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**“IT TAKES TWO TO TANGO”: SEXUAL HEALTH  
RESPONSIBILITIES OF KIWI HETEROSEXUAL  
MALES**

**A thesis presented in partial fulfilment of the  
requirements for the degree of**

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# ABSTRACT

Within an increasingly promiscuous society, utilisation of sexual health devices is extremely important yet some individuals choose to forego preventative and protective measures resulting in pregnancy or potentially fatal sexually transmitted diseases (STDs) such as Human Papillomavirus (HPV).

Globally, male HPV vaccination uptake rates were lower than that of females causing us to query why that is, what factors contribute to this and whose responsibility it is to care for sexual health.

This research aimed to provide insight on the male perspective about sexual health device use to comprehend how safe sexual health decisions are negotiated.

Five men underwent individual interviews and a focus group. Data was recorded, transcribed and a thematic analysis conducted.

Five main themes were identified as influential factors in decisions regarding sexual health device use: Gender-role expectations and societal influences, provisional and modal educational issues, absence of efficient advertising, marketing and awareness tactics, appeal, ease of use and access to devices and justifications for where responsibilities lie.

By normalising discussions regarding sexuality, social change can be generated by promoting safe sexual health. Factors influencing decision making processes, including gender-roles and external pressures, need renegotiation to include acceptance of safe sexual behaviours. Higher quality and quantity of education provision is required in a public realm to promote awareness of STDs, their consequences and prevention/protection measures available. Sexual health protective tools and services need to be easily accessible, appealing and convenient before individuals will actively prioritise sexual health.

The main themes identified in this study emphasise and redirect attention toward improvements required within future sexual health programme implementation to improve health outcomes. The themes established identify influential factors that require change in order to remove current barriers to care and to promote healthy sexual behaviours in place of risky ones.

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# OVERVIEW

The topic of sexual health is rarely openly discussed. In today's increasingly promiscuous society, this should be at the forefront of conversation.

Sexual health responsibility no longer pertains to only preventing pregnancy.

We now have to protect ourselves from the likes of sexually transmitted diseases or infections (STD's/STI's) also. Within New Zealand it has been noted that one in two sexually active young adults will acquire an STI prior to 25 years of age (The New Zealand Sexually Transmitted Infections Education Foundation [NZSTIEF], 2017). With consequences ranging in intensity from the need for regular medication to possible fatality in cases of prolonged exposure, how is it that something so threatening to the body can be overlooked? Why does the female involved have to bear the burden of caring for the sexual health of both partners? Should we not be interested and focussed on our own health rather than trusting that another individual will manage our health situation? The questions we need to ask ourselves are: what responsibilities should a male hold in this situation? And do these responsibilities align with the reality of behaviours and actions engaged upon? Normally the answer is no. But why?

To answer the questions above, this research focuses upon constructed gendered responsibilities and sexual health behaviours. The focus will remain on sexually active New Zealand heterosexual male residents between 18 and 30 years of age. The study intends to gain a deeper understanding how males understand sexual health tools, why sexual health prevention tools such as the Human Papillomavirus (HPV) vaccination have lower uptake rates in the male population, and how these trends have developed over time.

In New Zealand, as of January 1<sup>st</sup>, 2017, the HPV vaccination was made available and fully funded for males aged 9-26 (NZSTIEF, 2017). This progressive step made New Zealand part of the small minority within the world, one of three countries in fact; that offer the new fully funded Gardasil 9 vaccination to both males and females. The other two countries are Austria and the United States of America (USA) (NZSTIEF, 2017). The Gardasil 9 vaccination prevents contraction of nine different strains of HPV (types: 6, 11, 16, 18, 31, 33, 45, 52 and 58) (Seqirus, 2017a; National Cancer Institute [NCI], 2015). This is an improvement from the prior quadrivalent Gardasil vaccination which prevented only four strains (types: 6, 11, 16 and 18) (NCI, 2015). Because of this recent innovation, there is a rare opportunity on a global scale to discuss and gain a fresh understanding how the availability of this vaccination and other sexual health tools affect the decision making process regarding sexual health prevention, protection and management for men.

This is a new direction globally towards managing sexual health. Previously the quadrivalent Gardasil vaccination has predominantly only been available and fully funded for females. Only four countries (Australia, USA, Austria and Switzerland) included males within their funded vaccination programmes (NZSTIEF, 2017). Based on these countries' earlier recorded statistics, there is a clear trend that males have lower vaccination uptake rates than females, and lesser knowledge of the subject (Blödt, Holmberg, Müller-Nordhorn & Rieckmann, 2012; National Cancer Institute: The President's Cancer Panel, 2014; Kaiser Family Foundation, 2015; Donovan, et al., 2011).

In the United States, female HPV vaccination uptake rates are significantly greater than those of males, 40.4% versus 6.3% comparatively (Rahman, Islam,

& Berenson, 2015). Similar trends were also shown regarding completion of the vaccination programme, 27.4% of females as opposed to 1.7% of males. A staggering difference in HPV vaccination uptake rates was furthermore supported by the study of (Daniel-Ulloga, Gilbert, & Parker, 2016) noting only 5% of males received the vaccination compared to 30% of women.

We aim to establish why there is this gendered divide and how these gendered ideals are enacted in the context of using sexual health prevention tools. By understanding the logic behind gendered decision making, it may be possible to observe and promote health in a more gender-neutral manner to provide the best protection against STIs for both genders.

This is extremely important to study as worldwide, 14 million new HPV cases are detected each year (Rigaud, 2015). It has been identified that 90% of anal cancers, 63% of penile cancers and approximately 70% of oropharyngeal cancers can be attributed to HPV and as male antibody levels are substantially lower than those of females throughout the lifespan, HPV acquisition is heightened (Moscicki & Palefsky, 2011). This equates to an on-going HPV prevalence throughout their lifespan, with a slight decline in older age, and a higher likelihood of recurring infection (Smith, Gilbert, Melendy, Rana, & Pimenta, 2011). As HPV is the most prevalent STI on a global scale, it is likely to affect those that are sexually active at least once during their lifetime (Centres for Disease Control and Prevention, 2016). Furthermore, the likelihood of contracting an oncogenic strain of HPV within an individuals' lifetime if sexually active remains around 70-80% (Ministry of Health, 2017). Due to this, the risk of transmission is extremely high therefore preventing and protecting individuals against HPV needs heightened importance.

In New Zealand there has been a change in dating culture whereby application software and dating websites are being used more often. As a result individuals are engaging in sexual behaviours with strangers more than previously observed. This further increases the risk of STI transmission and contraction as partners' sexual histories are hardly known. If both males and females within the population were protected by tools such as the HPV vaccination, this would give the best protection possible to the entire population through acting in a herd-immunity like manner. The issue here however is that males are less inclined to utilise preventative or protective sexual health tools and we need to establish why this is.

Prior discursive psychology research has focussed primarily on heterosexual women's perspectives regarding sexual health responsibilities and safe sex. Less attention has been directed toward understanding how a heterosexual male constructs sexual safety and masculinity proving a need to study this population of interest (Bowleg, Heckert, & Brown, 2015). Furthermore, as also noted by Kerrigan et al. (2007) the influence of socially constructed definitions of what it means to be a man or woman has yet to be studied in the context of its impact on sexual health behaviours.

Numerous studies have been conducted focussing on contraceptive roles and responsibilities of both genders however STI prevention has been studied significantly less. STI protection, prevention and management have scarcely been studied outside of a focus on condom use. For this reason, this study has the ability to fill a gap in the current literature available within the field of sexual health and associated responsibilities. Prior studies that have focussed on sexual health or STI transmission and acquisition have heavily concentrated on

AIDS and HIV infected populations in particular. This has left a gap in the literature whereby lesser researched STIs such as HPV, can be explored in heterosexual groups and bring value to the field due to being an understudied population.

As Brown (2015) noted, young people are the group most affected by STIs nowadays. It is concerning that STI protection, prevention and management are viewed as secondary to preventing pregnancy in this population (Brown, 2015). As a result of this, a focus on the younger population would prove to be beneficial, as this is a high-risk population that needs to utilise alternative discourses in society in order to improve sexual health for the future. In addition, the importance of social reputation was prioritised over the risks of becoming pregnant or contracting an STI by New Zealand teenagers (Brown, 2015). This evidences the need for this study in order to understand how to change how we think about sexual health and the responsibilities that are associated with it.

As discourses alter according to the context they are portrayed in, in order to understand this better, it is imperative to assess the influence of numerous different settings on decisions made regarding sexual health. By analysing subjective views in a solitary setting versus a group situation, it may be possible to better comprehend how decisions are formed according to context. This will likely provide valuable insight into how a group setting shapes understandings utilised in everyday life regarding sexual health, protection, responsibilities, immunisation and masculinity.

Not all men endorse the same masculinity ideologies or behave similarly in equivalent contexts. Because of this, it would prove beneficial going forward to

assess individual subjective views in comparison to group consensuses. These individual versus group comparisons are necessary to gain an understanding regarding masculine ideals and views of sexual health behaviours showing inter- and intra-individual variation. This aims to show us the contrast of different views of individuals about normality of sexual health behaviours versus the effect of group persuasion tactics, outside influences and group consensus' in defining what is normal or abnormal in similar circumstances.

## **GENDER**

From a young age every individual is taught how to ideologically act and behave according to their biological sex. 'Gender' however is the appropriate term used to categorise individuals into a performed male or female role in life via social processes (Kelly et al., 2017). This gender-role is produced using a basis of cultural and social understandings as opposed to anatomical structure.

The gender of an individual is performed through demonstration of attitude alongside cultural beliefs, values, and norms constructed by society regarding what it means to be an ideological man or woman (Addis & Mahalik, 2003).

These include emotions, cognitions, language and behaviour which become notably prominent when socialising with others (Levant & Richmond, 2007; Courtenay, 2000).

Every decision made in life is driven by who we identify ourselves to be. As per Butler's (2011) performativity theory, our everyday communication and behaviours perform the role we wish to be identified by (Fiaveh, Izugbara, Okyerefo, Reysoo, & Fayorsey, 2015). Each gender has a different ideological

norm (normal). This ideological norm is what each gender aims to, and is expected to encompass, in order to fulfil their gender role accurately and appropriately according to dominant views of the mass media and society.

Through the actions, behaviours and language taught at an early age, each individual learns what it means to be a boy or a girl and the expectations of such roles. Behaviours and language taught are often gender specific and are associated with labels making them “masculine” or “feminine” acts. For a male, he is expected to display masculine characteristics such as strength and bravery. For a female, she is expected to be feminine in her every day manner including expressions of compassion and care. The manner in which each individual holds themselves within social transactions will define the gender category they fit into best according to the public eye.

When interacting with others, the reciprocal use or reproduction of these ideological actions and behaviours act as resources that legitimise common constructions and understandings of norms held within society as per what each gender-role entails (Courtenay, 2000). This further authorises continued use of these behaviours and actions, and strengthens the association between understandings held regarding gender labels and behaviours enacted.

The gender role enacted by each individual influences thought processes, decisions and actions, including those of sexual health responsibility. An example can be noted by explaining gender-role conflict. This is the resulting negative consequences of performing particular masculinity ideologies such as risky sexual health behaviours which oppose feminine concepts of sexual safety (Good, Dell, & Mintz, 1989). These behaviours are enacted to avoid being

“othered” by society for not conforming to what is considered as “normal” male characteristics (Houle et al., 2015)

An increased emphasis on gendered labels and categorisation over time has led to gender specific behavioural issues later in life (Martin & Ruble, 2010). These include expectations that a female be responsible for the health of both partners in an intimate relationship, not just herself. Unfortunately these expected gender roles do not align with the needs of today’s modern society including the need for one to manage their own sexual health without relying on a partner. The likelihood of STI acquisition is much higher when individuals have multiple sexual partners as is being observed more often nowadays. Additionally, as sexual partners are not always well-known, how can one trust or rely on someone they barely know with something as important as their health? How is it fair that one gender bears the burden of sexual health prevention, protection and management when both parties are involved in the acts engaged upon?

Demonstrations of gender are often altered according to the different cultural contexts and social locations we find ourselves in in everyday life (Levant & Richmond, 2007; Courtenay, 2000). In the context of sexual activity, it is more commonly found that a male will pass on the responsibility of caring for sexual health to the female despite this contradicting his masculine role of remaining in control of the situation as he would in alternative everyday activities.

Ideologically a male will pass the burden of caring for his health on to the female in the relationship. This is because protective health behaviours and actions are portrayed as, and perceived to be feminine social constructs within

the female gender-role (Courtenay, 2000). Gender ideologies however have the ability to change or be changed over time by both groups and individuals (Addis & Mahalik, 2003). By opening up to conversation surrounding gender and associated responsibilities (especially sexual health responsibilities), this study has the ability to change the way these ideologies are thought about and even renegotiate common and dominant understandings. It also has the ability to promote positive behavioural changes within men whilst not competing with gender-role norms. To do so however, we first need to understand why and how male and female (gendered) sexual health responsibility ideologies have emerged and how they have been maintained to this day.

Through discussions with individuals engaging in these gendered actions, explanations regarding why and how decisions are reached and made (with reference to males opposing sexual health preventative and protective measures) may be attainable. Justifications may add to literature by explaining both the individual thought processes and social group effects that occur when deciding to partake in more feminine behaviours of caring for one's own sexual health.

By focussing on the male population, it may be possible to gain an increased understanding as to why males do not bear the burden of these responsibilities and why they are less willing to take these responsibilities on when made available and easily accessible to the population with proven beneficial effects. What drives a male to allow their female counterpart to manage their individual sexual health when they themselves are also engaging in sexual activity?

It is about time we establish why males do not have the same drive as females to protect themselves against potentially life threatening diseases and infections passed on through sexual activity. Sexual health should be considered the sole responsibility of each individual that may be at risk of contracting an STI. In this case this refers to both partners engaging in sexual activity. By changing the way these gendered behaviours are considered, we have an opportunity to improve male health by promoting healthier sexual behaviours and minimising associated risks (Mahalik, Burns, & Syzdek, 2007).

## **MASCULINITIES**

It is thought that “men and boys experience comparatively greater social pressure than women and girls to endorse gendered societal prescriptions” (Courtenay, 2000, p. 1387). The male identity and hence gender-role, is socially constructed through displays of masculinity. Displays of masculinity encompass an individuals’ internalised view of societal and cultural ideologies, beliefs, expectations, stereotypes and norms of what it means to be a man (Addis & Mahalik, 2003). Masculine actions, behaviours, language and attitudes are to be conformed to according to the dominant view of the male gender-role (hegemonic masculinity) in order to fit in as a “normal” member of society (Levant & Richmond, 2007). This includes promoting participation in sexual activity regardless of protection or risks associated. It is these risky sexual behaviours such as inconsistent condom use in the young population however that have been contributing to a rising incidence of STIs (Castro-Vazquez & Kishi, 2007).

In fact, (Nunez et al., 2015) found that adolescents' choices to engage in health promoting behaviours or alternatively risky health behaviours were influenced by masculine and feminine expectations, norms and responsibilities associated with being a boy or a girl. Pleck, Sonnestein, and Ku (1993) further support this statement as they found those whom followed the ideals and attitudes associated with hegemonic masculinity were significantly more likely to utilise condoms inconsistently and have more sexual partners.

Traditional masculine norms include opposing any feminine associations or characteristics such as behaviours and actions, expectations that men should strive to be successful and authoritative, vulnerabilities and weaknesses will not present themselves, and also that risks are welcomed in order to appear strong and brave (Levant & Richmond, 2007). Emotional and physical control is to be maintained, any form of help offered is to be denied or dismissed, the individual should show physical dominance and display aggressive behaviour, alongside having a continual drive for sex (Courtenay, 2000).

The thought that a male should be responsible for his own health contradicts this notion of hegemonic masculinity as sexual health protection, prevention and management behaviours are considered feminine behaviours. Masculine expectations and norms often compromise health status in order to oppose a display of femininity. This can be seen to occur through engaging in unnecessary risks and rejecting health care needs to avoid seeming different ("othered") to the rest of the male population (Courtenay, 2000; Houle, et al., 2015). For this reason, men often tend to observe those around them before making personal health decisions or engaging in health behaviours despite their own personal beliefs (Mahalik et al., 2007). It has been noted that "perceptions

of others' health practices may provide information about how individual men should- act or not act - in terms of health behaviours they adopt" (Mahalik et al., 2007, p. 2202). Additionally they also found that "masculinity and the perceived normativeness of other men's health behaviours significantly predicted participants' own health behaviours" (Mahalik et al., 2007, p. 2201). This only suggests further that men make decisions based on social norms and expectations of their gender-roles.

Castro-Vazquez and Kishi (2007) explain identity as a form of belonging. Importance is placed on what you have in common with other members of a group and also what differentiates you from these individuals. The idea that one needs to care for their own health opposes one of the normalised beliefs that men should not show any vulnerabilities or weaknesses including the ability to be affected by any infection or disease. This however can also be weighed up against the need to remain in control or authoritative. By expecting a female be solely in charge of sexual health within a relationship, the male loses all sense of control in the situation as to whether he is protected from risks or harm arising through unprotected sexual contact. As the modern society is far more promiscuous, this should be of utmost importance in first world countries including New Zealand.

In addition, the ideology that a heteronormative masculine male has a duty to protect "others" or those deemed more vulnerable (such as women and children), is often dismissed with reference to sexual health (Castro-Vazquez & Kishi, 2007). He refuses to acknowledge this role requirement in order to not appear vulnerable himself. By doing so he places the female within harms reach due to disregarding the likelihood of contracting or transmitting STIs himself.

This is a prime example of one notion of masculinity contradicting another, placing both parties at risk of infection.

STIs more often contain indistinguishable symptoms that do not manifest themselves for large periods of time, therefore transmission occurs without prior knowledge (Ministry of Health, 2016a). As the dominant social portrayal of a male suggests stereotypically a male is not to put himself in a position of weakness, actions to protect health should not be carried out prior to infection. It is not possible to protect ones sexual health without defying dominant forms of masculinity.

Masculinity ideologies however vary according to different contexts making them contradictory. "Masculinity is not stable or fixed, but highly variable as men attempt to construct, and are constructed by what it means to be men in their everyday talk" (Bowleg et al., 2015, p. 323). Numerous different forms of ideological masculinities may present themselves in any given situation resulting in differential actions (Courtenay, 2000; Fiaveh et al., 2015). These masculinities are often expressed differently according to class, race, age and sexuality (Bowleg et al., 2015; Courtenay, 2000). For example hypermasculinity can be shown through thrill seeking and risk-taking behaviours including aggression or violence from those of a low socio-economic standing, as opposed to skydiving by those in a wealthier position. The resulting actions according to the context may or may not align with the dominant norm of what a masculine male should entail, therefore influencing his given status within society.

By conducting a study looking at both individual perspectives and group norms regarding sexual health responsibilities and gender roles, we are able to observe and learn about the way different opinions and beliefs are developed and maintained. Gender roles and masculinities are strongly linked to thought processes therefore are likely to influence the way in which a male perceives himself to be at risk. In turn this influences his decisions regarding sexual health protection. Because of this, attention is required within this discipline to attain a further understanding of gendered sexual health responsibilities and how these link to our decisions surrounding sexual health and medical actions, and why. To attain answers, we need to promote and create discussion surrounding these topics. By doing so we get exposure to a large range of perspectives in which aid our understanding of how and why males arrive at their decisions regarding personal use of sexual health tools.

Gender norms and expectations shape dialectical relationships and displays of power. They provide us with the understanding of what is considered masculine or feminine acts, alongside who is entitled to enact these. It provides us with a sense of normality to know any act similar is considered appropriate and any act that differs is abnormal and frowned upon. Individuals that engage in these inappropriate acts become the “others”, also known as social misfits. In a patriarchal culture such as ours, power relations are constructed according to gender hierarchy within society (Castro-Vazquez & Kishi, 2007; Brown, 2015). A heterosexual male that enacts hegemonic masculine characteristics is given dominant status and anyone that differs to this is subordinated. This includes females as a result of acting feminine, but also other males that do not conform

to the socially expected normal behaviours and actions that align with being masculine.

Males differ in the extent to which they demonstrate different masculinity ideologies (Addis & Mahalik, 2003). As a social power hierarchy is present according to masculinities portrayed, individuals' power standings within society are based upon the type of masculinity they perform. For example: heteronormative masculinity holds the highest power ranking, and any other alternative form of masculinity is subordinate in comparison including marginalised masculinities (Courtenay, 2000). Gay, rural or lower-class men often display different behaviours as alternative forms of masculinity when the heteronormative does not apply in their situation.

A heterosexual male maintains power within society through his heteronormative (dominant heterosexual) status. When this is breached, individuals lose their position in society and the associated power that comes with enacting the dominant heterosexual norm. For this reason, males construe themselves not only by adhering to masculine norms, but also by opposing any associated characteristics, behaviours and actions of being a woman (Mahalik et al., 2007).

Through discussions with individual members of the New Zealand male population, it is possible to observe the within-population masculinity variations engaged upon. In doing so, this study will have the means to gain a deeper understanding as to why certain males choose to engage in safe sexual health behaviours more than others, but also what inhibits some males from doing so.

It is important to understand how different masculine ideologies are supported if we wish to alter the way actions are categorised and endorsed within society. Furthermore, by discussing and making males consciously think about implications of masculinities on sexual health responsibilities and behaviours we may be able to bring about a move in the way males think about their own health behaviours. We have the ability to bring to the forefront the importance of looking after oneself regardless of social expectations or gender-roles, and potentially change the way males view gendered health behaviours. Re-negotiating health-maintenance behaviours is one way to improve lives within the male population (Addis & Mahalik, 2003)

## **SEXUAL HEALTH**

It is assumed that when a female hits puberty, she will automatically start taking the contraceptive pill (Brown, 2015). This unspoken assumption however is not accurate, making the need for preventative and protective tools to be used in the event of sexual activity even more imperative to avoiding unwanted consequences such as pregnancy or STIs.

Within the concept of masculinity, denial of sexual health prevention, protection and management tools such as the HPV vaccination align with the masculine ideal of not appearing vulnerable. They do however also oppose the notion of a male remaining in control in all situations (including sexual activity). Due to this ideological masculine mentality, the male population in particular is at higher risk of contracting STI's including HPV as they are often invisible to the public eye and considered a non-issue. Unfortunately this is not the reality, as men

continue to be at risk of contracting new infections throughout the entirety of their life (Blödt et al., 2012).

Those males enacting alternative forms of masculinity compared to the heteronormative approach in particular are considered to be high-risk for performing dangerous actions and behaviours. This is because alternative forms of masculinities may include dismissal of heteronormative risks and may include the likes of numerous different sexual partners or engaging in unprotected sexual intercourse (Courtenay, 2000). With a lack of screening programmes, the male population within New Zealand need to be more aware of the health issue at hand and need to be educated regarding protecting themselves. Sexual health is not a one sided responsibility. A male may be protected through use of condoms, whereas a female may protect herself from pregnancy utilising an intrauterine device, but when it comes to a gender neutral-form of protection, such as the HPV vaccination, who takes responsibility and why?

Although condoms are considered alternative forms of protection from STIs, they do not always 100% cover all areas of skin to skin contact when engaging in sexual activity (Seqirus, 2017b). For males however this has been the only form of contraception and protection available on the market for a large period of time (Castro-Vazquez & Kishi, 2007). The availability of contraceptives in the past has influenced and normalised whom the responsibility for safe-sex belongs to. (Oudshoorn, 2004)

Without further preventative or protective innovations being directed at males, the responsibility for sexual health will continue to remain a female role. This is

extremely important to address as without renegotiation of masculine identities we cannot move forward to develop new health technologies or materials targeting sexual safety (Oudshoorn, 2004).

It seems the male reproductive body has become invisible, therefore males are unaware of the high risks associated with STI contraction (Oudshoorn, 2004). Unfortunately over time the association between condoms and contraception has become so strong that individuals now discount their use as protection against STIs also (Castro-Vazquez & Kishi, 2007). For this to change, renegotiation of the male gender-role and associated masculinities may need to occur. The only way this will happen however is by bringing about discussion to normalise alternative behaviours.

In addition, with women being viewed as vectors of STI transmission but also as gatekeepers to the use of condoms when a heterosexual act is engaged upon by two parties, does this not make the issue of gendered sexual health behaviours even more important to discuss and understand? (Bowleg et al., 2015). Especially when masculinities are fluid and multiple!

By creating discussion and gaining an understanding about how sexual health decisions are reached, we have the ability to make a change! Renegotiation of masculinities and normalised gendered language and behaviours can be changed so that it is possible to increase male vaccination uptake rates in order to best protect the entire population, not just one half of it, only females.

## **RESPONSIBILITIES**

The use of the HPV vaccination is deemed unnecessary to males due to their belief in being invincible to any form of illness, whilst opposing any feminine behaviours such as caring and tending to one's own health. In addition, as per their ideological gender-role, females are to be responsible for the care of others. Because of this, females are left with the responsibility of being in charge of both their own and their partners' health in its entirety.

According to Good et al. (1989), gender-role conflict occurs when males are less likely to ask for help from a health professional regarding health status due to displays of masculinity. For most males it is the females in their lives that both monitor, and manage their health and medical appointments - wives, girlfriends and mothers alike (Courtenay, 2000). There are clearly different values placed on health promotion and prevention tactics according to gender. Those males attempting to take greater responsibility for their health face large barriers – going against the masculine norm (Courtenay, 2000). For these behaviours to successfully become normalised in the future as the public health system is crying out for, renegotiation of what it means to be masculine needs to occur.

Gender-role conflict can be seen to affect males' health seeking behaviours such as rejecting the use of protection or preventative methods that aid sexual health due to the requirement of not admitting to weakness or vulnerabilities (Good et al., 1989). Being seen adhering to unmanly behaviours such as health promotion results in social rejection and loss of status. By default, it is expected that females therefore bear the burden of being responsible for the sexual

health of a relationship. Additionally, if one's partner is not well known or there is a lack of trust, the female will automatically assume the responsibility of sexual health protection and prevention as it is unlikely that there is enough knowledge about previous sexual partners to feel safe engaging in sexual activity unprotected (Brown, 2015).

A male's life purpose previously consisted of being responsible for carrying on their legacy through reproduction. High value is placed on reproducing as a male and therefore it is extremely significant to his identity as a man. Because of this, when abnormalities are associated with this function, health promotion and help-seeking behaviours are less likely because they are ego-central (Mahalik et al., 2007; Addis & Mahalik, 2003). Rejection of these healthy "feminised" behaviours or professional help also occurs in an attempt to maintain autonomy and control over decision-making processes to once again appear masculine (Mahalik et al., 2007).

This idea of reproduction as a role in life however has changed somewhat in today's era. Kelly et al. (2017) notes that the act of engaging in sexual activity is not primarily for the purpose of reproducing anymore, it is now mainly used as a source of pleasure. This is where the female responsibility lies. To ensure their male counterpart experiences pleasure when engaging in sexual activities.

As per the 'coital imperative', dominant norms of heterosexuality prioritise men's sexual pleasure over women's during intercourse (Kelly et al., 2017). For this reason, as condom use is noted by Kelly et al. (2017) to be a distraction from the pleasure of the act occurring, alternative forms of protection (primarily for use as contraceptives) need to be looked into. By default the female therefore

becomes responsible for the use of these alternative methods to ensure her partner is pleased whether it is at her own expense or not.

With pleasure as a strong motivator behind engaging in sexual activity, risky behaviours have become the norm. Masculinities have promoted the likes of unprotected sex and multiplicity of sexual partners. These behaviours significantly increase the risk of acquiring an STI however are not acknowledged as risky due to females being viewed as the STI carriers. As a result it is seen as a female responsibility to ensure any STIs are not transmitted and hence they are responsible for the prevention, protection and management of sexual health.

## **DISCOURSES OF GENDER AND SEXUALITY**

Discourse can be defined as the expression of thoughts or beliefs through communication. In the context of this study, both sex and language are resources utilised to create identity and gender through performance (Courtenay, 2000). Again we refer back to Butler's (2011) performativity theory by stating that commonplace communication and speech acts are performative (Courtenay, 2000).

The way we engage in discursive practices influences our understandings of roles, subjectivities, performances and language both written and spoken. This plays an important function, dictating how we see the world and the roles or identities of ourselves and others within the world we live. Our "language constructs certain versions of social reality and reflects the culturally influenced discursive resources that speakers have available to them" (Bowleg et al., 2015,

p. 314). Discourse can be both constructed and constructive therefore what we understand to be characteristically normal masculine actions are likely constructed by the on-going societal use of pre-existing dominant actions and terms, and as such these provide authorisation and acceptance of these understandings (Bowleg et al., 2015).

The norms and expectations associated with each gender-role impacts the discourses performed and utilised on a daily basis. These ideologies and expectations, much like rules, shape and inform us of the discourses we view as acceptable, dominant and normal in a social setting versus what is not. For example in the context of STI risk, heterosexual women are constructed as vulnerable, therefore need to use protection, however men are not. Males are deemed untouchable despite their increased risk of STI contraction as a result of fulfilling masculine expectations of performing risky behaviours (Bowleg et al., 2015). Because social structures accept this gendered public health view of STI vulnerability and allow the belief that that females are vulnerable and men are not to be reinforced, we find that men are inclined to openly discuss and engage in unprotected sexual activities with multiple partners more than females, as they ignore the risks that pose.

As per Holloway's (1989) trifecta of sexuality discourses, specifically the male sex-drive discourse, it is natural and normal that a male is expected to always desire sex regardless of the context (Bowleg et al., 2015). This discourse overpowers logic that warns against engaging in this kind of behaviour when protection is not available. In the context of sexual health responsibilities, the on-going use of this discourse in particular allows males to be irresponsible

regarding sexual health and for this to be a socially accepted, normalised practice.

Under this discourse a woman does not desire sex as much as her male counterpart, however she is to submit to his need for pleasure. In the event a female does want to engage in sexual intercourse when there is a lack of protection, she is labelled promiscuous. This promotes shame and guilt within the female and hence influences her sexual health behavioural actions going forward. To avoid being labelled as such she will take on the responsibility for sexual health protection in an attempt to save her reputation (Kelly et al., 2017).

According to Castro-Vasquez and Kishi (2007) the manner in which one converses is considered a marker of masculinity, therefore it also impacts on his identity. By following cultural narratives, dominant norms are often portrayed through language including hegemonic masculinities. To explain, a male is normally seen as the sexually dominant party during heterosexual relations. The machismo image associated with this is created in a way we can understand by linking characteristics considered norms of both masculinity and fertility (Oudshoorn, 2004).

These cultural norms associated with masculine performances are validated, reinforced and patrolled through use within society and mass media (Castro-Vazquez & Kishi, 2007). The more they are performed, the more they become normalised and expected as part of the gender-role, much like a stereotypical belief (Courtenay, 2000).

Females are typically stereotyped within society in one of two ways. One being pure or innocent, the other being portrayed as promiscuous or easy. The

categorisation of the individual however is determined by their engagement in sexual activity. To be portrayed as promiscuous has negative connotations that result in a loss of status within society. The same cannot be said for males however as their social status remains the same regardless of their involvement in sexual activity (Kelly et al., 2017).

The importance of engaging in sexual activity to males and females differs significantly. To females it is motivated by emotional closeness, whereas to males it is motivated by a being a conquest, release or another form of pleasure-seeking (Kelly et al., 2017). This aligns with Holloways (1989) have/hold discourse whereby females will engage in sexual behaviours for the purpose of maintaining a relationship whereas males may do so for the purpose of procreation (Bowleg et al., 2015).

In the modern world, we are now however seeing a slow change to an increasingly permissive society. Attitudes regarding females and condom use are changing from being looked at in a negative view to a positive view that one is protecting themselves (Brown, 2015). Whilst we see this change occurring within society it shows that it is possible to change views and normalise alternative discourses over time. As a result in this change to a more permissive outlook we are now observing more gender equality regarding sex-drive, however double standards still present themselves in society (Bowleg et al., 2015). This is evidenced by the lesser reputational benefits and respect attained from society by women compared to men when enacting the same behaviours. Unfortunately this occurs in an attempt to deflect social attention away from risky masculine behaviours onto “others” (including females), in order to avoid

judgement oneself (Bowleg et al., 2015). These sexual double standards are often expressed through discourse and gender-roles in social situations.

For this reason the male population has an opportunity to reconstruct the dominant norms portrayed within masculine discourse as the active agents utilising it in social interactions (Courtenay, 2000). This therefore puts males at the centre of change. It is extremely important to focus on altering commonplace beliefs as we can recreate the social structures that were initially formed which both facilitated and limited social practices according to gender (Courtenay, 2000).

What is considered the norm and is performed by one male in a group is often repeated by another. The more a behaviour is spoken about or enacted, the more this behaviour influences other men to perform in a similar manner. The discourse utilised to portray masculine activities and behaviours (such as risky sexual behaviours) influences others significantly as it informs and guides them regarding acceptable versus abnormal behaviours of a male in social situations (Mahalik et al., 2007). This social proof is increasingly effective when one views himself as similar to others when performing his gender-role within the social group (Mahalik et al., 2007). By altering the functionality of groups' conversational behaviours, a ripple effect may be produced whereby the opportunity to change not only one but numerous males' approach to sexual health responsibilities is possible.

In the context of social engagement, if a female is often spoken of holding secondary status to a male, she will be thought of in this manner in all aspects of life including the bedroom. In turn this results in attaining a submissive

gender-role in accordance with the patriarchal society we live in. Gendered sexual health responsibilities are henceforth influenced by socially constructed power relations which work in accordance with the dominant ideologies and norms of masculinity portrayed in conversation (Courtenay, 2000; Addis & Mahalik, 2003).

Discourses are however flexible, therefore numerous beliefs can be applied to any one context (especially masculinities), meaning that the opportunity to alter the way people and specifically males think about sexual health responsibilities is still open to change (Fiaveh et al., 2015). To have any chance of changing the way individuals view gendered sexual health responsibilities including the HPV vaccination, the discourses they arise from need to be altered

The gender imbalance identified needs to be understood further in order to adjust discursive use promoting the belief that females should be in charge of sexual health responsibilities. Males need to look at changing these views and step up to take responsibility of their own sexual health as it is them that will be personally affected in the long run.

As time has passed, only a small amount of studies have been conducted focussing on the effect of gender on STI prevention (Kerrigan et al., 2007).

Even less have observed how socially accepted views of what it means to be a male have influenced the sexual behaviour of upcoming generations. Because of this, there is an opportunity to add to the current literature.

This study will utilise critical discursive psychology as its focus in order to achieve an understanding of the way males construct social identities (including masculinities) through discourse and also to question how these social identities

construct and influence male personal identity formation (Bowleg et al., 2015). By gaining a deeper understanding of how males are constructed and how they construct others, this may lead to further information regarding why the male population chooses to utilise sexual health prevention tools such as the HPV vaccine less than the female population.

We find ourselves now in an era whereby there is a public health need for males to assume greater responsibility for safe sex than currently do (Bowleg et al., 2015). It is morally wrong to allow young generations to grow up thinking STIs are inconsequential or easily treatable (Brown, 2015). Today's generation does not recognise the extent and intensity of potential consequences of risky sexual behaviours. Social rankings are more important than sexual health, priorities in life are out of order. The only way to eliminate these issues is by changing the way we talk about and act on such behaviours.

It is imperative that we strive to align masculinity ideologies with safe sexual health behaviours as without alignment there is no room for technological or innovative developments to protect against STIs further.

When we socialise and discourse is utilised, we use this as our basis for thoughts going forward in life. If we continue to utilise the same discourses that are already established, we become unable to develop further ideas without thinking outside the sphere of what we already know. For scientific and technological innovations to occur (including the development of future sexual health protection tools or new sexual health protection programme implementations), we need to allow alternative discourses to come forward. We

need to deviate from the norm, and the renegotiation of masculinities to include the concept of safe sexual health could be the very start of this.

# **METHOD**

## **RESEARCH DESIGN**

As a female researcher, it was imperative that an inductive study was conducted in order to better understand the way males think about sexual health tools and the way they make decisions regarding sexual health device usage. This ensured an authentic male perspective was attained and was not significantly influenced by the female stance when questioning participants.

This study seeks a posteriori insights intended to provide evidence towards understanding how males understand and respond to HPV vaccination and other sexual health tools alike. By conducting a qualitative study in this way, validity is established. Participant responses are as realistic and accurate as possible, as they pertain to each individual's own life views and lived experiences regarding sexual health behaviours, roles and responsibilities.

An interpretivist approach following a social constructivist paradigm allowed for development of thought and theory as data was acquired. As a result, grounded theory was one methodology drawn upon, especially during data analysis.

Using this subjective method with a female researcher and male participants, researcher bias may be likely (Mooney-Summers & Ussher, 2010). In this case however it was made extremely clear the gender difference had no impact on participants. Male comradery was shown through an established 'boys club' environment and 'ladsy' culture making jokes amongst one another about stereotypical female life roles within the focus group.

A qualitative approach was necessary in this study to allow each participant to authentically express their own unique opinion whilst also feeling they could self-disclose and freely explain their personal thought processes regarding sexual health decision-making.

## **RECRUITMENT**

Approval to conduct the study was attained from the Massey University human ethics committee. In order to recruit participants, a combination of purposive sampling and snowballing was utilised due to studying a hard-to-reach population. This was similarly done by Ibañez et al. (2017), DiStefano et al. (2012), Kelly et al. (2017) and Remes et al. (2010) in order to attain participants that met the requirements of their studies. In this case utilisation of these recruitment methods is essential due to the need for participants that had been sexually active in the past year within a heterosexual relationship. Study involvement was advertised via the social media website 'Facebook' due to its popularity and therefore large outreach to attract the target population: 18-30 year old heterosexual males. Kelly et al. (2017) determined this to be a successful form of outreach when conducting an extremely similar study with a focus on females, femininity, and the influence of gender roles on contraceptive use, rather than a focus on the male perspective alike this study.

The advertisement (Appendix A) was circulated through the Facebook pages of associates of the researcher as a method of social protection for the researcher to avoid public defamation or personal criticism due to the study's focus on sexuality and sexual behaviours. This was also to furthermore ensure there

were no ethical complications with potential recruits perceiving the study wrongly as a chance to make sexual advances towards the researcher or to behave in an inappropriate manner due to the sexual nature of the topics of interest.

To avoid discouraging any potential recruits, advertisements utilised the terms sexual health, protection and responsibilities as opposed to focussing on HPV and vaccines to avoid any misunderstandings in the case individuals were unaware of what HPV is. This also served to disclose topics of interest openly before individuals signed up for involvement. Due to the sexual nature of topics, an opt-in approach was employed and participants were to express their interest to the researcher via the email provided on the advertisement. By targeting masculinities within the advertisement as seen in Appendix A, individuals may have been more willing to participate when being represented as brave and heroic pioneers for kiwi heterosexual men speaking out about sexual health responsibilities as was successfully utilised by Oudshoorn (2004).

Due to the sensitive nature of what may be discussed, study aims, topics and procedures were disclosed in both the advertisement and information sheet provided for participants. Potential recruits could then decide if they wanted to be involved in the study and let the researcher know by email.

## **PARTICIPANTS**

Participants were accepted into the study upon meeting the inclusion criteria which specified that potential recruits must be New Zealand citizens, biologically

male, between 18-30 years, in a heterosexual relationship, and have been sexually active in the past year (from date of initial interview).

Individuals aged 15-24 years have been identified as accounting for 50% of all new STIs acquired in the United States (Centers for Disease Control and Prevention, 2013). Because of this, the age range required to be included in the study is 18-30 years. This includes the identified high risk group and ensures all participants are legally engaging in sexual activity as per laws of the Crimes Act (1961).

Additionally, in New Zealand the HPV vaccination is funded between the ages 9 and 26 years, therefore this age range accounts for opinions from those that both had and did not have the opportunity to receive the vaccination to note if any differences of view arise due to the vaccination program roll-out (Ministry of Health New Zealand, 2017).

This study specifically is interested in studying New Zealand citizens in order to benefit the future health of the country's population in addition to the fact that as a small country in the world it is often an understudied population. The hope is that this study's findings will add to the sexual health research field and aid understandings regarding male use of sexual health tools to improve STI/STD incidence and prevalence rates going forward.

A focus on heterosexual males was important as currently a significant amount of research on STDs and STIs, mainly HIV links to HPV, has been conducted with the men who have sex with men (MSM) population group due to their high risk of contraction. This leaves a gap in the literature and need for further research on those males that make up the majority of the population. By

understanding these males' perspectives, future research may also aid the health promotion of female counterparts by association. This provides the most benefit to a larger portion of the population as a result.

If an associate of the researcher wanted to participate, this was assessed on an individual basis by looking at the closeness of the relationship between researcher and potential recruit, and whether there was prior knowledge of study topics or themes having been discussed already within the relationship. If there was any record of this having been present, the individual was not accepted into the study to ensure ethical misconduct such as participant and response bias did not occur.

A small sample size was utilised due to the need for in-depth descriptive data. This was supported by Fahs (2014) as it was noted that participants required for studies focusing on the topic of sexuality can be hard-to-reach due to a lack of desire in the public to discuss such matters. In fact, within this study, after conducting five individual interviews and a focus group, difficulties recruiting further participants arose. As a result of this, data already collected was assessed. Fortunately, this data was deemed rich enough on the basis of the preliminary analysis conducted.

Due to the quality of information attained, despite the small number of participants, adequate material was collected to provide an insight into the perspective of heterosexual New Zealand males (18-30 years). As this was a qualitative study, depth and quality of participant responses far outweighed the importance of quantity (Aurini, Heath, & Howells, 2016).

Participant ages ranged from 23 to 30 years, with the average age being 26.2 years. Two of the five participants were not born in New Zealand therefore this sample can be considered culturally diverse. All five participants have a background in tertiary study, with only one being a current student. At the time of the study commencement, two participants had been in monogamous relationships with their partner for five or more years, one participant had been with his current partner less than a year, and the two remaining participants had been in their relationships between two and three years. All participants in this study would be considered middle socio-economic status as access to health services is not unattainable due to lack of funds. Because of this, this group was ideal to ask about sexual health device use and prevention/protection tactics, as financial strain was not a significant barrier to the access of such items meaning the reasons justifying lack of use would be irrespective of cost.

## **PROCEDURE**

Once the participant had confirmed their voluntary willingness to partake in the study, a time and place was agreed upon by both the researcher and recruit to conduct an individual interview. This place was to be a quiet area to ensure the interview could be recorded clearly and accurately interpreted and transcribed for later analysis.

Upon arrival at the agreed location, participants were provided with a hardcopy of the information sheet (Appendix B) and were given time to read over this before the interview began to ensure they were aware of what would be discussed and their rights throughout their involvement period. The focus of the

study was described as being based around 'gaining an understanding about how males think about sexual health responsibilities and how this relates to sexual health protection tool use'.

Any questions participants wished to ask regarding the study were responded to during this time. Participants were also informed at this time that the individual interview was going to be audio recorded for the purpose of data collection and further analysis later. This allowed for rapport to be built between the interviewer and interviewee without disruptions such as note taking, and that during each interview full attention remained on the discussions being raised. Furthermore this allowed for the formation of further questions to ask throughout the interview, in order to attain a fuller understanding of concepts or topics that arose during the course of the interview.

Participant rights were explained before asking each individual to sign a consent form (refer to Appendix C). Whilst filling out consent forms, recruits were asked to select their pseudonym and write this at the top of their consent form. This ensured participant anonymity within the written findings report. At the time these were selected by participants, it was explained that these must not contain any information that could identify or link back to the individual. Upon completion of these steps, the audio recorder was turned on and interviews began.

## **Interviews**

Individual interviews followed a semi-structured format whereby main topic questions regarding sexual health, HPV, vaccinations, sexual health

behaviours, gender, masculinities and gendered responsibilities were asked according to the interview guide, as seen in Appendix D. The majority of questions asked were open-ended to encourage extensive, in-depth responses. This format allowed a flexible, exploratory approach as when further clarification was warranted, extra questions could be formulated and asked as necessary.

Questions asked at the beginning of each topic of interest were very broad or generalised, however as each interview progressed these became more specific to certain contexts or topics as was also conducted in the same manner by Kelly et al. (2017). Examples of this included initially questioning participants about their understanding of terms following through to more complex questions including what it means to be a male, the safe sexual health behaviours engaged in within their relationship, who bears these sexual health responsibilities and so forth. This allowed for understanding of whether participants had prior knowledge of HPV as a STI, and awareness of associated health risks.

Each participant was asked about their perception of STI protection and prevention options available to them, and what the likelihood of utilising these alternative options to condoms would be. Gendered sexual health responsibilities were discussed in which participants were asked for their opinion regarding who should be, versus who is, responsible for attaining and using each type of sexual protection material, and why this is.

Each of these questions followed the interview schedule in the same order to avoid question order bias and to ensure reliability of topics discussed in each interview. On the basis of the responses received from these interview

questions, where further information was required to better understand a topic, perspective or prior question asked, extra questions, not initially included in the interview plan, were asked as they arose.

When participants were proceeding too far off topic and information being provided was no longer deemed relevant to the study, participants were prompted and redirected to the question asked or topic being discussed. Upon completion of the individual interview, prior to the audio recorder being turned off, participants were then asked if there was anything they wished to add in order to aid further understanding of the topics discussed. The timing of these individual interviews ranged from 25 minutes through to 45 minutes. Following the conclusion of individual interviews, audio data was transcribed verbatim by the researcher.

### **Focus Group**

Each participant completed an individual interview before engaging in a focus group discussion with four other male participants. This allowed for each individuals' subjective view of topics to be disclosed. After all of the individual interviews were conducted, transcribed and analysed, the focus group discussion schedule was formulated. Questions to be asked in this focus group were shaped as a result of my preliminary analysis of individual interview question responses. Where the researcher felt further details were required to understand a topic or key theme, these questions were put forward for participants to discuss further amongst one another in the focus group.

Triangulation of these two methods (individual interviews and a focus group) was a strength of this study. It allowed for assessment of whether independent responses, opinions and views of individuals regarding sexual health and associated safe sexual health device use remained the same when spoken about in a social setting, or whether they waived when in a larger group. It also allowed us to establish whether these views and opinions were shared by others or not.

Discussion flowed surrounding topics of interest from the contrasting views of all participants. By utilising this approach, participants could disclose as much or as little information as they desired, in both a one-on-one and group scenario.

All five participants were contacted separately by the researcher to arrange an agreed upon time and place to conduct the focus group which was to occur over a maximum period of two hours.

Upon commencement of the focus group, participants were introduced to each other by first name and given the study information sheet (see Appendix B) to read over. At this stage the purpose of the study was re-iterated and participants were informed that the discussion would be audio recorded.

Participants were further reminded that anything discussed within the focus group was confidential and this information was not to be discussed outside of the study setting as it contained private information regarding topics of a sensitive nature to some.

Participant rights were read out and they were all asked to sign a focus group consent and confidentiality form (see Appendix E). On this consent form the

option of having results supplied to them was provided and participants could supply an email or physical address for these to be sent to if desired.

After this was all completed, the purpose of the focus group, to promote discussion surrounding sexual health in order to understand a male's perspective better, was again explained and the need for participants to allow one another an opportunity to speak uninterrupted was expressed. Participants were asked to respect one another's views but also to question things they were not sure about or to speak up when their personal belief differed to others' opinions. The audio recorder was then turned on and the focus group commenced.

Participants were prompted to talk about specific topics or key themes using predetermined questions to begin with (see Appendix F) and from this point discussion was allowed to freely flow amongst one another. These predetermined questions were to be discussed with the aim in mind of understanding each key theme at a deeper level.

By observing others self-disclosing information about sexual health topics in an open setting, a comfort net could be provided so those more reserved participants felt at ease to disclose sensitive information due to the fact they could see others around them were comfortable doing the same.

Different perspectives and opinions were expressed and the next question was not raised until all participants had contributed what they felt they wanted to and the discussion had slowed. This enabled the study to gain insight into group versus individual understandings and beliefs about each topic as was seen to be successful by Bowleg et al. (2015). By doing so, an opportunity to observe

the effect of homosocial bonding on the normalisation of sexual health responsibility discourses utilised within common conversation was also provided.

When participants' comments were no longer seen to be relevant to the study or discussion, participants were coaxed back to the topic through repetition of the same question or by moving onto the next one at the discretion of the researcher. When all questions surrounding key themes had been discussed, participants were asked if there was anything further they wished to discuss or raise within the group. It was at this point when discussion had slowed and participants had nothing further to say that the focus group concluded.

The audio recorder was then turned off and participants were thanked and supplied with \$30 petrol vouchers to compensate them for their travel arrangements and time.

From this point, transcription of the audio data collected occurred in the same manner as individual interviews.

The focus group method in particular was beneficial as it allowed for assessment of how well each participant was informed about sexual health tools currently available in the market to identify some of the factors contributing to sexual health disease prevalence rates. In addition to this, it normalised conversation regarding sexual health topics and brought about further conversational topics that provided extra information relating to understanding the way males think of sexual health as a whole.

Using a mixed method approach (both interviews and focus groups) was seen to be beneficial in prior studies by Khan, Mishra, & Morankar (2008), DiStefano

et al. (2012) and Remes et al. (2010) as this provided them all with the means to attain a greater depth of information from numerous perspectives in a holistic manner. Despite the similarity of Kelly et al.'s (2017) work, for this study the use of individual interviews was complemented by a focus group due to the sample size being significantly smaller. For this reason additional time and further opportunity to extract more information from participants was required to attain thematic saturation.

This was an extremely important factor in this study as the small number of participants and meeting time meant a higher quality of information was required to attain sufficient data.

## **ETHICS**

Through conducting this study social value is evident, as results will further inform us about the areas within society that require improvement or adjustments in order to reduce future sexual health disease incidence rates. It will also provide information regarding the best way to promote sexual health protection and prevention methods to males to achieve a beneficial adherence rate to sexual health devices. By better understanding the way males think about sexual health and how they make decisions regarding sexual health tool use, it is possible to bring about social change via the introduction of targeted intervention programmes or by recognising areas that require further education commencing at younger ages. In addition to this, by understanding the way males make decisions about sexual health behaviours and tools, this may

provide further insight as to how gender-roles or labels influence daily social processes.

Prior to study commencement, ethical approval was sought and attained from the Massey University Human Ethics Committee to ensure the study was both ethical and safe to conduct. Participants were recruited mainly through purposive sampling to ensure participants met inclusion criteria. The use of snowballing, however ensured fair subject selection as all those interested in involvement were welcome to apply. By doing so, no one participant or social group would be subjected to heightened benefit or risk over others.

Throughout the study, participants were not placed at any significant amount of risk. In fact, minimal risks were present in this study. At most, participants may have felt slight social discomfort discussing the topic of sexuality. On the off chance a participant felt harm was occurring, or topics discussed brought about memories that evoked emotional harm, this participant would be provided with contact details for support services in order to maintain their well-being. In saying this, throughout this study no participants asked for further support resources nor did any mention discomfort due to topics discussed. No participant declined to answer any questions or discuss any topics that arose in conversation.

All participants signed a voluntary consent form after reading the information sheet which fully disclosed the study purpose, measures involved and all associated risks (see Appendix B). As consent and confidentiality forms contained private information, these were collected and locked away in a cabinet where access was restricted to the researcher alone. Any data collected

from interviews or the focus group was transcribed onto files that remained password protected.

No one particular social group, nor participant, was put at any significant amount of risk at any stage of this study. In fact, minimal risks were present in this study. At most, participants may have felt slight social discomfort discussing the topic of sexuality. On the off chance a participant felt harm was occurring, or topics discussed brought about memories that evoked emotional harm, this participant would be provided with contact details for support services in order to maintain their well-being.

At all stages of the study participants were aware they could withdraw or refuse to respond to any questions or discuss topics. Confidentiality was ensured as all participants signed a confidentiality form and agreed that what was spoken about as a group or within the study was not to be discussed outside the study setting. In addition to this, all identifiable names were replaced with pseudonyms within all written reports to ensure anonymity of participants.

## **ANALYSIS**

Within individual interviews, each of the males maintained a strong opinion regarding the specified topics and this did not waiver throughout their interview. Upon conducting the focus group discussion, dominant voices emerged and were heard more than others, allowing the strong opinions from individual interviews for some participants to become inferior. Despite this, the entire group agreed with one another on all points and were comfortable enough to provide further information, adding on one another's comments. There was a

very evident comradery, 'boys club' atmosphere to the conversation as each member was willing to joke around and ridicule one another regarding the topics being discussed. Meanwhile they were also not afraid to question one another when unsure about a response. The majority of the responses from participants during individual interviews aligned with the responses provided during the focus group therefore making it evident that there was no effect of researcher bias throughout the study. There were no obvious changes in perspective from individual interviews to a group scenario aside from the views of Slug and MPB. MPB initially explained that sexual health responsibilities and associated protective/preventative tool use were to be shared between partners. Towards the end of the focus group, this view was replaced by the idea that:

*The woman is the pregnant one, so then, so much more responsibilities and consequences are on her shoulders..... They've [the female in the relationship] got all the power, so they need to have as much of the responsibility as possible (MPB)*

Slug however changed his perspective from the initial belief that social pressures were an influential factor of sexual health to his focus group perspective of being unsure as to whether social pressures impacted sexual health behaviours at all.

With the exception of these participants' slight change in opinions, there appeared to be no effect of social desirability bias nor social influence. It must be noted that Noop-noop did not enter the focus group discussion until it was quarter of the way through, therefore his lack of opinion/voice was missing from the conversation initially.

Certain topics centralised on during individual interviews did not elicit as much information from participants as was desired. The topics surrounding 'gender' and 'masculinity' were not easily conversed about by two of the five participants. This could be attributed to the on the spot nature of the question, and for another participant the uncertainty of the definition of the term 'masculinities'. Two of the five participants expressed they needed more time to think about these topics and responses as it was not something they had thought about or considered in their life before, with one additional participant mentioning during interviews the difficulty of answering questions, and comparing some of them to existential questions a lecturer might ask at university.

By conducting five individual interviews followed by a focus group discussion consisting of all five participants (Slug, Mike, Noop-noop, MPB and Fatboy), it became very evident, post analysis, that five inter-related key themes provided the basis for reasoning as to why decisions made by males about sexual health are made, and why sexual health issues are still present today. Unfortunately the data collected did not explain why male vaccination uptake rates are lower than that of females. However it did provide insight into a deeper understanding why this may be via emergence of alternative information such as the way males think about sexual health tools/precautions, and how their gender-role in society impacts on the sexual health actions of not only themselves, but also others.

Thematic content analysis was utilised to identify the five key themes and generalised thoughts of all participants. By utilising a social constructionist framework and interpreting transcripts on the basis of social content and historicity, it was possible to gain an insight into why males think the way they

do about sexual health device use and further information about the factors within society that influence these decisions.

Each individual interview was transcribed and then independently analysed line-by-line. Interviews were repeatedly listened to whilst transcripts were re-read to ensure accuracy of transcripts and engrossment in the data as suggested by Gill (1997).

As suggested by Patton (cited in Marchi, De Alvarenga, Osis, & Bahamondes, 2008), the following thematic analysis process was followed. Points mentioned that were considered by the researcher as being of interest, relevant to the study or vital to understanding a males perspective regarding sexual health underwent preliminary coding to allow for pattern emergence. This coding included words and concepts considered as being important to study topics.

Each newly mentioned topic of interest was also coded for. As an increasing number of codes arose, similarities surfaced and any links or trends that were forming became evident. These similar codes were then combined to form a category relating to or identifying a key theme which had emerged from the data as seen in Appendix G. During this time memoing also occurred as was shown to be successful by Kerrigan et al. (2007). This meant that any ideas from the researcher that emerged due to links between categories as a result of codes, were noted (Glasser, 1998). This is seen to be a beneficial process within grounded theory methods, therefore was implemented to further aid later thematic analyses.

Key theme emergence and classification of codes was vital to understanding sexual health thought processes from the male perspective better. It also made

it possible to note if any differences in constructions or beliefs about sexual health were present between individual interviews and focus groups. Key themes were progressively made clear as participants expressed their views of what they felt. This was imperative in order for the researcher to get a better grasp of the male perspective regarding justification for sexual health behaviours enacted, and decisions made about associated device use.

By triangulating coded transcripts and memos, the most information could be extracted from the data presented.

After all individual interviews were transcribed and independently analysed, a secondary analysis occurred whereby each transcript was assessed alongside other participants' transcripts and they were each compared. This component served the purpose of distinguishing and recognising common themes, as noted from one interview to another, in order to gain an understanding of the group and overall stance regarding key themes discussed by participants. Importance of key themes was further made evident through the frequency and occurrence of code use throughout transcripts.

This method however, also served the purpose of revealing information or codes that differed to the group consensus, but still held significant importance to individual participants. By noting these similarities and differences it was possible to start to understand what factors had impacted sexual health decisions made and to understand where the basis of these sexual health behaviours came from. This also aided comprehension as to how sexual health responsibilities are maintained and how these affect males' perceptions of

sexual health responsibilities and behaviours in the context of protective and preventative STI devices, such as the HPV vaccination.

To gain an increased understanding of the topics that arose during individual interviews, clarification questions to be asked in the focus group discussion were formulated on the basis of participant responses to initial interview questions. This was shown to be beneficial by Cook (2011) as it ensured participant perspectives and responses were portrayed in the desired manner.

When the focus group data had been transcribed, this was analysed with the same method that individual interviews had been. The only addition was the comparison of key beliefs and opinions each participant held during individual interviews versus in a group scenario to note any changes that may have occurred as a result of social influence.

## FINDINGS

By listening to and analysing individuals' comments from both interviews and focus groups, it was possible to understand the way participants socially construct understandings regarding specific concepts according to different situations. Few prior studies have assessed understandings or perspectives regarding gender ideologies, and how these affect preventative or protective sexual health behaviours being actioned. This is where this study adds to the field. By attaining this information, it can be used to improve the implementation of interventions and identify factors worth addressing in future public health planning.

Throughout the analytical process within this study and also similarly noted in DiStefano et al.'s (2012) paper, Rhodes' (2009) 'risk and enabling environment' heuristic made sense of the persuasive factors involved when trying to understand how decisions are made within the lifetime, especially in regards to sexual health. On the basis of this framework, it was possible to understand how numerous interlocking factors at micro and macro levels of society, alongside effects of the environment and culture, can have an impact on decisions. By noting the influential factors identified on the basis of this paradigm, it was possible to observe how the scarcity or existence of environments that permit and promote healthy behaviours within men, strongly motivated decisions regarding sexual health. This included summarising the factors that significantly swayed decisions to receive or not receive preventative means or treatments when required.

After assessing transcripts, specific themes were identified as being significant to understanding the male perspective about sexual health. The five key themes observed through thematic content analysis of individual interviews and a secondary analysis of focus group transcripts are as follows: Effect of Gender-role expectations and societal influences (pressures), provisional and modal educational issues, ineffective advertising, marketing and awareness, lack of ease and accessibility to desirable sexual health devices, and the reasons for where responsibilities may lie.

### **EFFECT OF GENDER-ROLE EXPECTATIONS AND SOCIETAL INFLUENCES**

Within society individuals are expected to display gender-specific characteristics and follow the actions, behaviours and cognitions that adhere to their perceived sex. This is known to be their socially constructed gender-role. Alike this, society provides an unwritten set of rules for individuals to comply with certain customs, behaviours, actions and beliefs in order to fit in. These rules guide interactions between individuals and in part determine how we view and react to the world around us.

Adherence to ideological and stereotypical actions or behaviours result in their confirmation as social normalities and henceforth emphasise ongoing beliefs that these actions and behaviours modelled within society are acceptable or socially correct.

When an individual defies these norms they can be seen as a social outcast, therefore members of society usually try at all costs to adhere to the social rules

system to avoid exclusion. As a result of these socially determined norms, individuals are pressured to act or behave in certain ways - following social rules to avoid feelings of rejection or being ostracised. This adherence and lack of revolt only allows these behaviours to continue over time.

When participants were asked about social pressures that may impact on sexual behaviour or use of SH tools, the idea of a female getting pregnant and being sent to family planning was spoken of as a behaviour that had been normalised within society:

*M: girl gets pregnant, send her to family planning. You used to see girls going in there all the time.*

*S: mmmm*

*M: it was a bit of a joke back in the day*

This is an issue within itself as it has normalised the belief that it is okay to 'fix the problem' after the event, therefore allowing it to happen, as opposed to preventing it. It is these very thought processes and discourses utilised within society that prolong SH issues.

In addition to this, these behaviours normalised by society over time, were expressed as having a large impact in directing females down a certain path: *"I feel like society's geared it [SH responsibilities] towards the girls. Like the government will subsidise to that"* (Slug).

*S: they've geared it that way – the mum will take the girl to the doctor at a certain age and then says...*

*NN: birth control*

*S: ...you're on this now basically or you're not going out*

These same paths participants spoke of being geared towards can somewhat be described as the modernisation of society. This modernisation has been driven by institutions and the government as they have been shown to historically help females more than males when it comes to SH. Females have had far more opportunities to be educated about and made aware of SH diseases whilst receiving subsidies for SH tools, where males lacked the same benefits. The provision of funding for research and subsidies has made access much easier for females than males and has led to a female dominated industry. Participants alluded to the ongoing issue of more money being invested into female research and therefore advertising and marketing when compared with males – *“more money’s in female research than there is in males” (Fatboy)*. Because of this, females seemingly have increased chances of attaining greater awareness and education about health issues than males, as they have better access to SH information as needed.

As a result of the extra attention provided towards SH for females, the responsibility of females carrying out safe SH behaviours within the relationship has progressively developed. This comes as a result of the very institutions and organisations that promoted these safe behaviours in the best interest of improving health, unknowingly creating a new social issue by extending the divide between the genders.

This was consistent with later conversations in the focus group where Mike mentioned the unwritten/unspoken rule, much like a social normality, for parents to ensure their daughters are on birth control from their mid-teenage years: *“like*

*when your girl turns 14 or whatever age, take her to family planning, get it done.”*

MPB followed this up by expressing: *“I think that’s just responsibilities as parents”*. This only further evidenced this use of discourse as a normal social belief or expectation within the parental role.

Specific factors were found to influence the decisions made regarding sexual health behaviours enacted more so than others. The individual factors mentioned by participants that may have socially persuaded or pressured individuals to act, behave or think in a certain way regarding sexual health, to avoid social discrimination, are what are attended to within this theme.

The important socio-environmental factors spoken of by participants that influenced behaviours, actions and thoughts include: friends, family, culture, being in a relationship or not, having trust and security in the relationship, gender-role expectations such as masculinity and femininity, social expectations of gender-performance, normalised social behaviours, life exposure and experiences, rationalism for need for protection, showing off or peacocking, consequential impacts on others, protecting themselves first and responsibilities being shared.

Influence of the family or parents often was believed to involve educating the children. In fact one participant mentioned the occurrence of his parents scare mongering him as a child in order to get a message across regarding the consequences of not being safe:

*For me it was more the just being shit scared of all the bad stories my parents told me about what could go wrong if you caught*

*something, if you had kids too young, just all that shit. And it sorta got in my head, and I was like not ever not going to use one [condom]. (Noop-noop)*

This therefore was seen to strongly influence the way this particular participant thought about SH tool use going forward in life.

The exposures individuals become accustomed to in life when growing up help determine behaviours and actions that are right, wrong or needed in situations. *“It’s kind of like a live and learn thing”. (Fatboy)*

The role of friends was also noted as persuasive in determining the gender-role behaviours expected as a male and also impacted on the responsibilities one believed they held. Firstly, participants looked at peers as a “catch-net” or second line of defence when they did not carry a condom on their persons but required one.

*I guess socially it’s like... the way I see it, it’s like a catch net. So you hope if you forget to bring a condom, some of the people around you would be like, or your mate would be like hey here’s a condom if he sees you flirting with a girl and knows you’re single. Like hopefully he would, there would be other people that would help you that way as a catch net than not. (Slug)*

*Amongst my friends there was always someone’s wagon, someone’s car had condoms stashed in it or... before you go away on a trip someone would be like ohhh, I’ve got a box just in case someone gets lucky. (Slug)*

It must be noted however that this belief could also be counteracted by the negative influences of peers. These could include promoting promiscuity regardless of the presence of protection, with the intention of attaining a positive social standing or reputation as 'the man' or a player'.

Fortunately, opposing this view, it was expressed by participants that when mates gathered together, if one was poorly educated about SH, the others felt it was their job/rightful duty to educate the friend and offer advice to ensure they were up with the play.

*Maybe you're just talking at lunch or something and like, pull the mate aside and tell them a certain step he should know that he hasn't heard of or something maybe? Like yeah, socially we support each other to keep each other up to speed maybe. (Slug)*

*I think that might be common among guys.....I've heard so many stories from my guy friends being like oh mate I got tested, you do not want this, you do not want that, ahhhh so bad. (Noop-noop)*

The influence of friends was also shown to impact a males' sexual behaviour around females, as 'peacocking' was mentioned by participants to be a normalised behaviour. This was explained as the behaviour of showing off in front of a social crowd in order to attract a sexual partner. When questioned about the actions of this male being influenced by those around him, it was further clarified that when the goal is achieved and the partner has been attracted, the external pressures disappear and the peacocking stops. In this case, a different surrounding or setting resulted in different actions. He may decide to engage in SH behaviours without protection when being persuaded by

others, however when the partner is attracted and it is just the two individuals, motivations may change as the pressures disappear and he becomes aware of the situation – *“as soon as you go into the bedroom though, I don’t really reckon it’s a social perception, it’s more you’re private” (Fatboy).*

Over time society’s categorisation of individuals has altered, as has the gender-role expected of them. Responsibilities that were once attributed to males are now shared between both genders. Social evolution has brought with it drastic changes in which participants voiced. These included the development of unspoken social requirements expected of an individual before they can progress into the next phase of life to have children. Somewhat of a social checklist has developed specifying an order of life events:

*Like it’s society and different cultures have sort of pushed it to like a you know, you’re not ready for a kid yet, ya know, you need a house, you need to have a car, you need to both have good jobs, you need to do this, that and fucking everything. It’s just kinda like, back in the old days, one person would work; the other person would stay home and take care of the kids. You wouldn’t worry about a house and quite often people would be living with their parents like when they had their first kids. (Noop-noop)*

This was further supported by Slugs belief:

*Socially, I believe we’re at a point we’re having kids so late its causing health problems....so that shows how the power of influence on society can push you back. Like it’s driven us to think, oh we have to get this, this and this and then we can have kids.*

As a result of these unspoken expectations or social requirements, society determines the situational appropriateness of SH tool use such as when a female is expected to be on birth control versus not and whom should carry the condoms. This in turn is seen to affect the normalisation of such SH behaviours and therefore also the average age of childbirth; identified by participants as getting older despite the body's capability of having children from a younger age.

These social views have drastically changed from earlier generations perceptions of SH and roles or responsibilities one should uphold in a relationship. As views have changed over time, influential factors also have, in turn affecting the rate in which SH tools are utilised. This was mentioned by participants with reference to the 'hippie days' and the associated 'free love movement':

*NN: like in the 70's, the free love movement – like AIDS was a huge thing, whereas AIDS these days is, like it's big, but it's...*

*M: it's well managed*

Participants further discussed the influence of earlier societal generations' views and how these have impacted the views we hold today. The following was said with reference to the increased use of condoms as protection from STDs/STIs nowadays:

*I kind of feel like it's gotten to the point where we look back at it and we've learnt from it and gone away from what they used to do because we realised that that's not the way to do things. (Noop-noop)*

Another fundamental aspect to note is that societal rules and norms, pressures, expectations and influences all severely impact decisions regarding sexual health actions and behaviours. This key theme was identified as one of the largest reasons for why we perceive ideas as we do and how decisions are formed in life. It also alludes to what behaviours are normalised in society therefore it plays an imperative role in further understanding the male perspective on sexual health tool use.

Within society, the 'normal' [internalised gender-role] is usually what is strived for. What is considered to be 'normal' dictates what is wrong or right for individuals regarding the way to appropriately behave in situations; what to do, how to look and more importantly as a male or female it sets out what is expected of them in their gender-role. These act somewhat like social rules or pressures to perform gender and behave in specific ways.

As Butler (1988) states, gender is a set of social processes; it is historically formed and socially shared. In order to be seen or socially constructed in the desired way, one must perform the acts of their desired gender. This explains why the behaviours and attitudes individuals portray within society influences how they are socially constructed in their gender-role.

This was furthermore supported by the findings of Kelly et al. (2017) as the term gender performativity was utilised to explain the same concept defined by West and Zimmerman (1987), 'doing gender', or performing behaviours in a specific way to portray and distinguish oneself as the gender they wish to be identified as.

During individual interviews participants were asked what it meant to be a male and what characteristics were considered as vital to being constructed as masculine by society. The following responses were received:

*Just being the protector. Like to me, that's, that's being masculine.*

*It's not about you know, having huge arms or working out and getting huge. It's just about physical, mental, social – just being sort of, a leader or someone that people can go to and turn to. (Noop-noop)*

*Probably just being tough, being strong, physically strong, not expressing your emotions...as much (Slug)*

*I think of a man like taking charge in a situation....like being the leader in the group (Mike)*

*Reasonably loud, confident, having a deep voice, ummmm waving around money or sharing whatever they have in like a really sort of boisterous and comrade sort of way. (MPB)*

*Not being a poofter, essentially. Like to harden... not... not being a slight, it... yeah, I guess like, so if you wana be masculine you wouldn't as opposed to like talk about your feelings. (Fatboy)*

Overall, the key stereotypical attributes identified that describe how a male should be included: being aggressive, ladsy, blokey, authoritative, physically strong, tough, unemotional, staunch, macho, proud, cocky, arrogant, taking charge in a situation, provider, protector, loud, taking up space in a room and so forth. These attributes matched the findings of Kerrigan et al. (2007) and Slabbert, Knijn, and de Ridder (2015) with the exception of the role as a

financial provider and a lack of any mention of sexual prowess. When this was relayed to participants during the group discussion, they laughed it off and all still agreed that these traits were expected of a male deemed to be masculine. As a result of discussions surrounding this topic, the overall consensus was that males in society are viewed as the leaders, and females the carers.

When the ideologies mentioned above are not followed precisely, this can result in health deficits, physically and psychologically as suggested by Pleck's (1995) Gender Role Strain theory. When focussing on the male perspective, this is a problem that needs to be addressed as it is contributing to the lesser prevention and protection tactics taken up by males as opposed to females. Being vulnerable to illness and caring for one's health are seen as feminine traits, therefore in order to be constructed as masculine within society, males opt to avoid any behaviours that display forms of femininity (Houle et al., 2015). This often may involve hiding prolonged suffering from illness or disease rather than discussing it with a clinician at the risk of being seen as weak. As such, the consequences incurred include lack of protection, prevention and therefore awareness of an issue until it is too late. This contributes to heightened sexual health disease rates not only in New Zealand, but globally, as these men choose to prioritise their social reputation at the cost of their health. This is where we need to query at what point in humanity did social standings become more important than the value of life itself?

Furthermore, the identity-based motivation theory suggested by Slabbert et al. (2015) further explains that identification of gender affects ones health-promoting behaviours as a result of sociocultural factors motivating behaviours undertaken. As a male particularly, this corresponds to masculine ideologies

and a lack of preventative and promotional health behaviours. This was increasingly supported by the findings of (Pieterse, 2008) mentioned within Slabbert et al.'s (2015) study suggesting that a combination of sociocultural, biological, political and economic factors work in conjunction to affect the health of individuals within society.

Houle et al. (2015) studied the association of masculinity ideologies and health promoting behaviours and likewise found the function of masculinity and portrayal of masculine characteristics to be detrimental to health outcomes observed daily. This is due to their negative influence on health behaviours.

As this study showed, there is a significant need to address gender-roles and the associated characteristics of these in order to enable normalisation of positive health promoting behaviours. This was stated by Houle et al. (2015) through mention of the necessity for health promotion programmes to acknowledge the strong drive masculine ideologies have over males within their gender-role and the effect of this on their behaviours, including the lack of regard for protection.

Going forward, this demonstrates the need to conduct further studies looking at the effects of psychological stress specifically from adhering to gender-roles, on sexual health preventative and protective behaviours enacted across all sexualities.

As Kelly et al. (2017) mentioned, in the present day, double standards and gender expectations influence sexual and contraceptive practices. Historically these double standards have contributed to the social belief that SH behaviours such as sexual actions and use of contraceptives are gender specific (Kelly et

al., 2017). By challenging participants about the double standards of whom should be in charge of SH within the relationship according to the stereotypes provided above, the response I received was pleasantly surprising. In regards to whose responsibility it is to use protection or contraceptives, the concept of the male being the leader and in charge [as per masculine ideologies] is not guaranteed, but circumstantial.

The belief that a female is in charge of SH within the relationship as the carer, is contradicted by the socially constructed view of a male needing to be in charge in order to be viewed as masculine. This strict ideology of a female was contrasted to the expected role of a male, however society is deemed to be more relaxed about his sexual actions. In fact double standards were subconsciously noted by one participant:

*If a guy gets an STD it's kind of funny, whereas when a girl gets one it's like, like traumatic. Like they're not allowed to be, like ahhhh, promiscuous and um light-hearted with contraception or preventative measures or whatever, whereas when a guy does it, it's like ahhhhh, silly boys. (MPB)*

Surprisingly, few participants explained that to be viewed as a man, masculine traits can still be portrayed within the context of SH in a slightly different way than holding sole responsibility for the situation:

*FB: you could take the masculinity and be in charge by making sure that she's taking care of herself. You don't have to, like it's not all on your shoulders. You can still dish out...*

*S: good delegation*

Just as society determines the attributes a male needs to possess to be considered masculine, it also influences how a gender should and should not act, and what responsibilities each gender is expected to hold. As noted by participants, for a female there is an expectation one should not be promiscuous and should always be concerned about SH. If she chooses not to comply with these social rules, society looks down on her and she may be addressed by derogatory labels.

Behavioural changes over time within the way society views the gender-role were noted by participants to include a decrease in the level of acceptance society holds for a female carrying condoms on her. This is a catch-22 as the disapproval for a female to enact a safe SH behaviour such as carrying condoms on her person, contradicts social expectations that the female should care for SH within the relationship in order to enact feminine traits. This was expressed by one participant as he noted:

*I think it might be a dated thing but back... I duno, just talking to my cousin who's a little bit older, it was more like back then girls would also sometimes carry a condom because they knew they were up for some, couldn't trust that the guy was going to have one, carries a condom just you know, like when she's gona get frisky like cool, whips it out, put this on. I've never once in my life had that happen to me. (Noop-noop)*

One important male responsibility inferred throughout the discussion as being socially expected is the role of the male carrying the condoms and making sure they are accessible and have not expired/gone warm. As the idea of

females carrying condoms is no longer socially accepted within today's society, this responsibility has, by default, been relegated to the males. It is his responsibility or rightful duty to replenish these as needed. In addition to this, he is to make sure his sexual partner is comfortable and willing to participate.

*G: okay so when it comes to sexual health responsibilities what duties do you think the male should hold?*

*FB: making sure she's comfortable*

*NN: yeah.*

*FB: ... would be the first thing*

*NN: and that she's happy and willing to do everything rather than you just assuming and pushing on*

*MPB: packing jimmy's...*

*NN: yeah.*

*MPB: ... all the time.*

*NN: always! Always having condoms*

*S: not letting them go like hot in your wallet*

*NN: yeaahhh*

*S: like changing, cycling your jimmy's too*

It was at this stage that data showed trends whereby participants assumed subconsciously that females relied on males for protection against STI/STDs, whereas males relied on females for protection against pregnancy.

Participants indicated that as a male there was a fine line between fulfilling the male responsibility to ensure condoms are easily attainable, and having them be too accessible:

*It tends to be, make sure you have a stash at home, probably stash in the car – just anywhere where you might find yourself in a situation where you need to have one, and obviously one in the wallet cos that tends to be the one thing you always carry on you. But then when you've got a missus it's sorta like – if you still have all those stashes in all those many places, unless she's told you to have them there, don't have them there because you'll get in a lot of trouble. (Noop-noop)*

When males were seen to have too many condoms, despite their beneficial health outcomes, participants suggested their partners would question their motives and how old the condoms were - bringing forth ideas of infidelity. Resembling the findings of both Kelly et al. (2017) and Slabbert et al. (2015), this is where the notion of trust overriding the need for SH measures arose within this study. The importance of SH became secondary to their partner feeling secure within the relationship. As noted by Gomez and Marin (1996) within Marchi et al. (2008), “there is difficulty in admitting in stable relationships the need for prevention against STD/AIDS, for it would mean to acknowledging the possible existence of infidelity”.

This finding was reinforced by later discussion about the association between SH precautionary measures and infidelity. Participants expressed their concerns that if their partner was to randomly suggest getting a SH check it

would imply to them that they [the partner] had been unfaithful. To counteract this idea, when put in the context of requesting that their partner receives the HPV vaccination, the response received was *“yeah that’s okay, but not if they’re going, oh go get yourself checked!” (Fatboy)*. Acceptance for all SH safety measures was deemed acceptable aside from SH checks for the reason that *“you don’t go to the doctor when you’re healthy” (MPB)*.

## **PROVISIONAL AND MODAL EDUCATIONAL ISSUES**

The second key theme identifies numerous educational issues, specifically the lack of education regarding the range of STIs circulating the population and their associated consequences, problems with the mode in which education is provided when and if it is, naivety of individuals regarding sexual health diseases and a lack of education outside clinical settings; all of which commonly link to justifications why sexual health responsibilities fall where they do in a relationship.

As a result of individual interviews being analysed separately, interviews highlighted the lack of education regarding sexual health, especially that of HPV. One of these key themes pertained to the level of education individuals held about sexual health and the means available to prevent and protect against both STDs/STIs and pregnancy.

It became apparent that participants believed individuals [the New Zealand general population] lacked knowledge regarding the use of sexual health tools and the associated consequences of not using them, specifically condom use. Participants mentioned the need for better education about preventative and

protective devices available to them. Furthermore, when asked if education regarding STDs/STIs needed to be taught about more, all five participants responded positively. This may probably be in part due to the prevalence of HPV.

*S: If you said HPV, I'd be like what?... I know HIV.*

*M: but what does it do? [HPV] Is it herpes?*

Participants simply implied individuals would benefit from learning about potential consequences of STDs/STIs as these impact the decisions made regarding what preventative and protective measures to use; if any, such as receiving the HPV vaccination or not. In fact, to our five participants, it appeared that protecting against pregnancy was prioritised as the primary reason for use of sexual health tools rather than protecting against or preventing STD/STI acquisition. This may boil down to the perspective of pregnancy being seen as far worse and more intense than some sexual health diseases as the impact lasts a lifetime, not a short period of time.

Alternatively this could be attributed to a basis of evolutionary processes such as the desire to pass on genetic lines, therefore innately focussing on pregnancy as a consequence far more than disease acquisition.

The follow on effect of individuals becoming more educated about sexual health diseases, consequences of these and preventative or protective measures available, would likely include larger numbers of individuals actively preventing transmission and contraction of STIs due to higher risk perception. This in turn results in a lower incidence rate over time. This is necessary as the lack of education regarding consequences of HPV and other STIs translates to no

known reason or justification to warrant the need for preventative or protective measures.

As HPV does not present any visible signs or symptoms, the public is not aware of it [HPV] as a common disease. In order to reduce incidence rates and transmission of STDs, individuals need to be aware of the types of sexual health diseases present in the general public to ensure they are safe themselves, and not unknowingly engaging in sexual activity with someone whom may be a carrier. By educating individuals about sexual health diseases, an informed decision can be made regarding whether the individual chooses to forego preventative/protective measures available to them or not.

Participants subconsciously identified naivety as a factor influencing HPV incidence rates. Without prior education regarding STDs/STIs and the devices available to help protect against or prevent pregnancy and contraction of diseases, the naivety of not knowing or being aware ensures individuals do not worry, or think about consequences of a lack of protection. Due to this naivety, the likes of HPV and other such diseases are not considered to be a legitimate or serious health concern:

*What is it, I dunno what it does, oh fuck I'll get the, I'll get the vaccination later. (MPB)*

Because the idea that a lack of education regarding HPV and other sexual health diseases was alluded to, by association, the notion that HPV is not considered a common disease was also introduced by Slug: *"maybe cos it's not a common disease – or we don't think it's common"*.

Sadly, once a disease has been contracted and treatment is required, it is too late to educate the individual about sexual health prevention and protection tactics/tools.

*If you're not getting vaccinated or you haven't caught it [an STD]  
then maybe you wouldn't really know about it. (Slug)*

This was mentioned as a worry of participants as education is widespread within the clinical setting including hospitals and doctors clinics, but that is as far as it goes. The only time you ever hear or see anything to do with sexual health is in a clinical setting or hospital, not openly in public. As Fatboy mentioned, *"it's only bought up if you have a doctors' visit in the first place"*, but by this time it is too late to work on prevention. The real issue brought to the forefront was that sexual health education is lacking in the public domain where it is required the most - prior to contraction and transmission of disease.

In contrast to this, participants also spoke of an equity issue regarding the ease of access to information about sexual health tools due to the large discrepancy in variety of sexual health devices available to females as opposed to males. They voiced their understanding that it is easier for females to attain information about sexual health tools than males due to the fact there are more sexual health tool types available to them. The likes of organisations such as Family Planning were mentioned as aids to receiving further information when desired. This organisation [Family Planning] is considered an easily accessed and acceptable point of education for females. This may in part be due to the fact this behaviour for females has been normalised by society, however for males this is not the case.

Information is dispersed from a range of sources outside large name organisations. This information is frequently incorporated into the guidance/direction from schools for their students. Attention to detail was identified by participants as lacking when referring to education about sexual health within the New Zealand school-system. Similarly in Tanzania, Remes et al. (2010) identified limited or incomplete information as a concern parents held about educational systems when speaking of their children being taught about sexual health.

A significant issue raised by one participant in particular, but agreed upon by all, was the inappropriate methods of educating children at school about sexual health.

*My PE teacher did our primary school sexual health, so it was a bit like...yeah what'd he say – being pregnant's like peeing a tennis ball. (Slug)*

Physical Education teachers are being delegated the task of informing students about sexual health and sex-education according to a set curriculum rather than having a specialist teach accordingly. Unfortunately as these teachers are not experts in the field, some are going about it the wrong way. Scare-mongering has been singled-out by participants as an educational tactic utilised that has led to the distortion of facts about sexual health topics. As a result children being misinformed, inaccurate information is being disseminated and exchanged between peers with the good intention of helping inform or educate others when no prior knowledge is present.

*If their mum hasn't, or dad hasn't told them this, I better take this one on lads. (Slug)*

For those children that come from conservative cultures where talk of sexual health is considered a taboo topic, there is no way to correct the misleading information as parents are not likely to discuss the topic when or if the child has further questions. In this situation, these children are not spoken to about sexual health or sexuality to stop them being curious or acting upon this:

*MPB: umm, but honestly some cultures....might purposely not talk to their children about that because if you inform them about sexual health they're gona...*

*NN: want to do things*

*MPB: ... they're gona bang 300 people that night*

Consequentially for these individuals whose parents refuse to educate or talk to them, this impacts their current day use of preventative or protective sexual health tools. These individuals may lack the knowledge of which safety behaviours to follow, and are often naïve to the options available for them or the consequences of unprotected sex. The lack of conversation regarding sexual health is not only a cultural issue, but also societal, as often individuals feel uneasy and awkward discussing topics of a sexual health nature due to social discomfort. This is an issue that needs to be addressed as it is in the best interest of the population to be educated enough to protect oneself rather than to be curious and perform risky behaviours.

All in all, we need to make sexual health a more comfortable topic of conversation as without discussion in some way, shape or form, positive outcomes rarely follow.

## **ABSENCE OF EFFICIENT ADVERTISING, MARKETING AND AWARENESS TACTICS**

Just as lack of education and information regarding HPV and other STDs/STIs was expressed, participants also indicated that they had not seen any advertising or marketing about the HPV vaccination, or on sexual health topics in general as of late –*“I wouldn’t have even heard anything about it, or seen any marketing for it or just never turns up in anything” - Mike; “There isn’t really like HPV can affect you! Marketing schemes or whatever now. Like awareness sorta stuff” (Slug).*

This lack of marketing and advertising about sexual health diseases and infections was significantly focussed on as a persuasive factor in the HPV vaccination uptake rates of males. Awareness of diseases prevalent in society [resulting from education, marketing and advertising about STDs/STIs], was emphasised as a key reason for the decisions made regarding sexual health actions engaged in. These included decisions concerning sexual health device use such as receiving the HPV vaccination or not.

The third key theme, advertising, marketing and awareness seemed pivotal to understanding the male perspective better. It touched on the need for more awareness about sexual health diseases and infections, and the associated preventative and protective tool use. An increase in marketing and advertising

was furthermore expressed through need for improvements such as employing a more engaging approach and utilising better marketing strategies to make sexual health products more appealing. Health promotion tactics were specifically addressed suggesting the need for improvements. This specified the need for a sexual health campaign. Participants also mentioned the need for increased targeting in a benevolent way, as decisions made affect not only the individual involved but others outside the decision-making process also by knock-on effect. In addition, the final point mentioned was the need to push for discussion surrounding sexual health topics. We need to normalise these discussions and rid any taboo associated with sexual health, as without this individuals will continue to lead a life of naivety.

When asked whether sexual health needed to be taught about more, participants responded with 'yes' but also made a point to acknowledge the need for marketing, advertising and awareness:

*G: okay. So is this something you guys think maybe needs to be taught about more?*

*(ALL): yes, yup etc.*

*M: better marketed or advertised*

*MPB: more awareness*

Further conversation followed this trend with the following comments being made:

*I feel like that should have sort of been advertised a little bit more and be like – hey guys, we've discovered that a lot of people have*

*this or are getting this, probably go get vaccinated – and make it like a actual campaign rather than... cos I only found out about it through my doctor and then this [study]. (Noop-noop)*

*You never see a billboard being like ya know Durex or something, or like you're responsible for you and her. That would be a fucking eye opener. (Noop-noop)*

Marketing and advertising is not only used to make the public aware of an issue, it also serves the purpose of being an extra educational tool with a widespread reach. *“If we’ve got more people aware, more people recognise” (Slug)*. Fortunately as proof of the positive effect of marketing and advertising, participants mentioned prior messages from 2014’s ‘love your condom’ advertisements and campaign that have stuck in their heads regarding safe sexual health decisions.

What was questioned by participants however was the target audience of that specific campaign and why the key educational message was intended for only gay or bisexual men when the action they were promoting [safe sexual health decisions about condom use] applied to all men: homosexual, bisexual and heterosexual. The issue of who to include as the target audience instead became identified as an issue of *“not enough targeting” (Noop-noop)*. High-risk groups may be identified and marketed to, however the need for further marketing, advertising and awareness is present for all members of the public, not just select few:

*The only time you ever see anything to do with it [sexual health] is at the hospital or at the clinic – there's posters everywhere about sexual health but you never see it outside. (Mike)*

There is clear evidence for the need to get the message of safe sexual health out to everyone in a more public way so that the entire population is made aware. Unfortunately, this means that problems have developed within our current social system as a result of these sexual health diseases being a hidden issue until it is too late to prevent or protect, and the individual is already infected.

As Slug mentioned during the focus group discussion:

*I think the key is engaging people. Like advertising more of one thing or awareness..... You've given them a reason to focus on it and then they're like whoa this is really important.*

The creativity of advertising and marketing in the media is imperative to the efficiency of mass campaigns and educational tools. By gaining the attention of individuals a sexual health message is more likely to be remembered and acted upon accordingly.

A less publicised promotional tactic mentioned by participants as being effective at gaining the attention of individuals about sexual health in New Zealand was the use of GP clinic letters offering free sexual health services. This served not only as a reminder about sexual health checks and options available, but also as a great means for promoting awareness for certain sexual health diseases, such as HPV. In comparison to mass campaigns and alternative advertising methods, the scope of GP letters is limited. Regardless of this, participants

expressed their support for receiving these promotional tools as there is currently an absence of social and public awareness due to inadequate marketing and advertisements present. Participants furthermore suggested the need for more awareness via individual targeting similar to the actions of this health clinic.

*NN: yeah. I got the letter from my GP saying hey you're under 26 years old, we'll do this [HPV vaccination] for free for any males that come to our clinic.*

*S: oh, see that's cool. We need more of that.*

These comments further reinforce the need for supplementary promotion of safe sexual health. The overall message expressed by participants regarding marketing, advertising and awareness about sexual health diseases and their associated methods of prevention and protection, was the significant need for improvement.

Further awareness of sexual health conditions such as STDs/STIs in the public eye was desired by participants as they mentioned an association between this and incidence rates. This can be explained by the lack of visible warning signs of disease as often symptoms or evidence of contraction does not show. For this reason, it is near impossible to know whether male or female counterparts contain the disease, increasing the likelihood of transmission and therefore incidence rates. More awareness therefore leads to a decrease in the transmission and contraction of sexual health diseases:

*If we've got two parties aware then yeah it will improve and the rates will reduce. (Slug)*

This however, may also be dependent on the way sexual health devices are marketed or displayed to the public. The type of advertising or marketing influences whether sexual health apparatuses are used or not. This was made evident as participants emphasised their disgust in the dispensary machines utilised to advertise condoms: *“Eugh those machines are so seedy”*. (Slug)

Although these devices are made easily accessible, they did not appeal to any participants. If anything, they were viewed as off-putting, cheap and nasty, and as one participant put it, *“they just make you feel sad”* (Noop-noop). In addition, participants mentioned the products supplied by these machines often were not acclaimed, well-known brands. The condoms on option were *“generally some brand that you’re not familiar with”* (Noop-noop) and were compared to the likes of *“the cheapest, worst perfume ever option, or a condom that you don’t even know how long it’s been in the machine”*(Slug). Participants expressed concern towards the effectiveness of advertising or marketing condoms in this way as the repulsive reputation and sight of machines is enough to make individuals choose to engage in sexual activity lacking protection rather than utilising an unpleasant and non-trustworthy sexual health tool available. From this discussion, the following response manifested about condom choices in dispensary machines:

*These fucking gold knights or something and I’m like fuck, I’m having babies with these things, they do not work! (MPB)*

In order to improve this, Slug suggested *“they could make them [condom dispensary machines] a bit cleaner, look nicer that people would probably be like, oh this access is easy”*. In addition to displaying machines cleanly and

positively, by changing the condom brands to dependable, reputable sources that have already been marketed or advertised heavily, use may increase as the product appeals more to the market and is easily accessible. By addressing or setting standards for the presentation of products, the issue of item placement and positioning putting individuals off product use may resolve itself.

On a positive note, participants spoke about the beneficial impact of promoting cheaper, reliable brands of condoms within Family Planning organisations. This encourages awareness and promotes ease of access to means when needed. These community organisations alleviate barriers in accessing appropriate and necessary sexual health devices to promote sexual safety.

*M: you could go in there and get a box of condoms or 500 for like....*

*MPB: for like 80 cents.*

*S: mmm so that was a good thing to promote.*

Although we are heading in the right direction, there is still further room for improvement. First and foremost, conversing about sexual health needs to be normalised within society and the taboo dismissed. Secondary to this is the necessity to both increase the quantity and effectiveness of marketing strategies, advertisements and campaigns promoting safe sexual health.

Without sufficient marketing and advertisements, there is extremely limited ways in which individuals can become aware of diseases and the associated consequences. By utilising engaging health messages and increasing the appeal of protective and preventative materials, we can look toward better promotion, marketing and advertising of safe sexual health decisions for future generations.

## **APPEAL, EASE OF USE AND ACCESS TO SEXUAL HEALTH DEVICES**

Over time there have been many changes in the way individuals view sexual health and appropriate device use. Social changes identified pertaining to sexual health device use are discussed in the context of how decisions are cognised regarding sexual health device use today compared to previous times.

Participants identified ease of use, and access to sexual health devices as vital factors in regards to understanding how and why decisions are made about the active use of sexual health tools. This in part boiled down to the ease of attaining sexual health preventative and protective devices, the range of sexual health devices available in the market, safety of the devices available, and the lack of funding towards sexual health for males. Furthermore, convenience of device use, appeal of sexual health device access points, access to devices and ease of use of the sexual health tool, specifically condoms and the contraceptive pill, severely impacted individuals' decisions regarding sexual health tool use also.

At a time when there is such a strong focus within society pushing for gender equality, we would expect there would be a large range of options available for both males and females to protect themselves and their partners' sexual health, yet we are still seeing evidence of unequal opportunity. As a result of lesser funding for male research, females by comparison have further development opportunities within the sexual health device field. This was expressed by participants by acknowledging the lack of diversity in sexual health apparatus' available on the market for males compared to females.

For a go-to male tool, condoms were always readily available no matter where participants went. The only other alternative mode of prevention or protection was the more permanent method – a vasectomy:

*MPB: like mostly it's just....*

*NN: condoms*

*MPB: yeah condoms*

*NN; condoms are like...*

*MPB: everywhere!*

*NN: fuckin' easy*

*MPB: you go to Pak'N Save...*

*NN: you go to the airport and they're in the fucking bathroom*

*S: eugh those machines are so seedy – everywhere you go*

Alternative sexual health devices were near impossible to find and a lack of education regarding these devices was evident also:

*MPB: ...straight up, have you ever seen a woman use a diaphragm?*

*NN: no*

*MPB: have you ever used a dental dam?*

*NN: what?*

*MPB: a fuckin' dental dam*

*FB: what the heck is that?*

*\*confused faces around the group\**

*MPB: it's like a body condom for ladies*

*S: once for a laugh when I was younger*

In fact, certain types of sexual health devices have become what participants described as 'obsolete' due to the scarcity of their availability anywhere, resulting in their lack of use nowadays:

*MPB: but um those are types of like almost obsolete ah, ummm, the diaphragm, baby protection and the... what's the dental dam called... you know the one... the dental dam?*

*G: yeah it is.*

*MPB: I've never even seen one in my entire life, not like in a pharmacy.... Like no idea where the fuck it is.... Like mostly it's just...*

*NN: condoms*

When asked if there were the same opportunities and tools available to both genders, each individual strongly reacted with "no". MPB added to this by stating "*they're [sexual health devices] pretty much both just as easy to access. It just feels like we've got less of a range*".

Evidently, similar findings were noted in Brazil by Marchi et al. (2008) showing that lack of contraceptive and/or protective sexual health devices available is not an issue within New Zealand alone, but globally. It was found that sexual health responsibilities such as contraception, prevention and protection are

predominantly female-focussed as a result of this inability for men to take on a portion of the responsibility through lack of apparatus variety.

*MPB: there's no tangible pill that I can take that is gona make me...*

*NN: shoot blanks*

*MPB: yeah. Shoot blanks. Or there is but you know, it's dodgy. It fucks up your testosterone levels or something.*

During individual interviews a few participants mentioned the ease of the female in the relationship being on the pill. When asked why that was, the response received was:

*MPB: 'cos there is a pill.*

*FB: well they have a lot more access to the info as well, like they can go to family planning , it's not just the pill or the IUD, it's not just that now.*

Ease of access stood out as yet another key factor in making decisions about sexual health tool use, particularly when it came to being a recipient of the HPV vaccination or not. Mike specifically mentioned the need to “*make it more convenient instead of having to go to the doctor*”, and then he would “*get it just for the sake of it to make sure I'm vaccinated*”. The one issue that was identified at this time was that the preventative sexual health HPV vaccination was seen as more of a hassle than anything, and was looked at as “*just another adder in life*” (*Slug*) rather than of significant priority.

This identified a significant issue with the way we view personal health maintenance. Protecting oneself was seen as more of a chore or job than

anything else. It was not prioritised. By viewing maintenance of personal health in this way, this negative outlook results in a lack of motivation toward looking after ourselves and therefore worsening health over time. Upon changing this view within society, it is possible to alter individuals' routines to be inclusive of more beneficial health behaviours to actively avoid future medical complications.

Receiving the vaccination was not looked upon as an easy task as it is not as readily available to access as participants wish it was. The idea to “roll up in a van, to a work site and be like – get in boys, you’re getting a shot now” (Slug) was far more accepted, as was the idea of a mobile unit stating certain places and times they would be in each community:

*Yeah could almost be something that they – like the blood bank bus that comes around – like they could almost say alright, [on Facebook] this bus is going to be in \_\_\_\_\_ on Thursday evening or something – come get your shot. (Mike)*

All five participants made their autonomous view extremely clear at this point that they all independently supported the use of vaccinations to prevent and protect against STDs. All participants mentioned that they were willing to receive the HPV vaccination provided it was Food and Drug Administration approved and safe for their body, lacking significantly harmful side effects such as issues of fertility or structural birth defects. The only stand-out issue mentioned was the difficulty accessing it in common places, and pure laziness of the individual.

Other factors discussed by participants as playing an imperative role in the different rates of HPV vaccination uptake between genders included the lack of consequences and therefore drive to receive the vaccination, and also the fact of receiving it being seen as somewhat of a hassle or 'extra' thing to 'do' in life, just another thing to 'fit in'. Participants felt access to this vaccination needed to become more convenient than having to go out of their way to be immunised or protected as seen by the following:

*I'm overdue for my second shot of it actually, so that would be about right. I just keep putting off cos there's no need to have it done at the moment. (Fatboy)*

Unless we provide ease of access to both sexual health services and products, these are likely to suffer reduced priority in one's life. This comes as a latter result of the limited and inadequate range of devices available on the market to men alongside the lack of prioritising their sexual health when compared to females; as historically seen through funding discrepancies. In addition, without the improvement in appeal of product, there are no factors advocating use of preventative or protective methods to promote safe sexual health.

## **RESPONSIBILITY, AND WHERE IT LIES**

A key theme identified and discussed here is the justification for where sexual health responsibility falls within the scope of gendered practice. This includes convenience factors, social influences, gender-role expectations, if the individual is in a relationship or single, the reason protection is required, ease and access to sexual health devices, advertising, marketing and awareness,

and also whether responsibilities are viewed as equal, shared or individual duties.

When participants were individually asked about gendered responsibilities and were questioned on their understanding of the term 'responsibilities', all participants defined it as somewhat rightful duties or obligations that may be brought about as a result of ones upbringing. In the context of sexual health however, these responsibilities were deemed to be shared equally between partners and no longer viewed as individual duties or obligations, but more so as wants and morals.

Despite participant views regarding sexual health responsibilities being shared nowadays, a subtle underlying trend of this duty or obligation being a feminine role within the relationship was still made clear. In order to avoid going out of ones way to prevent pregnancy, females have become somewhat relied upon to take the contraceptive pill to protect both parties. When it came to discussing birth control, two of five participants [FB and NN] mentioned the normality and ease of female sexual partners being on the contraceptive pill and that they [the female] were responsible for being on this.

*MPB: whether she's having sex or not...*

*NN: yeah.*

*MPB: then it's part of her routine.*

This was however followed up by comments expressing they did not believe this was an expectation of females when questioned further.

*G: is that an expectation that a girl should be on the pill though?*

*(ALL): no.*

*FB: no it's their personal choice.*

*MPB: and then that's not even protection from sexual health, that's protection from babies.*

The reason these participants believed the pill being taken by a female was an easier method of protection is due to the incorporation of it in their daily routine and the reduced need to worry about spoiling the mood when engaging in sexual activity and in need of a condom.

*NN: she takes it in the morning, at night it's still in effect, whereas like you need to as a guy like have a condom on you to use a condom at that point in time – and it could be like literally the next room over but you're gona kill the buzz by going over to grab something from your stash to get back*

*G: so it's a convenience thing, is that what you're saying?*

*NN: yeah... oh it's more of a like, it's already in her routine and she's already done it and it's still in effect and it just goes daily, whereas like ours is a situational thing where, for us to control anything or to have any sort of safety measure in place we have to be conscious of it.*

This was further supported by Kelly et al. (2017) as they noted women were more worried about the use of physical contraceptives [such as condoms] acting as a barrier to their partner's experience of pleasure, than they were of their own safety.

As the contraceptive pill is often taken in the morning as part of her daily routine, it is still effective at night regardless of intentions to engage in sexual activity or not. Because of this, this particular method does not require conscious thought of having to attain or wear a condom at the time of behaviour occurring, and it does not risk destroying the mood. Adding to this, the idea that females are considered to generally be the more organised gender arose:

*Some guys are well organised, some guys aren't. Most girls are generally well organised, again generally the carer, like a bit more onto it with certain areas – like they can, it kinda fits their build better like genetically I duno, but they just, they're good at that, they're organised, quite well organised beings. (Slug)*

This opinion was further followed by the notion that “*the buck stops at them*” (Slug) when referring to preventing conception. “*They carry the baby*” (MPB), therefore they are the ones responsible for sexual health prevention and protection tools. The male involved does not have the same immediate bodily connection to the child as the mother, and can therefore walk away without consequences. The female however cannot dismiss the situation as easily as she physically carries the child. As a result of the female sex carrying the child, the male counterpart may not know if he has impregnated the female in the case of a one night stand.

*At the end of the day if you had a one night stand and you got a chick pregnant but you didn't know about it and she didn't catch your name or get your number or fuckin' anything, she ends up with a kid. She's fucked. And you don't know about it. (Noop-noop)*

*That all comes back again to consequences...you get someone pregnant, you don't have their number, you don't have their contact details, they, the woman, is the pregnant one, so then so much more responsibilities and consequences are on her shoulders.*  
(MPB)

In saying this, three of the five participants identified responsibilities for sexual health to be shared within the relationship on a 50-50 basis. The remaining two agreed but also mentioned their role in the relationship as the individual primarily responsible for purchasing or providing the condoms.

The idea of the male being in charge of purchasing the condom and female being in charge of ensuring there is use of the condom was also expressed:

*For strictly sexual health – men always having the condom, women always making sure that their partner is using one. (MPB)*

This concept was significantly supported by Noop-noop's follow-up comment:

*There have been times where I'm not keen to use one and she's been like, yeah put it on, and I'm like alright there we go.*

Aligning with this is the notion of shared responsibility for sexual health within the relationship which was expressed as an essential point throughout the focus group discussion:

*To me, she wants to be safe, I wanna be safe, neither of us want a kid. (Noop-noop)*

*I just like that it's an extra layer of protection, sometimes it's got nothing to do with anything else, it's just that you're both comfortable with something. (Fatboy)*

Furthermore, unexpectedly, participants conveyed their willingness to share the responsibility of taking the contraceptive pill to ensure impregnation did not occur:

*NN: to be fair if there was a pill that I could take to make sure she wouldn't get pregnant...*

*FB: then I'd take it*

*NN: I'd take it*

*S: I'd take it*

*M: I'd take it*

*MPB: hell yeah I'd take it*

Differences were seen between decisions made about sexual health actions and responsibilities when single versus in a relationship. Participants indicated that equal sexual health responsibility is held more in relationships as *"it's easier to talk to your significant other about what you want to do and the easiest way to do it, and what's best for you"* (Fatboy) in regards to protective and preventative actions.

This belief sits in opposition to the concept of Cathexis as per the theory of gender and power (Ibañez, et al., 2017). Cathexis was explained as the effect of both social and cultural norms alongside emotional or intuitive attachments of women in their gender role, and the impact this has on sexual behaviours

enacted. This specifically referred to decisions regarding condom use. The same however could be said of men. In a relationship, one aims to please their partner, and in doing so may overlook risky behaviours to do so. Men in particular often embrace machismo [also known as the tougher portrayal of masculinity] as per social norms and expectations, and therefore utilise it as a social tool for control (Ibañez, et al., 2017). Within a relationship, as a result of power imbalances, the stereotypical behaviours of the male gender-role often lead to ineffective sexual communication and negotiation of sexual health device use for prevention or protection. This therefore also strongly impacts transmission or acquisition of diseases and infections. In saying so, these behaviours are supported and prolonged by expressions of the female gender-role, marianismo [also known as femininity]: the expectation to conform to others in an inferior manner, including submission of oneself to their partner (Ibañez, et al., 2017).

Contrary to this, the essence of caballerismo, another male gender-role expectation, states that a male should embrace social responsibilities, contain emotional connectedness and should be the family provider and protector (Ibañez, et al., 2017). One would think that this would present as a barrier to the transmission of diseases, however this is not always the case.

Interestingly enough, one observation made within this study was that the younger a participant was, the more they were likely to be focussed on preventing pregnancy as opposed to STDs/STIs.

For the most part, preventing pregnancy when in a relationship was mentioned as the prioritised and primary reason for utilising sexual health tools such as

condoms, whilst staying safe was just an added bonus. This is due to partners already being aware that one another are clean and trusting in the relationship that each individual has remained faithful therefore are still free of disease – “*I know my partners clean so it’s not really a second thought to what has been done*” (Fatboy). Safety for both parties is desired collectively in this situation.

This was opposed by the need for protection when single as there is no knowledge of whether the other party has any prior diseases or not:

*If you’re out trying to hook up with some random chick in town, you have no idea if she’s got anything or vice versa. (Fatboy)*

The idea here that one is responsible for their own sexual health came into play. When single, in the likelihood of a one night stand, priorities for use of sexual health devices were shown to differ from those in a relationship as the primary use of condoms was identified as protection against STDs/STIs. Secondary to this was avoiding impregnation of a female whom he does not know. This was found to be consistent with previous results from studies conducted by Marchi et al. (2008) and Ibañez et al. (2017).

At this time, participants made it aware they knew that condoms protect health whereas the contraceptive pill does not.

*MPB: ahhh, whereas the...jimmy’s are protection, protecting sexual health and ideally...*

*S: mmmm, good point*

*MPB: and ideally, not have babies. So that’s the big difference there. Is that you wana be on the pill so you don’t have babies or*

*you want good skin or whatever, ummm you're on the pill, you wana protect your health, you gotta take the next step dude*

*NN: you gotta put a layer*

Slight differences in opinion regarding use of sexual health tools when single were observed within the focus group:

*NN: I know personally for me the condom was always more of a prevent children, added bonus, you staying safe.*

*S: yeah that's true, with a partner.*

*NN: whereas like with a one night stand situation it was a wear this to be safe...*

*FB: yeah*

*NN: ...and so that you don't have children with some random girl they you'll never want to see again*

This was expressed due to the belief that it is the personal responsibility of the individual, as they may choose to act upon impulses without protection at their own risk. Ultimately safety for both parties was seen to be desired individually in this situation.

Interestingly the opinion of MPB altered after the prior comment suggesting condoms were used primarily as protection from STDs/STIs. He later stated:

*If worse comes to worst you get the clap, go to your doctor, ask for some anti-biotics, that's it, it's done. You get someone pregnant, that's got a much longer half-life – you know, it's, it's like a big deal.*

When questioned if there was a difference in the way participants viewed condom use when single versus in a relationship, participants 100% agreed there was a drastic difference in use depending on the situation. Because of this perspective participants found *“it’s more responsible for both of you as opposed to just the one person” (Fatboy)* to claim responsibility for sexual health, and also that *“you’re both responsible for the greater good” (MPB)* appropriately sum up the idea of where sexual health responsibilities should fall.

In addition to this, the recent concept of ‘concessions’ was introduced. Slug explained this as individuals choosing whether to accept engagement in sexual activity [giving permission] regardless of protection being present or not. It is agreed upon that consequences will be dealt with together if anything is to go wrong and if any individual does not agree, the sexual behaviour does not occur. Both individuals are then aware of the situation and potential consequences. This was explained as the new version of shared responsibility when single. It seemed as though sexuality and promiscuity for women is becoming more accepted and as such women are taking on the responsibility of their own sexual health more than prior years.

Priorities for sexual health were seen by participants to be presumably affected by each individual’s upbringing. The exposure each person has to sexual health education, awareness and tools available was certainly expressed as having a large influence on behaviours enacted as the individual gets older. Perhaps what is more influential however is the exposure to the sexual health behaviours and associated consequences those around them display: *“it’s just what you’re exposed to when you’re younger as well” (Fatboy)*.

We learn and create our view of the world on the basis of the social discourses used by others around us, and as such we learn through modelling. If a child's parents choose not to utilise birth control or condoms due to beliefs, the child has more than likely not learnt the importance of such measures. This makes them less likely to utilise these measures themselves than those that are aware or educated about safe sexual health behaviours and precautions.

This can be explained by Bandura's (1977) Social Learning theory whereby behaviours are learnt according to life experiences and observations made being associated with different sources of motivation. For those children who have role models that retain a negative perception of safe sexual health tools, or no care for the consequences associated with lack of protection, when negative reinforcement or positive punishment occurs, the child learns to avoid the behaviours due to their negative construction. If positive reinforcement or negative punishment occurs however, the child is likely to imitate or reproduce the same values, beliefs, attitudes and behaviours seen by the role model. In this case this may include growing up with the same perspective and therefore disregarding the need for sexual health protection. For all our participants however, it was clearly made evident early on that their lives were shaped by role models in a manner that values sexual health safety.

The influence of the household and upbringing was detailed by one participant as follows:

*I was gona say so because based on myself and just friends that I've got, thinking about how they've grown up differently to me seeing as how I wasn't born in New Zealand ad come from a*

*different cultural background, the way I was raised is very different to how people here were raised. But at the same time, I feel like most people in the sort of western world all have the same sort of – when it comes to sexual health – same sort of mentality on you know, be safe, be you know courteous to your partner, this and that. But I've also got a lot of friends who have grown up in sort of rougher households who are sorta, you know when we were younger 15, 16 they were just kinda like - condoms, fuck that! That's not fun. (Noop-noop)*

The generational differences between parents' views and children's were also explored as the trend of increasing equality between genders was expressed on more than one occasion. It was voiced by all participants individually, that gendered life-roles have changed from males being the dominant hunter-gatherer, provider of the family to these responsibilities being shared by the female of the household also. In the newer generation, she is no longer viewed predominantly as the mother or housewife that does all the cooking and cleaning whilst looking after the kids, but has become an equal provider alongside her male counterpart. As discussion between MPB and Noop-noop developed, the following comments are consistent with the idea that the males' role as being authoritative and in-charge of all situations has lessened as the female in the relationship takes a share of these responsibilities, especially in the bedroom with regards to sexual health:

*NN: in the sixties it was more of a – mum stays at home, does all the housework, takes care of the kids; nowadays I kinda feel like if I was with a girl who just wanted to be a stay-at-home mum I guess*

*I'd be okay with it, but at the same time sort of want her to have more aspiration in terms of a career*

*M: equal opportunities for all*

*MPB: it's not just one person's responsibility...*

*NN: to bring home the bacon*

*MPB: I was thinking more like to be sex-wise ahhhh...*

*NN: oh*

*MPB: yeah, it's both people now, whereas before I don't know what it was. Was it just the male's responsibility?*

Alternative perspectives such as the concept of both parties being equally responsible for sexual health within the relationship, rather than the female predominantly being the carer were also thrown around.

When specifically referring to individuals casually engaging in sexual activity outside of a relationship, some of the strongest and most influential contributions made were:

*Even for singles like, if you don't want to catch something you carry condoms on you whether you're a boy or girl. (Mike)*

*That's on you to be prepared to do it because it's at your own risk of...well you don't know her so you don't know what is going to happen. (Fatboy)*

Individual responsibility was deemed appropriate specifically in this situation when single. You never know what the other person has and you always need

to protect number one [yourself] first especially if you do not know your sexual partner.

*MPB: if you're cowboying and raw doggin' al over town, like...*

*M: asking for trouble*

*MPB: yeah, you're just asking for trouble. It's just a bad move.*

*mmm so, I think, it's just like a UFC fight. Protect yourself at all times.*

The theme of protecting oneself first followed through the length of the discussion. One participant acknowledged the origin of this belief:

*So you've got to protect yourself. That's just from being educated in school though. That would be my personal view but not as many people are, like as well educated as we might be across the world.*  
*(Fatboy)*

What came from this participant was the idea that individuals must always remember that just because they are educated and know how to look out for themselves, does not mean their partner also knows. This again linked strongly into the idea that education heavily influences sexual health behaviours enacted and even habits formed that follow on through life. Fortunately, the thought of protecting oneself first can be viewed in a positive light - *"Looking out for me is going to look out for her"*. *(Noop-noop)*

The ongoing effect of looking out for oneself first also protects any sexual partners by default. This works in the same manner as herd-immunity.

*Everyone is responsible for sexual health or like HPV, now that this has come through like my doctor. (Noop-noop)*

This concept of individual responsibility as a single member of the public has a hidden agenda of being a shared responsibility if each and every member takes on sexual health responsibilities for them self.

Each gender holds their own responsibilities in regards to sexual health. These responsibilities for the most part have evolved as a result of biological bodily function. The differences in responsibilities are predominantly noticed amongst single individuals. As a male, responsibilities include carrying and providing condoms for use, but as a female, these revolve around utilising contraceptives. In a relationship scenario however, it is safe to say the responsibility is shared and negotiated to the best fit for the couple.

Over time however, socially constructed reasons for where responsibilities should fall have developed to include convenience of device. As such, prioritisation of contraceptive use over condoms in a relationship has occurred placing responsibility largely in female control to avoid ruining the mood by interrupting sexual activity at the time when required. Contrary to this, gender-role expectations suggest when a female is of age to bear children and all social requirements are fulfilled, she should no longer be employing use of a contraceptive. It is socially expected that when she is still young and not yet established, she should be utilising contraceptives from teenage years onwards, and as such her parents are responsible for ensuring this happens. As a male however, there are no such expectations. Responsibilities and influences outside those which the individual or partnership hold, also need to be

acknowledged. Parents need to be held accountable in their responsibility to educate children about sexual health to provide them with the ability to make informed decisions later in life.

## CONCLUSION

Within this study, it has been made extremely evident that we live in a society where conversing about sexual health is not always accepted nor deemed comfortable. By choosing to ignore the fact that unsafe and unprotected sexual behaviours can be the cause of legitimate health concerns, we do no favour to the health outcomes of future generations, nor do we aid our own. Through lack of consideration for our own sexual health due to not actively attending to it, these behaviours enacted as part of everyday life continue to be established and normalised within future generations. We are now at a point in life whereby discussions regarding sexuality and sexual health need to be normalised. Without the ability to openly discuss these topics, how are we to promote safer behaviours in life?

This study adds to the field through contributions focusing on the male population specifically. Prior studies conducted examining HPV or associated sexual health topics have focussed primarily on females. By conducting this study, we have been able to attain a fresh perspective as per the factors that play an influential role in the decisions made by males regarding use of sexual health preventative and protective tools. As the HPV vaccination programme was only recently funded and rolled out to males in New Zealand, all opinions and insights gained from participants are objective and unbiased as there have been no prior programmes to base responses off.

Health Promotion and Education stand out as the two main areas that require dire attention going forward. Through identification of my five key themes, this research has given significant insight as to how to beneficially implement public

health programmes aimed at promoting safer sexual behaviours and better health outcomes in the future. The themes identified as being significant in understanding the male perspective regarding sexual health prevention tool use include: The effect of gender-role expectations and societal influences, provisional and modal educational issues, absence of efficient advertising, marketing and awareness tactics, lack of appeal, ease of use and access to sexual health devices and justification for where responsibilities lie.

Issues identified within this study point to the need for further education and awareness around sexual health matters. Before informed decisions can be made regarding use of safe sexual health devices, individuals need to be educated regarding the consequences of not taking up preventative measures or choosing not to use protection. Alike this study, Remes et al. (2010) also suggested use of both educational and health promotional tools such as health awareness videos, advertisements or sexual health campaigns, alongside better access to sexual health devices as this would likely lessen sexual health risks enacted within society.

Consistent with the findings of DiStefano et al. (2012), all five key themes were shown to have an interlocking effect when influencing sexual health responsibilities and tool use specified to each. This was exemplified by the interplay of many different socio-environmental factors and the associated justifications for these behaviours including significant influences of friends, family, lived experiences, culture, gender-role expectations, and normalised social behaviours. These factors were extremely important to identify as they play an important role as mediators when looking to target and alter individuals'

sexual health beliefs and behaviours in the future. By addressing these mediating factors, change may start to occur.

In addition these mediating factors identified provided information which aided understanding of why different rates of vaccination uptake between males and females may have occurred globally. By identifying and then addressing these mediating factors, we may in future, see increased use of preventative and protective sexual health materials by males.

Remes et al. (2010) were quick to point out that both contextual factors and social norms have a significant impact on STI/STD transmission and as such influential factors like these need to be addressed. The findings of this study alongside those of Latkin and Knowlton (2005) and numerous studies within the literature review of Parker and Klein (2000) support this notion, and maintain the belief that future targeting of these mediators going forward is required.

Each key theme played a vital part in the understanding of a male's perspective regarding sexual health precaution decisions and also how their role in society impacts on this. As a positive addition, these findings also highlight why sexual health issues are still present in today's society.

Social expectations and gender-roles are present and influential right from day one in life. Such expectations play a significant function in what we are meant to believe, how we are supposed to act and the behaviours we should follow accordingly with our gender. As a male, further attention is need on accepting numerous displays of masculinity, not just confinement to the dominant view that he should be the aggressive, authoritative, strong, unemotional, brute provider. In fact, reconstruction of this role or the undoing of gender is much

needed within society. Currently, preventative and protective health behaviours promoting beneficial health outcomes are considered effeminate and therefore are avoided by males desiring to fulfil their gender-role and be seen as the masculine male. Within this study it has been identified as one important factor contributing to unequal health status between men and women. It only further explains why male vaccination rates are much lower than females, and why sexual health issues are still present today.

Contrary to the beliefs of Slabbert et al. (2015), through attaining this information, we can start to establish social change by targeting the areas identified as requiring improvement or change. By opening up just one person's eyes to the lack of awareness publicly present about STIs and the dangers of following social expectations or practices naively, a difference can be made. To change a social belief, we need the ability to alter individual beliefs first. This information allows us to understand the ways in which individuals think and make decisions to know the factors or beliefs to target in order to achieve behavioural changes in future.

## **LIMITATIONS**

Initially this study began with a focus on sexual health specifically looking at the context of HPV. As HPV is a relatively new STD/STI of interest within public health, prior studies have seldom focussed on this as their topic of interest, especially in a qualitative context. As a result of this, where it was not possible to assess the literature of prior studies focussing on HPV, those focussing on HIV as a similarly sexually transmitted disease have been utilised.

As individual interviews and the focus group unfolded, general sexual health trends emerged strongly, and HPV as a topic was discussed less by participants than expected. STIs and STDs as a whole were focused on more so than HPV. This in itself demonstrates the need for further studies to be conducted focussing on HPV going forward, as participants naturally went on to discuss something they knew more about. As a result of this, findings could not provide any further insight into the way males understand HPV specifically and how they act on the basis of this as a disease worthy of concern.

After concluding the first five interviews followed by the first focus group, recruitment efforts had reduced success rates. All recruitment efforts were exhausted as there were no further responses to Facebook advertisements, and snowballing brought no additional participants in. The data previously collected was analysed, and at this point it was decided that what had already been collected was sufficient to continue a more in-depth analysis with. Through utilising both interviews and a focus group to collect information from participants, data compiled was found to be rich in detail, especially as the population desired is considered hard-to-reach due to the sensitivity of discussion topics. As a result of the small sample size, findings can only provide insight to the opinion of New Zealand residents. In the future, further studies will be required once the vaccination has been established more firmly, in order to attain more detail regarding male responses to HPV.

Although a focus group is not the most favourable setting for participants to discuss private experiences and sexual failures, this method was advantageous, as the presence of other males in the same scenario prompted increased responses and provided a comforting environment to disclose sexual

behaviours. The use of individual interviews also proved to be beneficial as it accounted for shyness or possible discomfort felt in social settings and allowed sensitive information to be discussed openly in a private manner. Additionally, the point of confidentiality was emphasised to participants at the time in which the focus group commenced to encourage discussion. Despite the likelihood that participants may withhold sensitive information during one-on-one individual interviews due to their conduction by a female researcher, all participants remained open about their sexual behaviours.

## **FUTURE IMPLICATIONS**

According to the (World Health Organisation, 2006):

*“Sexual health is the state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled”.*

This thereby explains and supports our finding suggesting the need for social change if we wish to improve the sexual health status of society completely.

As time goes on, we can no longer target individual behaviour changes alone, but also now need to address mediating factors and contextual

influences that prolong issues and enable normalisation of such risky behaviours.

By piecing together the ways in which men make decisions and establishing the factors these decisions are based upon, we can start to understand how their ideas are shaped regarding discourses utilised and also understand their concerns about sexual health in order to aid public health planning, such as intervention development or prevention programmes, to address these issues in the future.

This study, alike Marchi et al. (2008), found that integration of men's reproductive sexual health into society is a necessity at this point in time. Prior to now research has had a strong focus on the reproductive or sexual health care of women rather than men. This has meant that some interventions and programmes aimed at improving sexual health within the community up until this point have ignored the role males play within the relationship (Hawkes & Collumbien, 2007). The involvement of males within sexual and reproductive healthcare could drastically change the way individuals view sexual health responsibilities going forward, hence would be highly influential toward safe sexual health behaviours enacted and resulting health outcomes.

It is better to prevent a problem from occurring than to protect against it once it is already established, therefore discussion surrounding sexual health topics needs to be targeted first and foremost. Facilitation and normalisation of discourse surrounding topics considered taboo or uncomfortable such as sexuality, is required in order for consequences of sexual health diseases and lack of protection to be taken seriously. To change larger scale societal norms

or views, individual perspectives at the micro level are required to change first. By alleviating the barriers to talking about sexual health, it may be possible to re-structure the way we view gender-roles, gendered behaviours, and therefore associated sexual health responsibilities.

As strongly stated by Kelly et al. (2017), the term 'undoing gender' holds strength in determining what is required to socially change in order to have an impact on the way we construct reality and acceptable behaviours. The need for open discussion surrounding gender, gender-roles and sexual health responsibilities or negotiations is something society lacks but requires if we wish to reduce sexual health disease rates for future generations.

As suggested by Hawkes and Collumbien (2007), and similarly observed within this study, the effect of behaviour change programmes alongside public education initiatives would prove most beneficial. With the support and commitment from large scale institutions or organisations it is possible to reduce STD/STI transmission rates.

This study serves as a strong reminder for the need to implement or introduce new, more beneficial health programs/campaigns and educational systems directed towards males also, to achieve better health status in the future.

If we wish to improve the sexual health status of the New Zealand population and reduce incidence rates going forward in life we need to address the factors identified within this study. By focussing on and attending to targeted health promotion and health education, improvement is inevitable and sure to follow.

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**Appendix A  
Recruitment Advertisement**

## **Do you want to be at the forefront of change?**

If yes, do you fit into the following:

- New Zealand Resident
- Biologically Male
- 18-30 years
- Heterosexual
- Been sexually active in the past 12 months

***Would you be prepared to talk about sexuality, sexual health, gender, gendered responsibilities, vaccinations and Human Papillomavirus openly?***

If this sounds like you, I have an exciting opportunity to help pave the way for men when it comes to sexual health responsibility.

I am looking for participants that are willing to talk about the topics specified above in individual interviews (1 hour maximum) and also group discussions of 5-6 people (completed on a separate day - 2 hours maximum). These discussions will take place **at an agreed upon location**. Time and Travel costs will be compensated via a \$30 petrol voucher upon completion of group discussions.

**I invite you to participate in this study and help pave the path for men toward a healthier sexual life!**

*If you have any queries or would like to show interest in participating, please do not hesitate to contact myself via email: [Gisele.Henderson.1@uni.massey.ac.nz](mailto:Gisele.Henderson.1@uni.massey.ac.nz) (Gisele Henderson – Researcher)*

## Appendix B Information Sheet

# Sexual health responsibilities of Kiwi Heterosexual Males

### INFORMATION SHEET

My name is Gisele Henderson and I am currently completing my Masters of Science endorsed in Health Psychology. I am conducting a thesis research project looking at Sexual Health responsibilities of males in New Zealand. My aim is to understand why males do not utilise sexual health prevention tools as much as the general female population.

I would like to invite you to take part in this exciting new research development. Please take the time to read the following information carefully.

By taking part in this study, you will agree to participate in an independent interview (1 hour maximum), followed by a group discussion with 4-5 other participants (2 hours maximum) completed on a separate day. These interviews and group discussions will all be audio recorded and will touch on topics including: sexual health and associated behaviours, masculinities, what it means to be a male, gender, gendered responsibilities, vaccinations and the Human Papillomavirus.

Data collected from interviews will be transcribed and brief participant quotations will be utilized within study findings.

All interviews and group discussions will take place at the Massey University Albany Campus, North Shore. Time and travel costs will be compensated for via petrol vouchers upon completion of group discussions.

**In order to take part you must meet the following requirements:**

- **New Zealand Resident**
- **Between 18-30 years**
- **Biologically Male**
- **Heterosexual**
- **Sexually active in the last 12 months**

In place of your identifiable/legal name, you may select an alias to use throughout the study. This will ensure any data collected will remain confidential/anonymous and cannot be traced back to you as an individual. Only the researcher will have access to legal names on the consent forms.

### **Participant Rights**

If you have any questions about the study, feel free to bring them up at any time during participation. If you do not wish to discuss a topic during interviews or group discussions, you can choose not to do so. Additionally, you may withdraw from the study at any point; however need to be aware that any data already collected cannot be withdrawn. If at any point throughout the interview you do not want details to be recorded you may ask the researcher to turn the recording device off. Upon completion of the study, if you wish to receive a summary of the project findings you can receive a copy via email or post (details to be provided on consent form).

Your participation is completely voluntary, however if you have any interest in participating in this study please do not hesitate to contact one of the following:

**Project Contacts:** Gisele Henderson (Researcher) Gisele.Henderson.1@uni.massey.ac.nz  
Kerry Chamberlain (Supervisor) K.Chamberlain@massey.ac.nz  
09 414 0800 (ext 41226)

**This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 17/24. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Acting Chair, Massey University Human Ethics Committee: Northern, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz)**

**Appendix C**  
**Individual Interview Consent Form**



## **Sexual health responsibilities of Kiwi Males**

### **INTERVIEW - PARTICIPANT CONSENT FORM**

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in the interview for this study under the conditions set out in the Information Sheet.

**Signature:**

.....

**Date:**

.....

**Full Name - printed**

.....

## Appendix D

### Individual Interview Schedule - Questions

# Sexual health responsibilities of Kiwi Males

## INTERVIEW SCHEDULE

1. Participants will be provided with the information sheet and given time to read over this and ask any questions they may have
2. At this stage, it will be re-iterated that all interviews will be Audio recorded.
3. Participants will then be reminded of all their rights within the study

### INTERVIEW COMMENCEMENT

4. Participants will be invited to talk about their take on Sexual Health in general.
5. This will be followed by prompts to talk about the following (in any order)
  - **Sexual Health behaviours** – what are sexual health behaviours? When engaging in sexual activity with a partner what health behaviours are they conscious of/think about? Who performs these behaviours, and why is it this person? What behaviours are normal to them (the participant), why this is?
  - **Gender** – what is gender?, is a gender performed/chosen?, what it means to be a male, what is expected in these gender roles, are there pressures to act a certain way? What way is this?
  - **Gendered Responsibilities** – do males and females act the same way? Why/how is this shown? What are responsibilities? Does each gender have specific responsibilities/jobs they fulfil/act out in life? Do these responsibilities differ to the opposite sex? What do they do as part of these responsibilities? – give some examples, How about sexual activity - What responsibilities does each gender hold?
  - **Masculinities** – what are masculinities, what this term means to a participant, what it means to be a male, how are masculinities acted out on? what masculinities the participant believes they perform,
  - **Vaccinations** – what are they? What purpose do they hold, what do they think of vaccinations, do they know of any vaccinations used in sexual health, if so what are these used for?
  - **Human Papillomavirus (HPV)** – have they heard of it? Do they know what this is?, who do they think it affects? How does it affect these people/this person? How do you get HPV? Are there consequences, if so what are they?
6. Close the interview and thank the participant for their input and time.

**Appendix E**  
**Focus Group Consent and Confidentiality Form**



## **Sexual health responsibilities of Kiwi Males**

### **FOCUS GROUP - PARTICIPANT CONSENT & CONFIDENTIALITY AGREEMENT**

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that I have an obligation to respect the privacy of the other members of the group by not disclosing any personal information that they share during our discussion.

I wish/do not wish to receive a summary of the study findings upon completion of the project.

I would like my copy of study findings to be sent to me via the email/physical address stated below:

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I agree to participate in the focus group under the conditions set out in the Information Sheet.

**Signature:** ..... **Date:** .....

**Full Name - printed** .....

## **Appendix F**

### **Focus Group Discussion Schedule - Questions**

#### **FOCUS GROUP FORMAT**

1. Give Information Sheet and explain what will be done today.
2. Introduction – introduce each other.
3. Consent/Confidentiality Forms
4. Explain it is a group scenario and others may have different opinions to you but please be understanding of these and let each person speak when they want to contribute something. You may each say as much or as little as you like. Please don't be afraid to speak up. Anything said in this group will stay in this group. You may call each other by real name, however your chosen alias will be used in place of this for my written work.
5. Please do not talk over one another. Let one person finish then another start as I need to be able to transcribe this and to do so the discussion needs to be legible on the audio recorder.
6. Gas vouchers will be given out at the end of discussion.
7. QUESTIONS

#### **SEXUAL HEALTH**

What is sexual health about?

#### **HPV**

Noticed HPV is not very well known about to males. Why do you think that is?  
Is this something that you think maybe needs to be taught about more? Yes/no? Explain why you think this.

#### **PROTECTION PRIORITIES**

Protecting against pregnancy = primary issue. Protecting against STD = secondary. Whys that. Why have these priorities been set? Is personal health not as important?

#### **VACCINATION**

You've all said if a vaccine was available that you would choose to get it. Why do you think male HPV vaccination rates are so much lower than females? What do you think would put males off receiving it?

Why in your mind (what reason) would there be such a difference in rates of vaccine uptake between males and females?

Pros and cons of getting it vs not

## **RESPONSIBILITIES**

Society holds a belief that females bear more of the burden by caring for sexual health tools/needs in a relationship more than males – talk me through that. True or not? And why.

Differences of the generation now versus prior generations – how does this affect sexual health tool use and who utilises what? Who is in charge of what sexual health aspect in the relationship? – How has this changed over time?

Does the way society pressures you to act affect sexual behaviour/use of sexual health tools? How so?

Can these be separated at all? One person in society vs another in the bedroom like 2 different personas? – is this the effect of peacocking as one of you have mentioned earlier?

Responsibilities have come across as rightful duties to be performed – would you say that's correct? When it comes to sexual health responsibilities what duties do you think the male should hold? – On a practical side of things, does this actually occur in reality?

Again, as responsibilities have quite often been referred to in the same way as duties/obligations – does this mean these are influenced by upbringing/expectations when younger. How might this influence what we see as our own sexual health responsibilities as we get older?

All of you mentioned seeing a change of gendered responsibilities and roles according to generation. Explain with examples. - Common theme that it has become more equal.

Do you think the older/earlier generations' way of thinking has influenced/impacted on how we view sexual health responsibilities and expectations of gender-roles now days?

Who usually takes the lead with sexual health in your relationships? - Why did that person take it?

There is a general perception that women are entirely responsible for birth control stuff – whys that?

A few of you have said it's easier for the girl to be on the pill – explain? Why is that?

## **SEXUAL HEALTH TOOLS/BEHAVIOURS**

Are there the same opportunities and tools available to males and females?

Male sexual health tools easier to access than female sexual health tools?

How we are brought up has been mentioned as impacting our behaviours and norms, now does that affect sexual health behaviours?

## **GENDERED BEHAVIOURS**

Based on what everyone has said, gendered behaviours are the behaviours a male or female stereotypically is understood to carry out as part of their duties/obligations as defined by society – correct?

Gendered behaviours – can you give any examples of gendered behaviours in the context of sexual health behaviours?

In what way might culture impact gendered behaviours and also sexual health behaviours?

A change in gendered life roles has been established by most of you. Elaborate on this.

## **MASCULINITIES**

To be a male, you have all described the following as being masculine traits = aggressive, ladsy, blokey, authoritative, physically strong, tough, unemotional, staunch, macho, proud, cocky, arrogant, taking charge in a situation, provider, protector, loud, taking up space in a room etc. – do you still agree with this?

The idea that men are seen as leaders and women are seen as carers has been thrown around a bit – would you say this may influence why being in charge of sexual health in the relationship is seen as more a female role?

So when I say the notion of females being in charge of sexual health is a double standard as it contradicts the ideology of being in charge/authoritative as a part of being masculine, what's your take? – How does this fit?

## **THEMES OBSERVED**

It has been noticed that the concept of trust between partners in a long term relationship overpowers the need for sexual health precautions eg vaccine or sexual health checks. – does this mean to say there is an association between the idea of mistrust/infidelity being assumed if partners feel the need to get checks or wear condoms? - Where is the line?

The idea of a woman taking charge of a situation has been mentioned to throw a man off and make him feel angry/bothered as it undermines his masculinity. In the case of sexual health why does this not occur when she takes charge of sexual health?

Do you think it is true to say that if everyone looked out for their own sexual health, it would have a follow on effect of looking out for others also because then everyone would be protected? - So why is it that some people may choose not to protect themselves and rely on others?

## **Anything else you wish to add/discuss?**

8. End recording
9. Give out Gas Vouchers and thank participants.

## Appendix G

### Thematic Analysis Categories and Coding Table

Table 1.

*Categories produced as a result of codes identified within thematic analysis*

Categorisation/Theme	Codes Identified
<b>Education</b>	Lack of education Naivety Mode/method of education Education outside clinic reason for where responsibility falls
<b>Advertising/marketing/awareness</b>	lack of advertising/marketing more awareness needed Naivety need to engage people lack of awareness bad marketing - not appealing health promotion push for discussion -normalise /rid SH taboo advertisement/marketing target approach need for SH campaign not enough targeting individual effect on others/society
<b>Ease/Accessibility</b>	changes over time lack of safe access to SH devices for males convenience factor family planning role in society limited range of male SH tools ease of contraceptive pill use dominant use of condoms unappealing access points effect of lack of funding for males
<b>Gender-role expectations/influence by society (pressures)</b>	protecting self first effect on others in society role of trust/security in relationship relationship vs single femininity vs masculinity role of friends role of family cultural effects protection against pregnancy vs STDs/STIs societal gender-role expectations

	<p>normalised behaviours in society</p> <p>Peacocking</p> <p>life exposures</p> <p>social expectations</p> <p>shared responsibilities</p>
<b>Reason for where responsibility falls</b>	<p>ease/accessibility</p> <p>advertising/marketing/awareness</p> <p>relationship vs single</p> <p>who does what</p> <p>gender-role expectation</p> <p>social influences</p> <p>femininity vs masculinity</p> <p>convenience factor</p> <p>shared/equal responsibilities</p> <p>protection against pregnancy vs STDs/STIs</p>