Sexual & Reproductive Healthcare

Do you know how to use a condom?'- UK nurse practitioners' conversations about men and family planning

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Abstract

Objective: Health professionals have been identified as central to encouraging men to take an active part in family planning. The aim of this article is to understand nurse practitioners' conversations about men as family planning patients.

Methods: One-to-one, semi-structured interviews were conducted with five nurse practitioners. Nurses interviewed worked in a northern UK student medical practice serving over 34,000 students with a diverse range of ages and demographic backgrounds (both home and overseas students). The research method was qualitative using discourse analysis.

Results: After completing the analysis, two discourses emerged. Discourse one, family planning services are culturally female centric, and discourse two, condom use by male family planning patients is problematic.

Conclusions: Implications for how nurse practitioners can continue to play an important part when providing care to male family planning patients is discussed, specifically in relation to culture and condom efficacy.

Keywords: *Men's Health**;** Culture; Condoms; Education; Nurse-Patient Relationship*

Introduction

Nurses are considered important to patient care, particularly to inform the reproductive life plan of individuals.[1] In the United Kingdom (UK) due to restructuring of the National Health System (NHS) nurses' responsibilities have increased to include consultations for family planning. [2] The UK lacks a national curriculum for nurses in sexual and reproductive health (SRH) despite research to suggest there are benefits to a national curriculum (e.g. an increased level of patient knowledge). [3] The number of UK health

professionals specifically trained to provide SRH care is low [4] and services report difficulty recruiting SRH educated nurses. [5] Regardless of the external strains on delivering SRH care, researchers in critical men's studies have identified that health professionals are central to encouraging men to take an active part in family planning. Nursing and other disciplines have been championed to work together to expand the limited research on men in the procreative realm. [6]

There are some concerns to including men in reproductive decisions, particularly the potential impact including men may have over women's power and autonomy. Irrespective of these concerns, men are already involved as part of women's reproductive decisions. Research exploring men's role in family planning could be used to inform the manner in which men could positively be incorporated to improve women's reproductive health. [7] Research on men's engagement in pregnancy suggests men can improve maternal health, with further research needed to include all areas of pregnancy (e.g. preconception). Healthcare professionals play a primary role in strengthening or reducing men's role, providing them a unique opportunity to directly influence men's engagement. [8] Reproductive health psychologists are increasingly aware there are also social and cultural influences behind men's reproductive decisions. For example, men with more egalitarian attitudes and beliefs have a more positive effect on women's reproductive health. [9] Currently little is known about the practices that occur during UK nurses' consultations with male family planning patients and how these consultations may influence men's engagement in family planning. This study aims to further understand these practices through conversations with nurses about their male family planning patients. The research question asks how do nurses' construct men as family planning patients?

Methods

The medical practice had over 34,000 student patients primarily between the ages of 18-25, with overseas patients (international students) described by the nurses as older (30 and above). The nurses provided primary family planning care to male patients (e.g. condoms, advice), male patients were only referred to see the General Practitioner (GP) if they presented with painful urination. Interviews were between 20- 35 minutes, lasting on average 30 minutes. A semi-structured interview schedule was created to allow for flexibility. Five semi-structured interviews were completed with practitioners during their scheduled lunch breaks at work. The interviews occurred in a private area or a semi-private location where nurses could feel free to express themselves without worrying about what other employees or managers may think. The nurses had various levels of professional experience. Regardless of total length of time in practice, the nurses had worked at the current medical practice for roughly 6-8 years. Prior to interviews, University ethical approval was obtained and the ethical considerations were made in reference to the British Psychological Society (BPS) guidelines for human participants.[10] Written permission to interview nurses was provided by the medical practice, with consent forms received by each nurse who participated. Anonymity was assured through creating a numerical assignment to each nurse (e.g. Nurse 1, Nurse 2). A table of the participants is as follows:

Table 1

Pseudonym	Training	Sex	Ethnicity
Nurse 1	7 years in practice	Female	White British
Nurse 2	17 years in practice	Female	White British
Nurse 3	30 years in practice, previously working with a men's health specialist	Female	White British
Nurse 4	48 years in practice, previously working as a midwife for 10 years before returning to general practice as a nurse	Female	White British

Nurse 5	9 years in practice	Female	White British

The interviews were analyzed using a method of discourse analysis from Willot and Griffin[11] and Gough[12] (see Wilson, Fylan, and Gough[13]). Discourse analysis has been used in critical health research with nurses to understand how language informs nursing practice.[14] To conduct the analysis the transcripts were divided into sections and numbered sequentially (e.g. the first interview transcript labelled section one). Once the transcripts were divided into sections, the sections were coded line-by-line for themes. Upon completing the coding of the first section, the themes identified were collapsed to create revised super-ordinate categories. Lines were re-coded as necessary before identifying themes in the subsequent sections. New themes were added as they emerged in each section and the themes continued to be revised within each transcript until they were finalised. Once finalised, the ways in which the themes were talked about were identified. The talk was then analysed for recurring patterns of discourse. From the analysis two discourses emerged: Discourse 1- Family planning services are culturally female centric, and, Discourse 2- Condom use by male family planning patients is problematic. The data was triangulated using multiple researchers; investigator triangulation includes two or more researchers during analysis[15] to reduce bias, increase internal validity and reliability.[16] It is a common practice in psychology[17] and has been used in discursive research.[18] Investigator triangulation involved the author and two academic researchers agreeing the themes, talk, and discourses that emerged from the analysis of the transcripts. Reflective memos were also created by the author and shared with the same two researchers to identify potential bias within the analysis.

Results

The results section is presented in two parts, one for each discourse. Within each part, quotes are presented and the talk that constructed the discourse is discussed. The quotes

presented best represented the dominant themes that formed the relevant discourses from analysis.

Discourse 1- Family planning services are culturally female centric

Male patients' were largely absent in the medical practice. However, nurses explained some men attended consultations as part of a couple:

> **Interviewer: Have you had any male family planning patients?**
> Nurse 2: I don't recall any men coming in on their own, for family planning. I have had the odd chap that's usually for like, um, sometimes they come in asking for Chlamydia screening, um, which I am always surprised about. They obviously don't know they can get it at reception, cause I don't know why they would want to put themselves through that, but that's fine. Um and it's, some of them are quite confident, quiet outgoing with it and then they tend to ask for condoms then so that's a positive I suppose. I don't recall ever having somebody that has come in for something totally unrelated asking anything with regards to family planning and contraception. So the main thing I would say is probably that we get partners coming with their girlfriend or with their wife. Um it happens a lot with the international students because a lot of the time the wives don't speak English or their English isn't very good so they HAVE to come with them to ACT as translator. But often you do get a girl that is coming in for emergency contraception, often she will DRAG the boyfriend with her, and say well this is your fault, so you know if I have to go your coming with me. I had a couple of guys that have seemed very interested and I suppose actually thinking about it I'm suspicious about that. Which, I shouldn't have been, but because it isn't normal I'm thinking why are you so bothered, why are you so interested. I wonder if it's a bit of a control thing or, but actually no they are probably just you know just don't want their girlfriend to be pregnant and because you know it effects them, well almost as much. But yeah I think because it doesn't happen often, it flags it up in your brain and you think why are you so interested in this? They [male patients] seem to be more interested when the woman is having like a coil fitted. Um, and I don't know if it's because they think it's going to affect them because some men have said that they can feel the strings during intercourse, so I don't know if that's the case or I don't know if in some cultures. Maybe it's to make sure she definitely has contraception, where she might say oh I got a coil and how would he check that. He can check that she is taking pills, or you know, so I don't know what the reasons behind that is, but that is what I've noticed. But yeah, you don't often get men coming in; they don't want to talk to you about sex really.

Nurse 2 did not see male patients for family planning, stating 'I don't recall' twice. Male patients only presented if there is a problem like sexually transmitted infections (STIs). Nurse 2's talk is ambivalent towards male STI patients; she 'supposes' it is

'positive' that some ask for condoms. Nurse 2 positioned male patients as accessories- it is likely that female patients had to 'DRAG' male partners, using a loud tone for emphasis. International partners attended more frequently because they had no choice; 'they HAVE to come with them to ACT as translator' for their wives (again using a loud tone for emphasis). Nurse 2 further positioned male partners as potentially coercive; her talk suggests it is 'suspicious' or not 'normal' to be 'bothered' and 'so interested' in their partners' contraception. Her dubious tone continues, they 'probably' want to prevent pregnancy, but pregnancy does not affect them 'as much'. Instead, she feels they attend because they are concerned with their own sexual pleasure- with a coil they may 'feel the strings during intercourse', or because they want to 'check' their partner has received contraception. Nurse 2 highlighted it is difficult to engage male patients in general because 'they don't want to talk to you about sex really', framing them as disengaged.

The nurses believed the absence of male family planning patients was due to UK culture, justifying male patients' absence. In response, nurses suggested that male spheres might be more appropriate places to engage men:

> **Interviewer: So what do you think is the biggest barrier to men coming in to say a medical practice and talking about family planning?**
> Nurse 4: Um, I think, the biggest barrier is men themselves, I don't think we put up barriers here necessarily, I think it is men themselves, there, the attitude that it's not their role, it's you know, the woman's role rather than the man's. Particularly in the British culture, the only time I do see it, is maybe with some of the international students that bring their wives in and that the man will bring the wife in for something for her and he decides what they are going to use for family planning.
>
> **Interviewer: [pause] so is there is anything you can think of that men need to overcome, any other barriers to engage in family planning?**
> Nurse 1: Um, perhaps see it's more relevant to them, if they could possibly do that, because it is relevant to them.
> **Interviewer: Yeah I guess that is really the struggle isn't it, how to make it relative?**
> Nurse 1: yeah, ooo, it's difficult I think the only things, the things they would be most likely to read or take note of in the men's magazines and gyms, that

> kind of thing, sports arenas. Um, if anything could be promoted there that would be a good thing, but even then it's a bit of a macho environment and again it's a cultural thing, and we [women] sort ourselves out you know. The women can go sort themselves out because they have to. I think so.

When asked what barriers existed, Nurse 4 explained it is the 'men themselves', which she says twice for emphasis. Nurses do not put up barriers, male patients present with traditional 'attitude' and gender roles; it is 'the woman's role rather than the man's'. Nurse 4 used the word 'only time' to show in her experience it is 'British culture' that dictated family planning as a woman's responsibility, not necessarily other international cultures. However, her talk suggested that international male patients might extract control over contraceptive decisions because they 'bring the wife' and 'he decides' on their contraception. Nurse 1 also suggested it is men themselves who do not see family planning as applicable, using the word 'relevant' twice to indicate importance. At first Nurse 1 tried to overcome this barrier by thinking of places where male patients may engage, 'be most likely to read or take note' such as 'men's magazines and gyms' and 'sports arenas'. However, Nurse 1 used words like 'macho environment' and 'it's a cultural thing' to suggest this may not be productive. Instead Nurse 1 explained culture as dominant, stating again it was a 'cultural thing', women are expected to 'sort ourselves out', using the word 'we' to show this is knowledge Nurse 1 is privy to being a women.

Discourse 2- Condom use by male family planning patients is problematic

Male patients required education to improve condom efficacy. However, the nurses indicated that male patients were embarrassed to discuss with them that they were unsure how to use a condom:

> Nurse 5: I think it is very taboo in this country and people need to talk about it more, how to kind of avoid pregnancy. You know I don't think it'd do any harm to have maybe an advert on the tele [television] showing you how to put a condom on or something like that, you know what I mean?
> **Interviewer: Yeah?**
> Nurse 5: Because men don't like coming in and saying, I don't know how to put a condom on because that kind of, (pause) makes them feel emasculated

> and like they should know how to put a condom on. It's the, the peer pressure thing. Um, whereas actually ways to advertise knowing how to put a condom on, there are adverts saying, "don't be silly cover your willy" and all that but do you KNOW how to cover it properly? Do you know how to use a condom? THAT'S what we need to be saying, not just I mean yeah use a condom, brilliant, at least they are trying, but there is no point if you're not going to use it properly it doesn't work.

Nurse 5 blamed culture again for male patients' failure to use condoms correctly and for the discomfort discussing condoms, which is 'very taboo in this county'. Nurse 5 however believed that nurses needed to talk to men about condom efficacy to prevent pregnancy, 'people need to talk about it more'. Nurse 5 implied teaching men to use a condom appropriately could be done by improving the adverts on the 'tele', or television, to ensure the message was broadly received. Nurse 5 discussed how male patients are 'emasculated', or embarrassed to come into a consultation and tell a nurse they are unsure of how to use a condom properly. She further explained this is a result of 'peer pressure' that men are expected to know how to use a condom, they 'should' know. She talked about adverts, such as, 'don't be silly cover your willy', with sarcastic praise. She expressed that encouraging condom use is only useful if men 'KNOW' how to use a condom correctly (which she inflects for importance). She felt adverts should be more informative, 'do you KNOW how to cover it properly? Do you know how to use a condom?', 'THAT'S' what adverts should articulate.

The nurses reported that when their patients used condoms they often tore, increasing the likelihood of pregnancy. If a condom tore, the nurses' explained that the responsibility would then fall onto the female partner to subject their bodies (not the men's bodies) to emergency contraception:

> **Interviewer: So you mentioned condoms breaking as one of the reasons that [couples] come for emergency contraception. With the men themselves do you think they are using them to that kind of standard or do you think its…**
> Nurse 2: I think it's a lot lower, I think probably most of our population are probably not using them, not just imperfectly, I think they are not using them

> at all really. I still think that message isn't getting across because they don't like them, it doesn't feel nice, you know it's not the same, they don't have one, they are in the heat of the moment, whatever you know. And I have noticed actually, I am quite surprised at how honest, and again, it's usually the girls, how honest they are and you say oh what happened? Do you normally use condoms? Yeah, well you know what happened, didn't use one. And I always think, I think I would lie, but (laughs), at least about it, but yeah, that, the efficacy of condoms is probably way down, even if they are using them. Like you say they probably aren't using them properly most of the time, and I think just a lot of the time they are probably not using them at all. And I think, you think girls, a lot of our patients are on the pill so that's the primary concern, well I'm not going to get pregnant whilst I am at Uni[versity], and Chlamydia can be, treated, and it's fine, I'll be fine. So I just think as long as the pregnancy issue is covered then they don't really consider everything else as much as they should do.

According to Nurse 2 male patients were not only using condoms 'imperfectly', they were not using them at all. Instead they were relying on their female partners to take responsibility for pregnancy prevention. She did not attribute blame to male patients, but rather she indicated that she was able to empathise with them, 'the message isn't getting across'. The men did not like how condoms felt, 'you know it's not the same', putting a personal emphasis by using the word 'you', they were in the moment or did not have one. As Nurse 2 said, the male patients were 'primarily concerned' with whether their partner was on the pill. Even male patients' attitudes towards STIs were nonchalant because they can be treated, 'it's fine, I'll be fine'. Nurse 2 positioned male patients as disengaged and poor condom efficacy as expected.

Discussion

The above discourses suggest that male patients are disengaged in family planning. In conversations the nurses concluded that a discussion on family planning was difficult to have with male patients but nevertheless these conversations should occur. Nurses related the failure to engage in family planning as cultural, with women expected to take responsibility for contraception. Nurses also indicated if male patients used condoms that they had trouble using condoms effectively. This positioning places the ownership of men's failure to engage

on male patients. These results are discussed further below in relation to British culture and condom efficacy.

While male patients were rare at the practice, male partners sometimes attended with their female partners. The tone used by nurses suggested at times they were suspicious of male partners, with concerns expressed they may be coercing the female patients. While assessing for reproductive coercion is important, further research is necessary to understand the prevalence of coercion in the UK. In the conversations nurses did acknowledge there suspicions may be unfair and men should be engaged individually. However, the nurses largely blamed British culture for male patients current absence as patients. Problem pages in UK newspapers (which provide insight into popular culture) have published viewpoints on sexual culture since the 1970s [19], providing little support that sex is a taboo British topic. Furthermore, since the 80s research has identified that in order to facilitate discussions on contraception health professionals should appear neutral in conversations and provide reassurance to men that they can make a positive contribution.[20] Despite this information, initiatives created to improve men's health in the UK, such as the Well Man's Clinic, still provide barriers to most men discussing reproductive health with a nurse.[21] One important barrier is nurses' beliefs in traditional masculine stereotypes, such as men are irresponsible and men are not interested in their health.[22] In conversation nurses' talk implied traditional masculine stereotypes, such as men see family planning as irrelevant and men are only concerned about their own sexual pleasure. Gender stereotypes can prevent health discussions, resulting in a self-fulfilling prophecy where men reflect the identity that the practitioner expects.[23] There is little evidence to support that British culture would prevent men from being capable of engaging in family planning. The nurses interviewed used traditional masculine stereotypes as a discursive practice to reinforce men's absence and promote women's presence, while also maintaining their positive identity as experts.

In the conversations with nurse practitioners, nurses believed that male patients should be more concerned over condom efficacy. If used correctly condoms are effective in reducing unwanted pregnancy. Research suggests men make confounded contraceptive decisions, with men associating condom use with HIV/AIDS rather than the dual benefit of pregnancy prevention.6 Similarly, the nurses reported that male patients associated condoms with STIs and relied on their female partner to take responsibility for preventing pregnancy. There was concern amongst the nurses that male patients who did use condoms to prevent STIs were using them imperfectly. According to the Durex Report 9 in 10 UK men reported obtaining condoms if that was their partners preferred method of contraception. [24] Few men however obtain condoms from general practice and instead obtain them from other services such as chemists. Obtaining condoms from other services removes the benefit of engaging in a consultation with nurses to improve efficacy.[13] Nurses' talk further explained that condoms tore and men were not receiving education to ensure the correct fit. This is problematic because the UK standard width of condom is unreflective of size and shape required for correct use.[25] Researchers have identified additional errors and problems crucial to closing the gap between perfect use and typical use of condoms. These include – not using a condom during the entire encounter, not leaving space at the tip for ejaculate, not squeezing air out from the tip, putting the condom on upside down, not using a water based lubricant which decreases the latex reliability, and incorrect withdrawal. Problems being, breakage, slippage, leakage, condom based erection problems, fit, and feel.[26] In addition to these problems and errors, nurses reported that men were not using condoms because they did not like how condoms felt or because they were in the moment. These concerns around condom efficacy were an interpretive repertoire used within nurses' talk as a discursive resource to articulate men's condom use as problematic.

In conclusion, nurses constructed male family planning patients' engagement as restricted by their own culture and their inability to use a condom correctly. Based on conversations with the nurses, there are recommendations that could improve consultations between nurses and male family planning patients. With nurses playing a primary role in male patients' care they can challenge their own cultural stereotypes of male patients, understanding male patients as a diverse group.[27] Training may be required on the diversity of male patients to help facilitate the understanding of the diversity of male patients. Research suggests taking a gender sensitive approach, where the aim is to transform gendered practices and create equitable relationships between men and others. [28] Nurses interviewed discussed gender sensitive practices, understanding there are differences in how male and female patients engage. For example, the nurses suggested using male spheres as an appropriate place to promote family planning to men such as men's magazines, gyms, and sports arenas. Using a gender sensitive approach is positive and should be expanded upon and implemented in future practices. Nurse Practitioners should also continue to be encouraged to have conversations with male patients about taking responsibility to obtain their own condoms and conversations should be had to ensure correct fit and use. However, continuing to target both men and women for correct condom use would be beneficial to prevent unwanted pregnancy. With the shortage of nurses trained in SRH, it may be beneficial to set up an online peer-to-peer network in which nurses could share with each other their experiences working with male family planning patients. This could include successful ways to overcome perceived cultural barriers and provide examples of how nurses can create a comfortable environment to have discussions with male patients around condom efficacy.

Limitations to the research include that while six medical practices were approached to participate only one practice granted permission for interviews. In an effort to conduct further interviews snowball sampling was attempted, however, there was little success in

overcoming the barrier of medical professionals being a hard to reach group.[29,30] The most frequent reasons being, - the local medical practices self-reported they do not provide family planning services to men and - the local medical practices were too busy as a practice to allow their nurses to be interviewed. Interviews were also limited to how long they could be, nurses were given different lengths of time for their breaks and nurses were unavailable to complete an interview that would run over 30 minutes. While time was limited, nurses who participated provided enough dialogue for a rich database to allow for a detailed analysis of the interview transcripts.[31] Another limitation included that the nursing staff interviewed were all female. In general the NHS is facing a shortage of trained nurses[32], with qualified nurses remaining disproportionally female.[33] Future studies should seek to interview both female and male nurses to see if there exist gender differences in how nurses understand their male family planning patients. Interviewing individual men should also be considered to understand any further support men might need to engage in primary contraceptive responsibility.

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