Claire O'Brien

Partner Involvement in Contraception and STD Prevention: What is Holding Men Back?

Contraception and sexually transmitted disease (STD), in this day and age, are not uncommon terms among young men and women in Canada, the United States, and many other parts of the world. As a guest lecture in the McGill undergraduate course, Gender and Health, Rebekah Lewis, a PhD Candidate in Sociology who specializes in reproductive health issues, explained that sexually active young men and women face several preventable health obstacles related to high rates of unintended pregnancy, abortion, pregnancy-related death, and STDs, including HIV. These issues are especially relevant to the large percentage of women, particularly in the Western world, who spend the majority of their lives preventing pregnancy while remaining sexually active. Despite women's efforts, in the United States in 2004, 43% of unintended pregnancies were due to inconsistent or incorrect use of contraception and 52% of unintended pregnancies were due to nonuse of contraception (Frost, Darroch, & Remez, 2008). Furthermore, as of 1996, there was a 25% increase in new cases of STDs across America (Makulowich, 1999). Pairing these high rates of unintended pregnancies and STD transmissions with the fact that approximately two-thirds of young men and women in developed countries are sexually active by the time they are 18 years old presents an urgent call for strategies that will ensure individuals today are healthier, safer, and more in control of their reproductive health (Makulowich, 1999). A wide range of medical and sociological research suggests that, among the many strategies intended to improve the effective use of birth control and condoms, increasing heterosexual partner participation is one meaningful approach to improving young peoples' ability to sufficiently prevent unintended pregnancies and STDs (Manseau et al., 2008; Leighton et al., 1994; Smith et al., 2011). Considering this potential solution for improved sexual health, the underlying question remains: Why are heterosexual males not more involved in sharing the responsibility of contraception and condom use with their female partners? Although research only recently began to tackle this question, many studies indicate that socially constructed attitudes towards reproductive health, medicalized approaches to women's bodies, hegemonic masculine norms, varying levels of risk awareness, and an overall disconnect between health services and sexually active populations are some main reasons for low male participation. This paper will briefly present research findings on each of these proposed determinants of reduced male involvement in heterosexual relations, while making links to larger, overarching sociological themes.

Qualitative and quantitative research shows that, in North America, males are less inclined to participate in contraception because reproductive health is a socially constructed, female-dominated domain. According to a study by Freeman et al. (1980) on male and female high school students' attitudes towards contraception and pregnancy, 40% of the females indicated that their leading source of contraceptive information was their mothers and that sexual health education in school was their next main source. Meanwhile, 69% of the males indicated they were most likely to have received contraceptive information from school, followed by books and friends. Males showed little indication of having discussed contraception with either of their parents, while females demonstrated a trend of having information passed down from their moth-

ers and sisters. Interestingly, males were more likely to believe that females had the correct information about contraception and claimed this deterred them from needing to be involved (Freeman et al., 1980). Another study—unique in it's exploration of females' role as providers of sexual health resources for males—presented qualitative evidence showing that sexual health is not perceived as a male's priority, that males do not feel socialized in the health care system, and that they are dependent on women for information even though they would prefer to speak with male role models or male peers (Marcell et al., 2010). These trends in gender stratification indicate that women have become the main bearers, users, and educators of reproductive health knowledge. On the one hand, this is an empowering outcome of the women's health movements of the 1960s, which resulted in the wide distribution of the birth control pill and in an overall "weakening of social prescriptions concerning the necessity of marrying and staying married, having children, and limiting sexual expression and childbearing to marriage" (Thornton & Young De-Marco, 2001, p. 1011). However, Leighton, Sonenstein, and Pleck (1994) suggest that the media is consequently guiding young people to rely purely on female based contraception methods, placing strong emphasis on public health campaigns that promote female controlled pregnancy prevention methods, at the cost of encouraging condom use and other STD prevention methods that require partner cooperation. Even though some studies agree that there still exists "a fairly high level of endorsement for the idea that men should attempt to reduce the risks of having sex without a contraceptive," young males often expect to only play a partial role in pregnancy prevention by, for example, sharing the cost of birth control or participating in pre-intercourse discussion (Marsiglio, 1993, p. 27). Therefore, contraception and pregnancy prevention have become a heavily female-reliant concern that will require movement away from socially mapping sexual health responsibilities onto women and their bodies, in order to increase male partner involvement.

Additionally, the emphasis on the biomedical and physiological aspects of pregnancy and STD prevention has led men to be less concerned about partner involvement. A study conducted by Marcell et al. (2010) indicates that there is a general focus on how to medically "fix" women's reproductive systems so they will not conceive or contract a disease in isolation from the social factors that determine the effectiveness of contraceptive methods, such as social stigmas, peer pressure, or partner participation. One of the young adults interviewed in the study stated that, "Women are known to go to the doctor's on a regular basis because they go to the doctors if their period is not regular, for birth control, anything about their vagina…Men, they don't go to the doctor" (Marcell et al., 2010, p. 301). This quote supports the argument that natural reproductive phenomena, such as pregnancy, are being medicalized and locked into a physiological and female domain. Another study investigating males' willingness to abandon control over pregnancy prevention demonstrated a common male belief that "pregnancy is something that physically happens to a woman," and that birth control is "a girl's responsibility" (Smith et al., 2011, p. 40). Manipulations of the medical system often reinforce these attitudes, particularly in cases where health care providers heavily distribute certain contraceptive methods that they personally support or prefer. This can result in medical bias towards pharmaceutical, non-participatory contraceptive methods and less medical support for more inclusive, male-oriented methods (Smith et al., 2011; Padamsee, 2011). Furthermore, Padamsee (2011) claims that the alleged "good work" that gynecologists and physicians do in allowing women to control their fertility through pharmaceutical solutions is often negligent of STD prevention and of the social and cultural factors involved in achieving aggregate safe sex. Ringheim (2003) complements this view by stating, "it is more desirable (and easier) to modify technology to suit people than to attempt to modify people to suit technology" (p. 95). Overall, studies show that pregnancy and STD prevention have

become highly medicalized, female specific, and negligent of the potential effectiveness of male participation and multi-faceted interpretations of sexual health.

Another explanation for why males tend to be less involved in contraception and safe sex is based on their persistence to maintain hegemonic masculine expectations. Although traditional gender roles have been gradually eroding since the late 20th century, enhancement and maintenance of stereotypical male procreative values still persist under modern sociological circumstances (Marsiglio, 1991; Thornton & Young-DeMarco, 2001). Studies on male perspectives towards contraception and pregnancy claim that objectification of female partners is a normal part of adolescence and that male sentiment of empowerment and control over their female partners is inevitable (Lee, 1999; Manseau et al., 2007). A qualitative study conducted on adolescent males from urban Quebec demonstrated a general attitude among the group that heterosexual expression—such as having many sexual partners, obtaining frequent sexual favors, and minimal emotional investment—is a means of establishing masculinity (Manseau et al., 2007). The adolescent boys indicated that being aware of the risks involved in sexual activity is irrelevant to the sexual pleasures and conquests that allow them to accomplish monolithic, virile masculinity. Similarly, according to Marcell (2010), young men expect themselves to believe that they "are supposed to be strong," "don't like asking others for help," and "can take the pain," which is why they avoid getting involved in reproductive healthcare (p. 301). Marsiglio (1993) indicates that this concept of idolized masculinity, particularly with respect to pregnancy and responsibility for sexual health, is socially stratified and varies among different populations in society. For example, young black men appeared to equate paternity, intended or not, with masculinity. However, despite this potentially problematic link between paternity and masculine status, this same sub-group demonstrated more responsible contraceptive behavior and more openness towards talking about sex. On the contrary, men with more traditional views who were also more likely to say that fathering a child would make them "feel like a real man" demonstrated that the importance of maintaining a stereotypical, macho profile was negatively correlated with contraceptive or condom use (Marsiglio, 1993, p. 30). Finally, men with well educated parents, living in higher quality neighborhoods demonstrated a negative association between feeling manly and unintended pregnancy, claiming that being responsible for an unintended pregnancy would ruin their future plans. Research, therefore, struggles to demonstrate one general trend among men regarding their involvement in contraception in relation to their interpretation of masculinity. Trends are especially variable in light of more recent, evolving interpretations of femininity and female sexuality (Marisglio, 1991; Lee, 1999; Marcell, 2010). Nonetheless, the socio-cultural constructions and power dynamics behind masculinity play a role in determining men's participation in contraception.

Another prominent determinant of men's level of participation in contraception and STD prevention is their poor risk awareness regarding STD infection and pregnancy. As previously noted, significant information on reproductive health is medically- and female-dominated, and consequently, men may be less capable or willing to making informed decisions. Additionally, research illustrates that, even though students may participate jointly in sex education at school, females' awareness regarding risk of conception tends to improve with increasing grade level, while males' knowledge remains stagnant (Freeman et al., 1980). Other studies, however, indicate that education has little to do with males' risk perceptions. Leighton, Sonenstein and Pleck (1994) demonstrate that males base risk perception and condom use on relationship status, age, and informal partner familiarity. In this report, males' inconsistent condom use was modeled by the "Sawtooth hypothesis," a tooth-shaped graphical pattern,

which demonstrates sharp rises and falls in condom use. This model depicts that males wear condoms at the beginning of relationships, but that their condom use severely drops as relationships progress, due to informal assumptions of low STD risk and suspected knowledge of their partners' use of birth control. Conclusively, the study indicates the four main reasons why males participate in condom use are because they are unsure of pregnancy and STD risks at the beginning of a relationship, their partner is not on birth control, social norms deem condom use a courteous gesture, and the relationship is short-term (Leighton, Sonenstein, & Pleck, 1994). Manseau, Blais and Engler (2007) agree that males' risk perception is commonly measured by personal familiarity, and not formal clinical testing or past sexual history. This is seen, for example, through one of the males interviewed in the study who said, with respect to his casual sexual partner, "With her, I did not use protection, I did not wear a condom, and I've known her for years. She is now 22 or 23 and I've known her since she was 15. I was very, very, very young. I really trusted her" (Manseau, Blais & Engler, 2007, p. 54). Although many men may fail to properly recognize all the important reasons for condom use, there are also findings that indicate some men reject condom use entirely because they dismiss or deny that they are at risk of STDs or AIDS (Lee, 1999). Therefore, men often miscalculate STD and pregnancy risk levels based on informal social perceptions and norms that have little to do with the biological concepts behind infectious diseases and conception. Inaccurate perception of risk is another observed reason for why men are less involved in the responsibility of preventing pregnancy and STDs.

According to this basic review of studies that disentangle male and female attitudes and behaviors towards contraception and STD prevention, several common findings were revealed with respect to why heterosexual females are often exclusively found responsible for initiating and maintaining safe sex. Research demonstrates that idealized masculinity, gender biased responsibilities, and skewed reproductive health awareness have resulted in socially constructed and gender stratified determents for heterosexual male involvement in contraception and condom use. Moreover, the disconnection between males and sexual health services and the heavy reliance on female-oriented pharmaceutical solutions for safe sex are proof of society's medicalized structures that require minimal male partner participation. Although unequal partner involvement in contraception is not the only determinant of elevated incidences of unintended pregnancy, abortion, and STDs, the empirical factors presented in this paper should encourage men, women, health care providers, politicians, and educators to work more closely in supporting creative, inclusive, and less gender-dichotomized strategies towards safe sex in our society.

References

Freeman, E.W, Huggins, G.R., Mudd, E.H., Garcia, C.R., & Dickens, H.O. (1980). Adolescent contraceptive use: comparisons of male and female attitudes and information. American Journal of Public Health, 70(8), 790-797.

Frost, J., Darroch, J.E., & Remez, L. (2008) Improving contraceptive use in the United States, In brief. Guttmacher Institute, 1, 1-8.

Lee, R. B. (1999) Men's involvement in women's reproductive healthy projects and programmes in the Philippines. Reproductive Health Matters, 7 (14), 106-117.

Leighton, K., Sonenstein, F. L., & Pleck, J. H. (1994). The dynamics of young men's condom use during and across relationships. Family Planning Perspectives, 26(6), 246-251.

Makulowich, G. (1999). HIV and STD prevention update. AIDS patient care & STDs, 13 (4): 251.

Manseau, H., Blais, M., Engler, K., & Bosse, M.-A. (2007). Integrating the perspective of vulnerable heterosexual male adolescents to prevent premature paternity and sexually transmitted infection. American Journal of Sexuality Education, 2(4), 43-66.

Marcell, A. V., Howard, T. L., Plowden, K., & Watson, C. (2010). Exploring women's perceptions about their role in supporting partners' and sons' reproductive health

care. American Journal of Men's Health, 4(4), 297-304.

Marsiglio, W. (1991). Male procreative consciousness and responsibility: a conceptual analysis and research agenda. Journal of family issues, 12(3), 268-290.

Marsiglio, W. (1993). Adolescent males' orientation toward paternity and contraception. Family Planning Perspectives, 25(1), 22-31.

Padamsee, T. J. (2011). The pharmaceutical corporation and the 'good work' of managing women's bodies. Social Science & Medicine, 72(8), 1342-1350.

Ringheim, K. (1993). Factors that determine prevalence of use of contraceptive methods for men. Studies in Family Planning, 24(2), 87-99.

Smith, J. L., Fenwick, J., Skinner, R., Merriman, G., & Hallett, J. (2011). Young males' perspectives on pregnancy, fatherhood and condom use: Where does responsibility for birth control lie? Sexual and Reproductive Healthcare, 2(1), 37-42.

Thornton, A. & Young-DeMarco, L. (2001). Four Decades of Trends in Attitudes toward Family Issues in the United States: The 1960s through the 1990s. Journal of Marriage and the Family, 63(4), 1009-1037.