Where Does Reproductive Health Fit Into the Lives of Adolescent Males?

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CONTEXT: *To develop interventions to promote responsible sexual behaviors and design reproductive health services for adolescent males, we need a better understanding of the context of reproductive health in adolescent males' lives.*

METHODS: *A total of 32 males (mean age, 15.5 years) were recruited from two urban high schools. At each school, three group sessions, consisting of both individual free-listing activities and focus group discussions, were conducted; each addressed issues related to one of three domains—masculinity, responsibility and priorities. Data from the focus groups were examined through standard content analyses.*

RESULTS: *Participants identified school, family, future career and sports as their current life priorities; health was not a top concern. Pregnancy and sexually transmitted infections (STIs) were not seen as interrelated health concepts. STIs were considered a health issue, whereas pregnancy was perceived as a negative event that could prevent achievement of specific life goals. At times, notions regarding how a male behaves reflected traditional masculine beliefs: that violence is justified as a way to protect oneself, that having sex is part of a male's role in a relationship and that males should handle health issues by themselves.*

CONCLUSIONS: *To meet the reproductive health needs of adolescent males, program developers should consider how other life priorities and traditional masculine beliefs may serve as barriers to care and how to ensure that services reflect the adolescent male's perspective.*

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The majority of males involved in the approximately one million pregnancies occurring annually among adolescent females[1] are also adolescents.[2] Among sexually experienced adolescent males, approximately 14% have made a partner pregnant and 2–7% are fathers,[3] with higher rates of fatherhood and involvement in pregnancy seen among inner-city and black youth.[4] From 1980 to 1996, the overall national rate at which teenage males became fathers rose.[5] Current evaluations demonstrate that adolescent pregnancy is declining among females,[6] but no current published rates exist for teenage fatherhood. Compared with females, males have an earlier age of sexual debut[7] and more sexual partners,[8] factors known to be associated with higher risks of acquiring sexually transmitted infections (STIs);[9] these differentials are especially large among blacks and Hispanics.[10]

If the negative consequences of sexual activity are to be reduced, young men must receive appropriate reproductive health information, education and services. Reproductive health services—i.e., the prevention, diagnosis and management of issues related to sexuality and childbearing—traditionally focus on females. However, recommendations are being made to involve adolescent males in the United States in family planning, reproductive and sexual health as part of an effort to promote responsible sexual behavior and reduce reproductive morbidity.[11] As males move from early to middle adolescence, health service use declines across the majority of service locations.[12] A small proportion of 15–19-year-old males report receiving any type of reproductive health care,[13] and compared with females, males are less likely to receive either family planning services or screening or treatment for HIV or other STIs.[14]

Certain attitudes and beliefs contribute to males' involvement in health risk behaviors. In particular, holding traditional attitudes toward masculinity—such as placing great importance on being tough, not "acting like a girl" and getting respect—is associated with engaging in risky sexual behaviors.[15] Although many adolescent males believe they should take responsibility for preventing pregnancy,[16] they may not practice safer sex or seek medical care related to reproductive health.

Previous qualitative studies with young males have focused only on issues related to sex, sexual decision-making and fatherhood.[17] Thus, our knowledge of the adolescent male's perspective on how reproductive health fits into his life is limited. One study examining the extent to which health is a priority in the lives of high-risk adolescents found that health cannot be addressed in isolation from the daily threats of the environment in which youth live.[18] To appropriately inform the development of male reproductive health programs at either the community or the clinical service level, we need a better understanding of how adolescent males prioritize reproductive health issues. For example, if males do not make reproductive health a priority in their lives, programs may need to raise their awareness

of reproductive health issues before providing detailed information and education or creating outreach programs.

This study was conducted as part of a larger project designed to expand the capacity of a reproductive health center to involve adolescent males in reproductive health. We collected formative data to guide the development of outreach efforts and services targeted to adolescent males.

METHODS

Participants

Adolescent males were recruited from two San Francisco high schools. A male outreach worker posted flyers and distributed handouts to recruit potential participants. The outreach worker was also available to answer questions and recruit participants during lunch breaks and between classes. Interested students were told that male health issues would be discussed and that participants had to be available for the entire session. The first eight male students to arrive at each session were included. Students could participate in more than one session.

A total of 32 males participated in six focus group sessions. Their mean age was 15.5 years (standard deviation, 1.2). Twenty-five percent were Hispanic, 50% black, 6% Asian or Pacific Islander, 3% white and 16% of mixed race.

Participants provided parental consent as well as their own verbal and written consent, as outlined by the University of California, San Francisco, internal review board and the Committee for Human Research of the San Francisco School District. They were given a stipend of $15 for transportation and meals. The primary author and a male project assistant conducted all focus group sessions.

Procedures

A series of established qualitative techniques (group interviews, free-listings and focus groups) were used for data collection. These techniques are widely used by anthropologists to assure that members of a study population generate and explain all ideas themselves and to obtain data not easily acquired using quantitative techniques.[19]

Prior to the focus group sessions, a series of short group interviews were held with 25 males from five health classes at the two participating high schools. The purpose of these interviews was to identify research domains, topics and terminology for use in the focus group discussions. The group explored open-ended questions about life choices and sexuality, such as: "What are all the reasons why a guy your age might want (and not want) to get a girl pregnant?" Questions were repeated until no new responses were generated. Each group interview lasted an average of 30 minutes. After all group interviews had been completed, the researchers reviewed the responses and identified three main research domains—masculinity, life responsibilities and life priorities. Six open-ended questions were developed for each domain (see box) and were explored during the subsequent focus group sessions.

During each session, participants engaged in written free-listings, immediately followed by a focus group discussion.

Questions used in focus group free-listings

Masculinity
- What does it mean to be a man or a male?
- What are some ways a guy can prove his manhood?
- What are some characteristics of a responsible man?
- What are some things a man should do in a relationship?
- What are some health problems guys can't handle on their own?
- What are some health problems guys can handle on their own?

Responsibility
- What are some things you do to take care of yourself?
- What are some characteristics of an irresponsible guy (or a guy who is not responsible)?
- Who or what influences you to be responsible?
- What are things that a guy could do to keep his girlfriend healthy?
- Why don't guys talk about sex issues with their girlfriends?
- How do guys pressure each other when they talk about sex, girlfriends, having sex?

Priorities
- What are the things that are important to you in your life right now?
- What are the health issues that you are most concerned about right now?
- What things would happen to a guy if he got a girl pregnant?
- What are some ways a guy who is healthy could be persuaded to get regular checkups by a doctor?
- What are specific fears guys have about going to a doctor?
- What do guys need to be comfortable when visiting a doctor or a health center?

In the free-listing activity, each participant responded to the six open-ended questions. For each question, the participant was asked to generate and write down up to eight answers. Free-listing took approximately 15 minutes. The focus group discussion used the same six questions. The two facilitators introduced the questions and mediated discussions that lasted, on average, 75 minutes. The group discussed each question until no new discussion points were generated. Three focus group sessions were conducted at each school, with each addressing one of the three research domains. All focus group discussions were audiotaped.*

Using free-listing to map cultural domains related to specific beliefs, knowledge and behavior[20] immediately before focus group discussions compensates for the limitations of focus groups, which include the risk that participants will rapidly reach consensus, the inability of the group to give a range of responses, participant reluctance to express minority opinions aloud and uneven subject participation.[21] It also can help participants elicit responses from others, share their own responses and engage in discussion. Researchers reviewing focus group transcripts may find responses from the free-listings helpful because they provide a full range of responses by which to gauge content.

Data Analyses

Free-listing responses from the focus group sessions were entered into a spreadsheet and categorized. Two principal investigators independently reviewed the lists and proposed categories; when the two sets of categories did not agree, the investigators jointly decided on a mutually acceptable category. Each unique response by a participant was coded;

*Because speakers are not identified on the tape, quotations used in this article cannot be attributed to specific individuals.

responses that fit more than one category were assigned multiple codes. A method called emphasis of response[22] was used to analyze free-listing responses. This method takes into account how often a participant makes a particular response and how frequently the response occurs among all participants; it also allows examination of responses in order of emphasis.

After audiotapes of the focus group discussions had been transcribed, a content analysis of transcripts was performed; it employed the same coding scheme used for the free-listing responses. Emphasis of response and content analysis data were then examined, and the following major themes from the focus group sessions were identified: life and health priorities, male responsibilities, relationships, pregnancy issues and health care–seeking behavior.

A summary of the focus group sessions, including participants' most emphasized free-listing responses (the top 3–4 responses) and major discussion themes from the content analysis, is presented here.

RESULTS

Life and Health Priorities

When participants were asked about the highest current priorities in their life, their most emphasized responses were school or education, family, future career and playing sports. The importance of education, the highest life priority, is best exemplified by the following quote:

"One of the top things in my life right now is school...because a lot of people don't realize, the harder you work now in school, the easier your life [will] be when you get older.... 'Cause you [will] have a good job,...attend a good college, and everything will be all right for you."

Students did not list or discuss health in itself as a life priority. But when specifically asked about it during focus group sessions, they agreed that prioritizing health makes sense. As one participant put it:

"Life is health...you got to be healthy just to do anything....You can't do nothing if you ain't healthy. If you [are] sick for one day, you ain't going to be able to go to school. So, health is...the key to life."

On the question of what health issues were of concern right now, participants' most emphasized responses were cancer, STIs, HIV and AIDS, and injuries. For example:

"[HIV], that's my worst issue. Just catching anything, 'cause you can catch something...so easily. You could be wearing a condom, and you still can catch something."

The focus group sessions revealed limited knowledge about STI symptomatology. In one group, for example, a participant asked if a person could get herpes on the lips, and another responded affirmatively, adding that the infection could be passed on "by sharing drinks." In answer to a question about whether herpes is like an itch, a participant said, "No, it's like a bump. Like a cold sore."

As ways to take care of themselves, the adolescents most emphasized attending to good hygiene, eating right, going to school or studying, and going to the doctor. They disagreed during focus group discussions on whether carrying a weapon for self-protection is a good way to take care of oneself. However, they agreed that staying aware of one's surroundings, choosing friends wisely and "trusting no one" are important ways of taking care of oneself on the street and differ from what they had learned at home.

Participants emphasized their family and education as influences that led them to be responsible. Parents, siblings and teachers were mentioned during focus group discussions as positive role models. Negative role models they cited included family members who had gone to jail or used drugs. Personal experiences, such as caring for younger siblings and being the first person in the family to complete an education, were also mentioned as influencing participants to be responsible.

Male Responsibilities

The factors that participants most emphasized as defining "being a man" ranged from having male genitalia to traditional notions of masculinity (being strong or defending oneself) to being responsible. Students defined a man as a leader; one who takes responsibility for his actions, morals, emotions, wife, family, job and home; one who wants to be noticed or liked by others; one who stands up for what he believes; and one who is mature and strong, not only physically, but also psychologically. Participants believed that younger adolescent males think becoming a man only involves having sex. They also distinguished between becoming a man and becoming an adult: Becoming a man, they believed, requires more responsibility and entails having a family. They said a man should have a female partner, especially if he wants his "name to go on." They cautioned, however, that it is important to be faithful.

When participants were asked to define a responsible man, their most emphasized responses were that such a man takes care of his family, has a good job and handles his business. He "has a plan for [his] family...not only for [him]self" and "knows his priorities."

During focus group discussions, adolescents shared their day-to-day responsibilities and experiences being males, including having to "step up" in their households because of absent fathers, being pressured by parents and teachers to succeed and take on more responsibilities, and being pressured by girls to have sex:

"Girls, especially, always want to [have sex]...so, [if] this is what a girl wants, I [need to] prepare myself."

Participants disagreed on whether males their age "should be responsible right now." Some preferred, instead, to "be into sports [and] have fun" before becoming a man.

The most emphasized responses of participants regarding how a male can prove his manhood included having sex, having a girlfriend and fighting. Yet the students disagreed during focus group discussions on whether proving one's manhood is best accomplished by fighting or by acting mature and walking away from conflict. One student commented:

"Knowing how to fight doesn't necessarily mean that you're a man....I had to learn [that] the hard way."

Participants said fighting is sometimes used as a means to get a girl's attention because she "wants to be with someone who can protect her," or as a result of her teasing or instigation.

When asked what methods they use to pressure each other about sex, the adolescents most emphasized "advocating," pestering each other to have sex, calling those who have not had sex names and bragging about having had sex. In the focus group discussions, males said such behaviors were used to build up a person's own ego when in a crowd. Yet these participants did not feel that the name-calling, teasing and pressure influenced their decisions about whether to have sex; they said they just did not care or listen.

When participants were asked what characterizes a man who is not responsible, the most emphasized responses were that he uses drugs and does not care for his hygiene. Discussions about irresponsible men reflected personal experiences with absent fathers or other males who abused drugs or were jobless. Participants also discussed personal examples of not being responsible, such as not doing homework, being late to school, making a lot of excuses, coming home late, procrastinating and being disorganized.

Relationships

The most emphasized responses of participants regarding the male's role in a relationship with a female were that he should be loyal and committed and should have sex. During focus group discussions, however, students differentiated between behavior in serious and more casual relationships. They described acting in negative and hurtful ways—such as "cheating" or "talking behind the girl's back"—in casual relationships. Serious relationships, however, involved "major work," commitment and trust:

"You gotta [have] time and determination....You really got to be prepared for [a serious relationship]. You really actually got to think it through."

Participants felt teenage males are not ready for serious relationships, unless they fall in love; however, they said it was important to learn "how to pleasure [the] girl" and "get [sexual] experiences."

When participants were asked how a male can best keep his girlfriend healthy, the most emphasized responses were "using condoms when having sex" and "having her go to the doctor." In this discussion, the young men equated health mainly with avoidance of STIs and HIV.

In another focus group, the discussion highlighted myths participants held about sex with virgins. Participants stated that having sex with a virgin without a condom is "safe" (meaning that there is no risk of getting an STI, and ignoring the risk of pregnancy) and that they could tell a girl is a virgin by just looking at her.

The adolescents disagreed during focus group sessions on whether a male is responsible for his girlfriend's health or if she is responsible for it herself. Those who did not want to be responsible for their girlfriend's health feared that telling her to do something she did not want to do, such as going to the doctor, would somehow disrupt the dynamics of their relationship and make it harder for them to get her to do what they want (e.g., have sex). Others felt that to keep his girlfriend healthy, a male should not cheat; instead, they said, he should be honest and build trust. One participant summed it up: "Do for her what you would do for yourself, but do it in a female kind of way."

Asked why males do not talk about sexual issues with females, participants most emphasized feeling embarrassed, shy or uncomfortable; scared or afraid of rejection; and inexperienced in sex or relationships. In the discussion groups, they cited fears that talking will make females get angry or think they sleep around, or that it will give females the opportunity to say no. They also said it is difficult to bring up sex "in the moment":

"Sometimes...you don't [want] to talk about it, you just want [sex] to happen...'cause if you talk about it...it ain't going to happen."

Most participants, though, said they did not find it difficult to talk about sexual issues with their girlfriends and believed both males and females should take responsibility:

"If [neither of them] brings it up, then they just don't care...and when the girl gets pregnant, they blame it on the [guy], and I don't think that's right."

[Many young males do not] find it difficult to talk about sexual issues with their girlfriends and [believe] both males and females should take responsibility.

Pregnancy

Participants were probed during focus group sessions about how pregnancy prevention fits into their general health and life priorities. Some participants identified pregnancy prevention as an important issue: "If your goal is to go to college, having a baby is going to hold you back." Others stated they did not specifically think about pregnancy prevention.

When participants were asked about the consequences of getting a sexual partner pregnant, their most emphasized responses were that the male involved would have to support the child or the family, would get upset or stressed and would get in trouble with his parents. Discussions focused mainly on the negative effects of pregnancy on a male's life: "His life will be messed up" and "He would lose his family and their respect." Participants disagreed on whether males their age think about consequences when having sex, but agreed that sex is "going to happen sometime before you [become] an adult."

Health Care–Seeking Behavior

In answer to a question about health issues males cannot handle on their own, participants' most emphasized responses were STIs, HIV and AIDS, cancer, other diseases (e.g., diabetes) and impotence. Participants in the focus group discussions said these health problems are "not manageable" because "there are no vaccines for [them]," "they can kill you," "they are serious illnesses" and "you need a doctor to handle them." They also said a male probably needs less help with his health as he gets older and has more experience with illness because he becomes better equipped to handle it on his own.

Asked to name health issues males can handle on their own, participants most emphasized colds or flu, hygiene,

injuries and physical fitness. Students considered these health issues manageable because they are temporary and one can get through them. They also said that males tend to delay getting care and instead wait to see if the health problem will "just pass," in contrast with females, whom they saw as tending "to take care of problems as soon as they see them." They felt that females are "smarter about health," "more aware about how their body [works]" and "more influenced by media." Furthermore, these adolescents acknowledged that females "go through more things, like Pap smears."

The adolescents' most emphasized responses regarding the reasons males fear going to the doctor were fear of getting bad news in general, or an STI or HIV diagnosis in particular, and dreading the doctor's reaction to their health status or concerns. Participants discussed disliking the "nerve-wrecking" feeling of waiting for test results. They also feared inappropriate disclosure of their health matters by doctors and had concerns about the same-sex contact involved in genital examinations performed by male providers.

Students most emphasized that to be comfortable when visiting a health facility, a male needs money or insurance to pay, a physician who "keeps it real" and "is not judgmental," a clinic that has "a good, clean and safe environment" and "helpful staff." It also helps if the male is able to go with a parent, family member or close friend. Participants discussed taking someone with them to provide support, especially if they might receive bad news. One participant said that his brother felt better when going for HIV testing because his sister went along:

"If [you go] with somebody, I think it's a lot more comfortable than going by yourself."

During the focus group sessions, students discussed wanting providers who are trustworthy, pay attention and are nice to them, with whom they will feel comfortable talking and with whom they can talk one-on-one. Although participants preferred female providers to perform genital examinations, they said they were comfortable having male providers perform general physical examinations and preferred talking to male providers.

When participants were asked how to get males to obtain regular health checkups, their most emphasized responses were to provide an incentive, make checkups mandatory, tell them it is a way to get checked for disease and STIs and tell them how they would benefit. Some participants said it is difficult to convince males to go to a doctor because they are stubborn, do not like to go and would rather take care of health problems themselves. Using peers to communicate was identified as an option, because males "will listen to peers before they'll listen to adults."

DISCUSSION

This is the first study using qualitative methods to examine the context of reproductive health in the lives of middle adolescent males. The participants do not place reproductive health within a simple framework. Health is not listed among their life priorities. Instead, they describe health in the context of ways they take care of themselves, such as eating right, taking care of their hygiene and going to the doctor. These middle adolescent males do not group concerns about pregnancy with health issues such as getting HIV or other STIs; for them (if they think of it at all), pregnancy is a negative life event that is likely to prevent the achievement of specific life goals.

Many of the issues raised in the focus group sessions are developmentally appropriate for males who are moving from early to late adolescence and into adulthood. During this period, the male is experiencing the rapid development of secondary sexual characteristics, as well as psychosocial, sexual, identity and emotional changes. In middle adolescence, a male's family and peer relationships move toward adult-adult models of relationships that may include intimacy; the median age of sexual onset for U.S. males falls in middle adolescence.[23]

Some participants held traditional attitudes toward masculinity—approving of violence as a way to protect oneself, asserting that having sex is part of a man's role in a relationship and believing that men should handle health issues by themselves. It has been hypothesized that males may form such beliefs as a normal part of identity formation during middle adolescence, and that most tend to adopt more moderate attitudes as they mature.[24]

Previous research has found that many adolescent males believe they should be responsible for preventing pregnancy;[25] our study provides insight into the challenges middle adolescent males can face in putting protective reproductive health decision-making into practice. These males are being pressured to step into adult roles in their households, to defend themselves on the street and to have sex. Such pressures to prematurely take on the adult male role can be overwhelming, especially for adolescents who have little external support. In this context, it is understandable that these males do not want to be "responsible" right now and instead want to have fun. Learning how to carry out responsibilities in relationships, they are still gathering the tools and skills needed to negotiate safer sexual behaviors.

Although male participants identified having sex as an important facet of becoming a man, they differentiated how an adult male acts in a relationship from ways males their age and younger act; they also distinguished between behavior in serious and casual relationships. They described multiple barriers to communication from both the male and the female perspective, including feelings of embarrassment, lack of sexual experience and fear of rejection.

The main factors influencing participants to be responsible were their families and schools. Studies indicate that the presence of family and school connectedness can be protective against involvement in health risk behaviors, including early sexual debut.[26] Developing mechanisms to link males to positive influences, whether at the family, school or community program level, should thus begin as early as possible.

Programs that serve young males can help address their reproductive health needs. By encouraging young males to communicate with their partners about their sexual his-

tories[27] and providing reproductive health counseling by clinicians,[28] these programs can increase the likelihood that males will use condoms; young males who have not had sex at the time they participate in such programs are the group most likely to use condoms when they do become sexually active.[29] That the young males in our study identify health care providers as health resources provides impetus for providers to capitalize on visits from adolescent males to discuss reproductive health issues. This is especially critical for older adolescent males, who overall use fewer general[30] and reproductive health services.[31] Participants' insights as to why males rarely seek health care included the fear of getting bad news, such as receiving an STI diagnosis, and the related anxiety of being tested and examined. Discussions by participants also suggested that promotion of reproductive health services for males may require broadening "traditional" reproductive-focused approaches by including services likely to be attractive to them, such as sports physicals, or addressing the psychological consequences of STI testing.

Finally, participants' insights regarding how to promote health services for males—including incentives, mandated services and reaching males through peers—suggest that involvement of males in the planning of male-specific services[32] is the first step in encouraging them to use those services.

Limitations

The generalizability of these findings is limited because the sample consisted of students who volunteered to participate. Males who were not interested in talking about reproductive health may not have participated in the focus groups; such issues may rank even lower in their lives. In addition, not separating young males who were sexually active from those who were not sexually active during group discussions may be viewed as a limitation. However, we believed that mixing the two groups would provide a more realistic picture of adolescent males' attitudes and beliefs about reproductive health issues.

Participants' emphasis on health-related issues during focus group discussions may have resulted in part from probes during the free-listing activity that sensitized them to these issues. To decrease such sensitization as much as possible, we asked probe questions in a particular order and restricted each focus group to one theme.

Finally, although the sample was diverse in racial and ethnic makeup, it was too small to adequately describe differences by race and ethnicity. The review of free-listings by race and ethnicity, however, did not reveal any such differences.

Implications

The results of our exploratory approach demonstrate that the context of adolescent male reproductive health is multilayered and complex. Only by understanding the life and health priorities of these young men can we truly appreciate where issues regarding reproductive health fit within this larger context and why they are secondary to issues of education, career and family. Programs that wish to serve young men will need to integrate this understanding so that their outreach efforts and the types of services they offer reflect the adolescent male's perspective.

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32. Center for Reproductive Health Research and Policy, *Young Men Moving Forward: California's Male Involvement Program–A Teen Pregnancy Prevention Program for Males,* San Francisco: University of California, San Francisco, 2002; and Sonenstein F, 2000, op. cit. (see reference 11).

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