
Anna-Karin L. Larsson | ORCID: 0000-0003-1882-4799
School of Law, Psychology and Social Work, Örebro University, Fakultetsgatan 1, 70281 Örebro, Sweden
anna-karin.larsson@oru.se

Abstract

The present study explores medical views on sexual health, gender and youth in Sweden from 1970 to 1999. In terms of gender-based roles, the responsibility for sexual health at this time turned out to be closely linked to girls. First, there was a clear perception that girls should take responsibility for their own and the couple’s sexual health, manifested in counselling, contraception and the understanding of risk-taking. Secondly, there was an underlying notion that boys had greater sexual needs than girls. Boys were seen as irresponsible and uninterested in counselling and decisions on contraception. Medical experts hardly mentioned joint responsibility for sexual health and contraception before the 1990s. In addition, there was a widespread perception that it was the risk-taking of some girls that increased exposure to sexual ill-health. They presented girls who did not adhere to the female responsibility norm as problematic. The study also showed a solid heteronormative view of young people’s sexual health.

Keywords


One of the most critical health issues for girls worldwide is sexual health and related problems. The right to sexual health for girls and women has progressed in several respects, historically and globally, but even today, this right has been neither self-evident nor achievable for all. From the perspective of history, girls today may enjoy greater sexual freedom and have access to more opportunities...
and resources, but they are also vulnerable and at greater risk because of hazards of sexuality, sexual expectations, and earlier maturation. In Sweden and the rest of the western world, sexual health advanced in the twentieth century, but in many parts of the world, fundamental rights, information, care, and preventive methods are still lacking. Gender-based violence and vulnerability linked to sexuality and reproduction are among the most significant health problems among girls and women worldwide. 

Gender ideologies, sexual double standards, and inequality are key factors in shaping sexual health. Girls learn from a young age to adapt to the needs and desires of others and to be passive and sexual gatekeepers. Several studies show that femininity is linked to contraceptive responsibility and controlling boys’ sexuality and needs. The present study aims to expand existing knowledge on the link between gender and responsibility for sexual health from a historical perspective. Additionally, there is also a need for further investigation on the concept of sexual health and its application in practice. Despite decades of discussions, research, efforts for young people, and societal information about sexual health, there are still needs and knowledge gaps among professionals and young people. Hence, this paper draws on medical articles published in journals for professionals working with young people in health care and school health care. By closely examining the content of the published texts, the present study explores medical views on sexual health, youth, and gender in Sweden from 1970 to 1999. First, I scrutinize what the medical experts defined as the key components of sexual health for young people. Second, I

examine the notion of responsibility for sexual health and how it was linked to a gendered view of youth. The aim is to contribute to the gender and sexual health field with knowledge about medical perceptions of young people’s needs and behaviours.

1 Historical Background to Discussions about Young People’s Sexual Health

The sexual revolution of the 1960s meant that sexuality and sexual health issues became publicly visible, and it eased attitudes towards talking about sex. Sex became more visible in media, and more research and information about sex reached the population. In the Nordic countries, a liberal view of sexuality developed, based on gender equality and sexual liberation ideas. A change in young people’s sexual habits also occurred during the 1960s, and the age at which young people became sexually active decreased. The interest in young people’s sexuality and sexual health was formalized in Sweden through welfare initiatives such as new institutions, information campaigns on protection against diseases and pregnancy, and compulsory sex education in Swedish schools from 1955. From the second half of the twentieth century, the acceptance and normalization of sex outside of marriage had increased. Still, sexuality was a societal concern and a public health issue, manifested in sexual politics and school sex education curricula. Lindgren and Backman Prytz claim that the initial purpose of sex education in Sweden was to diminish risks and problematic sexuality for children and young people and to discourage them from bad habits and risky behaviours. Abstinence and responsible family formation were advocated. In the mid 1960s, the contraceptive pill was introduced, and in 1975, legislators established the right to free abortion. Young people’s sexuality, which was previously curtailed and problematized, would now be confirmed and affirmed, and also guided in what was considered a

healthy direction. Healthy sexuality became an ideal and a right for adults and young people.

In the 1970s, the WHO gave expression to this idea in their definition of sexual health as physical, emotional, mental, and social health and well-being related to sexuality. Since then, this formulation has guided societies’ efforts around issues concerning sexual health and the control thereof. According to Giami, the meaning of sexual health has been interpreted and implemented in different ways in various countries, based on social and cultural contexts. Previous research has shown how rights and needs, responsibility, and risks have shaped the available information about young people’s sexual health. There are several pedagogical studies on sex education and ideas of sexual health and young people, but fewer on the medical profession’s view of young people’s sexual health from a historical perspective. Such studies are important, since professionals’ knowledge and attitude to sexual health and gender play a role in legitimizing behaviours and conditions for sexuality and sexual health.

The medical knowledge about young people’s sexuality evolved through research and practice in mainly four arenas from the 1970s: medical science, school healthcare, sex education, and youth guidance centres. These were all central in the medical discourse and practice, and were the arenas most commonly identified in the medical media.

First, in medical science, adolescent medicine was a relatively new field in the 1970s, during which the research, findings, and dissemination of the new knowledge evolved and improved.

10 Caroline Rusterholz, “If We Can Show That We Are Helping Adolescents to Understand Themselves, Their Feelings and Their Needs, Then We Are Doing [a] Valuable Job: Counselling Young People on Sexual Health in the Brook Advisory Centre (1965–1985),” Medical Humanities (2021), https://doi.org/10.1136/medhum-2021–012206.
12 Bäckman, Kön och känsla.
Secondly, school healthcare, already an important arena for adolescents and sexuality, saw an expansion in its remit and a broadening of its mission. The Swedish government had already established healthcare in schools in the nineteenth century, and its institution was made compulsory during the twentieth century. All Swedish children and young people have undergone health checks and examinations ever since. From the 1970s, school healthcare involved medical staff as well as counsellors, teachers, and study counsellors. Rarely discussed were issues such as depression, anxiety, or sleep difficulties, which are central to today’s health surveys. Nor were peer relationships, bullying, or other psychosocial or sexual issues discussed before the 1970s. Today’s school health is more comprehensive, and emphasizes both physical and mental health.

The third arena where young and healthy sexuality was on the agenda was sex education in schools. Until the 1970s, teaching was primarily biologically oriented to later include sexual cohabitation with a more accepting attitude towards young people’s sex lives.

And finally, the fourth arena, was the Swedish youth guidance centres. Established in the early 1970s, they quickly became a central domain where young people could come and talk about sexuality, relationships, sexual health issues, and medical and social problems. The centres had healthcare teams, usually consisting of doctors, nurses, counsellors, midwives, and child and adolescent psychologists. They were intended to complement medical care and quickly became popular. There seemed to be a high demand amongst young people for support, help, and advice for puberty-related problems, gynaecological or psychiatric issues, contraceptive counselling, and coordinating resources and competencies in youth care. At the end of the 1970s, there were about thirty centres in the country. In their activity reports, doctors described that several of the clients suffered from anxiety and depression and that many of them experienced stress around school and grades. The need for help was so great and had seemingly been left unanswered for so long that the first youth guidance centres in Sweden, in the towns Borlänge and Uppsala,
had to establish waiting lists. At the end of the 1990s, there were about 200 youth guidance centres in Sweden, staffed by professionals with a wide range of medical, social, and psychological competencies. Although these centres have never been statutory activities in Sweden, they play a central role in the development and transfer knowledge and information about young people’s sexuality and sexual health. Hence, they have a prominent place in the medical media and form an essential part of young people’s sexual health discourse.

2 Rights and Risks

In a long historical perspective, women have been held to be disproportionately responsible for relationships and sexuality. Until the end of the nineteenth century, most understandings and interpretations of sexuality, sexual behaviour, health, and desire were founded on a religious and moral interpretive framework. Chastity and virginity were the highest value in young womanhood. Women were responsible for dealing with and curbing perilous male sexuality, and also forced to deal with the consequences of unwanted pregnancies. In the secular science-based society from the late nineteenth century, medical understandings and explanations of sex and sexuality gained more ground. The view was still based on a binary understanding of male and female sexuality, marked by an expressive sexual drive in men and a more subtle or hidden sexuality in women. Conceptions of gender and sexuality have permeated medical studies and scientific results ever since, reflecting subsequent developments and more nuanced understandings.

Our views of sexuality, sexual norms, and risks with sexuality are context-bound and vary according to time and place. In large parts of the world, girls are exposed to more significant sexual risks and vulnerabilities. According

19 Brumberg, Body Project; Brown, “They Think It’s All up to the Girls”; Sandström, “Den välplanerade sexualiteten”; Moran, Teaching Sex.
to several studies, girls are also perceived – both by themselves and their parents – as weaker and more vulnerable to dangers associated with sexual health.23 This can be explained by the binary gender system that builds on the associative tendency links boys or young men with a threatening, irresponsible, and dangerous masculine sexuality. As young men engage in risky behaviour, young women are more exposed to sexual risks.24 Vulnerability, moreover, can differ within the cohort of young women. A study of young women in state-provided Swedish youth care showed that, in addition to reduced general health, these young and vulnerable girls also had poorer sexual health. They were exposed to more risks.25 A higher risk of poorer sexual health can thus be due to gender, class, and social vulnerability. During the second half of the twentieth century, public and medical discussions about young people's sexuality and sexual health were primarily about sexual risks and risky behaviours. However, from the 1970s onwards, and more so after the turn of the millennium, the perspective shifted to include also more positive aspects such as equality, relationships, love, intimacy, pleasure, and respect.26 The new issues and the ways of looking at sexual health for young people reflect a new emphasis on the rights to sexual health in Western societies.27

3 Gender and Responsibility

Being exposed to risks or exposing others to risks is closely linked to contemporary notions of responsibility for sexual health and health in general. Women learn from an early age to take care of their health and to go for regular health check-ups. The same expectations do not apply to boys at a young age, and even later in life, it is often regarded as the woman’s responsibility to ensure that the man takes care of his health.28 Constructions of femininity and

26 Lindgren and Backman Prytz, “Staten, skolan och sexuallivet.”
27 Tolman, Striepe and Harmon, “Gender Matters.”
masculinity thus affect both the institutionalized view of gender and health and the well-being of women and men. Research on young people’s notions of sex and responsibility has shown that these are permeated by ideas of strong, irresponsible, and threatening masculinity. 29 At the same time, women and feminine sexuality are regarded as responsible, credible, and pure. Dalessandro showed that these perceptions influenced young people’s attitudes towards risks and responsibilities concerning sexual health. 30 In this binary thinking amongst young people, masculine bodies and men represented danger, risk-taking and irresponsibility, while female bodies and women stood for responsibility, exposure to risks, and health hazards. Responsibility for sexual health thus seems to be closely connected to femininity.

Taking responsibility for oneself and others, and being responsible in life and relationships, moreover, is widely considered a vital component of young femininity today. 31 Being responsible is associated with growing up, becoming independent, active and strong, which also aligns closely with the Western ideal and the construction “girl power” – the popular discourse that has characterized girls, the perception of girls and girls’ upbringing since the 1990s. 32 In the Swedish context, the girl-power discourse has been prominent as it coincides with Swedish gender equality standards for strong and independent girls and women. 33 These norms with which girls today are confronted in various areas such as popular culture, media, and advertising, are also characterized by a message of an active, independent, and responsible female sexuality. 34

Several researchers have shown that gender stereotypes still exist in sex education. How schools teach girls’ and boys’ sexuality in education also limits and enables what expressions of sexuality are possible and permissible. This leads to different spaces for girls and boys in the sexual sphere. 35 Both girls and boys

29 Dalessandro, “Dangerous Sex: Gendered Sexual Bodies and Perceptions of STI Risk.”
30 Ibid.
35 Bäckman, Kön och känsla.
seem to believe that girls bear the primary responsibility for protecting themselves and avoiding pregnancy. While young women take greater responsibility for preventing pregnancy, young men also rely on girls to take responsibility for unwanted pregnancies.36 This kind of tacit agreement whereby young men rely on young women to use contraception or abortion reinforces the perception that responsibility for sexuality is largely the preserve of women.37

Gender plays a role in expectations and life choices regarding sexuality and relationships and has concrete consequences too in the form, for example, of girls’ exposure to child marriage and sexually transmitted diseases (STDs) such as HIV. On the other hand, boys have other health risks, and boys’ and men’s sexual health is still understudied. Sexual health and related issues are still primarily considered a women’s issue.38 But it is not just gender that is crucial for decisions and responsibilities for sexuality. Class, status, ethnicity, or race have been shown in studies to have consequences for the understanding of sexual activities and are key determinants for who will take reputational risks.39 Despite research in different disciplines on gender and sexual health, there remains a need for further studies on how gender notions affect sexual health and its perceptions.40 There is still insufficient knowledge of experts’ and professionals’ views on sexual health and young people, particularly those of medical experts, doctors, and counsellors who meet young people on a daily basis. Insights into the knowledge and ideologies promoted by medical professionals can help us to better understand the expectations and perceptions of the young people within their sphere of influence.

The present study explores the medical discussions and perceptions of sexual health and young people in journals for the relevant professions in Sweden. Taking the 1970s as its starting point allows the study to encompass a time when there was optimism and confidence in the future of improved health, increased resources, and expanded activities within medical and social institutions for young people in Sweden.41 The 1970s was also the decade when adolescent

38 Mmari et al., “Yeah, I’ve Grown; I Can’t Go out Anymore.”
39 Dalessandro et al., “Strategic Silence.”
40 Tolman, Striepe and Harmon, “Gender Matters.”
medicine was formed, and young people’s sexuality received increased attention. During the 1990s, optimism in youth medicine and school healthcare waned. An economic crisis in society, reduced welfare resources, and threats to sexual health in the form of HIV and AIDS characterize the increasingly pessimistic medical discussions about young people’s health in Sweden.

Since gender is a fundamental aspect of sexuality, gender clearly matters when it comes to questions of sexual health. This means, for instance, that the understanding of gender has influenced sexual health and conversations on the topic. The question of how gender influences adolescent sexual health is understudied, however. The study will hopefully shed light on this issue by answering the following questions: How were medical perceptions on sexual health and young people articulated and presented in the medical media? What were the perceptions of girls’ and boys’ vulnerability, risk-taking and responsibility for sexuality, and did these perceptions change over time? The aim is to deepen our knowledge of the gendered perceptions of young people’s sexual health and views on who bears primary responsibility for sexual health.

4 Materials and Methods

This study draws on articles and texts published in medical journals and pamphlets written by medical experts and professionals in health and school healthcare in Sweden between 1970 and 1999, primarily for a readership of their peers. By closely examining the content in the published texts, I first investigate what medical experts identified as the key components of sexual health for young people, and secondly, I examine the notion of responsibility for sexual health and how it was linked to a gendered view of young people. Läkartidningen is the leading journal for medical science in Sweden, written for and by medical staff and published weekly since 1904. Registers have been examined from all of the years surveyed, based on the search of relevant keywords, e.g., youth, adolescence, sexual health, sexuality, abortion, contraceptives, sexually transmitted diseases. The empirical data was constituted through the collection, in total, of about a hundred articles, debate articles,

---


44 Tolman, Striepe and Harmon, “Gender Matters.”
and shorter texts in *Läkartidningen*, alongside a few other relevant periodicals and publications with issues on relevant themes; among them, the periodicals *Hälsan i skolan* (Health in the School) and *Skolhälsovård* (School Health Care), and two Swedish Public Health Institute and National Board of Health and Welfare reports. These periodicals provided practical guidance to school healthcare staff on adolescent sexuality and sexual health issues. They had a narrower but more targeted target group than *Läkartidningen*. A small number of only the most relevant articles, around ten, have been included in the study from these periodicals and reports.

I have worked inductively and used a thematic analysis method, which meant reading the primary sources carefully and coding and dividing them into meaningful units based on the research question. The units were issues and debates from the empirical data which I then merged into themes that guided the analysis and outline. The whole process and organization of the source material have been part of the analysis.\(^{45}\) Inevitably, previous research and theoretical assumptions have also influenced my thematization. It is difficult to approach these texts without any preconceptions and to suspend one’s own biases, but in my reading, I strived to remain open to counter-discourses and unexpected debates. Three themes, nevertheless, clearly stood out. In the results, I will discuss each of these in turn: 1) Girls should take responsibility for sexual and reproductive health; 2) Boys are irresponsible and have sexual needs; and, 3) Girls are exposed to risks and are risk-taking.

5 Results

5.1 Girls Should Take Responsibility for Sexual and Reproductive Health

The notion that girls are responsible for sexual health was repeatedly communicated in the medical discourse. The majority of visitors to the youth guidance centres were girls; it was girls, first and foremost, who were identified as the ones responsible for the couple’s sexual health. Girls were furthermore expected to be responsible for protection against STDs and unwanted pregnancies; between boys and girls, it was only the latter who were also encouraged to postpone their initiation into sexual activity. We will closely examine how these assumptions and expectations were communicated by the experts in these texts.

The sources support the finding that, from the beginning of the youth guidance centres in the 1970s, most of the clients were girls. This pattern apparently remained largely unchanged during the whole period under review and seemed to apply to sexual and reproductive health visits at school healthcare centres as well as youth guidance centres. Most girls were seeking advice on contraception and prescriptions for birth control pills. The boys’ visits were more often described as exceptions. Girls would prioritize visits to get contraception, and boys rarely visited the centres. There was good reason for their being informally referred to as “girls’ centres.” It is difficult to know, however, if the girls visited in more significant numbers because the information and activities were targeted at them, or if they, in fact, took greater responsibility for their sexual health than did the boys. In an address to healthcare centre visitors in one article, it is stated that: “The fact that you visit a centre at all means taking responsibility for your own health, which in itself is positive.” Whatever the reasons why the numbers of girls visiting the centres far outweighed the numbers of boys, the girls who visited could access advice and help with contraception and sexual counselling and they would ask about relationships with boyfriends, peers, and parents. In one of the texts, the explanation of a young girl was quoted in her answers as to why she applied to the local youth guidance centre:

They are more human here than in hospitals—says Eva, 16—You can talk to them. They are like young people in that way. Just as if they had experienced the same things themselves, even though they did not. I mean, at that time, it could not have been as it is now. Mom thinks I should have

49 Persson and Jarlbro, “Tidig sexualdebut indikator på sexuellt riskbeteende?”
birth control pills, but Dad thinks I should have an IUD. I’ll do what they say here.50

Eva’s parents’ thoughts on their daughter’s need for protection are apparent, but whether she had a boyfriend, and whether or not he had an opinion, is not apparent from the text.

The attribution of responsibility for sexual health to girls seemed linked also to the idea of female puberty as problematic. During the 1970s, adolescence was commonly depicted in medical discourse as an unstable time in life, a period beset with puberty problems of varying degrees of severity. Girls’ puberty was considered a particular vulnerable stage in life and ideas of female puberty and fragility have long roots in the history of Western societies.51 Medical experts perpetuated the idea that there was a disjuncture between biological and social maturity.52 This was thought especially to be the case for girls. The onset of puberty for girls meant the advent of a particularly vulnerable biology, exposed to sexual ill-health. One doctor declared that “biological maturity is coming earlier, which is illustrated by a declining age for the first menstruation for girls. At the same time, social maturity is emerging later and later because working life requires an increasingly long period of education.”53 Another expert made the claim that, “Today’s teenagers have, compared to previous generations, a lower average age for the onset of puberty and often a corresponding earlier sexual debut. The earlier biological maturity does not usually correspond to the degree of social maturity.”54 The idea of girls’ puberty as a period of biological and social vulnerability could perhaps explain why the centres directed most of their attention and resources towards the girls, but also why it seemed obvious for girls to take responsibility for sexual health.

When adolescent medicine as a medical discipline was established in the 1970s, there were still many question marks over young people’s sexuality and sexual health. More research on young people’s sexual health was needed.55 A
journal for school healthcare staff stated that doctors and nurses needed more and sufficient knowledge about girls’ physical and mental development. Youth guidance centres had started to respond to young people’s needs, but other medical centres were also established in order to try to meet the needs of adolescents and the demands for expertise on the problems associated with adolescence. In Uppsala, for example, a gynaecological centre opened up in 1973. Almost all clients were young, with most of the girls in attendance seeking advice on contraception; birth control pills and IUD’s being the most desired options. In the 1980s, much of the focus of the journals was directed toward the problems with STDs and HIV. In debate articles, gynaecologists emphasized the need for more information to be given to young people about how to protect themselves from STDs. Class and age-related aspects of contraception responsibility were also on the agenda. According to a survey, girls in high school were generally considered to have better knowledge of sexually transmitted diseases, and many had had their first sexual encounter at an earlier age than boys. In another study on contraceptive choices, differences in contraceptive methods between girls from different social backgrounds were discussed. Girls in pre-vocational programmes showed a greater tendency to use birth control pills. Here, ‘working class’ girls were apparently encouraged by their families to use birth control pills but were not so good at insisting that boys use condoms. The text implicitly suggests that the responsibility for protection was on girls, and it was also implied that they should be better at making demands on boys to better protect themselves from diseases and pregnancies. Young women, moreover, are identified as “key persons” in preventing the spread of HIV. Girls should refuse to have sex, claimed one author, and they should avoid taking part in risky sexual behaviour.

Not only should girls take responsibility for contraception, but some experts also suggested that girls who became sexually active at a young age were a problem. A few explicitly suggested that girls should take responsibility by the

56 Tillinger, “Uppväxtårens gynekologi.”
57 Abrahamsson, “Ett års erfarenhet från en fristående ungdomsmottagning i Kristianstad.”
60 Tydén, “Mer information behövs för att bromsa spridningen av sexuellt överförbara sjukdomar bland ungdom,” 3562.
postponement of their first sexual encounter. Girls seeking help and contraception might also need support in saying no to boys. In summary, girls were expected to take responsibility for protection against the unwanted consequences of sexual activities. Boyfriends seemed to be secondary characters when it came to questions of the couple’s sexual health. There are few mentions of boys taking responsibility or offering support. This theme – girls should take responsibility for sexual and reproductive health – shows how, explicitly and implicitly, girls were left with the responsibility to prevent STDs and unwanted pregnancies. And even if girls seemed to embrace the responsibility for their own and boys’ sexual health, this may have been attributable to the lack of a realistic alternative when even the experts were repeatedly helping to underpin the link between girls and sexual health responsibility.

5.2 Boys are Irresponsible and Have Sexual Needs

Girls’ responsibility for sexual health and contraception corresponded to a perception of boys’ sexual needs, risk-taking and a lack of responsibility when it came to questions of sexual health. When boys are mentioned in the texts on sexual health, the topics are usually associated with risks and needs. Most articles about youth guidance centres focused on the girls and their visits, but none claimed that the boys were not welcome; there simply did not seem to be the same level of interest or need as for girls in terms of advice, support, or contraception. One school nurse reported that she sometimes heard boys saying that contraception is a ‘girl thing’: “If the girl does not say anything, then it is taken for granted that she has birth control pills,” the boys said. The boys did not have to worry or talk about protection according to that line of reasoning. Boys, in the texts, are thus described as irresponsible insofar as they take no initiative to seek out expertise, and they do not ensure that contraceptives are used. A gynaecologist at the youth guidance centre in the town of Borlänge thought that the staff should encourage the girls to bring their boyfriends to the appointments and share in the responsibility for birth control. In fact, some boys came to the youth guidance centres with their girlfriends as

confirmed in a survey in which boys were asked how they received information about youth guidance centre activities and how and why they decided to go to the centres. The main answer was that their girlfriends had persuaded them to attend the centres. One author ruminated on the issue as follows:

The question is whether or not young girls here show the well-known female attitude of not only being responsible for their own health but also for their loved ones.67

During the 1980s and 1990s, girls and young women still seemed to be the target group for information about sexuality and relationships, but a few articles emphasized the role and responsibilities of boys and young men. From the late 1980s, the idea that boys should take on more responsibility and be addressed in sexual health issues became more frequent. In a text based on a study of adolescents’ sexual habits conducted in the form of two extensive surveys in 1986 and 1991, one author explained how boys had taken on more responsibility through their increased use of condoms.68 Another writer reporting from a meeting with young people on contraception and prevention, said it had been difficult to engage and recruit boys for discussions about love, sexually transmitted diseases, contraception, and abortion. It seemed as if boys were not interested or comfortable enough to talk about these issues.69

In summary, there was an increasing premium on the idea that both individuals in a couple needed to get information and knowledge to have responsible, safe sex. It was crucial to find ways to attract the boys to come and acquire information and knowledge. One expert thought it was important to offer activities to couples, not just individuals, and to increase staff competence on problems specific to both genders, not just to girls.70 However, the boys seemed to be absent, not only in terms of knowledge acquisition and decisions about the consequences of sexual activities; an article on abortion decisions pointed out that boys and men often completely surrendered the responsibility and the right to decide to girls and women.71 Since the Swedish abortion law of 1975 gave women the right to decide over their bodies and the right to free

67 Bolin, Det handlar om killar, 42.
69 Van Rooijen et al., “Att lyssna på ungdomars idéer.”
abortion, it is not surprising that women decided for themselves. However, the article suggested that young men were not interested in sharing responsibility for the unwanted pregnancy and for obtaining an abortion. Men’s perceptions and feelings regarding abortions were practically absent in the texts, except for one article wherein a doctor pointed out that men may also need therapy and support in a situation where an abortion was sought.72

If the responsibility for unwanted pregnancies was female, there were tendencies to blame boys and men for the spread of sexually transmitted diseases. Here, young men were held responsible for their behaviour, promiscuity, and lack of protection. An article about male conscripts and male and female students and the spread of STDs advocated for the need for improved knowledge about sexual consequences. Sex education and lessons on venereal diseases were needed in the military training precisely because young men “are at the age of high sexual activity and often have occasional sexual contact during this period.”73 Another study on venereal diseases and sexual behaviour in young Swedish conscripts showed that there seemed to be a negative attitude to condoms among young men.74 School health personnel also mentioned the reluctance towards the use of condoms.75 Accordingly, in several texts, boys and young men were described as irresponsible and unable or unwilling to protect themselves and their partners. However, in one text about changes in young people’s sexual habits, it is mentioned that condom use is increasing and that boys had thereby taken on more responsibility by a willingness to use condoms more often.76 It is noteworthy to mention that the increase in condom use may also be related to the fear that arose in the 1990s of birth control pills as a potential cause of blood clots. The authors of this text nevertheless interpreted the increased use of condoms as evidence of an increase in the responsibility taken by boys for the preservation of theirs and their partners’ sexual health.

During the 1980s and 1990s, the non-attendance of boys at youth guidance centres began to receive more attention and was considered problematic, especially in the light of an increasing spread of STDs.77 So, how could the centres attract visits from boys? From the beginning, the centres’ focus on contraceptive counselling and abortion prevention work meant that they had

---

76 Swedin et al., “Stora förändringar av ungdomars sexvanor.”
77 Bojs, “Ungdomsmottagningar kräver venerologi,” 3932.
appealed mainly to girls. The National Institute of Public Health in Sweden published suggestions for attracting the involvement of boys and making them take responsibility for sexual health, contraception, and relationships. To prevent HIV and other sexually transmitted diseases, the institute also provided support to youth guidance centres to develop activities for boys. From the start, the youth guidance centres had been open and aimed at all young people, but the boys, as already mentioned, had been absent: “It is hardly a secret that youth guidance centres are regarded as ‘girls’ centres’ that primarily offer contraceptive information and contraceptive prescriptions.”

The centres needed to change their image in order not to be perceived as gynaecological centres. They needed to be welcoming, accessible, and to offer free-of-charge advice and services so as not to scare the boys away. One expert speculated, however, as to whether the youth guidance centres had ever been intended for the boys: “It is the girls who are considered to have the problems and who need help and support, victims of the male power society.” In the texts about boys’ centres, it seems that there was an ambition to change the image of boys as irresponsible and uninterested in sexual health or other issues concerning sexuality. The report Det handlar om killar (“It is about boys”) explained how boys were not used to taking responsibility for theirs and their partner’s sexual health and that traditional sexual education had had a feminine approach and a negative view of male sexuality. There was speculation on how best to reach various categories of boys: the macho guys, the homosexuals, the quiet and withdrawn ones, the immigrant boys, and then the unruly boys and boys on vocational or study preparation programmes in high school. One suggestion was to customize messages to each category to lure them in. One school counsellor who examined boys’ perceptions and propensity to seek advice, support, and care described how she became aware of the centres’ perceptions of the girls as victims and the boys as perpetrators. If boys were seen only as irresponsible and ignorant characters driven primarily by their sexual needs, they would not be interested in visiting the centres.

Heterosexuality among young people seems to be taken for granted, and homosexuality and sexual health is hardly mentioned. When discussing how

---

78 Persson and Jarlbro, “Tidig sexualdebut indikator på sexuellt riskbeteende?”
79 Bolin, Det handlar om killar.
80 Ibid., 9.
82 Bolin, Det handlar om killar.
83 Nilsson, Pojkar på ungdomsmottagning.
young couples should avoid diseases and other risks beyond unwanted pregnancies, and, the couples in question almost exclusively consist of a girl and a boy. In two reports addressed to school healthcare personnel, two texts about homosexuality are discussed. Both texts describe a homosexual student, in each case a young man who is unsure of his feelings and identity. The texts discuss only a professional approach and how to talk about feelings of being different; there is no mention of the risks, responsibilities or needs in a homosexual relationship. In the publication Det handlar om killar (“It is about boys”), male homosexuality is also addressed with reference to how boys who find themselves outside the norm may have questions and needs to talk through with an adult. Another group mentioned here is immigrant boys, some of whom might have wanted to come to centres for boys to talk about “Swedish sexual culture,” Swedish values, and how to interact with girls. Both homosexual boys and immigrant boys are singled out as not belonging to the norm.

The purpose of specific youth guidance centres for boys or outreach activities aimed at boys in the 1990s was to promote a shared responsibility for sexual health. Alongside many descriptions of boys as uninterested, irresponsible, and relying on girls to take responsibility, there was also a gendered perception of males as sexually driven with profound sexual needs.

5.3 Girls are Exposed to Risks and are Risk-Taking

In most texts on young people and sexual health, gender undoubtedly mattered throughout the three decades from the 1970s to the 1990s. Among the medical experts, there was a perception that young people, particularly girls, were exposed to risks and sexual ill-health related to sexual activities. In the 1970s, the standard explanation for a worrying increase in STDs in adolescents and young adults gave reasons such as their having a higher number of sexual contacts, becoming sexually active at a younger age, and having the opportunities and resources to socialize and engage in new habits and pleasures. One doctor claimed in the 1970s that one of the consequences of women gaining access to birth control pills was that condom use decreased and the incidence of STDs increased. In the 1990s, the spread of HPV among girls was a concern and a significant risk among sexually active girls.

84 Bolin, Det handlar om killar, 43–48.
87 Cervical and other cancers can be caused by human papillomavirus – HPV –, one of the most common STDs today.
88 Andersson-Ellström et al., “Osäkert sex’ vanligt trots goda kunskaper.”
In the 1970s, statistics showed that STDs among young people in Sweden had increased. Education and information campaigns were seen as critical. Several authors argued for more information in schools and guidance centres. A study of young people's beliefs and knowledge about STDs showed that young people had basic knowledge of the spread of disease. However, their knowledge was seldom more than rudimentary and did not seem sufficient to fully protect them from STD infection. Changing sexual behaviours put higher demands on school doctors and school nurses' knowledge and information about sexual health and gynaecological problems. Improved contraceptive advice was seen as essential to protect girls and give them the tools to make better choices. "Unfortunately, a large proportion of unwanted pregnancies arise – regardless of age – since contraceptive measures have not been used at all," explained one doctor, putting the responsibility on the girls to protect themselves from unwanted pregnancy.

Throughout the period under review, sexually active girls were thus portrayed as problematic, particularly those girls who became sexually active at an early age and those who did not use contraception or who relied on abortions. After the introduction of free abortion in Sweden, the number of teenage births decreased. The number of pregnancies also decreased, despite studies showing that girls were increasingly becoming sexually active at a younger age. Teenage pregnancies, abortions, and STDs are recurring themes in 1980s texts on sexual health and adolescents. In addition to an extensive thematic issue on abortion in 1980 in Läkartidningen, there were articles discussing how young girls' first sexual encounters and their sexual habits affected the number of teenage pregnancies and the effectiveness of contraceptive counselling. In discussions of why the number of abortions among young women had increased towards the end of the 1980s, the focus was primarily on the girls' sexual habits and how it affected the use of birth control pills, the number of abortions, and the number of unwanted pregnancies. It seemed as if young women were increasingly exposing themselves to risks in sexual relations. One of the doctors expressed the perplexity in the medical profession as follows: "What is it that makes so many women exposed to the risk of an unwanted pregnancy?

---

90 Tillinger, "Uppväxtårens gynekolog.
91 Eckerberg et al., "Vem ska ta hand om ungdomen i tonåren?"
92 Tillinger, "Uppväxtårens gynekologit.
with a termination as a result?"^{94} Contraception, STDs, unwanted pregnancies, and abortions were all presented as female issues. Towards the end of the 1980s, the use of contraceptive pills seemed to decrease. This tendency was partly due to girls’ concerns about the connection between the pills and cancer, and due to greater access to free condoms. Still, obtaining contraception was primarily seen as the girls’ responsibility. They were the ones who would seek advice and contraceptive methods, not the boys.\textsuperscript{95}

Studies and alarming reports in the mid-1990s about a presumed connection between birth control pills and an increased risk of blood clots led to a temporary reduction in the use of birth control pills and an increase in the number of abortions. Seemingly, young women paid attention to these reports and were affected by them.\textsuperscript{96} The texts in the medical journals from this decade raised the issues of an increase in abortions among young people, sexually transmitted diseases, and HPV. Disapproving reference was made sexually active girls, who became sexually active earlier and earlier, and who would have unprotected sex.\textsuperscript{97} The girls thus described were portrayed as irresponsible and at greater risk of sexual ill-health, especially if they were early developers and spent time with older friends.\textsuperscript{98}

A study of teenage girls’ knowledge and attitudes towards STDs showed that the girls’ knowledge was good but did not result in safe sex behaviour.\textsuperscript{99} In another study, researchers said that young people (mainly girls) “know a lot about STDs and contraceptive methods but have difficulty applying the knowledge in practice.”\textsuperscript{100} They claimed that the problem was a communication issue between the girl and boy, and that the girl must dare and be able to argue about condom use or refrain from intercourse. None of the studies raises the question of the role of boys in responsible sex. No author argues that condoms should be a shared responsibility, that it could be a shared duty to address the issue, and that boys could also insist on protection.

\begin{flushleft}
\begin{itemize}
  \item^{97} Persson and Jarlbro, “Tidig sexualdebuts indicator på sexuellt riskbeteende?"; Andersson-Ellström, “Ungdomars kunskaper om könssjukdomar varierar – behov av kondominformation,” 2190.
  \item^{98} Andersson-Ellström et al., “Osäkert sex’ vanligt trots goda kunskaper.”
  \item^{99} Ibid.
  \item^{100} Persson and Jarlbro, “Tidig sexualdebuts indicator på sexuellt riskbeteende?".
\end{itemize}
\end{flushleft}
6 Discussion

The present study explored medical views on sexual health, youth, and gender in Sweden from 1970 to 1999. To understand how, in what ways, and to what extent gender norms influenced these perceptions and how medical experts understood sexual health for girls and boys during the examined period, the link between gender and responsibility was investigated and analysed. A gendered view of young people’s sexual health emerged. Following previous research, responsibility for sexual health was closely connected to femininity and girls. Throughout the later decades of the twentieth century, there was a perception that the responsibility for one’s own and the relationship’s sexual health was first and foremost the girl’s responsibility. This view is also closely aligned with previous research on ideals of independence that are characteristic of ideal young femininity.

The three themes that were investigated based on the source material – 1) Girls should take responsibility for sexual and reproductive health; 2) Boys are irresponsible and have sexual needs; and, 3) Girls are exposed to risks and are risk-taking – clearly showed that there was a notion not only that girls took more responsibility for their sexual health but also that were expected to do so. From the beginning, the newly established youth guidance centres, which later increased in number throughout Sweden, played a significant role in health-care for young people and their psychosocial arena. The activities at the youth guidance centres were primarily aimed at girls; birth control pills were recommended, and the responsibility for choosing and handling contraceptives and was predominantly imposed on girls. Only from the 1990s did separate centres and activities start for boys. These can and should be seen as an attempt to get the boys to take more responsibility for sexual health. Boys were most commonly described, however, as seldom showing an interest in their own or the couple’s sexual health. The notion that boys are basically irresponsible is consistently underlined in the texts, both explicitly and implicitly. Boys were not even mentioned in most texts when it came to questions of counselling for contraception or the consequences of sexual activities. There was no expectation that boys would voluntarily take responsibility for the consequences of sexual activity. Throughout the literature under review, girls were thus seen as responsible for protecting themselves and their partners. As previous research had shown also to be the case in other contexts, girls moreover were expected

101 Dalessandro et al., “Strategic Silence”; Brown, “They Think It’s All up to the Girls.”
to have to deal with boys’ needs and sexuality. Boys’ sexual needs and their right to sex are taken for granted, and seem to constitute a norm. The fact that girls have sexual needs and a right to sexuality, pleasure, and sexual intercourse was almost entirely unacknowledged. Their sexuality was not acknowledged. On several occasions, the view emerges that girls should not have sex prematurely and should take responsibility for protecting themselves and for saying no to the boys on occasion. Risk-taking on the part of boys or the idea that boys should take responsibility for contraception, for themselves or as a couple, was seldom mentioned before the 1990s. On the other hand, girls were regarded as accountable for their own exposure to unnecessary risks with consequences such as unwanted pregnancies and sexually transmitted diseases.

Examining how young people’s sexual health and responsibility was discussed is vital for understanding how perceptions of gender and responsibility for sexuality changed, and how medical staff sought to include young men in a joint responsibility for sexual health. It is also important to link the emergence of youth guidance centres with society’s desire to affirm young people’s sexuality on the one hand, but still to steer it in a specific direction on the other. The articles on girls, boys, and sexual health are primarily exclusively about a homogeneous group of heterosexual young people.

The study’s three themes originated from what was explicitly expressed in the sources. Some things, such as heterosexuality, seemed taken for granted and normative, while the sources hardly ever mentioned homosexuality or non-normative sexuality. Questions about class, ethnicity, or other aspects are also very seldom raised. Today’s medical discussions about youth sexual health are more multi-faceted and acknowledge that young people are a heterogeneous group with diverse needs. Most visitors to youth guidance centres for sexual health issues are still girls, however. While the view of shared responsibility for sexual health seems to be well established nowadays, there is still a narrative according to which it is the personnel at the centres who must adapt to the boys’ needs, and not the boys’ own obligation to be responsible for sexual health.

103 Brown, “They Think It’s All up to the Girls”; Moran, Teaching Sex.