talks about this kind of trust when she says, "Honestly, we were just sitting there and I was just there. He and I were friends before dating, so, we were very familiar with each other's dating history and stuff." (Interview # 4). This clearly demonstrates that even though many young women growing up in Northern Ontario believe that the smaller communities share a built-in-trust about disclosing information and not jeopardizing one another's health, this is not necessarily true in practice.

The isolation of Northern communities was also reported to cause boredom amongst youngsters leading young people to engage in sexual activity at a young age. According to Kendra,

> We are pretty isolated here. We don't have any neighbouring communities here. People here, their knowledge of contraceptives is way, way limited. In large cities, there are way more open ways to talk about things like that. You walk down Queen Street (Toronto), there are sex shops all around. It's not like hidden. It's like right there downtown. I think that's definitely important because it's made to look like a negative thing here, behind closed doors. I think it has a large influence on the way people use condoms and contraceptives. I think if we educated people more in Thunder Bay, maybe people are not listening here. It's just as easy to put on a condom as to take a pill. I feel like if we could communicate to younger people and stress, make a huge impact to influence their decision. You have to shock them. (Interview # 7)

She attributes the high rates of teenage pregnancy to the lack of education and the isolation people experience in northern communities. Jen and Angela also raised similar concerns. Lack of education was believed to

lead young people to engage in unsafe sexual intercourse. Talking about the lifestyle in northern Ontario, Jen says:

> The lifestyle in Northern Ontario is very different. We joke around the house because every second person in this city has a kid. They are like 18 or 19 years old. It made me think about the decisions that people make. You should be so scared of STDs and also of pregnancy. I don't know the feeling of the people, but, I think the educational system is just flawed. I think that it's just the idea of the lack of education. In the middle of the day, you go into Intercity (the shopping mall here) and there are tons of kids there. Shouldn't they be at school? In Thunder Bay especially, it's like less and less people graduating from high school. Some guy at McDonalds last day was like "I'm 17 and I've only 3 high school credits". He was proud of it. Having nothing to do and getting involved in these different activities that create that, I don't think if you were in school, you'd be out causing trouble or seeking different sex partners or finding these people who have STDs. There are no jobs here with the exception of the mall for younger people. So they get bored and start becoming sexually adventurous. And young girls are all running around with babies. Yuck, so so gross. (Interview # 5)

Even though Jen was asked about STDs, Jen deferred, by talking about the high rates of teenage pregnancy in Thunder Bay. This once again makes the reader aware of the stigma attached to teenage pregnancy. Many interviewees share the view that contracting an STD is not a good thing, but having an unwanted pregnancy is the worst thing that could ever happen to a woman. The comment Angela makes about young people in Thunder Bay is also noteworthy.

> Coming from the country anyways, outside of Thunder Bay, everyone there was a lot more sexually active than people in town because there's a not a lot to do out there. So, there's lot going on like that, not so much me but I grew up hearing about it. (Interview # 2)

It is indicative from Angela's comment that boredom and the lack of availability of interesting events for young people may be a reason for young

people to engage in risky sexual intercourse. All of the participants agreed that the soaring rates of STDs in Northern Ontario, especially among the youth are a cause of concern in Northern Ontario. Everyone was aware of this issue too and felt that if proper education was provided to the youth including raising awareness on STD prevention, there would be a more positive response in using condoms for the prevention of STDs.

CONCLUSION

This chapter summarizes the key themes from the qualitative research interviews. The main findings from the interviews fall under three major themes. These themes are trust, social influences, and social construction of morality. The trust section discusses power dynamics between couples, enquiry about STD testing from the past and the role of trust while negotiating dual contraception in long-term relationships. The social influences section shows us where the attitudes on dual contraception are derived from – sexual health education, parents and peers. The last theme, morality, talks about the stigma of unwanted pregnancy and its influence on use of dual contraception. Although religion did not have a big influence on sexual behaviour overall, this is where the idea of unwanted pregnancies as something that happens only to immoral women, seems to arise. Living in Northern Ontario also affects the views on morality because of the underlying issues of confidentiality, tight kinship between people and the constant stigma placed on young women who are mothers. This stigma is taking the focus away from the high rates of

STDs in this community and is placing more emphasis on the prevention of pregnancy among young women. Many of these factors have led to the use of dual contraception being neglected among many of the interviewees.

The major conclusion from this chapter is that women are more concerned about preventing pregnancy rather than preventing STDs while engaging in heterosexual sexual encounters. Even though women indicate awareness of all the risks associated with unprotected sexual intercourse, they are not assertively taking precautions to protect their own health. Condom use is neglected as soon as a relationship is perceived as monogamous and women feel trusting of their male partners. The birth control pill then becomes the favourite choice of contraception for many because of its ability to prevent pregnancy.

This chapter also illustrates that sexual health education, parental guidance, and peer attitudes are key social influences that contribute to the belief that pregnancy is the worst outcome of heterosexual sexual intercourse. There is also a great emphasis placed on female morality by reminding women constantly of the stigma associated with unwanted pregnancies. However, this has not helped the problem of STDs to disappear in northern communities. STD rates are shown to be rising among these communities in Northern Ontario today (See Chapter One).

The next chapter compares my data with the findings from the secondary literature review. Chapter Five also outlines commonalties and

differences between my research and the secondary sources. It ends with recommendations for future research.

CHAPTER 5 – DISCUSSION OF RESULTS AND CONCLUSION

In this chapter, I compare and contrast the findings from my own research and the secondary source literature on factors influencing contraceptive use among young heterosexual women discussed in Chapter 2. As explained earlier, primary factors discussed in the literature review were: the power of the partners involved in heterosexual sexual relationships; spontaneity of sexual intercourse; length of the relationship; sexual health education; parental involvement; peer attitudes; and the geographical location of Northern Ontario. My own study found that women are not using dual contraception regularly, particularly in relationships that last more than a few months. Their views on dual contraceptive use are influenced by three major factors. These factors are trust, social influences, and social construction of morality.

Some of my results concur with the current literature; others, however, challenge or add to the present literature. One such area pertains to the reasons why women in Northern Ontario neglect to use dual contraception even though they are aware of the high rates of STDs in their communities. Women talked about the value of tight knit communities having an inbuilt trust, and the boredom faced by young people in these communities leading them to risky activities. The results are compared and contrasted in the three major sections below.

1] TRUST

i) ROLE OF TRUST IN NEGOTIATION OF CONTRACEPTION

Tschann et al. talk about women having less emotional power over their male sexual partners, thus placing women at the risk of acceding to their male partner's wishes and not using condoms regularly (2002:18). Woodsong and Koo also discussed how women have problems insisting on the use of condoms once the men know they are on the birth control pill (1999:567). Numerous women in my study reported similar problems. Negotiation of dual contraception was described as challenging for the women I interviewed. In many relationships, the women were using the birth control pill while the men were not using condoms. Therefore, dual contraceptive use was not practised in these relationships.

According to the study by Oncale and King (2001:383), young men used a variety of rationalizations to dissuade their female partners from using condoms. Some of the reasons mentioned were that condoms do not feel right, sex feels better without them, and the woman will not get pregnant. In this study too, the main reason why women found it hard to negotiate condom use was also because of men's attitudes towards condoms.

Kendra said that women also did not want to pressure a man into wearing condoms because they might be viewed as promiscuous because they were being sexually knowledgeable and assertive which might suggest that they were experienced. This issue was not evident in the literature reviewed, but it is an area that was clearly central in my interviews. Shanta

talked about men mentioning skin-to-skin pleasure which can only be gained if condoms were not used. This was also an issue raised by men in Oncale and King's study (2001:383).

It became clear from the interviews that none of the women in my sample asked male partners if they have ever been tested for STDs. The participants willingly talked about the problems that would arise if they asked a male partner about STD testing. Shanta and Jen said it would be awkward and difficult because they did not want to make the male uncomfortable. Joleen talked more about the norms of femininity. She felt that men are allowed a certain amount of sexual freedom that women are not. They are also trusting their partners to disclose whether they have had an STD, rather than assertively making inquiries about it. The women want to show the man that they trust him, and to some extent they actually do trust the man to honest with them about his sexual past. Trust here is seen as a part of commitment where women that they are willing to trust the male partner even when it does not seem appropriate to do so and risks their own health. This part of my study clearly illustrates that the role of trust is very important while women are negotiating condom use. This finding is an important contribution to the existing literature because this issue is not discussed in contraceptive use studies.

Kelly and Bazzini say that the norms of femininity call for women to be unassertive and passive in the bedroom (2001:787). My findings are consistent with the literature on the issue of men having more sexual power

over women. However, my research also provides additional information on women's feelings about asking male partners about important issues such as STD testing. By asking women questions regarding their partner's history of having STD testing's, factors such as not wanting to make the male uncomfortable and norms of femininity emerged. The importance of the role of trust between partners is evident here in understanding women's commitment to dual contraception. When women are unwilling to make such inquiries, they are also not being assertive enough to request that the man use a condom to protect themselves against STDs. Therefore, the engagement in sexual intercourse without condoms is placing women at risk of contracting STDs from their male partners. It is evident from the previous chapter that these norms of female morality continue to be reinforced by education, family, and religious beliefs.

ii) ROLE OF TRUST AND LENGTH OF THE RELATIONSHIP

The literature showed a strong connection between the length of a relationship and the use of dual contraception. When the relationship lengthened, the use of dual contraception steadily dropped. The birth control pill was seen as the main choice of contraception once the relationship evolved. For example, in their study of young students, Everett et al. found that condom use declined as soon as the students believed they were in a monogamous relationship (2000:115). Poppen and Reisen also state that women use dual contraception early on in relationships, but do not use condoms once the relationship becomes committed (1999:63).

In my study, the length of relationship along with the assumption of monogamy was found to an important factor that influenced the use of dual contraception. Even though most of my participants started out their relationships using dual contraception, condom use steadily declined once the relationship was perceived to be exclusive between the two partners. The length of the relationship and the stopping of dual contraception varied among couples, the shortest being only two weeks. Spontaneity of sexual intercourse was another factor influencing condom use. My study found that when participants perceive they are in a long-term relationship and the female is on a systematic form of birth control to prevent pregnancy, condoms were seldom purchased. When the condom supply runs out, it may or may not be replenished. When sexual intercourse happens spontaneously, it is often continued without a condom because there is already a form of contraception in place to prevent pregnancy – the birth control pill.

Spontaneity and non-usage of condoms is discussed in the work of Henderson et al. According to Henderson et al., 32% of the sample said sexual intercourse happened on the spur of the moment, and 20% stated that it was a completely unexpected action (2002:486). This makes spontaneity an important factor in obtaining a contraceptive like a condom or even having the time to discuss dual contraceptive use and safe sex. Hacker, et al. state that when their research sample was asked about not using contraceptives, the largest proportion of respondents (approximately 11%) answered that they did

not expect to have sexual intercourse and that contraceptives were not readily available at the time of intercourse (2000:285).

My results on spontaneity support these findings, as the participants including Kendra, Amy and Leah, stopped using condoms as they were not easily accessible on the spur of the moment. However, they also stopped using condoms as soon their relationships were perceived to be long-term and monogamous. Being on the birth control pill gave women the assurance that there would be no chance of pregnancy. The women were confident that their male partners were not cheating on them and bringing STDs into their relationship.

I also asked the participants about the time frame it took for dual contraceptive use to disappear from their relationships. It was found that the time it took differed among the participants. Dual contraceptive use usually disappeared once monogamy was perceived by the female partner. It took Kendra two weeks to reach this decision and dual contraceptive use stopped in her relationship. It took Amy about a year and half to stop using condoms entirely in her relationship. Even though much of the literature talked about the perception of monogamy, time frames for dual contraceptive use to disappear were not mentioned. This was an important factor that was addressed in my interviews. This finding will be an addition to the existing literature.

The next section on social influences looks at how schools, parents, and peers can be important factors in developing attitudes and adopting dual

contraceptive use among young women while engaging in heterosexual sexual encounters.

2] SOCIAL INFLUENCES

i) SCHOOLS AND NATURE OF SEXUAL HEALTH EDUCATION

The current Ontario Ministry of Education and Training calls for contraception and healthy sexuality to be taught and introduced in grade 9 in physical education classes (1999:3). The participants in my study confirmed that they did receive sexual health education through their physical education classes in grade 9; however, many of them did not remember much of the details about the sexual health education they received.

Even though the majority of the participants went to schools in Thunder Bay, there were also a few participants who attended schools in Rainy River, Sault Ste. Marie, Sudbury, and Longlac. It became apparent from the interviews that Angela, Marie, Ann, and Jane felt that prevention of pregnancy was the key component of their sexual health education class. All the participants stated that the term dual contraception was never introduced during their sexual health education classes. Another problem faced by the participants in my study was the emphasis on biological and anatomical knowledge of sexuality, rather than the emotional aspect of it.

An addition to the literature from this study is that sexual health education in Northern Ontario needs to start focusing more on the STDs in addition to pregnancy. The emotional aspects that are accompanied with the

act of sexual intercourse need to be introduced into classrooms. The notion conveyed to students that sexual intercourse between two people is purely biological is very limiting. Respecting each other in sexual relationships may be the most important lesson in both STD and pregnancy prevention. This important finding should be conveyed to sexual health educators and incorporated into the design of their sexual education programs in the future. This will enable them to be more effective in relaying the message that dual contraceptive use is important for young women who want to prevent both STDs and pregnancies.

In a recent study done among 461 Swedish students, it was shown that when sexual health education encourages intervention through methods such as access to telephone counselling and free condoms upon request, attitudes towards condoms became more positive and condom use increased among young people (Larsson, Eurenius, Westerling and Tyden, 2006:124). Therefore, this implicates that it would be beneficial for many students including the ones who took part in my study that if these kinds of intervention techniques were used, their frequency of condom use during heterosexual sexual encounters might also increase.

Sexual health education is not the only source of information for many young women who are starting to become sexually active. Parents are also cardinal figures for young people to obtain information on healthy sexuality. This will be discussed in the following section.

ii) PARENTAL INVOLVEMENT

According to Bull and Shlay, three-quarters of their sample did not talk about healthy sexuality with their parents (2005:75). Many women considered their parents to not be open-minded enough to discuss sexuality with them. Many women also thought that their parents would judge them harshly (2002:75). Many of my participants also stated that their mothers only talked to them about contraception after they had become sexually active.

Discomfort in discussing contraception with parents was a big problem for many of the participants in my study[6]. Even though there was some communication between the majority of the participants and their mothers, it became evident through the participant interviews that parents were less supportive of unwanted pregnancies in their daughters. Hence, when parental involvement was found between mothers and daughters, it was mostly based on preventing pregnancy rather than STDs. There was no evidence in the literature that supported the idea that mothers were in favour of pregnancy prevention over STD prevention.

iii) PEER ATTITUDES

Hacker et al. stated that peers were often the group that young women went to for advice (2000:283). Poppen and Reisen also felt that peers could influence women's contraceptive choices in both positive and negative ways (1999:11). It became evident through my interviews that peers were used to obtain information about contraception.

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[6] Sex education from parents also doesn't generally include a discussion of same sex relationships. Even though this was not the focus of this study, this point is worth noting as an additional gap in sexual health education. (Frankman, J. 2006)

Carla's friends pressured her to use the birth control pill when she became sexually active. Kendra talked about exchanging birth control pills among friends if one ran out of their prescription. Lou's friends had the attitude that the man should always carry the condom while the woman is on the birth control pill. Peers have also offered a helping hand by making sure their friends never run out of a supply of the birth control pill. It is evident that peers are a very important group for these women to talk about their birth control choices with.

However, this study supports the literature arguing that peers could also be a negative influence. It is clear that the information provided by peers is not always the correct information on healthy sexuality. An example would be where Carla's friends pressured her to use the birth control pill when she started sexual activity. Such pressure ensures that Carla is working towards preventing pregnancy rather than prevention of STDs. Kendra talked about exchanging birth control pills with friends when they ran out of their prescriptions. This also proves to be a health hazard since prescriptions are determined specifically by the health history of the individual for whom it is prescribed. The study by Poppen and Reisen (1999) is the only one that talks about this negative and positive influence by peers. Therefore, this study supports the breadth of peer influence on contraceptive behaviour, as in Poppen and Reisen. This factor from this study can also be added to existing literature

3] SOCIAL CONSTRUCTION OF MORALITY

i) RELIGIOUS, CULTURAL, AND ETHNIC VALUES

In the secondary literature, there was no relationship found between ethnicity and culture and use of dual contraception. Tschann et al's study found no connection between a woman's ethnicity and using a condom during sexual intercourse (2002: 22). However, the study by Everett et al found that Caucasian women tend to use more systematic methods of contraception to prevent pregnancy compared to African-American women (2000:115).

My study had only one woman of Aboriginal descent and she also talked about the high rates of pregnancy among Aboriginal teenagers in Northern Ontario. However, she could not directly attribute any reason for this cause except that many Aboriginal women are unable to access systematic contraception because of limited services in their communities. One must notice that there is no mention here of prevention of STDs. All the women in my study stated that their ethnicity and culture did not play a role in accessing contraception. They were all in favour of the common goal of prevention of pregnancy because of the stigma attached to unwanted pregnancies.

In addition, prevention of STDs held a very unimportant role when religion was brought into the picture. However, the interviews concluded that prevention of pregnancy continued to remain important for people who were involved in the church. Shanta, Angela, Marie, Lynn, and Joleen claimed to have some religious affiliation, and they all acknowledged that they should not be engaging in pre-marital sexual intercourse due to their religious views. In

order to prevent the stigma of pregnancy from pre-marital sexual intercourse, these women use the birth control pill. Their moral values are against unwanted pregnancies rather than prevention of STDs. This coincides with the literature that stated that women who attended church were more likely to prevent unwanted teenage pregnancy because of the emphasis on sexual responsibility (Miller and Gur, 2002:404).

Class was another factor that became evident through the interviews. Jen and Rose talked about the class issue in their interviews. They felt that unwanted teenage pregnancy was something that happened among lower class women. Henderson, et al. state that sexual intercourse before the age of 16 along with pregnancy is often seen a symbol of being from lower class or as being the child of a mother who probably was a single mother and gave birth in her teens (2002:484). The opportunities for a young mother are very limited in terms of her ability to attain higher education and obtain a good job. The class issue was one main reason why many mothers of my participants felt that their daughters should be on the birth control pill in order to prevent pregnancy. There is no commitment to dual contraception or using condoms to prevent STDs. Prevention of pregnancy remains the key focus.

ii) SEXUAL HEALTH IN NORTHERN ONTARIO

When asked if the participants knew about the high rates of STDs in Northern Ontario, everyone said yes. The Aboriginal people of Northern Ontario also have high rates of STDs compared to non-Aboriginals (Ontario Aboriginal HIV/AIDS Strategy, 1996:24). Amy, who identified herself as

Aboriginal, talked about the lack of sexual education through parents in the Aboriginal culture. In her interview, she stated that Aboriginal parents do not engage in discussions about safe sexual intercourse with their children. Even though it is not possible to generalize this from one case, an article in *The Aboriginal Nurse* supports this viewpoint when it talked about educating Aboriginal youth on health sexuality. The article states that,

> Many adults find it hard to talk about sexuality with young people, especially our own children. We are embarrassed, shy, not sure of the facts, not sure how we feel about masturbation, teen sex, and gay, lesbian and bisexual people. For some Aboriginal people, sexuality education is wrapped up in other issues as well: European and religious ideas that go against traditional knowledge and teachings, and cultural values that have been lost; and early experiences of sexual abuse and later sexual violence that have a negative effect on how we see sexuality" (2002:60).

One of the key informants in that study was a nurse practitioner with the Anishnawbe Mushkiki Aboriginal Health Access Centre. She discussed how the parents in the Aboriginal culture are reluctant to educate their children on healthy sexuality. Combined with the information from the literature and the insight provided by the nurse practitioner from the local Aboriginal health care centre, Amy's identification of this problem is a vital addition to the existing literature.

The problem of confidentiality in accessing contraceptives was evident in the literature and the interviews. Shroff and Clow argue in their work that adolescents living in smaller communities are more reluctant to purchase condoms at their local pharmacies (2003:238). Marie talked about how hard it is to purchase condoms if you live in smaller communities that only had 150

to 200 people. Joleen discussed the small town her parents grew up in as having only one drug store, therefore, making it problematic to purchase condoms. These problems of purchasing condoms, along with the reluctance to use them as talked about in chapter four, are important in contributing to higher rates of STDs in Northern Ontario.

Regarding the purchase of birth control pills, Angela and Amy purchased their birth control pills through the Thunder Bay District Health Unit (TBDHU). However, they also talked about problems of accessibility with regards to the operating hours of TBDHU. According to Angela, if she had not come into town for school, she might not have been able to obtain the birth control pill from the health unit. Amy concluded the same for the young women living on the reserves (First Nations communities) around Thunder Bay. Amy felt that the operating hours of the health unit during school hours makes it hard for these women to visit the sexual health clinic at TBDHU[7]. As only two women mentioned this as a concern, it cannot be generalized as a problem for the rest of the female population living in Thunder Bay. Other women in this study are still able to access birth control pills from their family physicians, and, other health care centers.

Two other factors that became evident through the study that were found to influence the use of dual contraception among young women in Northern Ontario were a naïve sense of trust with their sexual partners and

[7] The website of the TBDHU (www.tbdhu.com) advises patients that their sexual health clinics have a doctor on Monday, Tuesday and Thursday from 1:30 pm until 5:00 pm. The doctor is also available on Friday from 1:30 pm until 3:00 pm. This service may be accessed by scheduling appointments in advance. It must be understood that the TBHDU has a sexual health clinic that not only provides services to obtain systematic contraception, but also regular STD testing and mandatory pap smears when women go in for birth control prescriptions.

lack of activities to engage in, leading to boredom. Neither of these factors has been discussed in previous literature. Rose described this trust as people not venturing out to bigger cities and bringing STDs into their small knit communities. Leah talked about the same trust as one where the sexual partner would disclose to you if they had an STD. However, Leah and Rose also admitted that they now know they are in the wrong by assuming the existence of such built-in trust.

The boredom experienced by young people in Northern communities was discussed by Kendra and Angela. They both felt that youth in Northern communities are often bored due to the lack of entertainment and activities for them to engage in. Therefore, they are prone to experiment with risky behaviours at an earlier age including unsafe sexual intercourse. Along with Kendra, Marie and Carla felt that enhancing the knowledge of young people in the north could lead to better sexual practices including use of dual contraception. This, along with programs to assist in alleviating boredom for young people, was a crucial factor discussed by Kendra.

This section on living in Northern Ontario is crucial to this study. Numerous factors that only affect the north are explained in this section – problems of confidentiality when purchasing condoms, built-in trust between the youth because of the small size of the community, and lack of entertainment leading to boredom causing engagement in risky behaviours such as unprotected sexual intercourse.

Since this is the first study of its kind to be conducted in Northern Ontario, new areas that discuss the sexuality in Northern Ontario have emerged here. One of the additions to the literature will be the problems women face because of the built-in trust in the small communities. Some of the above mentioned factors have connections with the literature. However, some factors that have been explored by this study, such as geographical perspectives of living in Northern Ontario, focus on prevention of pregnancy rather than prevention of STDs and the stigma of unwanted pregnancies are very crucial aspects of this study.

The following conclusion section will discuss the implication of these findings from a feminist sociological perspective along with recommendations for future research on this topic.

FUTURE DIRECTIONS

This study is a small scale preliminary study that has been geared towards finding out what factors influence the use of dual contraceptives among young women aged 18-25 attending a university in Northern Ontario. During open-ended interviews, the women reflected on the factors along with their experiences of using contraception. A comparative study of young women in other rural and Northern universities would allow one to explore whether these trends are common to other university age women.

Women who took part in this study expressed interest in a future study on knowing the views that university males hold about dual contraceptive use.

They noted that a male's perspective on the same issue would help to further our understanding of why condoms are not being used and why the commitment to dual contraception is so poor for both genders. Future research should explore factors that influence men's use of condoms during heterosexual sexual encounters even if the woman is on a systematic form of contraception to prevent pregnancy.

CONCLUSION

The purpose of this study was to understand the factors that influenced women's use of dual contraceptives during heterosexual sexual encounters in a Northern Ontario sample of university students. Women's perspectives were listened to and documented through this qualitative study. This is the first of its nature in Northern Ontario and it has provided an opportunity to hear women's own perspectives on factors influencing dual contraceptive use. Therefore, it makes an important contribution to our knowledge on this issue in a regional context. While the findings of this study cannot be generalized because of its limited sample size, they provide important insights into the challenges of dual contraceptive decision-making for one group of university women and could provide the genesis for a larger scale comparative study in future.

In the past few years, many studies have been done on contraceptive use in Canada. However, with the rising rates of STDs, more studies are starting to focus on simultaneous use of condoms. Women are often trusting

of their male partners in relationships that are perceived to be monogamous. While in these relationships, dual contraceptive use passively disappears during sexual encounters. The birth control pill takes over as the main choice of contraception. This change also reveals the commitment for a woman to avoid unwanted pregnancies at all costs. The pressure to engage in such a commitment comes from many sources such as male partners, family, friends, educators, and religious structures. This study shows general disregard of the importance of using condoms to prevent STDs. With advanced knowledge women are aware of the risks of engaging in sexual intercourse without a condom. However, they are taking this very serious risk at a young age. There is a greater need to educate young women to assert themselves and demand the use of condoms during every sexual encounter, to enforce dual contraception as a mandatory part of sexual intercourse, and to protect themselves from the rising rates of STDs for a healthier future.

APPENDIX A: QUESTIONAIRE FOR INTERVIEW

I. Demographics

-How old are you presently?

-Where were you born?

-Where did you grow up?

-What was your family constitution growing up?

-What was your family religion growing up?

-Do you belong to any ethnic group?

-Does your parents belong to any ethnic group?

-What class would you designate your family to while growing up?

II. Contraceptive use

- When you are beginning a new sexual relationship, would you normally use a contraceptive?
- What contraceptives do you use?
- What is your primary purpose in using a contraceptive?

III. Power/Negotiating contraception with male sexual partner

- How do you negotiate the type of contraceptive to use with your male sexual partner?

-Do you use any contraception for the prevention of STD's/STI's? (This will be asked keeping in mind that the male condom is the most effective form of contraception for STDs/STIs)

- Do you think it's your or your partner's responsibility to use contraception?
- What happens if you and your partner do not agree to the same method of contraception?
- Whose viewpoint usually wins?

-If you use a contraceptive to prevent pregnancy but your partner refuses to use condoms to prevent STDs, do you still continue the relationship?

-Can you describe to me how you would go around discussing or talking about this to your partner?

-Have you ever asked a male sexual partner if he has had an STD testing?

IV. Length of the relationship with male sexual partner

-Has your use of contraceptives changed while you were/are in a long term relationship?

-(If yes), whose decision was it ?

-Was there collective negotiation involved?

-How long into your relationship did you reach the decision to use only a certain type of contraceptive?

V. Sexual health education

-Where did you learn about contraception?

-Did you ever receive sexual health education in school?

-Did any form of sexual health education or knowledge insist on the dual use of contraceptives?

VI. Peer attitudes

-Do peer attitudes influence your choice of contraception?

- Have they ever brought out any negative experiences that happened with regard to contraception with you?

VII. Parental involvement

-How does your comfort level with your parents affect your choices of contraception?

-How does your comfort level with your siblings affect your choices of contraception?

VIII. Cultural, religious and ethnic values

-Does your cultural, religious and or ethnicity affect your views on use of contraceptives?

IX. Geography

-Is there anything about living in northern Ontario that might have influenced your values and behaviours surrounding contraceptive use?
-How would you reflect on the high rates of STDs in the north?
-Growing up and obtaining more sexual experience, how did your views on contraception change?
-Are you experiences typical of the other women here you know?

X. Defining healthy sexuality

-How would you teach your children about contraception?
-Do you personally think that dual contraception is the most effective form of contraception to prevent pregnancy and STD at the same time?

APPENDIX B : COVER LETTER FOR PARTICIPANT

Dear Potential Participant:

As a graduate student in the Departments of Sociology/Women's Studies at Lakehead University, I am conducting research on factors that influence young university women's use of dual contraceptives in heterosexual sexual encounters. Dual contraceptive use is defined as the concurrent use of two contraceptive methods– one to prevent a sexually transmitted disease and the other to prevent pregnancy. This study is being supervised by Dr. Pamela Wakewich in the Departments of Sociology/Women's Studies.

The sample will include heterosexual women aged eighteen to twenty five and currently studying at Lakehead University. In order to study this topic in further detail, you will be involved in a semi-structured interview. It will take approximately one hour to conduct. With your permission, they will be tape-recorded and transcribed for later analysis. Your identity will remain anonymous.

Although many of the questions may be of personal nature, there is no anticipated risk of physical or psychological harm. Please keep in mind that you are a volunteer and have the right to withdraw at any time. You are not required to answer any questions that you are not comfortable with. All information you provide will remain confidential and be securely stored for seven years upon completion. If you wish to receive a summary of the project, following its completion, you may e-mail me at snair@lakeheadu.ca or call me at (807) 345-8203. If you have any further questions concerning this research project, please contact me or my advisor Dr. Pamela Wakewich at (807) 343-8353 or pam.wakewich@lakeheadu.ca.

Thank you for your time and cooperation.

Sincerely,

Sasikala Nair
Graduate Student at Lakehead University
Collaborative Masters Program in Sociology/Women's Studies
(807) 345-8203
snair@lakeheadu.ca

APPENDIX C: CONSENT FORM

Dear Potential Participant:

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Thank you for your time and cooperation.

Sincerely,

_____

Sasikala Nair
Graduate Student at Lakehead University
Collaborative Masters Program in Sociology/Women's Studies
(807) 345-8203
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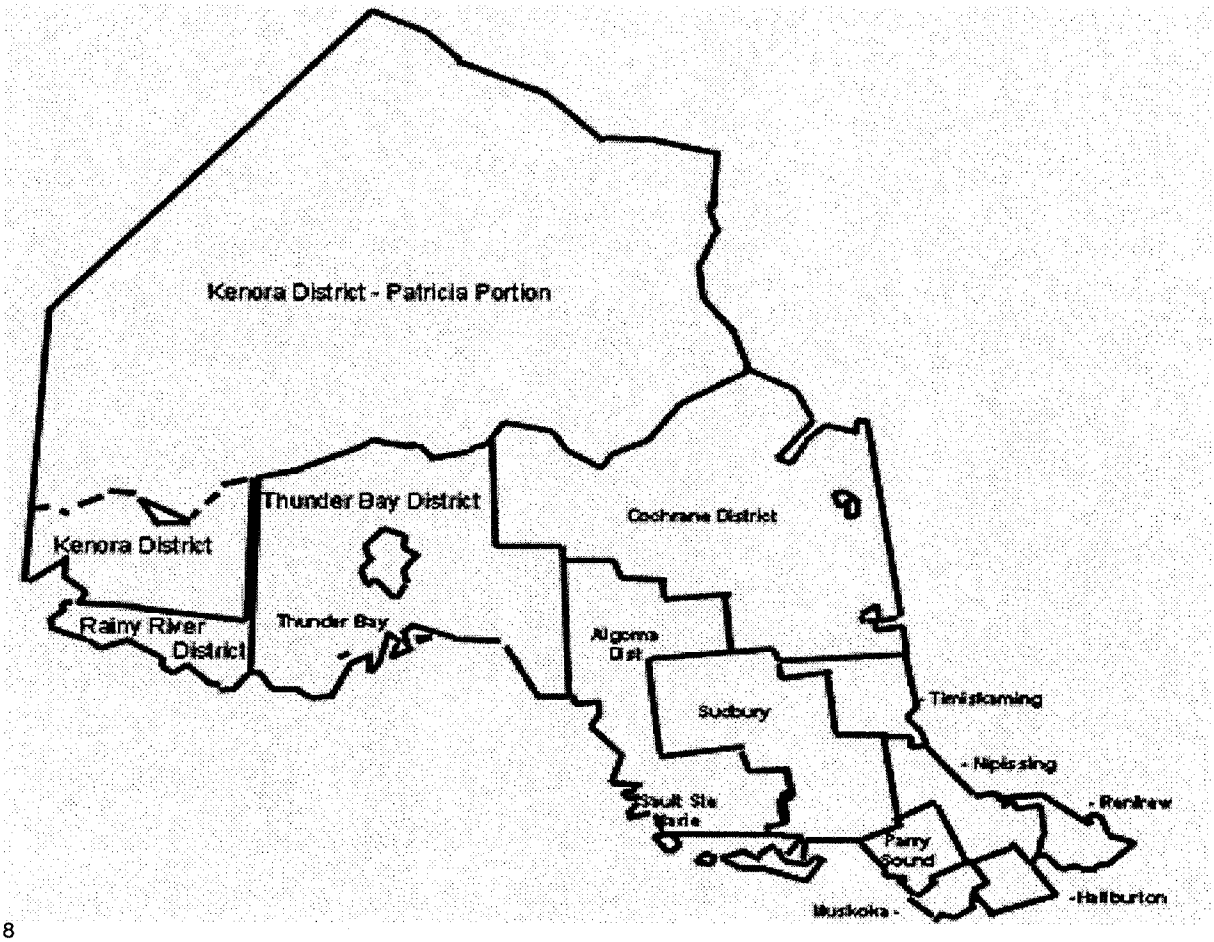
APPENDIX D : MAP OF NORTHERN ONTARIO



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[8] This map is the courtesy of www.ldao.ca (The Learning Disabilities Association of Ontario)

APPENDIX E : DEMOGRAPHICS

Interview #1 - Amy[9] is 23 years old and is of Aboriginal origin. She was born and raised in Thunder Bay. She is currently in a long-term relationship. She had no family religion growing up. Her parents are still married and she identifies herself as upper middle class.

Interview #2- Angela is 24 years old and is of Norwegian, Scottish and Aboriginal descent. She was born and raised in Thunder Bay. She is not in a relationship at the present moment. She was Lutheran growing up, her parents are still married and she identifies herself as middle class.

Interview #3- Carla is 20 years old and did not want to identify by any ethnic or religious group. She was born and raised in Thunder Bay. She is not in a relationship at the present moment. Her parents are still married and she identifies herself as middle class.

Interview #4- Cathy is 24 years old and is of Portuguese (mother) and English, Irish, Dutch and French descent (father). She is currently in a long-term relationship. She was born and raised in Thunder Bay. She was Catholic growing up and Baptist since she was nine years old. Her parents are divorced and she identifies herself as working class.

Interview #5- Jen is 19 years old and is of English and Scottish descent. She was born in Toronto and raised in Thunder Bay. She is in a long-term relationship at the present moment. Her family religion growing up was Presbyterian. Her parents are divorced. Before the divorce, she identified her family as upper class. Now, she identifies herself as middle class.

Interview #6- Joleen is 23 years old and did not want to identify by any ethnic groups. She was born and raised in Sault Ste Marie. She is not in a long-term relationship at the present moment. Her family religion growing up was Anglican. Her parents are divorced and she identifies herself as lower middle-class.

Interview #7- Kendra is 21 years old and did not wish to identify by any ethinc and or religious groups. She also did not wish to identify her family by a certain class. She was born and raised in Thunder Bay. She is currently in a long-term relationship. Her parents are still married.

Interview #8- Leah is 22 years old. She was born in Thunder Bay and raised in Dorion. She identified herself as half Finnish. She is currently in a long-term

[9] All names used are pseudonyms to ensure confidentiality of the participants.

relationship. She did not wish to identify by any religious group and designated her family as middle class.

Interview #9 - Lynn is 19 years old. She was born in Toronto and raised in Thunder Bay. She identified herself as British. She is currently in a long term relationship. Her family religion growing up was Anglican. Both her parents are still married and are of middle class background.

Interview #10 - Marie is 23 years old. She was born in Nipigon, raised near Fort Frances until she was 3, then moved to Thunder Bay. She is currently in a long-term relationship. Her family religion growing up was Catholic. Marie's ethnicity is French and Scottish on her mother's side and Icelandic on her father's. Her mother deceased when Marie was 19 years of age and her father remarried since. She identifies her family as middle class.

Interview #11 - Rose is 25 years old and was born and raised in Sudbury. She identified her ethnicity as Irish. However, she did not wish to identify a family religion. Rose also did not wish to identify her family structure. Rose's family was middle class growing up. She is not in a long-term relationship at the present moment.

Interview #12 - Shanta is 21 years old and was born in Fort Frances. She was raised in Rainy River. Her parents are currently separated. She is in a long term relationship at the present moment. She identified her ethnicity as Swedish and German. Her family religion growing up was Lutheran and her family was working class.

Interview #13 - Jane is 20 years old. She was born and raised in Thunder Bay. She is currently in a long term relationship. Both her parents are still married. She identifies herself as Ukranian and Finnish. Her family religion growing up is Catholic and family belongs to middle class.

Interview #14 - Ann is 23 years old. She was born and raised in Longlac. She is not in a long-term relationship at the present moment. Her parents are divorced. She identified herself to be of German and French descent. Her family religion growing up was Roman Catholic. Her family was middle class growing up. She has one dependent.

Interview #15 - Lou is 25 years old. She was born and raised in Thunder Bay. She did not wish to identify by any ethnic and religious groups. She is currently in a long-term relationship. Her parents are still married and she belongs to a middle-class family. Lou has one dependent.

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