

**international  
encyclopedia of  
men and  
masculinities**

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### *References and further reading*

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**See also:** body image; culture and representation

TIM EDWARDS

### **CONTRACEPTION, MALE**

Since the Second World War, thirteen new contraceptives for women have been developed, including the contraceptive pill. This is in sharp contrast to contraceptives for men. The major methods of contraception available to men (condom, withdrawal and periodic abstinence) do not differ from those available to men over 400 years ago, with only one exception: sterilisation techniques, an irreversible contraceptive method (Clarke 1998; Tone 2001). The 'Contraceptive Revolution' thus remained largely restricted to female methods. Because of the innovation in female contraceptive methods – including the hormonal contraceptive pill, intrauterine devices (IUDs) and hormonal methods such as Norplant – women's methods have come to predominate as practices of family planning. Female sterilisation, oral contraceptives and IUDs account for the majority of contraceptive methods currently in use (Lissner 1992).

The gender gap in contraceptives was first challenged in the late 1960s and early 1970s. As in the case of the pill for women, the request for developing new male contraceptives came from outside the scientific community. In this case, social pressures came from two different sides: feminists in the Western industrialised world and Southern governments, most notably in China and India. Feminists demanded that men share the responsibilities and health hazards of contraception, whereas governmental agen-

cies urged the inclusion of 'the forgotten 50 per cent of family planning' as a target for contraceptive development (Oudshoorn 2003). Although research in male reproduction and the development of new male contraceptives has increased due to these pressures, the pill's 'male twin' has not yet appeared on the market.

The delay in the development of new contraceptives for men is usually explained by referring to biological and technical constraints. Biomedical scientists and journalists encourage us to assume that techniques to intervene in male reproductive bodies have not proliferated because the male reproductive system is by nature more resistant to intervention than that of women. Biological explanations are, however, inadequate to understand the slow pace of development of male contraceptives. Whereas contraceptive drugs development usually covers a period of approximately fifteen years, the development of male hormonal contraceptives has already taken more than three decades. Most importantly, the technical feasibility of hormonal contraceptives for men had already been demonstrated as early as the late 1970s. The delay in the development of new contraceptives for men can thus not be explained by technical constraints but is caused by social and cultural processes (Oudshoorn 2003).

First, the slow pace of development can be understood in the social context of the specific infrastructures in which this technological innovation takes place. Until the late 1990s, pharmaceutical firms had shown hardly any interest in male contraceptive research and development (R&D) because of stringent drug regulatory requirements, liability issues related to safety concerns, and a reluctant market. The advocates of new male contraceptives thus had to create an alternative R&D network to compensate for the pharmaceutical industry's reluctance to participate in the development of this new technology. Because of the resistance of industry, international public-sector agencies and most notably the World Health Organization (WHO) became the major actors in promoting

and coordinating R&D for male contraceptive technologies. They created networks of academic centres with the expertise, skills and facilities to synthesise new hormonal compounds and to conduct clinical trials. Although these networks were successful in mobilising resources to overcome major barriers to male contraceptive development, they could not rely on any previous experience or routines in such a collaborative endeavour. It is therefore not surprising to notice that most activities, including collaborative efforts to synthesise and test hormonal compounds, were very time-consuming. The history shows that persistence prevails. Eventually, the results of these alternative networks convinced the pharmaceutical industry of the technical feasibility of male hormonal contraceptives. In the late 1990s, two European pharmaceutical firms, Organon in the Netherlands and Schering in Germany, decided to start a joint effort to develop hormonal contraceptives for men (Oudshoorn 2003). Representatives of Organon now expect to have a product on the market within seven years.

Second, the delay in male contraceptive development can be ascribed to cultural constraints. Ever since the idea of a male contraceptive pill or injection was first articulated, many scientists, clinicians, journalists, feminists and pharmaceutical entrepreneurs have questioned whether men or women would accept a new male contraceptive if it were available. The predominance of modern contraceptive drugs for women has disciplined men and women to delegate responsibilities for contraception largely to women. Consequently, contraceptive use came to be excluded from hegemonic masculinity. The successful development of new contraceptives for men therefore depends to a great extent on changing cultural ideas about reproductive responsibility. In the last two decades, the advocates of new contraceptives for men have worked hard to accomplish the cultural feasibility of this technology-in-the-making. Reproductive scientists and feminists have promoted the view that men are willing to share responsibilities

for contraception with their partners. Family planning clinics, which used to be almost exclusively women spaces, have developed new services for men. Social scientists and reproductive scientists have conducted acceptability studies among both men and women, articulating positive attitudes towards the new technology. These studies have played an important role in convincing industry of the cultural feasibility of the new technology. And, last but not least, many men have taken the step of participating in the clinical trials of the new technology (Oudshoorn 2003). The major conclusion to be drawn from this history is that the development of the new contraceptives for men is ultimately a story as much about the design of masculinities as it is about the development of safe and effective technologies.

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**See also:** bodies and biology, male; condoms; feminism; hegemonic masculinity; reproductive issues and technologies

NELLY OUDSHOORN

### **COUNSELLING AND THERAPY**

Based on the way they are socialised by a patriarchal culture in a 'macho', hypermasculine way, Euro-American men are reluctant to ask for help or directions. Many men have different relational and coping styles than women. Traditional men are reluctant to seek therapy because it does not fit within their conception of what it means to be a man, how they define their masculinity. These 'traditional' men have been observed to be