Women on men’s sexual health and sexually transmitted infection testing: a gender relations analysis

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Abstract

Sexual health and sexually transmitted infection (STI) testing is typically portrayed as a women’s issue amid men’s estrangement from healthcare services. While the underreporting of men’s STIs has been linked to masculinities, little is known about how women interpret and respond to heterosexual men’s sexual health practices. The findings drawn from this qualitative study of 34 young women reveal how femininities can be complicit in sustaining, as well as being critical of and disrupting masculine discourses that affirm sexual pleasure and resistance to health help-seeking as men’s patriarchal privileges. Our analysis revealed three patterns: looking after the man’s libido refers to women’s emphasised femininity whereby the man’s preference for unprotected sex and reticence to be tested for STIs was accommodated. Negotiating the stronger sex refers to ambivalent femininities, in which participants strategically resist, cooperate and comply with men’s sexual health practices. Rejecting the patriarchal double standard that celebrates men as ‘studs’ and subordinates women as ‘sluts’ for embodying similar sexual practices reflects protest femininities. Overall, the findings reveal that conventional heterosexual gender relations, in which hegemonic masculinity is accommodated by women who align to emphasised femininity, continues to direct many participants’ expectations around men’s sexual health and STI testing.

Keywords: youth sexual health, gender relations, femininities, masculinities

Introduction

Sexual health and sexually transmitted infections (STIs) are a growing public health concern. STI rates among Canadian youth are well above the national average and are increasing, notably among 15–24-year-old men. For example, in Canada over the past decade, reported rates for both chlamydia and gonorrhoea among young men aged 20–24 have doubled, with similar increases among 15–19-year-olds (Public Health Agency of Canada 2009). While global STI prevalence rates among men vary, since the mid-1990s many regions have seen high and rising rates of infection among young men. In the USA, for example, it is estimated that one in every 89 men aged 20–24 is infected with chlamydia (representing 1121 cases per...
100,000 population) (US Centers for Disease Control and Prevention 2010). In the UK chlamydia rates are even higher in this group (1599 cases per 100,000 population in 2007) (Health Protection Agency 2010) and have risen sharply, almost tripling from 1998 to 2007 (UK Office for National Statistics 2009).

While the adverse social and health outcomes of undiagnosed and untreated bacterial STIs in young women are well known, there is compelling evidence that men also experience significant negative health consequences. Many STIs are asymptomatic in young men (Pack et al. 2000). When left untreated, STIs can lead to conditions such as epididymitis (Peipert 2003), prostatitis (Cunningham and Beagley 2008), decreased fertility rates (Idahl et al. 2004, Public Health Agency of Canada 2006) and penile or anal cancer (US Centers for Disease Control and Prevention 2007). Furthermore, untreated men continue transmission, furthering the cycle of (re)infection. Regrettably, low male participation in STI testing persists (Health Canada 2003, Lewis 2004, Shoveller et al. 2010).

Masculinities and men’s sexual health

Men’s health practices have been linked to diverse enactments of masculinities that can both negatively and positively influence men’s wellbeing (Oliffe et al. 2012, Robertson 2007, Sloan et al. 2010). Hegemonic masculinity idealises men’s bodies as robust and resilient (Charles and Walters 2008) and as more amenable to self-management than to seeking help from healthcare providers (Hyde et al. 2009). Some men align with such masculine ideals by delaying help-seeking despite experiencing symptoms (Galdas et al. 2005), while disregarding health promotion messages (Smith et al. 2008). Recent studies suggest that masculinities and men’s sexual health are also connected. For example, hegemonic masculine performances are often linked with valorising plenteous sexual encounters (Courtenay 2000a, 2000b) and sexual risk-taking behaviour (for example, the avoidance of condoms) (Devries and Free 2010, Kimmel 2008). Studies have also described men’s structural or sociocultural barriers to sexual healthcare services, such as their fear of STI testing procedures, for example, a genital examination or a urethral swab (Shoveller et al. 2010). Potentially marginalising experiences with sexual health service providers (Lindberg et al. 2006) especially those related to disclosing and discussing stigmatised, sensitive or illicit behaviour have also been highlighted as barriers to men’s help-seeking (Perry et al. 2010). Shoveller et al. (2010) detail how young men who align with dominant forms of masculinity characterise STI testing as a potentially dangerous sexualised encounter (for example, fears of getting an erection, homophobic anxieties about having a male clinician). ‘Feminised’ clinic spaces, for example, the absence of ‘men-friendly’ resources (Shoveller et al. 2009) and local social contexts and norms have also been shown to affect men’s access to STI testing services (Goldenberg et al. 2008).

In sum, the literature suggests that the ways in which men align (or do not align) with hegemonic masculinity influence their sexual health and STI testing, particularly their engagement with clinical services and professionals. However, women’s accounts of masculinities remain conspicuously absent in the context of men’s sexual health. Given the relational nature of gender and the potential relevance of heterosexual gender relations, we decided to examine how women interpret and engage with men’s sexual health and STI testing.

Femininities, gender relations and men’s health

Schofield et al. (2000) suggest that researching men’s and women’s health experiences through gender relations can advance understandings about health opportunities and constraints. Empirical studies conducted in Africa have uncovered the deeply entwined nature of gender relations and family health practices in the context of women’s reproductive health (Mumtaz and Salway 2009, Tolhurst et al. 2008). Gender relations research has also
described smoking among new fathers from the perspectives of women partners (Bottorff et al. 2010) and contributed insights to how heterosexual couples rely on hetero-normative food practices when the male partner experiences prostate cancer (Mroz et al. 2011). A study of men’s depression highlighted how most heterosexual couples traded places in breadwinner roles and domestic work to compensate for men’s illness-invoked disabilities (Oliffe et al. 2011). These empirical accounts afford some context towards understanding commentaries about the connections between heterosexual gender relations and health practices. For example, western women are often portrayed as having a positive influence on the health of their male partners (Robertson 2007, Westmaas et al. 2002) as a by-product of aligning to feminine ideals around nurturing, caring and concern for others (Bottorff et al. 2012). In addition, being a woman is the strongest predictor of preventative and health-promoting behaviour and women are consistently depicted as coping more effectively and accepting and providing greater social support than men (Courtenay 2000a, 2000b, Ratner et al. 1994). Research has also shown that married men live longer than single men, as well as the significantly shortened life expectancy of widowed men following the loss of a partner (Bowling 2009, Dupre et al. 2009, Johnson et al. 2000). However, women are more vulnerable to negative reproductive health outcomes and intimate partner violence as a by-product of having a male spouse (Chang et al. 2010, Lee-Rife 2010).

While the aforementioned patterns may be explained by women’s roles in promoting the health of their male partners (Lee and Owens 2002, Johnson et al. 2000), the specific gender interactions from which these outcomes arise are poorly understood. Some men’s risk-taking behaviour and poor health outcomes are linked to masculine ideals, though many questions remain about how these connections vary within and across men (Galdas et al. 2005). Increasingly, gender and health researchers are interested in investigating the everyday lived experiences of women and men with the aim of developing an understanding of the links between gender relations and health (Schippers 2007, Schofield et al. 2000, Smith and Robertson 2008).

Theoretical underpinnings of gender relations
Connell’s (1995) gender framework detailed diverse masculine practices in response to hegemonic masculinities (Connell and Messerschmidt 2005). Central to Connell’s (1995) thesis of masculinities was that hegemonic masculinity could function to subordinate other masculinities as well as femininities. Though theorising femininities received less attention (Lyons 2009), Howson (2006) further developed Connell’s work using the femininities bloc in which he described a tripartite of emphasised, ambivalent and protest femininities emerging in response to hegemonic masculinity. Emphasised femininity expresses complete compliance with and accommodation to hegemonic masculinity; ambivalent femininities strategically resist, cooperate and comply with hegemonic masculinity; and protest femininities challenge the foundation of the gender order, contesting the hierarchies that govern masculinities and femininities. We used Howson’s (2006) masculinities schema to examine how women interpret and engage with men’s sexual health and STI testing.

Methods
Data collection
The current analysis draws on data collected for a larger qualitative study that examined young people’s sexual health and STI testing experiences in British Columbia (BC), Canada. Interview participants (aged 15–24 years) were recruited between 2006 and 2008 using posters
in clinical sites (for example, youth clinics and walk-in clinics) and non-clinical sites (for example, universities and community centres) in four communities in BC: Vancouver, population 578,041, Canada’s largest western urban centre; Richmond, population 174,461, a suburb of Vancouver; Prince George, population 70,981, an economic hub of northern BC; and Quesnel, population 9326, a rural community located approximately 115 km south of Prince George (Statistics Canada 2007). A purposeful sampling strategy was used to maximise diversity in distilling prevailing patterns among the participants rather than formally focusing on place comparisons to highlight differences within and across the four communities. Participant diversity was also achieved by including women with a variety of experiences (for example, single or currently in a relationship) and of various ethnic and cultural backgrounds. Interested participants telephoned or e-mailed the research office and their eligibility for an interview was assessed, based on their having accessed or considered accessing STI testing, being previously or currently sexually active, or both, and being able to understand and speak English. Ethics approval was obtained from two university review boards. Those under 19 years of age did not need parental or guardian consent to participate.

Semi-structured, individual, face-to-face interviews were conducted by trained interviewers (five women and one male interviewer). The participants were able to choose to be interviewed by a woman or man; however, scheduling round mutually convenient locations and times rather than participants’ gender preference typically directed who conducted the interviews. There were five female interviewers: three Euro-Canadians, one Chinese-Canadian and one Israeli-Canadian. There was one Euro-Canadian male interviewer. The interviewers’ ages ranged from the mid-twenties to the early thirties. None of the youth participants personally knew the interviewers. A rapport was established with the participants during the interview process and interviewees were provided with information on how and where to access sexual health services in Vancouver. The interviewers were acknowledged as co-constructing the data along with the potential for bias in the interpretation of that data. In this regard the investigative team discussed the data collection processes and data to ensure that a consensus was reached about the analyses and findings. The participants described their perceptions of their community’s social and gender norms (for example, attitudes towards young men and women being sexually active) as well as their experiences in negotiating sexual practices with sex partners (for example, using condoms and inquiring about their partners’ sexual histories). The interviews were audio-recorded and lasted between 1 and 1.5 hours. Participants received a CA$25 honorarium for each interview.

From this larger dataset, we selected 41 interviews with a total of 34 women (seven women completed follow-up interviews) in order to examine how heterosexual (n = 30) and bisexual women (n = 4) interpret and engage with men’s sexual health and STI testing.² Follow-up interviews were conducted with a diverse subset of participants from our overall sample in order to capture additional data from the participants, who reflected a range of ages and experiences with STI testing, and who had demonstrated (in their initial interviews) a willingness and ability to participate in second interview. The mean age of these participants was 20.6 years (see Table 1 for the participants’ characteristics).

Data analysis
The interviews were transcribed, checked for accuracy and uploaded to NVivo 7 for coding. In the early stages of data analysis (that is, the first four to five interviews), constant comparative techniques were used to develop an initial set of codes that represent the key gendered processes described in the interviews (Dey 1999, Strauss and Corbin 1998). As

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additional interviews were completed, axial coding was used to group the open codes into more abstract conceptual and theoretical categories related to femininities and masculinities. As data collection and analysis continued we incorporated the individual experiences that participants shared with us during their interviews with their descriptions about broader, social and cultural issues; paying attention to the ways in which gender influenced their relationships and expectations in the context of sexual health. The analysis focused on the ways in which the words and phrases used by individual participants reflect or challenge characterisations of emphasised, ambivalent and protest femininities and how masculinities and masculine ideals featured in interview transcripts.

As the coding and writing proceeded we also began to examine more deeply how context and structure influence the ways in which femininities are described by women in relation to men’s sexual health and STI testing, with a particular focus on their relational experiences within heterosexual relationships. At this stage of the analysis we also incorporated published empirical and theoretical findings to inform and examine the emergent thematic patterns. We examined the varying degrees to which Howson’s (2006) femininities bloc was represented within and across the interviews to describe gender relations and show how hegemonic masculinity and related practices consistent with marginalised, subordinate, complicit and protest masculinities were linked and delinked to men’s sexual health and STI testing via the following processes: looking after the man’s libido (and then health), negotiating the stronger sex and rejecting the patriarchal double standards. While the processes are not mutually exclusive and the participants often described an array of perspectives and practices fitting more than one pattern, the pattern predominant in each participant’s interview determined where they were assigned. In what follows the three findings are presented from the most to least common.

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<th>Table 1 Self-identified characteristics of female study participants (N = 34)</th>
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Women on men’s sexual health  

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Findings

Looking after the man’s libido (and then health) (emphasised femininity)

The participants described conventional heterosexual gender relations whereby men’s sexual needs trumped any expectations about them tending to the couple’s sexual health. In the context of looking after the man’s libido Kristy, a 16-year-old woman, understood that, ‘if you don’t have it [sex], then you’re considered stuck-up or something like that … and guys are like, just sex all the time’. The women put forward explanations for men’s heightened libido, often drawing on biological explanations, as Halle, a 16-year-old, observed:

I think boys have higher hormone levels than girls, that’s my opinion. ’Cos if you notice there’s more, like more guys are into the whole sexual thingy than most girls.

Embedded here, and in many interviews, is the social acceptance of the male body as more highly sexed, and by virtue of the discordance between men’s and women’s sexual needs, participants tended to focus more on the couple’s sexual health. Related to this were participants’ commentaries about women’s and men’s sexual histories. For example, the number of sexual partners that women had had determined their reputation and the fewer partners they had the better. Alyssa, a 22-year-old, conceded that there were fewer expectations that men would be monogamous or limit their sexual partners to a few:

Okay, men have sex with many women. For women? No. If you have sex with your husband and have sex with your boyfriend and have sex with someone else … you’re a slut.

In this example, Alyssa went on to accept the inequality amid idealising a sexually discerning and conservative femininity while suggesting that infidelity and multiple partners were to be expected in men. In this arrangement, a woman’s limiting of the number of her sex partners was also desired as a means to attracting and retaining a loving and respectful man.

The participants also told us that their male partners were hesitant or unwilling to get tested for STIs, which they considered to be indicative of men’s general reluctance to acknowledge illness and their resistance to health help-seeking. Some women hypothesised that the gendered structure of sexual health services created barriers to men’s testing. For example, Jessica, an 18-year-old woman, explained that her partner was unwilling to seek medical help for his testicular swelling because he was uncomfortable with the possibility of being seen by, and aroused in the presence of, a female clinician:

Well, he makes jokes about it. Like he says, ‘What’s the point of going there, like if there’s just some woman who’s going to tell me to undress, she’s going to touch my testicles, and what she wrote down on the last report was ‘It stands up.’ And he was like, ‘How useful is that to my health?’

Jessica understood her partner’s concern, acknowledging that getting an erection during a previous visit to the doctor had left him vulnerable, embarrassed and fuelled his steadfast resistance to seeking further help for his testicular swelling. Though she was ‘a bit offended by the fact that he hadn’t gotten tested’ to determine if his testicular swelling was caused by an STI, Jessica accepted her partner’s resistance to being tested as his right. In accepting his
defence, which focused on discrediting the necessity of being touched by a clinician, Jessica took responsibility for their sexual health.

Many participants described the role of women as primary caretakers of men’s health and, through those descriptions, illustrated how men’s power in heterosexual relationships played out at the nexus of emphasised femininity and hegemonic masculinity. Ultimately, beyond Jessica’s belief that her partner should seek help, she viewed getting tested herself as the only available route to knowing his STI status (that is, she argued that if she tested negative, then her partner was also clean). Taking responsibility for other aspects of sexual health, including contraception and reproductive health, also featured in women’s narratives. For example, 20-year-old Cassandra told us that when she has routine Pap smears and renews her prescription for the contraceptive pill, her boyfriend:

takes a nap in the car while I go get my thing done … I don’t think he’s uncomfortable, he never mentioned that … We’ve talked about it, but I never got the vibe that he’s not comfortable coming in. It’s just, I know he likes his sleep so I let him. Yeah, he’s okay with everything.

Cassandra’s response to her long-time boyfriend’s behaviour does not interrogate the power imbalances that appear to be present in their relationship, perhaps reflecting a dominant discourse that prevents her (or him) from analysing their experiences more deeply. Other participants confirmed that women need to take primary responsibility for sexual health care because men are uncomfortable discussing such things with a partner or healthcare provider. As Jennifer, a 23-year-old, assured us, ‘[My boyfriends], they just need me to talk about those kinds of things.’

Central to emphasised femininity was the women’s care-giving, which generated particular discourses (including silences) that may ultimately reinforce men’s resistance to sharing responsibility for sexual health. Sophie, a 21-year-old, had asked her previous partners to get tested with her, but none of them had ever agreed to do so. She was complicit in their refusals by not forcing the issue; instead subscribing to the belief that it was less traumatic for women to get tested for STIs:

They said they would, but … well I never made them, so … Apparently it’s worse for the guys. They say it’s a lot harder for guys. It’s pretty horrible.

Like many participants, Sophie accepted the male body was not built for STI testing, particularly if a penile swab test was needed. Feminine norms round regular surveillance of women’s bodies (for example, pelvic examinations and Pap tests) based on their perceptions about women’s biology, were understood, as were issues of male pride that excused men from such uncomfortable experiences. Similarly, Erin, a 19-year-old, said:

I feel really bad for men for their examination because it goes right up their [pause] penis. And that hurts guys especially bad. It doesn’t hurt girls – like it’s uncomfortable for a couple minutes but you know it’s going to protect you. It doesn’t hurt, it’s uncomfortable. … I’ve been told that by my boyfriend and he says it really hurts and it’s not fun. It’s not pleasant. Most guys don’t want to go through that because it’s uncomfortable and they take great pride in their manhood.

Erin’s account positions the heterosexual male body as active rather than passive in signalling discordance between manhood and being tampered with or penetrated. The female body,
however, was described as accommodating, less vulnerable to being marginalised by such examinations and therefore better able to tolerate any discomfort that might accompany STI testing. Evident also are participants’ quest to care for their men by not subjecting them to unmanly STI examinations.

Emphasised femininity resembled conventional heterosexual gender relations whereby women understood that the sexual practices of men and women were different, amid being resident caretakers of men’s sexual health, a performance that nourished feminine ideals around nurturing while neatly fitting with compensating men’s inability to attend to such matters.

*Negotiating the stronger sex (ambivalent femininities)*

Some participants detailed how they strategically resisted, as well as cooperated and complied with, hegemonic masculinity. Underpinning this, participants questioned to varying degrees why the responsibility for sexual health and STI testing might reside entirely with women. Moreover, they mobilised a range of strategies to question some of the inequitable gendered practices. For example, women lobbied their partners to jointly share responsibility for ensuring the couple’s sexual health by being regularly tested for STIs, while also negotiating that condoms were used regularly to avoid STIs or an unplanned pregnancy. Yet, negotiating these arrangements was often portrayed as delicate and potentially strained, whereby the women, to varying degrees, countered men’s resistance while avoiding confrontation to strategically motivate their partners to action. Some women worried that they might lose their partner as a consequence of making an ultimatum and reaching a stalemate that risked their relationship. In these ways, ambivalent femininity revealed how participants accommodated some of their man’s practices, despite wanting to make sure they themselves stayed healthy.

Julia, a 21-year-old, spoke of the difficulties that had arisen in her relationship with a man who was three years older and more sexually experienced than her. Specifically, Julia’s boyfriend had previously tested positive and had been treated for chlamydia. He had assured her after they had had unprotected sex that he was clean. However, Julia told him that she wanted to use condoms until she had STI testing herself. Her boyfriend countered by emphasising how condoms dulled his sexual pleasure:

> He said, ‘it’s like me trying to rub your arm with a plastic bag over it. I don’t feel anything.’

Julia explained that her boyfriend continued to put ‘this big guilt trip on me’, so eventually they went to the clinic together to discuss it with a physician. The doctor assured them that if neither of them had an STI, they did not need to use condoms (if they remained monogamous and if Julia continued to take the birth control pill to avoid pregnancy). To a certain extent, by accompanying her to the doctor, Julia’s boyfriend broke with dominant masculine discourses (that men do not care enough about themselves or others to seek sexual health services). Paradoxically and concurrently, the impetus for him to get tested with Julia is rooted in his quest for (condomless) pleasure. Adding to the complexities, despite not entirely trusting him or his assurances, Julia explained, ‘He’s getting frustrated and I feel like I always sort of ruin the mood for him. So I just kind of gave in’. This example revealed how resistance (challenging men’s reticence to seek help) and compliance (giving in to the man’s preference for condomless sex) emerged in relation to discrete masculine ideals.

For other participants, men who took action (for example, underwent STI testing) as compared to men who reassured their partners (‘I am clean, you can trust me’), were described as fulfilling an attractive set of virtuous masculine ideals. For these participants, a
joint project was negotiated in which couples proactively addressed their sexual health. For example, Suzanne, a 20-year-old, asserted:

If I get involved in a relationship, I wanna know about the person’s previous history. I say, ‘Go get yourself tested’.

The participants referenced qualities embodied by the ‘right type of man’, including being honest, respectful and protective and these characteristics were idealised as constituting an equitable relationship. These manly qualities were also explained as detectable by cautious women. For example, Alana, a 20-year-old participant, argued that a woman who tested positive for an STI is irresponsible in that ‘you’ve not taken proper precautions … not that a girl is loose in terms of sexuality, but loose in terms of trust’. In these examples women itemised and, to varying degrees, assessed and attempted to co-construct men’s ideal qualities (honesty, respectfulness, protectiveness). Related to this, participants tended to oscillate in their demands for these qualities. For example, men who were said to be ‘players’ were seen as being more susceptible to STIs and this could result in the players being assigned a subordinate rather than an idealised masculinity by women whose ambivalence located men’s sexual promiscuity as a risk to their own sexual health. That said, being known as a person who had had an STI was perceived to have fewer negative consequences for men than women. For example, Julia, a 21-year-old, explained that compared to women

Men can definitely reverse it [STIs] and blame it on the girl, whereas … if a girl were to say, ‘Yeah, my boyfriend was sleeping around’, it’s like, ‘Well, you should’ve expected that because that’s what guys do’, right? So it’s still my fault.

The participants reflected on how their own attitudes towards young women’s real or perceived sexual behaviour can reinforce feminine ideals. Lora, a 19-year-old woman, told us that she disagreed with the gendered double standard yet felt compelled to reinforce it for fear of being judged by future partners:

If I have a new boyfriend I wouldn’t have told him I have nine partners before. I would just say, ‘Oh, I have two’, and that’s probably because – it’ll be hard for him to accept.

This example reveals how Lora, by acquiescing to the double standard, prioritises a wholesome female reputation as a means to avoid her partner’s judgment based on her true sexual partner count. These details might also diminish a potential or current partner’s respect for her, which in turn may jeopardise the kind of relationship Lora wants. In part, Lora relinquishes the honesty and equality she hopes for by conceding that a lie, rather than the truth, will protect any new relationship.

Ambivalent femininity reveals this subgroup of participants as embodying a diverse, complex set of practices to strategically negotiate hegemonic masculinity and an array of complicit, marginalised, subordinate and protest masculinities that can emerge from those ideals. Interconnected with this, feminine ideals about preserving emotional and sexual health prevail, but the ways and means by which this is negotiated are contextually bound and subject to revisions.

Rejecting the patriarchal double standard (protest femininities)
A few participants enacted protest femininities whereby they rejected hegemonic masculinity as well as the more complicit actions of other women who accepted double standards around

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the sexual practices of men and women. Alison, a 21-year-old, pointed out that women who frequently reinforced gender inequalities were ultimately complicit in sustaining men’s patriarchal privilege:

I think it’s on women to change that stereotype. Guys accept other guys as being promiscuous, but girls don’t accept other girls being promiscuous. . . . So I think that maybe if that was equal, then there would be more of a chance of guys feeling the same way.

Alison did not labour the specificities of what might constitute promiscuity; instead, she turned her attention to arguing that women need to avoid imposing inequitable and unjust judgments on other women before men will fall in line. Contested are complicit actions synonymous with emphasised femininity, and contradictions within ambivalent femininities are challenged as a significant source and site of the stigma that accompanies some women’s sexual practices.

Similarly, in terms of guiding and governing men’s sexual health, protest femininities emerged as strong and self-assured in demanding that equal roles and responsibilities be taken up by men and women. There was also a consensus that masculine virtues of honesty, strength and honour be assigned based on men’s actions, rather than their assurances. Rita, a 21-year-old, forthrightly recommended that women are best served by refusing to have sex with a partner who will not test for STIs:

Go with your partner. If you are sexually active with somebody, get them to go with you. If they won’t go with you, maybe don’t be sexually active with them. I think that could be indicative of larger characteristics – or for me at least.

In denying or offering the specific conditions under which sex can occur, Rita enacts a form of protest femininity by asserting control over her body and wielding power to afford or deny her partner sex. In this example, masculinities are marginalised and subordinate in that the woman’s sexual health rather than the man’s desires determine or dictate when sex can occur. While contesting the power differential invoked by hegemonic masculinity, Rita also revealed her naivety on the capacity of many women (and men) to engage in a rebalancing of power that would be required to act as strategically as she suggests.

The small subset of the women who embodied protest femininities also described how, based on previous experiences, they had steadfastly set the terms for what they would (and would not) accept in terms of their partner’s sexual health and STI testing. For example, Sarah, a 23 year-old, was certain that she had contracted chlamydia from her partner. After she had confronted him with her STI test results he refused to be tested and blamed her for his having to get treatment (which was made available to him through the partner distribution system, meaning that he did not need to go to a clinic to be tested):

I was like, ‘Well if we’re sleeping together and I take this medication to get rid of it, you’re going to take some’. You know, and he was like really stubborn about it and stuff. ‘Cos it’s my fault, right? ‘Cos I’m the one that went to the doctor and got it [STI testing]. He never actually went to the doctor. He just got the medication prescribed to get rid of it – ‘cos he didn’t want to take any tests, he didn’t like going to the doctor.

After convincing her partner to take the antibiotics, Sarah endured his anger and blame for being put in such a position until she ended the relationship. In this scenario, Sarah resisted
inequalities in reaction to a specific context and issue, yet these experiences strongly influenced her expectations and governance of subsequent relationships.

Protest femininities were also expressed in stories about the importance of women caring about themselves. Being slutty was described as being both a cause and effect of women’s low self-esteem (that is, being slutty implies that one must possess low levels of self-esteem; having low self-esteem predisposes a woman to being slutty). Contesting the power differential and inequality invoked by labelling some women as sluts was directed to women and men by participants embodying protest femininities. Again, in this regard women resisted the pressures and labels that can be assigned by gendered double standards in advocating that all women should take the initiative to respect and assert themselves. Barb, a 24-year-old woman, argued that ‘there’s sex everywhere’ in suggesting that it is more accepted for young women to be sexually assertive in dismissing the judgments of others:

[I]t really just matters what she thinks in her heart ’cos people are always going to say something, they’re probably just jealous, kind of wish they were having that sexual activity themselves.

Protest femininity reveals this subgroup of participants as highly resistant to conventional heterosexual gender relations. Central were women’s right to choose their sexual practices and priorities for self-health by protesting against the subordination invoked by discordant masculine and feminine ideals and the patriarchal powers that attempt to sustain that inequality. That said, it is important to recognise that the examples of protest femininities most often emerged from participants’ previous negative experiences rather than from their current gender relations issues.

Discussion and conclusion

As Schofield et al. (2000) and Smith and Robertson (2008) suggest, empirical work in gender relations is vital to extending masculinities and men’s health research. Likewise, Schippers’s (2007) and Lyons’s (2009) eloquent assertion that the development and empirical testing of femininity frameworks will advance health and gender relations research also influenced our study design. The current study provides empirical and theory-based insights for an emergent gender and health literature intent on demonstrating the intricate connections between men’s and women’s health rather than perpetuating a competing victim discourse (Broom 2009).

From an empirical viewpoint, our findings run counter to those of Oliffe et al. (2011) who argued the greatest bandwidth around femininities resided in ambivalent femininities, one consequence of which was that most of the women in his study were designated as embodying ambivalence in response to their male partner’s depression. Conversely, similar to Bottorff et al.’s (2010) work in smoking among couples and Mroz et al.’s (2011) on diet and prostate cancer research we found that emphasised femininities and conventional heterosexual gender relations were dominant as guides that often also governed the actions of the women in the current study. Alignments to emphasised femininity may be an artefact of young women following previous generations (that is, their mothers) where perhaps more traditional and established gender roles and practices resided. They might also emerge as conservative protective practices in response to the promiscuity assigned to alternate practices. That said, based on the diversity in our findings, it can also be reasonably argued that across time and context young women’s gendered expectations about sex, health help-seeking and STI testing might shift in ways that neither entirely support nor disrupt
dominant discourses about conventional gender roles in heterosexual relationships. While we were somewhat surprised to find emphasised femininity prevailing among many young women in this study, we suggest that it may be a foundation from which many women (and men) launch other gender identities and relational practices.

While not wanting to overstate the potential application of our findings they do provide some clues about how and when sexual health-promoting interventions might advance the wellbeing of young women and men. Historically, most sexual healthcare services targeted to heterosexuals have focused on women rather than men (Shoveller et al. 2009). This approach may have inadvertently reinforced ideals that femininity, and therefore women, are best credentialled to be the caretakers of men’s sexual health. Yet, by describing a range of femininities, our findings indicate an appetite for alternatives to sustaining that status quo and the inequalities accompanying it. For example, couple-based interventions might best garner the sexual health preferences of women whose practices align with ambivalent or protest femininities.

We were also reminded that many young women draw on limited personal experiences to guide their interactions around sexual relations and health. In this regard, offering young women and men strategies for negotiating sex and sexual health (as distinct from warnings about the poor outcomes associated with unprotected sex) might be timely in positively influencing emergent, and often experiential gender roles, identities and relations. Benefits may also be drawn by directly targeting men with sexual health campaigns that highlight STI testing with urine samples (as distinct from penile swabs), for example, the 1 - 2 - Pee Campaign (Evergreen Clinic 2011; see also Shoveller et al. 2010). Such strategies can waylay men’s (and some women’s) concerns around embodied masculinity (that is, being touched, inappropriately aroused and penetrated with penile swabs) while contesting dominant masculine ideals about their lack of action and accountability in sexual health.

From a theory viewpoint, Howson’s (2006) femininities bloc provides important traction towards a better understanding of the heterosexual gendered performances that emerge in and around sexual health and STI testing. Yet, important questions remain, including, is there a hegemonic femininity and what might constitute feminine ideals in the context of health? Schippers (2007) has argued that heterosexual desire is defined as an erotic attachment to difference, and in this regard masculinity and femininity are poised, and perhaps idealised, as complementary opposites. In our study, this played out in emphasised femininity whereby feminine norms (being nurturing, cooperative, virtuous and submissive) (Lyons 2009) complemented hegemonic masculine ideals (self-reliance, competitiveness, conquest and dominance). Schippers (2007) also makes the argument that non-normative versions of femininities – which she refers to as pariah femininities – contaminate this complementary ‘opposites attract’ relationship. While some such contamination was evident in protest femininity in the current study, pariah femininity is differentiated in that, aside from contesting women’s subordination to hegemonic masculinity, it also critically interrogates the performativity of other femininities. While this differentiation is important, the pariah label suggests, at least to us, a potential to cast those displaying it as deviant within a competing femininities framework, rather than as heroines rallying for gender equality with men. Related to this the predominance of protest femininities that emerge from previous unsatisfactory heterosexual gender relations may indicate this position among participants in our study as reactive, and perhaps more likely philosophical, rather than reflecting an actual relationship.

Distilling hegemonic femininity and feminine ideals through more neutral language and labels may also help to detail how specificities of power and performance among women, as well as between men and women, influence sexual health practices. For example, if nurturing and self-health are western feminine ideals, then how might we work with those virtues to
disrupt other equity-detracting norms (such as only women care) in the name of advancing sexual health for all? Related to this, do we focus on strength (that is, affirming feminine ideals of nurturing) or deficit (that is, contesting and disrupting such norms) to launch interventions? In summary, we need to thoughtfully consider not only what constitutes hegemonic femininity, feminine ideals and the plurality of performances, but also how we catalyse, contest or change the sexual health practices that flow from those findings.

In terms of limitations, care should be taken to recognise our data are collected from young women who live in western sociocultural spaces, where the freedoms to talk and act on sexual health may differ from those operating elsewhere. Our findings therefore, are not representative of heterosexual gender relations or sexual health practices in other parts of Canada and the world. The cross-sectional nature of the study is also a limitation in that it seems very likely that women’s feminine ideals and gender relations will change across their lifetimes and context to reveal the femininities bloc, and adaptations thereof, as fluid processes rather than discrete categories to which women steadfastly align or in which they remain. Furthermore, though our participants’ predominant narratives enabled us to assign particular categories to their attitudes, because these narratives represent configurations of femininity practices that are context-specific it is entirely reasonable to predict that at particular points in time individual women could move into and out of these categories. Nonetheless, these limitations offer exciting directions for extending health and gender relations research by conducting longitudinal and multisite studies to describe the patterns and diversity that exist within and across women, men and couples in the context of sexual health and STI testing.

In conclusion, it is clear that sexual health and STI testing are intricately connected to gender relations. However, as Schofield et al. (2000) remind us, gender relations are lived as bodily practices, only some of which produce illness, disability and premature death. Thus, while gender relations focus on health, they extend to many aspects of people’s lives, and complex challenges emerge in attempting to abstract contextually specific elements (for example, sexual health). That said, future efforts to engage with this challenging terrain will afford opportunities to better understand and address how the gendered organisation of sexual lives confers different opportunities from men’s and women’s practices.

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Notes

1 The data in the current study are drawn from a larger study that interviewed a total of 33 men and 37 women between 15–24 years of age to examine their sexual health and STI testing experiences.
Three of the 37 women participants did not report having engaged in heterosexual sexual relationships and were therefore excluded from the dataset from which the current findings were drawn. We use the term heterosexual gender relations to describe sexual relationships between men and women, regardless of the participant’s sexual identity. Hence, the inclusion of four bisexual women.

References


