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SEXUAL HEALTH

Understanding how young cisgender heterosexual men navigate sexual health conversations and practices during casual sex: a qualitative study

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ABSTRACT

Background. Young cisgender heterosexual men in Australia are the least likely population group to undergo testing for sexually transmissible infections (STI) and ensuring barrier method use during casual sex with cisgender women who have sex with men, with rates of STIs increasing among this group. This research examines how these men navigate sexual health conversations and practices during casual sexual encounters. **Methods.** A total of 30 semi-structured interviews with young cisgender heterosexual men living in Australia during 2021 were conducted. Participants were asked questions about their dating and sexual practices, including sexual health knowledge, how they learned to have sex, and navigating sexual health conversations with partners, such as STI testing, and barrier method and hormonal contraceptive use. Findings were analysed using reflexive thematic analysis techniques. **Results.** Findings note that men use various strategies of avoidance including sustaining the erotic moment, and assuming women's responsibility. Participants also noted limited relationality, in which they highlighted individualised concerns for their own sexual health wellbeing but not that of their partners. **Conclusions.** This research highlights that despite increased awareness and promotion of STI prevention and contraceptive responsibility, young cisgender heterosexual men continue to forego their responsibilities regarding their own and other's sexual health during casual sexual encounters. Findings highlight a need to include gender transformative approaches to sexual health promotion and practice to address continuing gender inequities.

Keywords: barrier methods, communication, contraception, heterosexuality, men, pregnancy prevention, responsibility, sexual practices, STI prevention.

Introduction

Research in Australia has focused on young cisgender heterosexual men's sexual risk-taking behaviours that can lead to sexually transmissible infections (STIs),[1] their sexual health knowledge and attitudes,[2] and their perpetuation of sexual violence.[3–6] Some studies in Australia and internationally have explored men's interest in using a hormonal form of birth control (i.e. the male pill), finding most men interviewed or surveyed would not trust it, or would not use it for concerns about its potential side effects.[7–9] Research has also found that women continue to hold the burden of contraceptive responsibility in terms of hormonal birth control methods, having to ask partners to use condoms, and to insist on STI screening results prior to a sexual encounter.[9–13] This expectation is compounded with increased push towards women's bodily autonomy, in which some research has found that while men believe it is a shared responsibility, they often leave the contraceptive decision to women to allow for this autonomy.[14,15] There is limited understanding as to how young cisgender heterosexual men in Australia are navigating casual sexual encounters with women when it comes to conversations regarding the use of barrier methods for STI prevention and hormonal contraceptives for pregnancy prevention.

With the advent of digital technologies creating new avenues for the dissemination of sexual health information outside of school-based relationships and sexuality education

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(RSE) programs,[16–18] alongside the increased awareness about the relationship between gendered violence and sexual health discussions, there is a need to better understand if men's responsibility expectations are changing, and how that might be occurring. This has important implications for sexual health promotion activities seeking to reduce STI transmissions and unwanted pregnancies, as well as to consider the important role such interventions have regarding gendered violence prevention. Drawing from 30 semi-structured interviews with young cisgender heterosexual men in Australia, this paper explores the research question of how men make sense of and navigate sexual health conversations and practices during casual sexual encounters with women who have sex with men. It looks at structural and agentic factors that contribute to participants' motivations for the overall avoidance of sexual health conversations, and the impact on their sexual health practices. This paper begins with a discussion of sexual health policy and practice in Australia, and theoretical considerations of gendered power relations and sexual health.

Heterosexual gender relations and sexual health dynamics

Young cisgender heterosexual men's capacity for sexual health communication during casual sexual encounters in Australia rests on both individual socialising as young men, and broader systematic structures that contribute to the shaping of their sexual health education, understanding, and awareness. In this paper, I am interested in the gendered power dynamics (i.e. relations and interactions that challenge or reinforce certain norms regarding gender) that underpin these men's sexual health, and communication and associated STI and pregnancy prevention expectations.[15,19,20] This includes a careful consideration of both structure and agency regarding these dynamics; that is, the structures that may shape young men's identities, and the manner to which they may enact agency in favour for or against these structures.[21–24]

Heterosexual relations between men and women are understood through framings of heteronormativity, a set of social rules, norms and values that shape how men and women are expected to engage sexually with each other. On an individual level, young cisgender heterosexual men in Australia are expected to perform what is often described as a 'hetero-masculinity';[25] that is, a gendered and sexual identity that subscribes to a particular set of norms, behaviours, and values that prioritise certain expressions and practices of masculinity and heterosexuality. This involves practices of masculinity emphasising strength, aggression, and stoicism, and heterosexuality that prioritises sexual aggression, virility, casual sex over relationships, dominance, penile-vaginal or anal sexual activity in which men remain the penetrator, or oral activity in which men are the main receiver, and an overall sense of entitlement to women's bodies and men's own self-gratification.[25–27] Men are expected to view women as sexual conquests, be engaged in casual sex, while women are perceived as sexual gatekeepers, to prefer long-term relationships, to need to be manipulated into having casual sex, and denied opportunities to explore casual sex for personal pleasures.[28–30] Long standing medical, political, and social control that involves restriction and surveillance over women's bodily autonomy ensure that women continue to hold significant burden and responsibility for STI and pregnancy prevention and associated impacts.[9–12,31–38] These expectations about sex, contraception, and STI prevention can shape young men's (and women's) sexual relations practices.

Australian policy sexual health promotion activities are guided by the *Fourth National STI Strategy 2018–2022*,[39] which contribute to these broader heterosexual relations discourses. Research has found that this strategy and associated sexual health promotion programs do not target cisgender heterosexual young men in Australia, with most health promotion and prevention work targeting cisgender women.[40–43] While young people are a priority focus in the strategy, this does not mean young cisgender heterosexual men are receiving adequate information and education that resonates with their lived experiences. Studies both in Australia and internationally have also found that gender transformative programs seeking to address men's violence do not usually include content concerning sexual and reproductive rights.[19,20,40,43] Likewise, studies across the globe and nationally have also noted significant gaps in RSE that do not address topics such as gendered power relations and dynamics.[44–47] As such, young cisgender heterosexual men may lose out on vital opportunities for education and awareness which could address these gendered gaps.

However, research has also found that young men in Australia search for and engage sexual health information outside of formal programs, with the internet and social media being their preferred source.[16,18,48] Young men do ask sexual health questions such as STI prevention, and about relationships and sexual practices. These spaces have been noted to have positive and helpful information, with many informed by queer and feminist lenses that prioritise gender transformative approaches.[49,50]

This consideration of structure and agency provide a framework to understand how men might choose to navigate sexual health conversations during sexual encounters, as well as the decisions they make regarding responsibility for contraception and STI prevention.

Materials and methods

Methodology

This study is part of a much larger project (www.m-sex.org) exploring how young cisgender heterosexual men in Australia are navigating sexual consent, sex, and intimacy.[40,43,51–53] This study takes a qualitative approach of semi-structured

interviews in understanding men's engagement with sexual health during sexual encounters. Using reflexive thematic analysis techniques,[54,55] I pay attention to not only what men do or do not do, but also how they conceptualise their responsibility for sexual health in relation to their engagements with women, and what broader discourses may be shaping those conceptualisations. This means paying some attention to the language they are using when discussing their practices through a methodological approach and gendered lens of 'heterosexual intimacies';[40] that is, how men's understandings of their sexual health practices and responsibilities may be shaped by broader gendered discourses and gendered power dynamics concerning men and women's intimate and sexual relations with each other.

Methods

This research was conducted with the La Trobe University's Human Research Ethics Committee (HEC20110) approval as it involves human participants.

Data collection

A total of 30 semi-structured interviews were conducted with young cisgender heterosexual men between May and September 2021. Participants were recruited using Facebook advertising and directed to an eligibility survey (see Eligibility Survey in Supplementary material) hosted on the survey platform RedCap. Participants were assessed for eligibility, and then were contacted to take part in an interview or focus group of their choosing. Participants needed to be between 18 and 35 years of age, reside in Australia, identify as cisgender, heterosexual men, and had casually dated and/or engaged in casual sex in the past 5 years. More than 214 men were eligible to take part and 30 men enrolled (see ref. 53 for a detailed account of this process). Data saturation was determined based on the analysis technique of reflexive thematic analysis.[54,55] A total of 30 interviews were chosen as data saturation sits around 15–20 interviews, with an extra 10 interviews to cover outliers.[54–56]

Participants were sent a copy of the participation information statement, consent and withdrawal of consent forms. Once signed, participants were interviewed and audio recorded via Zoom technology. Interviews were conducted during one of several coronavirus disease 2019 (COVID-19) lockdowns in Australia, and participants had the option of a video, audio only, or IM (instant messaging) interview. Prior to the interview, participants were read a statement about the project, as well as a statement of reporting if they chose to disclose experiences of sexual or other violence. On completion of the interview, a debrief protocol was engaged that included direction to services and resources, and additional check ins if required. Participants were provided with a AUD50 gift voucher on completion. Participants were offered the option to review their manuscript prior to analysis, and seven participants opted in with no changes made.

Participants were asked a series of questions concerning their dating practices, sexual practices, their sexual health knowledge and practices, and their perspectives on potential impacts #MeToo may have had on their experiences of dating and sex. In this paper, I am focused on participant discussions of biological sexual health, such as using contraceptives and/or barrier methods for STI and pregnancy prevention. Interviews were professionally transcribed and verified. NVivo was used to organise and code interviews in preparation for data analysis.

Participants

Table 1 outlines the demographic characteristics.

A total of 47% of participants were aged between 25 and 30 years, and were single at the time of interviewing (57%). Most identified their preferred relationship style as monogamous (83%) and resided in urban areas (63%). Seven percent identified as having a neurominority such as autism or used the language as being neurodiverse. A total of 53% of participants identified as having Australian (white) backgrounds, 73% born in Australia, and 40% identified as having no religious or spiritual association.

Analysis

Findings were analysed using reflexive thematic analysis.[54–56] Quality reflexive thematic analysis follows an approach in which themes 'do not passively emerge' but rather, are 'creative and interpretive stories about the data, produced at the intersection of the researcher's theoretical assumptions, their analytic resources and skill, and the data themselves.'[54] This is conducted in six stages, with the first reading and rereading the transcripts to familiarise oneself with the data and provide summaries of emerging thoughts, themes, and ideas. *A priori* categories were used to develop a descriptive codebook based on these summaries and then coded. The code 'Sexual Health' that included discussions of sexual health knowledge, getting tested, sex education in school, and navigating sexual conversations was then exported for deeper analysis. Emerging latent themes were explored through reading the coded material and considered against the research question, and then written up. Quotations have been edited for clarity, and participants have been denoted using pseudonyms as well as age and interview type.

Findings

Table 2 provides some participant knowledge findings. Like several other studies already conducted in this space,[18,44–46,49,57,58] participants in this study indicated having a range of none to some RSE in their formal primary and secondary schooling, and often accessed the internet for further information.

However, participants also indicated they did not have sexual health conversations prior to encounters, which also impacted their sexual health practices. Findings below

Table 1. Demographic characteristics ($N = 30$).

Demographic characteristic	N	%
Age (years)		
18–24	7	23%
25–30	14	47%
31–35	9	30%
Current relationship status[A]		
Single	17	57%
Partnered	7	23%
Casually dating	3	10%
It's complicated	2	7%
Relationship style		
Monogamous	25	83%
Polyamorous	1	3%
Casually dating	4	13%
Have children		
No	27	90%
Yes	3	10%
Ethnicity[B]		
Australian (white)	16	53%
Asian	1	3%
Burmese	1	3%
Chinese	4	13%
Eastern European	1	3%
English	2	7%
Egyptian	1	3%
Fiji Indian	1	3%
Greek	1	3%
Hong Kong	1	3%
Indian	4	13%
Pakistani	1	3%
Philippino	1	3%
Saudi Arabian	1	3%
State or territory of residence		
Australian Capital Territory	1	3%
New South Wales	11	37%
Northern Territory	1	3%
Queensland	3	10%
South Australia	2	7%
Tasmania	1	3%
Victoria	10	33%
Western Australia	1	3%

(*Continued on next column*)

Table 1. (*Continued*).

Demographic characteristic	N	%
Birth country		
Australia	22	73%
China	2	7%
India	3	10%
Philippines	1	3%
Saudi Arabia	1	3%
United States	1	3%
Residential area		
Urban	19	63%
Suburban	8	27%
Regional	2	7%
Rural	1	3%
Employment status[C]		
Employed	21	70%
Studying	10	33%
Unemployed	2	7%
Housing		
Own, single	8	27%
Own, family/partner	4	13%
Rent, dingle	5	17%
Rent, partner	1	3%
Rent, dhared/housemates	8	27%
With parents/family	4	13%
Education		
High school	2	7%
Army	1	3%
Bachelor degree	19	63%
Postgraduate degree	8	27%
Religion/spirituality[D]		
Agnostic	2	7%
Atheist	4	13%
Catholic	5	17%
Christian	3	10%
Hindu	3	10%
Jewish	1	3%
Muslim	1	3%
None	12	40%
Disability or neurominority		
Yes	2	7%
No	28	93%

(*Continued on next page*)

Table 1. (*Continued*).

Demographic characteristic	*N*	%
Interview mode		
Audio	14	47%
Video	12	40%
Instant messaging	4	13%

[A]Some participants indicated more than one relationship status; hence, percentages adding up to more than 100%.
[B]Ethnicity has been denoted using participants' own identification. As some participants noted more than one ethnicity; hence, percentages add up to more than 100%.
[C]Some participants indicated studying and working; hence, percentages adding up to more than 100%.
[D]Some participants indicated conflicting faith backgrounds, (i.e. identifying as Christian and agnostic); hence, percentages adding up to more than 100%. I have used both religion and spirituality to account for varying perspectives and experiences.

Table 2. Participant knowledge findings.

Topic	Data examples
Formal school-based sex education experiences	Our sex education, was basically what sex is, what you use, what you don't use, that sort of thing (Steve, 29 years old, video)
	Oh there wasn't any (Sakash, 26 years old, audio)
	So anatomy and reproduction and contraception, we also talked about more social side as well [. . .] case scenarios between a boy and a girl and what their relationship is and how they might proceed (Declan, 28 years old, audio)
	I did but I didn't really pay attention (Scott, 32 years old, video)
Informal sources of information	Doing research from my end, or going through the internet (Kamraj, 25 years old, audio)
	The research is basically reading up on it, maybe watching YouTube videos or something (Layton, 33 years old, video)
	Yes I have at times done that kind [sexual health] of research (Avery, 33 years old, IM)

explore three motivations that underpin men's avoidance sexual health conversations and associated practices with potential casual partners: (1) sustaining the erotic moment; (2) assuming women's responsibility; and (3) maintaining limited relationality.

Sustaining the erotic moment

Discussions involving STIs and potential pregnancy are often regarded as awkward and stigmatised.[59,60] Participants often avoided the conversations with the assumption that conversations were taboo, and could ruin a sexual encounter:

> I feel like it's easier to have that, it's easier to have those conversations afterwards – I feel like people are a lot more relaxed and easy going after you've got past that stage. So usually I would just, like in my mind if I'm wearing a condom then we're pretty much safe anyway [. . .] Nothing kills a mood more than like talking about STDs [STIs] or something like that. (John, 29 years old, video)

> I guess it's not really something I do discuss. It's something I feel like I probably should, but yeah no [. . .] it's just a taboo topic I guess. (Chris, 29 years old, audio)

For some, condom use was regarded as expected, and thus for them a potentially difficult conversation unnecessary:

> [When asked about using contraception] I'm not going to do it [have sex] if I don't have a condom, that's my rule I guess. Because yeah, birth control I don't really – yeah it's a bit of a discussion with birth control, so condoms just makes it easy I guess. (Liam, 20 years old, audio)

> No not really, it just happens, you already know 'okay you use this [condom]' and that's what usually happens. (Layton, 33 years old, video)

Such conversations indicate that these men may have felt sex with women is potentially precarious, fragile, and subject to an unexpected end. This is premised in broader heterosexual relation discourses in which women are perceived to be gatekeepers to sexual activity and need to be carefully convinced into having sex,[28,30] alongside sexual health being a stigmatised subject of conversation.[59] Sexual health conversations were thus avoided or deemed unnecessary to sustain the mood and atmosphere of an encounter, and not risk it unexpectedly ending.

Women's responsibility

As noted earlier, women are framed as being largely responsible for managing STI and pregnancy prevention.[11,15] In this study, such framings underline men's motivations and sexual health practices, in which this responsibility was left for women to manage. Men often expected women to be on some form of hormonal birth control as opposed to discussing potential options:

> It was sort of a given that most were on birth control. (Seth, 25 years old, audio)

This expectation as noted by Seth was assumed through a lack of discussion or insistence about whether to use barrier forms of protection. For others, women were expected to ask men to use condoms, or men asking women if they should use one:

> I've only ever had 1 girl who insisted on wearing a condom. (Brody, 28 years old, IM)

> I might briefly be like 'oh do you want me to wear a condom?' (John, 29 years old, video)

> We started off with a condom and then removed it like kind of halfway through because she said 'just take it off.' (Jaxon, 34 years old, IM)

In these cases, participants such as Brody, John, and Jaxon all note that sexual health decisions involving their own anatomy (i.e. using or not using a condom) were the responsibility of women they engaged. This reflects work that has noted that men may leave sexual health decision making (and potential repercussions) to women as a way of respecting women's bodily autonomy, which then absolves participants' responsibility.

This expectation of responsibility was also noted during conversations about sex during menstruation, whereby Alec notes how he said no to having sex with a woman while she was menstruating, but says this is because she did not want to do it (as opposed to him not wanting to):

> Personally I've, never had sex with a woman when she's been on her period, and they've never really wanted to. They've sort of said like 'you know, if you really want we could' and I've just said 'oh you know it's not a huge....not really.' (Alec, 30 years old, video)

For Alec, this shifting back onto his partner at the time is reminiscent of work that notes how women are often having to manage their potential partner(s)' disgust towards their menstruation, which can lead to an avoidance of sexual activity.[61,62] Alec articulates that his partner has made this choice, but as other research has suggested, it is likely she was managing a potential reaction of disgust and could have wanted to engage sexual activity.

When asked about whether participants would consider taking a male version of contraception should it be available, participants noted they would not:

> I just feel like it's a bit of overkill using a [male] pill to avoid conception, I think a condom is probably enough to avoid it. (Logan, 25 years old, audio)

Others, such as Neil (23 years old, audio) did think male contraceptives 'sound a bit I guess fair to women that they are not the people who are solely responsible for contraception' but when asked if they would take it if it had similar side effects as women's birth control they said 'probably not' but did not elaborate further. While some such Brody (28 years old, IM) noted that 'yes, I would [take a male contraceptive]', it is assumed that 'side effects would be extremely minimal if any.' Where hormonal birth control is regarded as required and standard for women, it is seen as unnecessary for men, reminiscent of the broader systematic and institutionalised expectations where women's bodies are expected to be controlled and regulated.[34,63] Brody's comment about minimal side effects highlights how it is normalised for women to experience what can be major side effects from hormonal contraceptives use;[37] and yet, similar side effects in clinical testing of a male contraceptive were deemed too great (thus ending the trials).[64,65]

Limited relationality

Men not assuming responsibility for STI and pregnancy prevention; however, was contradicted by their concern for their sexual health in engaging unprotected intercourse. This was compounded with a lack of care (limited relationality) towards their partner(s) sexual health and wellbeing, while care was expected from those same partners. By relationality, I refer to their capacity to understand the potential impact their choices and behaviours can have on the women they engage. For example, the men in this study were concerned about catching a potential STI, but did not articulate concerns about their own role in potentially transmitting one to a partner:

> I'd prefer not to use a condom [. . .] I just got like a very common STI, chlamydia and it was like after sleeping with multiple people in a short amount of time [. . .] I knew they'd [person from whom the STI was transmitted] just come out of a long-term relationship through chatting with them, so I thought 'oh like there's not going to be that much of a risk there.' (Jaxon, 34 years old, IM)

> With people I do not know then the expectation is that condoms are standard. (Avery, 33 years old, IM)

Participants such as Jaxon and Avery noted they weighed up risks depending on their assumptions about a person's sexual history. Jaxon relies on the belief that women are less likely to engage in casual sexual activity, particularly after a relationship breakdown.[28] Research has shown that men are more likely to transmit STIs to women than in the reverse,[66] and that the potential for STI transmission does increase with more partners and not using barrier methods of protection. Jaxon expected their partner(s) to protect him from a potential STI through their sexual health practices, but not consider their own role in transmitting them with their practices.

These expectations were echoed in terms of pregnancy prevention. Men were not concerned about the impact a pregnancy could have on their respective partner or their own role in contributing to conception, only on the impact pregnancy could have on them:

> [Discussing not using a condom] You're not thinking with your head so you're like 'whatever I'll just do this [not wear a condom]' and then afterwards you're just thinking 'oh shit, like was that really worth it' [. . .] like I have no control [. . .] [thinking] like 'you could screw me over completely, am I going to be paying child support for the rest of my life because of this'. (John, 29 years old, video)

> One of them [casual sexual female partner] actually said something which was so comforting [regarding condom use], 'do you think I want to ruin your life, wow.' [. . .] she was looking out for me. (Eric, 35 years old, video)

Both John and Eric refer to concerns about potential entrapment as fathers and associated consequences when they did not use condoms during sexual encounters, noting a perceived lack of control over their own sexual health and associated responsibilities, and referring to broader negative tropes that women may purposely get pregnant without consent, which as Eric highlights, is regarded as life ruining for men. In these cases, while men were aware of the risks of unprotected intercourse, they expected women to take both the responsibility for prevention of these risks, and the blame for potential negative outcomes.

Discussion

Findings of this study echoes previous research, around not wanting to use a male version of hormonal birth control, and women's responsibility for STI and pregnancy prevention.[3,6–15,18]

Gendered assumptions about heterosexual relations, responsibility, and accountability for sexual health continue to underpin men's decision making in Australia when it comes to sexual encounters. Findings noted that sex was regarded as a sensitive event in which conversations about sexual health could abruptly end the encounter. Men indicated an understanding of the need for STI and pregnancy prevention, but did not take full responsibility for their own sexual health, or demonstrate responsibility towards others. Rather, these men framed their sexual health as something that exists outside of their control, and subject to the women they engage.

Implications

Sexual health promotion in Australia is focused on those most at risk for the adverse effects of STIs and conception.[40] This means cisgender, heterosexual men are routinely missed in sexual health promotion initiatives, thereby potentially continuing to contribute to a broader discourse in which women remain responsible for sexual health that perpetuate gendered inequalities.[15] This is compounded with broader systematic issues where in Australia, sexual health education, support, and resources for these men is either absent or inadequate.[40,42,43] Broader discourses that push for the necessary acknowledgement and respect for women's bodily anatomy, and women's expected roles in STI and pregnancy prevention mean that women also continue to experience the burden of responsibility.[9,14,15] These findings reflect concerns that gendered power dynamics are often absent from broader RSE programs in Australia, and how sexual relations are absent from Australian-based gendered violence prevention work that do use gender transformative approaches.[19,20,40,44,47] For example, Respectful Relationships is an Australian-based program that provides young people information about healthy and equitable relationships through a consideration of gendered power dynamics but is adamant that it does not contain information about sex.[67,68] While comprehensive sex education is available in Australia, this differs by state and territory, and is difficult to implement effectively due to moral backlash, and lack of funding and resources to support teacher training or outsourcing to youth and sexual health educators.[69,70]

The men in this study did make choices based on their assumptions and needs, sought out information about sexual health, and were aware of the risks of engaging unprotected intercourse. As such, it is important to recognise the role of agency men do have in their sexual practices, including their own capacity to self-educate and push towards equitable sexual health and reproductive rights when it comes to contraceptive and barrier method decisions. For example, health movements in Australia mobilised by LGBTIQA+ people (i.e. HIV, trans and gender diverse needs) have managed to push back against inadequate resources and support systems.[71] Such communities have shown capacity to take it upon themselves to advocate for their sexual health rights, and create and promote education to support these endeavours despite broader systematic oppressions. The men's health movement, however, has been primarily focused on addressing individualised harms of masculinity, and does not come from the same background of challenging discrimination.[72] This approach has been heavily criticised by its tendency to frame men as sole 'victims' of masculinity that absolves men of any responsibility or agency for their gendered expressions, presumed inability to advocate for their needs, and associated harmful behaviours and practices.[22,73] The lack of focus on cisgender heterosexual men in policy and practice is also beneficial to men as risk prevention activities and associated consequences remain the mental, emotional, and physical responsibility of women.[36]

Explaining away men's behaviours as only the result of broader discourses and structures may ensure that they continue to avoid responsibility for sexual health during casual sexual encounters, thus perpetuating gender inequities. The findings highlight a need to focus on education, policy, and sexual health promotion for cisgender, heterosexual men that prioritises a gender transformative lens,[19,20] with a more direct focus on men's personal responsibility and accountability. This could potentially help address the continued gender inequities apparent when it comes to sexual health decisions

and practices during casual sexual encounters for cisgender, heterosexual men and women.

Supplementary material

Supplementary material is available online.

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