VIEWPOINT

Bringing the Fundamentals of Gender Studies Into Safer-Sex Education

By Janet Lever

Condom advertisements and public service announcements to stop the spread of the human immunodeficiency virus (HIV) seem to be disproportionately aimed at women. Their content reveals two underlying assumptions—namely, that women are likely to encounter male partners who resist using condoms, and that women have enough power in their sexual relationships to overcome that resistance. These messages fail to take into account persisting gender roles that constrain the types of power that men and women can exert in different types of sexual relationships.*

The basic premise of 25 years of gender research—that men desire control and women are willing or forced to relinquish control—casts doubt on the prospect that many women, especially young women, can follow the recommendations of the safer-sex messages aimed at them. Strategies that depend on female assertiveness will work for some but are doomed to fail for many others. Campaigns that target men as the ones perceived by both partners to be "in charge" of sexual interaction might be more effective, since this message agrees more with real, rather than ideal, gender roles.

Not only do gender roles and stereotypes play a role in constraining styles of interaction between potential sexual partners, they also shape the assumptions of sex educators and the designers of advertising campaigns. Targeting women may reflect the common cultural belief, developed with the advent of the pill, that contraception is the woman's responsibility.[1] Targeting women, however, may also be based on the unquestioned gender stereotype of women as "gatekeepers" of sexual activity, and on the stereotype that women have greater control over sexual impulses than men. However, gender research challenges the veracity of these old stereotypes, too.[2] The assumption that women hold more favorable attitudes toward condoms than do men and are therefore less likely to object to their use is also at odds with survey data.[3]

We have only to look at issues of *Family Planning Perspectives* for examples of advertisers' pitch to women. A recent ad for the female condom sends the following message, aimed at health educators and practitioners—when a woman's partner is unwilling to wear a prophylactic, advise her to wear one and protect herself.

The headline on another ad reads *"Why every woman should use a condom,"* even though the ad is for a male condom. The accompanying text starts with "We don't need a condom because he says he loves me," but continues with statistics showing that condom use rates among men are low, whereas the proportion who have lied about their sexual past is high. There is also a reminder that women pay a higher price for an unwanted pregnancy, followed by data on women's increasing risk of infection with a sexually transmitted disease (STD), including AIDS.

The ad ends with the phrase "every woman must be convinced that 'I love you' should mean 'I'll use a condom.'" The message: his love and his words cannot protect you, only a condom can. In effect, the ad gives a woman the data and repartee with which to rebut a partner's claim that a condom is not needed.

Survey data on sexual practices tell us that health promotion ads and sex education curricula have not yet succeeded in persuading people to abstain completely or to use condoms at every sexual encounter. Condom use among adolescents and unmarried young adults is increasing, although recent data show that the practice is still far from universal.[4] Qualitative research methods are far better suited than surveys to providing additional insight into why couples resist using condoms. Focus groups, for example, which have long been respected for their utility in market research and political campaigns, are underutilized in health promotion planning.† They can be especially useful in shedding light on a problem because of the surprising directions conversations can take when a moderator probes for participants' opinions, experiences and problems with certain situations or products.

As an example, Landry and Camelo reported on focus-group encounters, held in Denver, in which young men and women spoke for themselves about obstacles to condom use.[5] When asked to reconstruct their contraceptive decisions, both male and female participants blamed their occasional failure to discuss or use condoms on embarrassment, alcohol or drug use, dissatisfaction with condoms for reducing physical sensation and disrupting sexual activity, and fear that they would slip or break. Among other reasons for nonuse were trust in their partner's assurance that they were not infected with

Janet Lever is associate professor of sociology at California State University, Los Angeles; health policy consultant at The RAND Corporation, Santa Monica; and coauthor of the "Sex and Health" column for *Glamour.*
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*In a classic examination of sex and gender roles within the context of power, Lipman-Blumen defined power as "the process whereby individuals or groups gain or maintain the capacity to impose their will upon others, to have their way recurrently, despite implicit or explicit opposition, through invoking or threatening punishment, as well as offering or withholding rewards." (See: J. Lipman-Blumen, *Gender Roles and Power,* Prentice-Hall, Englewood Cliffs, N. J., 1984, p. 6.)

†A search of the AIDSLINE index produced only 23 titles from 1980 through 1994 for studies of adolescent sexuality education that included focus groups in the study design; of these, only two were conducted with nonminority U.S. teenagers. Three studies were done with special populations (minorities, prostitutes and drop-outs) and 18 were conducted outside the United States.

an STD (despite the lack of medical confirmation) and, most simply, because a condom was not handily available.

However, an additional obstacle to condom use was not discussed in the Landry and Camelo groups, nor has it surfaced in any other report I have seen in over a decade of monitoring AIDS research. Namely, the maintenance of power over women, in and of itself, can lead to resistance to using condoms. This unacknowledged link between the assertion of power and some men's reluctance to comply with requests for the protection condoms provide was raised during a peer-led, all-male focus group conducted with five first-year and second-year students at an elite private university in California. Here is the relevant portion of the tape-recorded dialogue:

Leader: It's kind of uncomfortable when you're with a girl and someone has to pull out protection. One of you has to, but neither one wants to, so it's like, you're waiting for the other person to do it. How do you feel when a woman takes out a condom?

Bill: Well, I've never had it happen to me, so I can't tell you.

Len: Yeah, let's first say who has had a girl say that. See, I've gone out with girls who say (he lowers his voice in imitation of their whispers), "Uh-uh, unless you have protection," but I haven't had a girl say, "I've got some condoms in the glove compartment."

Bill: Well, I find it kind of common to be getting serious with a girl and she'll say, in a low whisper, "Do you have protection?" and if you say, "Yes," you get the picture that you have to stop, you have to do all the stuff. I mean, if it's the only way you're gonna get something, you might as well do it. Even though I *have* it on me, and I have it just for that use, it still kind of pisses me off. It's like, "Do you think I'm dirty, or what?"

Len: Yeah, it's like they're accusing you. I'd say, "Forget it." You get pissed off. (Background chorus of "Yeah's.")

Len: I'd be very uncomfortable, 'cause you'd feel like she's making you do something, 'cause girls aren't supposed to do that.

Leader: Ooh, don't let Janet [me, their professor] hear you say that.

Len: It's like, you're not used to girls telling you to do something.

Bill: But if it's a one-night stand, hey, what the hell, you gotta use it.

Len: Yeah, if it's the only way you're gonna get down her pants, you might as well use it.

How often does the battle for control motivate men to resist using a condom? From this very small group, it is hard to know how common the problem is. One methodological weakness of focus groups is that they are susceptible to group bias—that is, members sway each other. These southern California students, in all-male company, may have been displaying more agreement than they actually felt.

One of the method's strengths, on the other hand, is that subjects feel comfortable and encourage each other. In the presence of peers who expressed "socially undesirable" sentiments about male domination and aversion to safer-sex practices, some participants may have felt safe in agreeing with those sentiments, especially when no outside moderator or authority figure was present. Other same- and mixed-sex focus groups that were not peer-led were held in Wisconsin as well as California. Not surprisingly, the members of another male-only group in Wisconsin, for which I was the moderator, did not express similar sentiments, nor did any members of mixed-gender focus groups.

Whether the young men's dialogue was the product of group sway or group support, it yielded insight about an important gender issue that is totally missing in AIDS awareness campaigns—that young men are not accustomed to taking directives from young women. A young woman who halts the sexual action, even with a whispered plea for caution, may be seen by some as gaining control of a scenario that the young man thought he was directing.

It would be a mistake to generalize from focus groups to all young men, but focus groups are useful in generating hypotheses. The extent to which representative samples of young men would agree or disagree that female-initiated condom use challenges male authority becomes an empirical question for future systematic research. More to the point, we could test the hypothesis that the threat of female assertiveness triggers a reaction that makes some men resist condom use.

While the health education literature does not totally ignore the associations between condom resistance and concerns about masculinity, such associations are limited to particular subpopulations. The condom ad previously mentioned notes this when it states, "…many ethnic and minority cultures consider the use of condoms to be forbidden or unmanly."

But the focus-group dialogue suggests a more general gender dynamic. The woman's demand (more likely phrased as a request) rather than the condom per se may be what makes the young man feel less of a man; the issue of who is in control could be troublesome for many men, regardless of ethnicity or race. By reinforcing the notion that women should take the lead in initiating condom use, educators and advertisers may be putting into motion a power struggle that has little to do with safer sex, and one that makes protected sex less likely to occur.

Although men might like to feel they are in control during sexual encounters, they concede that women have the real power in their prerogative to refuse sexual overtures, especially in first encounters and in the early stages of dating. According to Landry and Camelo, many focus-group participants reported that women demanded condom use, and some men acknowledged that they would not use a condom without the woman's initiative. As one Denver man honestly described his strategy of resistance "… if they are at the point where they are not going to have sex if you don't have a condom on, I try to talk them out of it."[6] The California men also conceded that they would use a condom if a woman insists, rather than miss a sexual opportunity.

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In other words, young women do have some power in sexual situations and sex educators should reinforce their awareness of that power. The problem arises when we divert attention from the obvious source of that power by telling young women they have the power to display bold verbal initiative, a power some may, in fact, not have.

What proportion of young women are able to initiate a discussion about condoms or forcefully demand condom use as a condition for sex? We simply do not know. The men in the focus groups analyzed by Landry and Camelo said that they rarely discussed contraception with casual partners, but when they did, the women initiated the conversation. The participants' testimony indicates that

some young women can initiate talk about condoms, but the fact that such conversations were rare suggests that many have difficulty raising the topic.

The concern about women's willingness and ability to take the lead in discussions about contraception was illustrated in my focus groups. The women, in demonstrating what they say to a partner, and the men, in imitating women's speech, were strikingly consistent in portraying women as speaking in a hushed tone. The most verbally aggressive participant in the Wisconsin women's group, Nicki, a 20-year-old junior from an affluent suburb, described her own past behavior in the following terms:

"After my boyfriend and I broke up, I felt if I go on the pill without a serious boyfriend, it's an excuse for me to have sex. But then every time I have ever had a one-night stand, I never had the nerve to come out and say, 'Do you have a condom or some form of protection?' But I'd always whisper something like 'Be careful' or 'I'm not on the pill' [she lowers her voice in demonstration]. I'd say that and that would cause him to withdraw. But that's still stupid thinking."

Was Nicki's whispering due to embarrassment (she certainly was not shy), or because she intuitively understood that her demure presentation would be less threatening to men's sense of control? Nicki admitted she did not have the nerve to use the word "condom," and the two male students confirmed that the women they know employ the euphemism "protection" when they mean "condom."

There is an important difference between Nicki's alternative statements, even if both are spoken in a lowered voice: "Be careful" is an order, whereas "I'm not on the pill" employs the "I" language strategy, which counselors recommend for stating one's needs or giving constructive criticism to a sexual partner.[7] "I cannot relax and enjoy this intimacy because I'm worried about pregnancy" has a very different impact from "You have to wear a condom if you want sex." "I" language emphasizes the initiator's feelings; "you" language is more likely to be perceived as an order or threat.

These whispered euphemisms illustrate what sex educators already know: Teenage and young adult women need more communication skills to help them raise sensitive, embarrassing subjects and discuss them comfortably. Contrary to stereotypes, there are also young men who want to use condoms who could benefit from guidance in condom negotiation dialogue. As one group participant in Wisconsin explained his failure to use a condom on a one-night stand, "I felt if I said that I wanted to use a condom after she said she was on the pill, she would've been offended."

Health educators and advertisers who believe in equality between the sexes face an ideological dilemma, however. If we continue to depend on female assertiveness in strategies to increase condom use, we then model gender roles as they ought to be, i.e., women should be able to make a straightforward declaration of their intent to protect their bodies, but we place at risk those women who are unable to assert themselves and those who try but fail when faced with the protests of a dominant male partner.

Teaching young women a variety of less forceful, more ingratiating styles of communication (such as using a hushed tone of voice and various euphemisms) may be most effective for those who are somewhat submissive. However, such an accommodation of male dominance to expand safer-sex practices would be distasteful to many educators.

One part of the solution to the dilemma is to shift the focus and target men as the initiators of condom use. Urging men to initiate use would be more consistent with what actually occurs between casual partners. According to the male participants in the Denver focus groups, shortly before intercourse, most either produced a condom or asked their partner if she was using a birth control method.

Such reinforcement of male-initiated protection is also more consistent with gender roles that place the responsibility to "take charge" on men. Messages that appeal to the concept of the male as provider or protector are similarly congruent with predominant gender roles.

Health curricula and advertising campaigns that stress a shared responsibility for contraception would be even better than those that simply shift the target from women to men: Targeting men and women alike is ideologically compatible with a belief in equality between the sexes, and it doubles the chance that at least one partner will act responsibly. When we do target women, we cannot afford to ignore gender realities we might find unsettling when we frame messages about sexual communication. But the recommendations need not be sexist. Learning to use "I" versus "you," for example, is a useful communication skill for both men and women, whether bold or shy. Learning how to articulate one's own needs while being sensitive to the other person is the most persuasive way to influence the other's behavior.

At a minimum, educators ought to acknowledge, rather than ignore, the gender role and relationship realities in condom negotiation. Ironically, a young woman may have more power to avoid risky sexual behavior during a one-night stand or in a casual dating relationship, when the man may place a higher value on getting sex than on being in control. Sexuality education may help women realize their power to be the one who says "yes" or "no" in such encounters. In a steady relationship, by contrast, the man may care more about being the dominant partner, and use the threat of a break-up to get what he wants. But women could do this also.

As relationships become established, many steady couples give up the protection of condoms and switch to pill use; messages to them should emphasize mutual monogamy and joint medical tests to rule out any infections from previous partners. Recognizing how gender roles and relationship status affect sexual behaviors and power dynamics will help us create better AIDS and STD prevention campaigns.

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