‘Not the swab!’ Young men’s experiences with STI testing

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Abstract

In Canada, STI rates are high and rising, especially amongst young men. Meanwhile, the needs of young men regarding STI testing services are poorly understood, as are the socio-cultural and structural factors that influence young men’s sexual health-seeking behaviours. To better understand this phenomenon, we draw on interviews with 45 men (ages 15-25) from British Columbia, Canada. Our research reveals how structural forces (e.g. STI testing procedures) interact with socio-cultural factors (e.g. perceptions of masculinities and femininities) to shape young men’s experiences with STI testing. STI testing was characterised as both a potentially sexualised experience (e.g. fears of getting an erection during genital examinations), and as a process where young men experience multiple vulnerabilities associated with exposing the male body in clinical service sites. In response, participants drew on dominant ideals of masculinity to reaffirm their predominately hetero-normative gender identities. Despite growing up in an era where sexual health promotion efforts have been undertaken, participants did not feel they had permission to engage in discussions with other men about sexual health issues. Attending to young men’s perspectives on STI testing represents a starting point in reforming our approaches to addressing how socio-cultural and structural factors shape these experiences.

Keywords: men’s health, masculinities, sexual health, help-seeking, sexually transmitted infection (STI)

Introduction

Reported rates of sexually transmitted infections (STIs) are high and rising amongst youth in Canada, and since the 1990s young men account for an increasing proportion of cases. For example, chlamydia rates for young men in British Columbia (BC), Canada, doubled between 1997 and 2006, with 245.2 cases per 100,000 reported amongst men aged 15-19 and 677.9 cases per 100,000 amongst men aged 20-24 (compared with the BC average of 212.5 per 100,000) (PHAC 2007, BCCDC 2006). Gonorrhoea rates amongst BC men increased 106% (1997-2006), with males aged 20-29 years experiencing the highest burden of infection (93.7 cases per 100,000, compared to the BC average of 24.8 cases per 100,000).
Men who do not receive timely treatment for STIs are at increased risk for developing epididymorchitis (painful swelling of the testes), decreased fertility rates, (PHAC 2006, Idahl et al. 2004), chronic Hepatitis B, and penile or anal cancer (Centre for Disease Control and Prevention 2007). STIs are also synergistic, meaning that acquiring one can increase the risk of others, including HIV (UNAIDS 2007). Unfortunately, male participation rates in STI testing remains low in Canada (Health Canada 2003, Lewis 2004).

Gendered health-seeking behaviour

Many authors suggest that men and women seek and experience healthcare differently (Courtenay 2000a, O’Brien et al. 2005, White 2002, Marcell et al. 2002, White et al. 2006). Emerging literature has detailed the connections between various forms of masculinities and men’s health risks, denial of illness, and avoidance of healthcare services and providers (Watson 2000, Courtenay 2000b and 2004, Lee and Owens 2002, Robertson 2003). Dominant forms of masculinity idealise the male body as robust (e.g. as indicated through physical and/or sexual prowess) (Potts 2000, Potts et al. 2003 and 2004). When symptoms are experienced, reactive self-care amongst men typically includes medium- to long-term self-monitoring, coupled with some form of self-treatment, before asking partners for advice and/or reluctantly seeking professional medical care (Courtenay 1998 and 2000b, Hayes 2001, White 2001, Mansfield et al. 2003, Smith et al. 2008). Men also face challenges when accessing health services. For example, enactments of masculinity can create barriers to effective communication with health professionals (Moynihan 1998, Seymour-Smith et al. 2002, Courtenay 2000a, O’Brien et al. 2005). Men’s avoidance of health services has also been linked to ‘male-unfriendly’ waiting rooms (Heesacker et al. 1999), clinical interactions overly focused on ‘improving’ men’s behaviour (Watson 2000), lack of anonymity, feelings of marginalisation, and fears of physical and emotional subordination to authority figures (e.g. physicians) within healthcare institutions (Courtenay 2000a). However, emerging critiques advance the notion of multiple masculinities and can inform new approaches to sexual health promotion in ways that better address the complexities of men’s lives (Emslie et al. 2006, Gurevich et al. 2004, O’Brien et al. 2005, Moller-Leimkuhler 2002, Epstein et al. 2000). Other authors focus on more ‘complex relationships between identity, agency and social structures’ (Popay and Groves 2000: 85) and how gender identities interact within men’s social positions (Flood 2002). These approaches describe masculinities not as isolated acts, but as actions that interact with other areas of social lives (e.g. race, class, sexuality) (Connell 1995, Flood 2002) that also influence health practices and status (Robertson 2007).

Factors affecting young men’s STI testing practices

Previous research has examined the impacts of technological advances for specimen collection (e.g. urine-based testing) on young men’s STI testing practices, although most of this research has focused on the reliability and functionality of various testing methods (Chernesky et al. 2005, Domeika et al. 2007). Some studies suggest that because public health efforts tend to focus on testing women (or men who have sex with men) (White et al. 2006, Tebb et al. 2005), the system fails to attract men who have sex with women, especially young men who are an important population for intervention. Fortunately, there is a growing body of research investigating the contextual and structural forces that affect young men’s (non)participation in STI testing and/or other forms of sexual health promotion (Gautham et al. 2008, Goldenberg et al. 2008, Mantell et al. 2006, Shoveller et al. 2006, Shoveller and Johnson 2004, 2006). For example, a qualitative study conducted with young Black men referenced ‘internal’ barriers (e.g. stigma from peers related to being ‘infected’; embarrassment about discussing sexual health) as well as ‘external’ barriers to accessing
sexual health services (e.g. waiting times; interactions with service providers) (Lindberg et al. 2006). Other studies demonstrate that age, ethnicity, place of residence, and sexual identity are important influences on men’s preferences for a male or female service provider (Heaton and Marquez 1990, Barcan 2004), especially when a genital examination is performed (Rousseau-Pierre et al. 2006, Gurevich et al. 2004). Connections between masculinities, culture and young men’s sexual health-seeking behaviours have also been explored in relation to youth engagement in HIV testing (Kumar et al. 2003, Worthington and Myers 2003), although several researchers suggest that we need to better understand STI testing from the perspectives of young men themselves (Pearson 2003, Lindberg et al. 2006).

**Purpose**

We undertook this analysis to describe young men’s experiences with and perspectives on STI testing. We paid particular attention to aspects of young men’s socio-cultural environments (e.g. gender relations; masculinities; culture) and structural factors (e.g. healthcare service delivery protocol; specimen collection) to investigate how these forces influence young men’s experiences with STI testing.

**Methods**

**Data collection**

Forty-five men, 15-25 years old, were recruited using posters and pamphlets distributed at clinical (e.g. youth clinics; public health clinics) and community-based sites (e.g. washroom stalls in coffee shops; bus stops; community centres) in each community so as to include both youth who have undergone STI testing as well as those who have not, despite having the potential need for such services. Each participant completed an in-depth, semi-structured interview regarding their experiences with STI testing. Study participants resided in one of the following:

1. Greater Vancouver (pop. 2,116,581), BC’s largest metropolitan area (Statistics Canada 2007a). Visible minorities are present at more than two times the provincial average (Statistics Canada 2007a) and Vancouver is home to the largest lesbian, gay, bisexual and transgender population in Western Canada (Tourism Vancouver 2008);
2. Richmond (pop. 174,461), a suburban community adjacent to Vancouver. Richmond is home to 99,660 immigrants (compared to 71,650 non-immigrants) (Statistics Canada 2007b);
3. Prince George (pop. 70,981) is BC’s largest northern urban centre located 778 kilometres north of Vancouver (Statistics Canada 2007c) and serves as a hub for northern healthcare services. Aboriginal persons make up approximately ten per cent of the community (compared to four per cent in the whole of BC);
4. Quesnel (pop. 9,326), a rural community located 115 kilometres south of Prince George (Statistics Canada 2007d). Approximately nine per cent of residents are Aboriginal;
5. Fort St. John (pop. 17,402), one of Northern BC’s most rapidly growing communities, located 1,237 kilometres northeast of Vancouver and 478 kilometres northeast of Prince George; eleven per cent of the population in Fort St. John identify as Aboriginal (Statistics Canada 2007e). STI testing is available throughout Vancouver and Richmond at sexual health clinics, hospitals and private clinics throughout the week, including weekends and evenings. In Prince George, Quesnel and Fort St. John, testing is available at the public health unit and private clinics, but not during weekends or evenings.

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Participants were asked five questions to determine if they were eligible for our study (i.e., age 15-25 years; English speaking; live in one of the study communities; are HIV negative; and had had an STI test or considered having one). We used a purposive strategy to select a sample of young men who reported a variety of STI-testing experiences, ranging from youth who had tested more than once to those who had never been tested. Participants could choose to be interviewed by a male or female. There were five female interviewers: three Euro-Canadians, one Chinese Canadian and one Israeli Canadian. The male interviewer was Euro-Canadian. Interview participants received a CDN$25 honorarium and chose their own pseudonyms.

Ethics approval was obtained from the University of British Columbia and the local health authorities. Participants under 19 years of age did not have to obtain their guardians’ consent to participate. In-depth, semi-structured interviews (n = 45) were conducted with young men (ages 15-25 years) who were recruited from the five communities described above. Each interview took about 1.5 hours to complete. Participants were asked to describe their community’s norms related to gender roles and sexuality, and their experiences accessing or considering accessing STI testing services, as well as their reasons for (not) seeking testing. This included reflections on the influence that relationships with sex partners, family members and peers might have on their decision and experiences getting tested. Insights were also solicited regarding gender and power issues within personal relationships and across their communities in general. Clinic locations and spaces were discussed, including issues of privacy, confidentiality and transportation. Youth were also asked to describe their perceptions and experiences interacting with healthcare professionals. Participants also completed a socio-demographic questionnaire. Interviews were conducted in private research offices in each community.

Data analysis
Transcribed interviews were uploaded to NVivo, a computer software programme for organising and managing data. Each interview represented a ‘case’ and was labelled with a unique identifier. Each ‘case’ (unit of analysis) was then coded. The coding process included comparisons of data across interviews. The analytical process was informed by constant comparative techniques (Strauss and Corbin, 1998). Initially, we coded the raw data line by line, using codes to label each new major idea represented in the text. As data analysis progressed, we iteratively developed interpretations about recurring, converging and contradictory ideas/codes within the interview data. We identified key concepts and preliminary themes, along with illustrative examples from the data (Spradley 1980). Initial codes were then re-organised into broad categories that were developed to represent coherent patterns across the interviews and emergent themes (Morse and Field 1995). Data collection and analysis occurred in an iterative fashion (Stenner 1993), whereby, data gathered throughout the study (including follow-up interviews with twelve participants) were used to more fully characterise young men’s experiences and the socio-cultural factors affecting those experiences. Follow-up interviews with a convenience sample of participants from each community (five in Vancouver; three in Richmond; three in Prince George; and one in Quesnel) occurred one to three months after their initial interviews, which provided opportunities for them to comment on themes and concepts that emerged from our preliminary analyses.

Throughout the analysis, relevant literature, particularly in the area of gender identity, was revisited to prompt theoretically-informed questions about the data, and to test new ideas against additional empirical data as they developed during the analysis (Hammersley and Atkinson 1995, Denzin 1994). We used author team meetings to further develop our coding.
schemes, drawing on new interview data and our collective reflections on our interviews to refine the analysis. As the analysis progressed, we discussed and tested our data’s ‘fit’ with existing theory and empirical evidence. In the final stages, we also revisited our data to examine the ways in which our gender analysis intertwines with and/or varies by young men’s social positions and/or geographic locations.

Findings

Table 1 summarises the characteristics of the interview participants.

Table 1 Characteristics of study sample

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>AGE GROUP</td>
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</tr>
<tr>
<td>15–18</td>
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<tr>
<td>19–25</td>
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<tr>
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<tr>
<td>South Asian</td>
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<tr>
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<tr>
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<td>Living with partner</td>
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<tr>
<td>Living in foster care</td>
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<td>4.4%</td>
</tr>
<tr>
<td>Living in a group home</td>
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<tr>
<td>Living in university residence</td>
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</tr>
<tr>
<td>Other (e.g. variety of arrangements)</td>
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<td>8.9%</td>
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<td>COMMUNITY</td>
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<td></td>
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<td>Fort St. John</td>
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<td>Prince George</td>
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<td>22%</td>
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<tr>
<td>Richmond</td>
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<td>18%</td>
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<td>Quesnel</td>
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<td>11%</td>
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<tr>
<td>Vancouver</td>
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<tr>
<td>Never</td>
<td>14</td>
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<td>1 time or more</td>
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<td>36%</td>
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</tr>
</tbody>
</table>
Pre-test experiences

Participants were asked to recall when they had considered going for an STI test. Many men explained that they only considered testing after a sexual encounter that was outside their ‘normal’ sexual behaviour (e.g. ‘one-night stands’; unprotected sex under the influence of alcohol and/or drugs). However, thoughtful consideration did not necessarily prompt all participants to access STI testing, as Riquita, a 24-year-old Richmond man explained:

I met this girl and we got to drinking and the condom broke and yet we just proceeded, and the day after I kind of considered taking it [an STI test]. The reason that I didn’t actually get tested is because she had only been with one [other] guy. I know the guy personally and he’s a pretty clean guy - so that’s kind of what deterred me from getting tested.

Riquita’s narrative illustrates a common practice described by the young men, whereby they conducted a risk analysis that negated their perceived need to be tested. In particular, participants explained that their opinions about the risks posed by a sexual partner (an ‘other’) were often influenced by rumours that explicitly (and sometimes implicitly) situated specific partners as ‘risky’. Jordan, a 16-year-old Quesnel man, explained how rumours about a local woman convinced him of his need to be tested for STIs following his sexual encounter with her:

I just heard from the rumour mill… that she had an STI from a threesome. And that - well, not so much that she had an STI, but one of the people who participated in the threesome had one. So, I just decided to get checked.

Many participants described having talked with their sex partners about their sexual histories before making a decision to get tested. These men suggested that self-reported sexual histories were useful in determining if their partners were ‘clean’. Although this was a strategy reportedly used by most study participants, they also expressed scepticism about the validity of such self-reports, as is illustrated by Tyrone, a 20-year-old Vancouver man, who described his reactions to his partners’ disclosures about their sexual histories:

Like they would tell me, ‘Oh, I haven’t been with too many people’. And, I’d be like, ‘Yeah. I’ve been careful too’... But then again, they’re not going to tell you, ‘I have been sleeping with this many guys’, so you really don’t know.

While most participants had been tested previously, 14 had considered testing, but did not follow through. There were many reasons for their decisions not to seek testing. Some men explained that they did not have opportunities to engage in routine testing, especially in comparison to women. Dale, a 21-year-old man from Vancouver, suggested that comparatively, women engaged regularly with sexual health services:

Researcher: Men tend to be less likely to go for STI testing than women… Any ideas about why that might be the case?

Dale: Well I guess...really part of the reason would be if you’re a woman you’re having a Pap smear. You know, there’s not really anything that I can think of that a male is doing annually that they would be offered [STI testing]... sort of like on the spot.
Embedded here are cultural norms in which women’s bodies are routinely examined and an acknowledgement that young men’s bodies are not subjected to this type of surveillance. Rather than being contingent on a formal evaluation, young men are routinely assumed to be in good health. Many men also suggested that to consider the male body otherwise would be to challenge some dominant ideals of masculinity. For example, Joel, a 24-year-old from Fort St. John, explained how ignoring symptoms helps to maintain a perception of oneself as a ‘normal, healthy young man’, which he suggests is important to maintaining a form of social dominance:

It’s like an alpha male mentality, right? Like, if you show any signs of weakness, then...you will be weak. And it’s also, you’re fine and if somebody says you’re not fine, that’s something to be worried about. Whereas if you ignore it [symptoms], you’re still fine.

Joel’s comment also embodies a pattern well established in the literature that suggests that men prefer to self-monitor, rather than consult a healthcare professional, as the means to aligning with dominant ideals about how men’s bodies should operate (Courtenay 1998 and 2000a, Hayes 2001, White 2001, Mansfield et al. 2003). By ignoring symptoms, several types of perceived vulnerabilities are avoided, including those related to help-seeking behaviour, the embodied nature of self-examination, and the fear of discovering a problem (in this case an STI).

Testing Experiences

Physical examinations: Primarily, the young men in our sample were concerned about exposing their genitals to a service provider during the physical examination – a situation that represented a potentially sexualised encounter. For some men, to be viewed or touched by another individual was difficult to dissociate from the sexualised situations in which this behaviour ‘normally’ occurred. Participants often expressed strong preferences about being tested by a male or female service provider. For example, Jake, an 18-year-old gay man from Vancouver, explained: ‘I think it’s just the whole like sexual exposure with another male and it’s just weird, like I’m only naked in front of another man if we’re going to have sex’. Participants who identified as ‘straight’ said that they either: (1) avoided male clinicians due to homophobic anxieties (e.g. ‘I wouldn’t want a guy checking my junk’, Bad Hatter, 20-year-old from Prince George); or (2) worried about being tested by a female service provider for fear of getting an erection, like John, a 22-year-old from Richmond: ‘If the nurse is, let’s say, she looks good, and she is doing something with my genitals, there may be some sort of reaction… it will be pretty embarrassing’.

Dominant ideals of masculinity, typically associated with ‘uncontrollable urges’, erection, penetration and climax models of men’s sex, were frequently referenced by participants. Many men described how their ‘natural’ sex drives prevented them from de-objectifying the examiner as a sexual being (especially female examiners in the case of straight-identifying men); and, as a result, an erection during genital examination was perceived to be likely to occur. These descriptions position erections as a reflex and link uncontrollable erections with an aspect of young men’s idealised masculinity (insatiable libido). Indeed, the same ‘uncontrollable urges’ were said to correspond to the sexual risks that rendered some of the men susceptible to STIs (e.g. having unprotected sex); thus, privileging pleasure above control and caution regarding sexual health. Only one of the young men in our study discussed anxieties about penis size as being a concern during the physical exam. This may reflect the research dynamic, where some anxieties are acceptable to reveal during interviews,
while others are not (Oliffe and Mroz 2005, Flood 2008). Thus, the narratives related to physical exams, which primarily focused on sexualising encounters with service providers, may allow some participants to signal their virility and potency during interviews. The absence of other narratives that may have been part of the meaning-making process related to the exam (e.g. anxieties about penis size; having a history of sexual abuse) also could be interpreted as helping participants establish or retain control over the self-images that they projected during interviews.

**Specimen collection:** When participants described their perceptions and experiences with specimen collection, they focused on the urethral swab. Young men frequently cited stories that they had heard from peers about the swabbing procedure, and explained how these stories lead to substantial fears about getting tested. Jordan, a 16-year-old Quesnel man, explained: ‘I have heard a whole wag of stuff about sticking the six-inch dick swab and, I was like, Uhhh…No’. The ‘folklore’ around urethral swabs was a powerful force inhibiting the men’s willingness to undergo STI testing. But, for men that had experienced ‘the swab’, their pre-test fears were sometimes assuaged by the actual experience, as Tim, a 24-year-old Vancouver man, explained:

> For guys, the stories that are told of [the swab] are always larger than the reality of what it actually is. So, when I did actually get the swab, I didn’t really find it that…well, it wasn’t that bad…Before I ever went [for testing], it was a big deal. It [the swab] was scary, especially the way the stories are told. I think it’s just the misconception of what it is that scares a lot of people away from it.

Most men were unaware of the availability of urine testing for chlamydia and gonorrhoea. In this way, the interviews also became educational opportunities. They also told us that if they had known urine testing could replace a urethral swab, they would have been more likely to have sought testing previously. For example, Dale, a 21-year-old man from Vancouver, explained:

> I think for a lot of males…it’s not clear what you have to do [to be tested]. And so…maybe it’s not something you can advertise on a bus panel, but, by explaining the kind of procedures that [STI testing] involves, I think it would definitely be helpful… When the procedures are better than you think they’re going to be – when they’re not as invasive or not as painful – of course you’re going to be more likely to go and get tested.

**Post-Test Experiences**

**Social relations and contexts:** Participants who had undergone STI testing were asked to describe what they thought and felt following their STI test(s). Most said they had felt anxious waiting for potentially bad news in their results, in addition to feeling that their masculinity had been compromised through an admission of needing help (i.e. admitting that they needed to be tested). As Dale, a 21-year-old Vancouver man, explained, seeking help signals a lack of competency over one’s health and may call into question one’s social standing:

> I think in…in some cases, getting tested is almost seen as weak. Like you know, ‘Oh you’re worried about that,’ um you know, ‘That’s stupid,’ and it sort of almost ties into the kind of like strong male stereotype that like, ‘If you’re, you know, a capable male, you’re not
sick. You don’t need to get tested. Why do you need to get tested? You’re perfectly healthy, an upstanding male in human society.’ [...] It’s almost an admission of weakness to get tested and…because you have to go and do it specifically so it’s an acknowledgement that (a) you’re worried, and that (b) you think there might be an actual risk that you’re sick, that you’ve contracted an infection, which is I guess a kind of weakness as well, being infected.

This quote also reveals expectations about the ‘robust’ masculine body – one capable of fighting off infection, and positions the ideal masculine body as a bastion of resistance to infection. Most participants suggested that stoicism and silence prevailed around the topic of men’s STI testing. Some suggested that these barriers to talking about STI testing stem in large part from other taboos surrounding ‘sex talk’ in the broader social context in which young men live (e.g. ‘conservative’ attitudes towards sexuality).

Barriers to engaging in open discussions about sex-related topics also made it difficult to talk with their male or female sexual partners (and male peers) about testing. As is illustrated by Joel’s difficulties, talking with his same-sex partner about personal issues, the lack of permission for men to talk with one another about topics that would ordinarily be considered taboo can impede communication on many levels: ‘It’s just weird. Like, I can barely get him to talk to me, let alone, talking to him about whether he should get tested or not’.

A few participants had however been able to engage other men in discussions about STI testing, and they had been surprised by the supportive reactions they had received. As Tim, a 24-year-old Vancouver man, explained, talking with other men about having had an STI test can be an empowering experience:

I’ve told lots of my guy friends about it – that it’s not a big deal and that they should go get a test done ‘cause then you feel a lot better about it afterwards and I’ve always had a good reaction from people. Like guys are surprised to hear how easy it is and how it’s not a big deal and that one of their friends has done it... It’s not embarrassing or anything like that.

The potentially liberating experience of men being able to talk with one another about STI testing was an idea that resonated with most participants (our experience of talking with these young men demonstrates that they can, when given the right opportunity, engage in open dialogues about sexual health); however, most of them explained they were unable to discuss issues of sexual health with other men. Tim, a 24-year-old White, middle-class professional from a large urban centre was one of the few men in our study who explained that he could talk openly with other men about sexual health. Tim’s access to cultural and economic capital (e.g. by virtue of his ethnicity, social class and self-reported urbane way of life) situates him in a social position where he can more easily contest (some) forms of masculinities and juxtapose his own construction of what constitutes acceptable social relations in this realm. The younger study participants, especially those of lower social positions (e.g. lower socio-economic and educational groups) as well as most of the young men that we interviewed from rural and/or northern communities, explained that they were unable to discuss sexual health in their everyday social relations with other men.

Discussion

For most participants, STI testing was characterised as a potentially sexualised (as opposed to a strictly clinical) experience. In particular, the genital exam represented a vulnerable and
highly sexualised situation (McWilliam and O’Donnell 1998). While service providers have training to neutralise these situations, patients tend to rely on their social context and personal experiences for clues about how to behave. Clearly, the exposure of one’s genitalia – or the ‘nude body’ – is never rendered neutral or stripped of cultural value (Barcan 2004). Thus, the vulnerability of a man’s exposed body is fundamental to understanding young men’s experiences with STI testing: ‘It is through the body that gender and sexuality become exposed to others, implicated in social processes, inscribed in cultural norms, and apprehended in their social meanings’ (Butler 2004: 21). Connell (2005) would add that each masculine performance is context dependent, and masculinity can be contested at any time and place. Vulnerability in this context is epitomised by the possibility of an ‘unwanted erection,’ a situation in which a man is unable to choose between his ‘public’ and ‘private’ sexual impulses – for many young men, this reflex may represent ‘a glaring failure of privacy’ (Velleman 2001: 39) and a loss of control over their sexuality (something that may also cause them to question their masculinity).

Thus, some participants used stereotypes about ‘real men’ to reaffirm their own masculinity and to distance themselves from this potentially dangerous situation (Holland et al. 1998). The men who explained that they preferred an exam conducted by a female clinician reaffirmed their masculinity by both implicitly distancing themselves from homosexuality and explicitly reaffirming their heterosexual masculinity by having their penis touched or seen only by women (although they also acknowledged the potentially problematic situation of being examined by physically attractive female clinicians). For the men who feared being examined by another male, their narratives suggest that the penis can only be seen by another man through a homosexual ‘gaze’ (Holland et al. 1998). By refusing to be examined by a male, they therefore deny access to such gazes and reaffirm their heterosexuality. As they forge identities, it appears that homophobia contributes to their hetero-normativity and the construction of their version of idealised masculinity, where the phallus is a site of power rather than vulnerability. Avoiding the male physician also ensures that an erection in the presence of another man does not occur – which is important since an erection under these conditions could call into question the man’s ‘true’ desires.

Many participants also appear to be engaging in potentially ill-informed risk assessments regarding sexual health (e.g. frequently basing these on rumours about a partner’s sexual history and/or reputation). The participants’ narratives positioned most female sex partners as being reluctant to disclose their sexual histories and/or current STI status. In these narratives, participants also tended to position some women (e.g. those perceived to be promiscuous) as potential threats to men’s health, blaming them for being sources of infection (Darroch et al. 2003). Our data also reflect the ways in which women sex partners are frequently ‘othered’ by their male sex partners (e.g. illustrated in Riquita’s narrative) – primarily as a means to deflect the burden of responsibility for risk/safety within sexual relationships, which subsequently undermines the effectiveness with which women might exert agency (e.g. negotiating condom use). Moreover, ‘othering’ further reinforces the privileged position that many men occupy and reinforces the gendered power relations associated with naming the behaviour of the ‘other’ (e.g. promiscuity) as well as other features of the social position of the ‘other’ (e.g. class; race; age) as the problem (Shoveller and Johnson 2006, Mankayi 2009). In addition to being subject to different versions of morality and power, our data also concur with the findings of previous studies that have demonstrated how female partners are simultaneously constructed as agents who both promote and negatively impact the health of male partners (Robertson 2007), although we acknowledge that traditional ideals of femininity locate women as being the primary health advisors of the men in their lives (Lee and Owens 2002). Despite the general view that women
tend to be more in touch with their bodies and health than are men, our findings confirm the complex ways in which masculinities, femininities and gender relations interact to affect perceptions and behaviour within the context of sexual health.

The findings described here have important practical and theoretical implications for sexual health promotion. First, men’s sexual healthcare service provision should take into account the hyper-sexualised meanings attributed to the penis when creating men-centred sexual healthcare services. Strategies that may help to put young men more at ease include: using non-judgemental approaches to building rapport throughout the clinical encounter (including body language); offering the option to choose a man or woman service provider; performing non-invasive procedures (e.g. urine-based testing for chlamydia and gonorrhoea) prior to more invasive techniques; and explaining in clear, ‘youth-friendly’ language why a genital exam is important (Bates 2002). Service providers should routinely perform urine-based STI testing in asymptomatic patients, even when they refuse or are reticent to undergo a genital exam. In these situations, offering urine-based tests could establish rapport, and perhaps on the second or third visit, a patient might feel more prepared to have a genital exam. Providing alternatives to the urethral swab is important for young men, especially in light of dominant, hetero-normative notions that position the man as the penetrator – not as the one being penetrated (Potts 2000). Indeed, some authors have suggested that future successes in men’s sexual health promotion may depend on our culture’s ability to accommodate alternative versions of male sexual embodiment, separated from the phallus and its hyper-sexualised meanings (Potts 2000, Bordo 1994).

In addition, the ‘pronounced silence’ around young men’s sexual health issues needs to be addressed by public health promotion programmes that address some of the structural barriers to men’s use of STI testing (e.g. campaigns to explain the procedures and options related to testing). Men have been found to be less likely to ask for sexual advice and to be more likely to avoid talking about sexual health with peers (Courtenay 2000b, Pearson 2003). Participants told us that a public health campaign aimed at young men needs to describe in detail (using clear language) what the STI testing experience will be like for men. A health promotion campaign that clearly explains that men do not need to get a urethral swab to test for chlamydia and to screen asymptomatic gonorrhoea would be a good first step (e.g. the recently launched male-centred STI awareness campaign which uses the slogan, ‘It’s as easy as 1-2-Pee’ (Planned Parenthood Regina 2008)). Some authors have suggested that young men’s health campaigns should be informed by the experiences of the Pap/gynaecological screening for women, encouraging male pelvic exams from puberty onwards (Alt 2002) – or at least incorporating STI testing and treatment within a range of health services (Lichtenstein 2004). While these techniques warrant consideration given the current state of young men’s sexual health-seeking behaviours, at the very least, clinicians need more consistently to offer young men opportunities for sexual health counselling (e.g. inform them of what is involved in STI testing, even when they present for other health issues). Moreover, clinicians need to become more aware of the ways in which gender-biased perceptions about men, men’s health, and masculinities affect the provision of care (e.g. questioning current approaches that may not acknowledge or be sensitive to a diversity of masculinities) (Moller-Leimkulhler 2002).

All the interviewees grew up in an era when there have been considerable efforts to promote the notion of protecting young people from sexual risk (Shoveller and Johnson 2006, Shoveller et al. 2006) and there is consensus that these messages have failed to get through to men, especially young men (Courtenay 2000a, Lewis 2004, Pearson 2003, Watson 2000). While we agree to some extent that most previous messaging around youth sexual health has not been effective, our findings add further evidence of the importance of social
relations and context in effectively promoting sexual health. In particular, our findings show how vulnerabilities around masculine identity trump available knowledge about sexual risks. Moreover, despite being exposed to multiple sexual health promotion initiatives and growing up in a post-feminist era, the young men in our study have also come to maturity within a dominant set of social relations that reflect what Flood (2008: 342) refers to as the ‘homosocial ordering of men’s heterosexual relations’ (e.g. male-male friendships are prioritised over relationships with females; platonic relationships with women are perceived as potentially feminising; sexual activity is the most important pathway to attaining ‘masculine’ status). To date, these notions have received relatively little theoretical or practical attention within the Canadian context.

Our data illustrate how male-female social/sexual relations, even within clinical encounters with female service providers (e.g. genital exams), remain ‘dangerously feminised’ (Flood 2008: 342). Many young men in our study also shared narratives that illustrated the importance of sexual activity to the development and maintenance of masculine identities. Building on Flood’s notions of sexual activity and masculine status as well as Gurevich and Colleagues’ (2004) work on ‘health anatomy’ and masculinity, we were struck by the narratives that featured sexual activity as both a vehicle towards masculine status and, concurrently, as the cause of illness. Linking sexual activity with potentially emasculating outcomes (e.g. ‘falling ill’) may make it more difficult for young men to assert claims with impunity regarding their masculinity as derived from their sexual activity. However, as Gurevich and colleagues’ (2004) demonstrate, fears about health problems interfering with sexual activity may supercede the links between male weakness and help-seeking behaviour. For example, some health-promoting behaviours can be linked with maintaining sexual prowess (e.g. seeking immediate medical attention for a testicular lump); and, other more generalised forms of health-promoting behaviour have been associated with enhanced perceptions of masculinity (e.g. fire-fighters preserving their healthy bodies in order to maintain both their ability to work effectively and other enactments of masculinity) (O’Brien et al. 2005). We have yet to address fully the theoretical and/or practical implications of the fact that sexual activity is simultaneously positioned at the nexus of the creation (and potential downfall) of masculine status, although there is an emerging literature focusing on resisting and/or challenging masculine hegemony (Emslie et al. 2006).

Perhaps what is needed in thinking about more effective sexual health promotion efforts is a concerted effort to make visible – and de-construct – existing stereotypes about masculinities (and femininities) in ways that give permission for men to ‘do’ sexual health. Although this phenomenon has been detailed among older men (Gibson and Denner 2000, Oliffe et al. 2009), our study suggests that many young men may also feel that they need ‘social permission’ in order to engage in meaningful discussion regarding STI testing (or other health-related issues) with other men.

Although the aim of this study was not to generalise the findings to all young men’s experiences, the diversity of our sample indicates that these findings are illustrative of the experiences that many young men encounter when accessing or considering accessing STI testing services in BC, Canada. Recruiting participants from community-based locations was important for including the views of men who might have been missed if we had only recruited through clinical sites (Coleman and Lohan 2007). For example, including young men who may not have undergone STI testing, despite having potential need for such services, enhanced the diversity of experiences presented in our study beyond that of the ‘active patient’ (Pryce 2001) to also include young men’s insights into the ways in which social spaces in communities affect their experiences with STI testing.

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The data gathered in the current study add to the growing evidence of the need to re-evaluate our approaches to young men’s STI testing (Barker et al. 2007). Ultimately, the fact that sexual health clinics throughout BC (and elsewhere in Canada) report seeing far fewer men than women points to a gender-based inequity in sexual health service provision. Our failure to fully engage men in STI testing and other forms of sexual health promotion represents an important lost treatment opportunity for many individuals; and, moreover, reveals a serious gap in the public health system’s efforts to reduce disease spread at the population level. Attending to young men’s perspectives on STI testing represents a starting place in reforming our approaches to addressing this issue in ways that account for the socio-cultural and structural factors that shape those experiences.

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Note

1 Canadian Guidelines on Sexually Transmitted Infections (2006) indicate specimens collected using first-catch urine are appropriate for individuals who are at risk for STIs and/or are asymptomatic across a number of STIs, including chlamydia and gonorrhea. First-catch urine specimens may also be used to test for chlamydia in symptomatic individuals. For symptomatic individuals, either urethral swabs or blood samples analysed using NAAT (nucleic acid amplification tests) may be used to identify gonorrhea (PHAC 2006). Cost concerns and policies may vary across jurisdictions, although urine-based testing is now commonly used in Canada and the UK.

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