

Marginalisation of men in family planning texts: an analysis of training manuals

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Abstract:

Objective: Men's engagement in family planning has become part of the global health agenda; however, little is known about the training manuals health practitioners' use and how the manuals describe and explain men's roles within a family planning context.

Design: To further understand engagement, this paper examines how training manuals written for health practitioners define men's participation within family planning.

Setting: The training manuals were written for UK health practitioners and covered men's contributions to family planning.

Method: This paper used discourse analysis to examine the three training manuals focused upon.

Results: Three main discourses were identified: 'contraception is a woman's responsibility'; 'men disengage with health practitioners'; and 'men are biologically predisposed to avoid sexual responsibility'.

Conclusion: Together, these three discourses function to marginalise men in family planning, constructing them as detached accessories that lack the ability to engage.

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Introduction

Men's engagement in family planning has become part of the global health agenda (Oudshoorn, 2003), with many countries implementing successful practitioner-led initiatives to engage men (Hardee, Croce-Gails, and Gay, 2017). Global initiatives to re-engage men in family planning have been implemented to encourage men to act as partners in family planning. Examples include the Young Men's Clinic, New York City, USA, a community-based reproductive and sexual health clinic specifically for men (Armstrong, 2003), and the Men Engage Project, Ireland, a national scheme funded by International Planned Parenthood, providing family planning clinics with male centric services such as vasectomy, STI screening/treatment, contraceptive advice, crisis pregnancy counselling for men, fertility advice, and men's reproductive and sexual health videos (Irish Family Planning Association, 2012). Not many health-based initiatives have been created to engage men in the United Kingdom (U.K.).

To date, the few initiatives aimed at U.K. men have had little evaluation regarding their success or failure. Two main initiatives have been piloted in England: 'It Takes Two' and 'The New Man'. The Contraception Education Service England (CES) ran the 'It Takes Two' campaign in 1997, which aimed to encourage British men to ask health professionals at genitourinary medicine (GUM) clinics for contraceptive information and advice (Measor, Tiffin, and Miller, 2000). Evaluating the CES initiative, Hoare and Walsh (2001) found that participating clinic practitioners were less likely to initiate and have conversations with men regarding contraception. This is in contrast to the authors' focus group data that suggest it is important for men to receive contraceptive information from health professionals and that health professionals should be provided the training resources to do so. In 2008, the Family Planning Association (FPA) ran a campaign targeting men - 'The New Man' - in order to assess men's contraceptive attitudes, knowledge, and engagement levels (FPA, 2008a). 'The New Man' campaign reportedly reached 22 million British citizens (via broadcast and print media), including a national survey. The national survey found that "20 per cent of men said that if a man doesn't want to get a woman pregnant he should use condoms every time he has sex" (FPA, 2008b, p. 20). The survey results show that a small percentage of men took responsibility regularly for contraception for family planning. The FPA concluded that family planning services do not currently fit with men's lifestyles and needs (e.g. work constraints) and how these needs may change over the life course (e.g. young adulthood to older adulthood) (Family Planning Association, 2009). These preliminary initiatives suggest that there are some engagement concerns in the U.K. context that require further exploration.

Little is also known about the training manuals health practitioners' use and how training manuals construct men within a family planning context. According to research in critical men's studies, health practitioners play a central role in improving men's health, particularly when finding alternative ways to improve men's use of health services (White and Witty, 2009). Dolan and Coe (2011) suggest that health practitioners perceive men and masculine identities to be responsible for men's general disengagement with health. This creates a wider debate around the extent to which

men's 'bad' behaviour e.g. not being concerned about health, is responsible for men's poor use of services - or if services are at fault by discouraging men e.g. services are perceived by men as feminised and alien (Smith, Braunack-Mayer, and Wittert, 2006). A study by Hale, Grogan, and Willott (2010) of male GPs' views of men's help seeking found that men are perceived by male GPs with ambivalence, restricting men to masculine gender norms of poor service use. Specifically, male patients who frequently attended health services are described as feminised and abusing services, while those who attended less are seen by the male GPs as more masculine and appropriately engaging with services. The above studies suggest that some health professionals may accept that there exists a simplistic relationship between being a man and being relatively unconcerned with health or help seeking (Farrimond, 2012).

How men are constructed in the reproductive realm is an area of research that deserves further attention (Lohan, 2015). The aim of the paper is to examine the gendered nature of family planning training manuals, with particular reference to prevailing constructs of men and masculine identities. This study focuses on the discourses available to health practitioners from the training manuals, exploring how the training manuals construct male family planning behaviour. The term 'health practitioners' is throughout the paper used as an umbrella term for anyone in the health field who men come into contact with, such as general practitioners (GPs), nurses, pharmacists, etc.

Methods

Discourse analysis is the study of written text and/or spoken language, where understanding is created using both social interaction and social symbols (Parker, 1993). The analysis of publically available texts (media articles, health promotion materials, online discussion forums etc.) is frequently employed to explore contemporary health phenomena and has been used by researchers to explore the constructions of men, masculinities and health. For example, in an analysis of the magazine *Men's Health*, Crawshaw (2007) demonstrates the constraints of hegemonic masculinity as depicted in mass media, with casual sex as valued and risk and danger constructed as natural male behaviour (see also Gough, 2006; Hall and Gough, 2011; and Hall, Gough and Seymour-Smith, 2013). To understand the discourses available to health practitioners regarding men and family planning, three different texts recommended for professional training and development were analysed. Training and development texts are informational resources used to influence health professionals' practice and behaviour, often written by medical professionals.

In this study, before deciding on the training and development texts to be analysed, a range of print media were assessed. As the research was exploratory, with little previous research to guide the inclusion criteria, a search for media was performed using library catalogues, books and Internet resources such as newspaper websites and journal/magazine websites. With the research focusing on providing further understanding of U.K. men's use of family planning services, texts were limited to U.K. resources. We also considered newspaper articles, family planning websites designed

for health practitioners (e.g. Faculty of Sexual and Reproductive Healthcare of the Royal College of Nursing <http://www.fsrh.org/>), and online journals aimed at health professionals (e.g. *Reproductive Health Matters*). While there exists an overabundance of written media for health practitioners on how to interact with women regarding family planning, there were very few media sources found that discussed how to interact specifically with men, which would not provide enough data for analysis. By narrowing the inclusion criteria to both media that concentrated on men within family planning and that could influence future practitioners practices, one form of written media could be most appropriate - the training and development texts.

Among the training and development texts that discussed men and family planning, the focus is largely placed on young men (i.e. 16 years of age and under) (e.g. *Adolescents and Sex: The Handbook For Professionals Working With Young People*, by Sarah Bekaert, 2004, and, *Young Men, Sex and Pregnancy*, by Brook [sexual health services], 2010), with less focus placed on the experiences of men between the ages of 18-45. The texts that focused on young men were discounted because of their narrow focus on a limited age range and a narrow focus on contraception for sexual health, with little coverage of family planning. Also, young men and sexual health has already been well researched (Crosby et al., 2015, Elley, 2013, Griffiths, 2015, Saunders et al., 2012, Tyler, 2014). Other texts were similarly discounted as they were also written for specific age groups, failing to incorporate different ages to account for varying life stages of pregnancy prevention beyond the teenage years.

Three chapters from three different texts met the inclusion criteria and were best suited to answer the research question. While the sample left is modest, the texts included were those most relevant to the topic once the inclusion criteria were applied. Using a small, but rich dataset is a common practice when conducting a media text analysis (see Gough, 2006). The three texts chapters included in the analysis were:

Men's Health: The Practice Nurse's Handbook by Ian Peate, a publication by John Wiley & Sons, (2007);

Haynes Manual- Man Sexual Health Manual by Ian Banks, Tim Shand, and Lynn Hearton, a joint publication by the Men's Health Forum, International Planned Parenthood, and the FPA, (2010), and

The Handbook of Sexual Health in Primary Care, by Toni Belfield, Philippa Matthews, and Catti Moss, a publication by the FPA (2006).

The texts met the final inclusion criteria because they enjoyed special status within the field, endorsed by professional bodies. Two of the texts analysed, the *Haynes Manual- Man Sexual Health Manual* and *The Handbook of Sexual Health in Primary Care*, were recommended by the Family Planning Association (FPA). These two texts are listed as resources for health practitioners' continued professional development. *Men's Health: The Practice Nurse's Handbook* is recommended as a training manual by several different professional nursing journals, such as *Primary Nursing Care* and *Practice Nurse*.

In the three texts, one chapter per text (on 'contraception') was selected in order to focus the analysis on health practitioners' perspectives of men within family planning. Ethical approval to conduct the study was received from the relevant Leeds Beckett University ethics committee.

The analyses of the text chapters were conducted using a similar approach to Willott and Griffin (1997) and Gough (1998). Starting with the first text, the chapter was divided into sections. In each of the three texts, the 'sections' were already signposted (designated by each of the chapters' subheadings). Once the chapter had been divided into 'sections', these were coded line-by-line using a concept of in-vivo themes developed in grounded theory analysis (Glaser and Strauss, 1967). Upon completing the coding of the 'sections', in the first text's chapter, there were a total of 13 in vivo themes (e.g. right to contraception, choice of contraceptive method, access to services, condom efficacy). These themes were then revisited for similarities and collapsed into 6 themes, creating revised superordinate categories. Lines were re-coded as necessary before starting the analysis of the second text's chapter. For example, a subordinate revision joined the two themes of condom use and condom efficacy to create the new theme responsibility. All data re-coded under the revised in-vivo theme were then selected. Using these selected themes, the ways in which the themes were talked about were identified, with attention paid to how different objects (e.g. condoms) and subjects (e.g. men) were constructed. For example, the theme 'responsibility' included talk of men as problematic, contraception as women's burden, men as accessories and disengaged. Once the themes had been finalised, the lines were then analysed for recurring patterns of discourse. After all patterns of discourse were identified in the first chapter, the next text chapter in the second text then would be divided into 'sections' and the same process repeated- and also for the third text/chapter. (See Willott and Griffin, 1997, pg. 112 for a diagram of the analysis stages). Themes and discourses were decided upon using researcher triangulation. This was done through discussion of the themes and discourses between the researchers to enhance quality of the analysis. Using multiple researchers to address potential bias during analysis is an accepted practice in qualitative research (Madill and Gough, 2008).

After discourses were identified for all three chapters of text, themes and discourses were reviewed, re-organised and streamlined, leaving three dominant discourses:

1. Contraception is a woman's responsibility,
2. Men disengage with Health Practitioners, and
3. Men are biologically predisposed to avoid sexual responsibility.

Analysis

Discourse 1- Contraception is a woman's responsibility

In each of the three texts, men are constructed as secondary participants, and absent, disengaged accessories. Most contraceptive methods are presented as being reliant on the woman for use:

Currently men are often forgotten or ignored when the issue of contraception is discussed, with the burden of family planning falling on women.

– *Men's Health: The Practice Nurse's Handbook*, p. 103

However, as a science and understanding grows, this may allow men the opportunity to become fully engaged in family planning, encouraging them (if appropriate) to take up their equal share in this important activity.

– *Men's Health: The Practice Nurse's Handbook*, p. 115

There are numerous methods of contraception, most of which, it has to be said, depend more on the woman than the man

– *Haynes Manual: Man Sexual Health Manual*, p. 3

Men's lack of involvement is presented as context-bound ('currently') – which opens the way for men to become more involved in the future. This future, 'as science and understanding grows', largely absolves men from taking part in family planning presently, reinforcing men's relative lack of involvement for health practitioners. It also fails to specify when men should fully engage. Men themselves are positioned as passive in the present and also as (passive) potential beneficiaries in the future to 'take up their equal share'. The language used is tentative, 'this may allow', 'if appropriate'. The situation is problematic, as women are lumbered with the 'burden' of contraception. The frank tone continues 'it has to be said', justifying 'numerous methods of contraception' as women-centred. Male responsibility is then presented to practitioners as secondary and contraception is presented as reliant on female-dependent methods.

The texts' presentation of condom use is contradictory. The manuals suggest that in order to choose an effective contraceptive method, men must consult with a health practitioner. At the same time the expectation presented to health practitioners is that male patients' likelihood to use a condom is intermittent, inconsistent, and secondary:

The practice nurse has a vital role to play in enabling the patient to use condoms effectively... the correct choice of condom is vital.

– *Men's Health: The Practice Nurse's Handbook*, p. 109

(Condoms come) In different shapes and sizes, and it is often necessary to try a few different types before the right one is found.

– *Haynes Manual- Man Sexual Health Manual*, p.3

[Men obtain condoms from] supermarkets, from garages, by mail order, through slot machines, as well as pharmacies

– *Haynes Manual- Man Sexual Health Manual*, p. 3

The use of the word 'vital' in the first extract above implies a state of necessity: namely, that consulting a health practitioner is crucial to choosing the correct condom and using it effectively. The need to consult is emphasised as well by pointing to the diversity of condoms – men should not simply go and buy any condoms and assume they will be appropriate. Condoms should be discussed with men as needing consideration for shape and size. While there is encouragement that practitioners should have a discussion with men about condoms, the texts explain that condoms are sought elsewhere, that they are available even 'through slot machines'. This leaves little need to engage with health practitioners, making services obsolete.

Discourse 2- Men disengage with health practitioners

The health practitioner addressed in the texts is understood as the 'expert' who is to be consulted by the relatively naïve male patient for knowledge and advice. This professional authority is established by providing a credible evidence base to support health practitioners' knowledge:

This chapter summarises the main issues involved when giving advice about contraception. Several expert groups have provided advice on the medical criteria for different aspects of contraception.

– *The Handbook of Sexual Health in Primary Care*, p.71

Hannaford (2006) provides a model of good practice for contraceptive services in primary care (see Table 6.2).

– *Men's Health: The Practice Nurse's Handbook*, p.105

Pressures of everyday general practice, especially those of time, can sometimes undermine efforts to meet this challenge. Nonetheless, many practices are able to show that it can be done. These practices are usually well organised, with appropriate human and material resources.

– *The Handbook of Sexual Health in Primary Care*, p. 73

In these quotes, contraceptive 'advice' is seen as needing to be delivered by 'experts'- since it is a 'medical' issue. The direction provided to health practitioners comes from larger institutions, such as the Department of Health, whose advice warrants credibility. 'Good practice' is script-like, mechanical, and dispassionate, reinforcing the practitioners' objective position, leaving little room for dispute. 'Many' practices can achieve the provided good practices. It is the men who are positioned as less knowledgeable and disengaged from the contraceptive process, even with 'pressures' during practice. The services can be 'well organised, with appropriate human and material resources'. 'Time' is what 'undermines' the practitioners from providing good service, not other factors like training.

There is relatively modest acknowledgement of men as individuals and partners for contraceptive decisions. Overall, the texts deem men to be secondary users of family planning services:

The provision of comprehensive information, tailored to the needs of each individual or couple, so that correct choices are made'
– *The Handbook of Sexual Health in Primary Care*, p. 73

The HSCIC (2004) points out that in England in 2003-2004: there were approximately 2.7 million attendances at family planning clinics; the number of women attending was estimated at 1.2 million; male attenders totalled 106,000"
– *Men's Health: The Practice Nurse's Handbook*, p.103

In 2003-2004 the number of men opting for vasectomy as a method of contraception was estimated to be approximately 9000; this number has fallen from 21% in 1993-1994 to about 8% for 2003-2004 (HSCIC, 2004).
– *Men's Health: The Practice Nurse's Handbook*, p.104

A discussion of services being 'tailored' to men's needs is rare despite the potential benefit for men. Practitioners are expected to inform 'correct choices'; however there is little indication in the training manuals on how to design and deliver services to engage individuals or couples. Men (106,000) make up a 'very small percentage' of those who use family planning services, particularly when compared to women's family planning service use: '1.2 million'. There is little discussion of what these smaller percentages of men attend for, or where the majority of men go for family planning information. Men's service use is framed by the texts not only as low, but diminishing, 'fallen from 21%...to about 8%'. Social factors (e.g. masculinities) that could be influencing the disengagement with services are not discussed in the text. In general, the text explains men's poor service use as natural.

Discourse 3- Men are biologically predisposed to avoid sexual responsibility

While there is little difference between perfect use of female and male contraceptive methods, male contraception is presented as less effective in the manuals, suggesting men are biologically disadvantaged. Male responsibility is presented as secondary; with women positioned as more capable of effectively using contraception:

If used correctly condoms are 98 per cent effective at preventing pregnancy and they have the added advantage of providing good protection against many sexually transmitted infections
– *Haynes Manual-Man Sexual Health Manual*, p. 3

May not be effective enough if it is important that a woman does not become pregnant...Reliant on user for effectiveness... [barrier methods should not be used] with these conditions: any condition where pregnancy would be unacceptable to the user (use a more effective method).

– *The Handbook of Sexual Health in Primary Care*, pp. 110-111

[Fertility Awareness/Natural] Disadvantages: requires commitment from both partners...[Vasectomy] Not reliant on the user for effect, can remove the fear of pregnancy.

– *The Handbook of Sexual Health in Primary Care*, p. 113 -118

Men's use of contraception is presented to practitioners as possibly 'not effective enough' because it is reliant on men. Health practitioners should advise against condoms if pregnancy is 'unacceptable', despite the additional 'advantage' of 'good protection' for sexual health, a benefit not provided by the contraceptive pill. Statistics for male condom efficacy are similar to the 98% effectiveness of female methods. 'If used correctly' condoms can be effective, however this position is subordinate in the texts. Absent from the texts is a reference to efficacy requiring consistency or encouragement for consistent use. Other forms of contraception available to men are also presented negatively. The 'disadvantage' mentioned to natural methods is to be read as 'commitment' from men. The male method explained as most effective to health practitioners is vasectomy -because it 'is not reliant' on the user. This positioning of men as capable of contraceptive responsibility only if sterilised suggests that men lack the agency, interest or capability to engage in contraceptive responsibility.

There is special concern in the texts for the biological processes of men's reproductive bodies. Across the sections, one of men's 'fears' of being involved in family planning is the 'supposed' impact contraceptives can have on men's spontaneity and virility:

Perhaps the single biggest stated reason for not using a condom is the widely held belief that they inhibit spontaneous sex.

– *Haynes Manual: Man Sexual Health Manual*, p. 4

often disliked because of aesthetics, reduced sensitivity during intercourse (with some latex condoms).

– *The Handbook of Sexual Health in Primary Care*, p.111

Some men will need reassurance about the fluid produced on ejaculation after the vasectomy has been performed. It should be explained that the ejaculate will contain fluid that is free from sperm and that the volume of the ejaculate will remain approximately the same and that obstructed sperm are reabsorbed.

– *Men's Health: The Practice Nurse's Handbook*, p.113.

Men are expected to be spontaneous when it comes to sex with condoms perceived as decreasing 'inhibition'. Resistance to using condoms is expected and health practitioners should be aware condoms are 'often disliked'. Men are constructed as needing encouragement that condoms 'can be pleasurable'. Discussions around virility should be had with men due to the 'fears' over changes in their biological function after a vasectomy. Volume of ejaculate is also presented as a possible concern and 'reassurance' should be provided. In general, the texts often use biological language, with social factors relatively neglected and there is no discussion of how to relay this information in lay terms to men. This overall emphasis on the biological functions of men suggests to health practitioners that men are naïve about their bodies and lack control. This construction positions men as helpless and reinforces men as marginalised.

Discussion

Overall, the three discourses together indicate that men are marginalised within family planning. The way health practitioners are led to understand men is problematic. There is an absence of information in the manuals, despite global initiatives and British campaigns, on how to engage male patients on specific topics such as crisis pregnancy, how to give fertility advice and what additional resources (e.g. videos, websites) can be used with male patients. This leaves further work to be done to facilitate a more patient centric family planning service that is designed for men. The texts promote family planning as a women's responsibility, with men being to blame for poor service use – but also excused from engagement because of technology and virility. Men are further positioned as biologically programmed 'that way', undermining efforts to engage men in family planning. While the texts try to promote to health practitioners that men should have a place in family planning, the discourses present in the training manuals function to emphasise men as disengaged. There are several implications to be discussed below, particularly in terms of responsibility, engagement and masculine identities.

The training manuals continue to marginalise men, reinforcing the positioning in the texts of women as central and men as secondary when taking contraceptive responsibility. The marginalisation of men in the manuals is similar to findings discussed in the introduction by Hale, Grogan and Willott (2010). Health practitioners are given ambivalent and conflicting message around male patients in the texts. For example, men are constructed as being unable to take further contraceptive responsibility presently but that they may be able to be equal partners in the future. This is in contrast to the messages around men needing to consult with practitioners currently in order to use condoms correctly. These messages reflect gender dynamics on a global level, with primary contraceptive responsibility being shifted from men to women (Marks, 2010). Gynaecological and obstetric services are considered a normative part of health services for adolescent girls and women including cervical screening programmes, prenatal and postnatal care (Hunt, Adamson, and Galdas, 2012). This engages women with family

planning services more frequently, with services aimed at boys and men absent across the life course (Pinkhasov et al 2010). The gendering of responsibility may directly restrict men's likelihood to engage, not that men fail to engage as the texts suggest.

The training manuals construct health practitioners as experts in engaging men, however men are unable to benefit from a consultation. In the manuals it is explained men use other services such as chemists to obtain condoms. This removes the opportunity to engage with a health practitioner, placing the onus for disengagement with services. As discussed in the introduction, Smith, Braunack-Mayer, and Wittert (2006) suggest that services discourage men. According to Pearson and Clarke (2007), very few men use general practitioners for contraceptive advice because there are limited male dependent contraceptive methods and GPs do not prescribe condoms. This representation privileges health practitioners; it positions them as absolved from engaging men if contraception is unavailable. Work by Culley, Hudson, and Lohan (2013) emphasises how men have largely been absent from psychosocial research on reproductive practices, further marginalising men within patient care. Data from Sexual and Reproductive Health Services England 2015/16, continue to support the idea that men are marginalised service users, with 88% of women accessing services compared to 12% of men (Lifestyles Team, 2016). If training manuals continue to marginalise men, disengagement with services could become normalised and men could continue to use alternative resources, which may or may not be helpful.

In the manuals sampled men are constructed as a largely homogenous group who subscribe to the hegemonic norm (e.g. women are responsible for contraception), embracing attributes and practices that are stereotypically seen as male (e.g. risky behaviours such as not using a condom). Treating men as homogenous decreases the likelihood that individual men will seek help from a health practitioner and perpetuates stereotypes of masculinity (Wenger, 2011). It also reinforces findings from the research by Farrimond (2012), where a simplistic relationship between masculinity and men's disengagement is assumed. The manuals fail to acknowledge that masculinity is complex, fluid and multifaceted, and that many men do engage in health-promoting practices (e.g. Gough and Robertson, 2009; Gough, 2013). Men are often stereotypically portrayed as being unconcerned and unknowledgeable about reproductive health when compared to women (Inhorn et al., 2009). Men are further constructed as biologically programmed 'that way', undermining efforts to engage men in family planning. These stereotypes of masculine identity can discourage some men from seeking help in regards to their health (Coles et al, 2010; Noone and Stephens, 2008) and establish men as unreliable: i.e. they cannot be expected to use contraception effectively.

Overall, findings suggest that there is a need to refashion how training manuals for health practitioners can act as a resource to engage men in family planning. Men should be positioned in the texts as capable of being active when taking contraceptive responsibility in order to alleviate the burden currently placed on women. For example, men should be encouraged to believe that they are capable of using condoms correctly, particularly with the added benefit for sexual health. Training manuals should further discuss how services could be made appealing to men and explain how health practitioners are a real resource for men. Texts should construct engagement as

involving emotional and identity dimensions which reflect masculinity as complex and facilitate personalisation between practitioner and patient (Epstein et al., 2005, Beckett, 2013). Training manuals in particular should use language that challenges biological determinism and directly address and debunk myths surrounding the male reproductive body.

Limitations

Like all studies, this one is not without its limitations. These include the fact that the analysis consisted of text, not talk, making it difficult to determine how health practitioners engage with, convey and disseminate the constructs presented in the training manuals. Further qualitative research with practitioners might usefully begin to explore how the discourses presented in the texts are taken up, used, reproduced, reworked and resisted.

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