The Pleasure Deficit: Revisiting the “Sexuality Connection” In Reproductive Health

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In a seminal 1993 article, Ruth Dixon-Mueller questioned the reproductive health field’s conceptualization of sexuality, arguing that it had treated intercourse as a sanitized, emotionally neutral act.1 If one were to learn about human sexuality by reading family planning research and program manuals, she suggested, one would have no idea that sex leads to great enjoyment—as well as pain—for human beings. She called for a more gender-sensitive approach to sexuality in research and programming, including greater attention to the ways in which women want to maximize sexual enjoyment and minimize sexual harm, and to how these desires influence their reproductive health behaviors. Such an approach—which Dixon-Mueller called establishing the “sexuality connection” in reproductive health—not only would garner a more accurate understanding of sexuality and sexual risk reduction, but also would acknowledge women as sexual agents rather than merely as sexual victims or as “targets” of contraceptive programs and HIV prevention efforts.

During the nearly 15 years since Dixon-Mueller’s article was published, many important developments regarding sexuality have occurred within the family planning field. Most symbolically, the phrase “reproductive health” has been superseded by “sexual and reproductive health,” and the terms “sexual health” and “sexual rights” increasingly appear in public health and human rights discourse.2,3 The HIV/AIDS epidemic has highlighted the desperate need for better data on sexual behaviors and spurred collaborations between clinicians and social scientists who study sexuality.3 This very journal changed its name from Family Planning Perspectives to Perspectives on Sexual and Reproductive Health in 2002, reflecting that its focus encompasses topics related not only to pregnancy prevention but also to HIV/AIDS, sexuality and men’s reproductive health, among others. Thus, at least at first glance, the reproductive health field has opened its doors to deeper explorations of sexuality.

Threats to women’s sexual and reproductive well-being have been especially well documented during the past 10–15 years. An impressive body of work reveals the ways in which women’s sexual autonomy—and thus their pregnancy and disease prevention practices—are limited by gender inequalities at both individual and structural levels. At the individual level, gender-based violence,4–9 nonvolitional sex10,11 and relationship power imbalances12,13 all have been associated with reduced sexual autonomy and thus greater vulnerability to unintended pregnancy, HIV and other STDs, and reproductive morbidity14 and mortality. At the structural level, the combination of poverty and gender inequality leads many women to exchange sex for money, clothing, gifts and other goods—yet another risk factor for HIV infection and other adverse reproductive health outcomes.15–17 This literature has significantly deepened our understanding of how experiencing sexual harm influences women’s sexual and reproductive health and risk.

However, the ways in which the positive aspects of sexual experience contribute to women’s sexual health and risk are little understood. Despite a few notable exceptions,18,19 the public health research community has largely failed to explore the factors that contribute to optimal sexual functioning for women or the ways in which sexual pleasure-seeking (as opposed to love-seeking or money-seeking) influences women’s risk for unintended pregnancy and disease. This “pleasure deficit” inspired a 2006 review in The Lancet,20 in which the authors called for the promotion of pleasure in HIV and other STD prevention programs, and warned that negative messages about sexuality can undermine, rather than promote, effective condom use.

Notably, the authors of the Lancet review suggested that acknowledgment and discussion of pleasure has been absent from all areas of HIV and other STD programming, and not just those pertaining to women. However, at least some research has focused on the ways in which the desire for pleasure motivates men to take sexual risks. For example, several studies have examined the role of pleasure in men’s decisions to have anal intercourse with other men without using condoms (“barebacking”),21–23 and others have documented heterosexual men’s lack of interest in using male condoms during vaginal sex because they diminish sexual pleasure.24–27 These studies provide some insight into the ways in which men’s desires for sexual enjoyment...
shape their willingness to use male condoms. They also explore how cultural norms about masculinity, such as the social benefits for men of sexual conquest and virility, can influence men’s pleasure-seeking. In stark contrast, relatively little research has examined women’s pleasure-seeking and how it influences their sexual and contraceptive behaviors.

Below, we discuss in greater detail some examples of the “pleasure deficit” for women in sexual and reproductive health research and programs, and highlight areas for future research.

RESEARCH AND PROGRAMMING
Women and Male Condoms
The public health approach to women’s and their partners’ use of male condoms has evolved significantly since the beginning of the HIV/AIDS epidemic. Many public health programs seek to strengthen women’s skills to negotiate with male partners for condom use. However, a substantial body of research suggests that gender inequality (particularly in the social and financial realms) makes it difficult—and sometimes impossible—for women to ensure condom use. Furthermore, even when women are able to negotiate for condom use, they may not want to do so, because some women view condoms as incompatible with sex that is intimate, loving and monogamous. Thus, women’s social, emotional and financial dependence on both men and romantic relationships can make it difficult for them to encourage male partners to use condoms.

In comparison, women’s sexual resistance to condoms has been relatively unexplored. Theorists within the HIV field have developed behavioral models that directly or indirectly acknowledge the role of pleasure for both partners in shaping uptake and use of male condoms. In particular, the AIDS Risk Reduction Model asserts that how condoms feel matters to both women and men. Conversely, the literature suggests that many men do not like using condoms because they curtail sexual sensation. A 14-country study by the Joint United Nations Programme on HIV/AIDS found that a decrease in users’ libido, enjoyment, lubrication or ability to achieve orgasm, or of how such effects shape the uptake, continuation and consistency of use. Similarly, current behavioral models of contraceptive decision making suggest that a woman’s choice and consistent use of a particular method are related primarily to access, effectiveness, ease of use and the woman’s desire to limit or space births; models rarely consider how methods either enhance or detract from the sexual experience.

In sharp contrast, researchers rarely consider the possibility (although there have been a few exceptions) that condoms’ effects on pleasure may alter women’s preferences or use patterns. Yet in our own qualitative research on sexual pleasure and contraceptive use in the southeastern United States, we found that a greater proportion of women than of men disliked the feeling of male condoms. Some women reported that condoms “cover up” sensation and exacerbate vaginal dryness, which led them to discontinue use. Systematic research is critically needed to examine how the desire for sexual pleasure (or, more broadly, the full range of reasons why women have sex) shapes women’s willingness to use male condoms.

Research and Development
Male condoms are not the only contraceptive method for which information on pleasure is lacking. Most contraceptive research and development has failed to collect information on how various methods influence women’s sexual functioning and enjoyment. Information is particularly scarce for hormone-based methods. Although the effects of hormonal contraceptives on ovulation have been extensively documented, these contraceptives’ potential effects on the increase in libido that women often experience during ovulation have received little attention. Nor have hormonal and other contraceptives’ effects on sexual pleasure, and thus on contraceptive preferences and practices, been extensively studied, even during new product development. This lack of attention to the sexual side effects of hormone-based methods for women is particularly striking when viewed against the concern with side effects evident in acceptability studies of hormone-based methods under development for men.

Fortunately, the sexual dimensions of acceptability have received more attention in the development of microbicides and the female condom, both of which emerged from efforts to create female-controlled HIV prevention strategies (rather than from the family planning field). Ideally, all future contraceptive development and acceptability research will demonstrate the same concern for women’s sexual functioning as hormonal trials have for the sexual functioning of men.

Contraceptive Use Patterns
A pleasure deficit also exists in most research exploring the ways in which women use—or fail to use—the contraceptive methods currently on the market. Few systematic reviews exist of these methods’ effects on women’s libido, enjoyment, lubrication or ability to achieve orgasm, or of how such effects shape the uptake, continuation and consistency of use. Similarly, current behavioral models of contraceptive decision making suggest that a woman’s choice and consistent use of a particular method are related primarily to access, effectiveness, ease of use and the woman’s desire to limit or space births; models rarely consider how methods either enhance or detract from the sexual experience.

Data do suggest that a woman’s sexual experiences can shape contraceptive practices, and vice versa. Again, research on the female condom has been particularly innovative in this regard. A woman’s sexual comfort with and enjoyment of this method (influenced by such factors as the polyurethane’s enhancement of heat transfer and the potential for increased clitoral stimulation from the condom’s outer ring) reportedly contribute to uptake and continuation.

Other methods also have been studied for sexual acceptability, albeit less comprehensively. In a longitudinal study of new oral contraceptive users in the United States, researchers found that a decrease in users’ libido and sexual enjoyment was strongly associated with
The literature on HIV risk and barebacking provides a strong foundation for this idea, although the bare-
backing findings are not completely applicable to sex between women and men. Not only are the power dynamics different in heterosexual and same-sex couples, but the consequences of “risking” an unintended pregnancy differ from those of risking an HIV infection. Pregnancy, at least on some occasions, may be generative, life-affirming and relationship-strengthening. The field requires theoretical and empirical research on how the eroticization of pregnancy risk and the “heat of the moment” shape sexual risk practices, particularly if unintended pregnancy prevention remains an ongoing policy priority.

**Contraceptive Marketing and Programming**

To promote the adoption of disease prevention practices, particularly among men who have sex with men, a number of condom promotion campaigns in the United States have eroticized condom use. The condom advertisements, training materials, and clinic pamphlets and posters created for these campaigns stand in marked contrast to comparable contraceptive materials, which often portray women as medical consumers but not necessarily sexual agents. Ads generally tout these methods’ noncontraceptive benefits or convenience, but not their potential contribution to enjoyable, exciting or spontaneous sex. Similarly, advertisements for erectile dysfunction drugs broadcast sexy images of couples kissing, cuddling or dancing, whereas contraceptive advertisements often depict a highly sanitized, de-eroticized version of sexuality, if they allude to sex at all. Most contraceptive ads show a woman by herself, exercising, dressing for work, shopping or taking part in other solitary activities—images that seem based on a vision of middle-class women as autonomous and responsible.

In our qualitative study, middle-class women spoke about the benefits and pleasures of buying and using contraceptives. Procuring contraceptives was an important part of how they—as young women just beginning their sexual lives—took care of themselves. Many women spoke about methods’ noncontraceptive benefits, such as their effects on acne and on the extent and timing of menstruation. Women literally buy into the corporate marketing of contraceptives. Several even used the phrase “the pill that clears your skin,” a direct quote from a 1990s marketing campaign for a particular oral contraceptive. Although pharmaceutical companies have done little to explore the sexual side effects of contraceptive methods in their research and development processes, they could nonetheless play a role in addressing the pleasure deficit by highlighting sexual pleasure in the marketing of contraceptives. Use of contraceptives might increase if the methods were marketed to women and men in the same way that condoms and erectile dysfunction drugs are (e.g., “the pill that increases sexual spontaneity!”). Sexual and reproductive health clients could be well served by further explorations of the feasibility and benefits of eroticizing contraceptives.

**FUTURE DIRECTIONS**

Despite the outpouring of HIV-related research on sexual behaviors in the last 10–15 years, the family planning field remains largely remiss in terms of Dixon-Mueller’s “sexuality connection,” specifically regarding the positive aspects of sexuality. However, there are certainly exceptions to this pleasure deficit.

Several family planning programs have already incorporated sexuality into their frameworks or have suggested such incorporation. (We should note that some of these programs are more than a decade old, surprisingly few have followed suit, providing another illustration of the pleasure deficit.) A Population Council program in Latin America and the Caribbean trained family planning counselors to discuss their clients’ sexual relationships and practices before recommending certain methods over others and to review these issues during follow-up visits. Similarly, our research has led us to advocate for “pleasure profiling,” in which a client’s relationship and preferences for wetter, drier, “natural” or more spontaneous sex are considered before contraceptive recommendations are made. For this approach to work optimally, culturally appropriate models of sexuality must be developed, implemented and evaluated, because women define and seek pleasure in different ways, both across and within cultural settings.

Along similar lines, offering sexuality training to health care providers more generally (and not just to family planning counselors) holds promise as a strategy to better meet women’s and men’s sexual health needs. Few clients report that health care practitioners ever ask them about sex, despite the evidence suggesting that such discussions—not merely those about sexual risk, but also FUTURE DIRECTIONS

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*Whereas middle-class women were more likely than poor women to see themselves as contraceptive consumers who shopped for the best method, respondents from all class backgrounds spoke about how particular kinds of condoms can be fun. A number of women (and men) said that condoms with novel flavors, scents and packages can be sexier and more enjoyable than ordinary condoms.*
addition to hosting a flashy, user-friendly Web site, the project generates support among public health practitioners at venues such as the International AIDS Conference and sponsors academic research in this area. Time will tell if such initiatives will be fundable and feasible, especially in the current political climate.

CHALLENGES, CAUTIONS AND CONCLUSIONS

We have highlighted a few initiatives that may serve as useful models for family planning practitioners. Yet, as the Lancet review notes, the few programs that have attempted to “promote protection and pleasure” have been small, unevaluated or based on anecdotal evidence. Furthermore, even if proven effective through evaluation, micro-level behavioral interventions are limited in their ability to change culture or social structure. For example, the programs described above can do little to address the broad social and cultural forces that make pleasure-seeking easier and more important for men than for women, or that limit women’s sexual enjoyment by fueling gender-based sexual and physical violence. Similarly, systemic change will be required to alter the troubling assumptions about sexuality and reproduction that are alive and well within our field—for example, the belief that pregnancy prevention is primarily, if not entirely, women’s responsibility, or the notion that sexual pleasure is irrelevant to women, especially in developing countries.

Another challenge to future work in this area is that pleasure-based initiatives may inadvertently perpetuate gender inequality. For example, some authors have cautioned against the promotion of a gender-neutral “right to sexual pleasure” as a basic human right, arguing that men’s demands for sexual pleasure can infringe on women’s human rights. Globally, men have more access to sexual enjoyment and autonomy than women do, and men’s pleasure is likely to take precedence over women’s pleasure, potentially leading to the abandonment of male condom use or to the eroticization of men’s sexual domination.

Well-intentioned sexuality programs could also enforce existing unequal gender norms. For example, we have heard about sex technique workshops for married women in countries in which men’s extramarital affairs fuel the spread of HIV. The basic premise of these programs is that greater sexual knowledge and comfort could discourage men’s infidelity and thus reduce the risk of HIV transmission. Undoubtedly, many women could benefit from workshops in which they gain familiarity and comfort with their sexual selves. At the same time, however, such programs may fail to address issues such as men’s abuses of their male privilege and their greater access to opportunities for extramarital sex.

Another example of a program that both reflects and promotes existing gender roles is one that promotes the use of male condoms by highlighting the advantages of delayed ejaculation. In India, the Kohinoor Xtra Time brand of condom is coated with a lubricant containing local anesthetic, which its promoters say enables longer lasting, and thus more pleasurable, intercourse. Such an advertising campaign could unintentionally reinforce pressure on men to fulfill expectations (their own or others’) as sexual performers. Performance anxiety contributes to men’s sexual dysfunction, including erectile difficulties, which in turn have been associated with condom misuse and nonuse. Both this example and that of the sex technique programs underscore the advantages and disadvantages of working within dominant constructions of masculinity to promote sexual and reproductive health. Furthermore, evidence on the average amount of time that women, either in India or in most other cultural settings, want to engage in vaginal intercourse is limited. More research on both women’s and men’s sexual preferences and needs would be warranted before large-scale condom campaigns aimed at lengthening pleasure are initiated.

We hope that any future work in this area will explore pleasure in relation to gender and power. A thorough understanding of pleasure-seeking behaviors requires consciousness both of social inequality and of cross-cultural and intracultural differences in the ways in which women and men seek pleasure. Future research should develop models to capture the various aspects of pleasure, and explore how masculinity and femininity shape these pleasures in each research setting.

Despite these challenges, we have tried to suggest the importance of pleasure-seeking to sexual and reproductive health. Researchers and program developers can no longer assume that the sexual aspects of family planning are irrelevant to women. Rather, they should work from the notion that the way sex feels matters to women, and that recognizing and addressing this aspect of women’s lives will positively influence sexual risk behaviors—and more broadly, their sexual health and well-being.

REFERENCES


Acknowledgments

At the time this article was written, Jenny Higgins was supported by a National Institute of Mental Health training grant (T32 MH19139) and by a National Institute of Mental Health grant to the HIV Center for Clinical and Behavior Studies (P30 MH43250). The authors thank the following colleagues for their insights on earlier drafts of this article: Susie Hoffman, Shari Dworkin, Theresa Exner, Joanne Mantell, Theo Sandfort and Bobby Gillespie.

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