



Exploring masculinities, sexual health and wellbeing across areas of high deprivation in Scotland: The depth of the challenge to improve understandings and practices



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ABSTRACT

Within and across areas of high deprivation, we explored constructions of masculinity in relation to sexual health and wellbeing, in what we believe to be the first UK study to take this approach. Our sample of 116 heterosexual men and women age 18–40 years took part in individual semi-structured interviews (n = 35) and focus group discussions (n = 18), across areas in Scotland. Drawing on a socio-ecological framework, findings revealed experience in places matter, with gender practices rooted in a domestically violent milieu, where localised, socio-cultural influences offered limited opportunities for more egalitarian performances of masculinity. We discuss the depths of the challenge in transforming masculinities in relation to sexual health and wellbeing in such communities.

1. Introduction

In a widely-cited, although not officially endorsed, definition from the World Health Organisation (WHO), sexual health is:

“...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO, 2006)

There has been an increasing shift towards holistic definitions of sexual health, rather than a limited focus on sexually transmitted infections (STIs), blood borne viruses and unplanned pregnancies. The most recent National Survey of Sexual Attitudes and Lifestyles (Natsal-3) survey, conducted across Britain with 15,162 people age 16–74 years found 1 in 10 women and 1 in 71 men reported an experience of ‘non-volitional’ sex (i.e., sex against their will) (Macdowall et al., 2013). Physical, psychological and sexual abuse is associated with sexual health outcomes such as sexually transmitted infections (STIs), un-

wanted pregnancies and sexual dysfunction (Coker, 2007; de Visser et al., 2014; Ellsberg et al., 2008; Garcia-Moreno et al., 2005; McMillan, 2013; World Health Organisation, 2013), so it is right that the WHO offer a broader holistic definition. Such a broad definition has been taken up in policy frameworks, including the Scottish *Sexual Health and Blood Borne Virus Framework 2015–2020*, developed to promote key outcomes including in relation to STIs and unintended pregnancies, inequalities, and sexual violence (Scottish Government, 2015).

In this article, one of a series of articles from our ‘DeMaSH’ study (Deprivation, Masculinities and Sexual Health), we first draw upon a social determinants of health framework as it intersects with our analysis of how masculinities in places influence sexual health and wellbeing. Here we draw out the importance of neighbourhood and community level factors, citing examples of how we might engage in interruptions in ecological systems (Hawe et al., 2004); elsewhere we focus on findings relating to holistic sexual health understandings, the blaming of women for sexual violence, and alcohol and sexual consent understandings. Thus, in this paper we only mention such findings tangentially. Here we prioritise narratives of violence because they often receive less emphasis than ‘bugs and babies’ within the sexual

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health field, and they provide a useful vehicle through which to convey the social embeddedness of behaviours, contextualised within environments of strain and adversity.

1.1. Levels of influence on sexual health and wellbeing, and the importance of neighbourhoods and communities

Immediate determinants of sexual health and wellbeing include, for example, individuals' knowledge of sexual risks; however, although knowledge improvement is important for behaviour change, it is insufficient on its own to effect significant change as influences upon sexual health stem from factors beyond individual knowledge. At the more distal level, poverty is a significant contributor to various forms of gender-based violence (Jewkes, 2002). Epidemiological data reveal the impact of low socio-economic status (SES) upon sexual health (Arnold et al., 2011; Denning et al., 2011); this is compounded by those in low SES often being part of sexual networks with high underlying rates of STIs and HIV (Denning et al., 2011). The provision of laws (and law enforcement) to protect people from discrimination, violence and poverty can significantly improve the success of individual behaviour change strategies (Coates et al., 2008). For example, the funding associated with the 1994 US Violence Against Women Act resulted in significant effects on sexually violent behaviour (DeGue et al., 2014). By challenging dominant norms, change can occur that results in improved gender equity and reductions in sexual risks, violence and coercion. However, structural factors that can influence sexual health and wellbeing (e.g., poverty) tend to go beyond specific domains of health (e.g., HIV prevention), and tackling such issues are commonly for governments to implement across policy fields; as such, interventions to improve sexual health and wellbeing more commonly operate at community- or individual-level.

Given the geographical variations in sexual behaviours and HIV risks and acquisition (Wadsworth et al., 1996), what are the 'chains of causation that might link place of residence with health outcomes' (Macintyre et al., 2002). The 'broken windows' theory applied to STIs found deteriorated physical conditions of local neighbourhoods were associated with gonorrhoea rates, independent of poverty (Cohen et al., 2000). The acquisition of STIs has been associated with exposure to neighbourhood poverty during adolescence (Ford and Browning, 2014). Data from the US National Longitudinal Study of Adolescent Health also found neighbourhood influences upon earlier sexual initiation (Cubbin et al., 2005). Exposure to community violence has been associated with increased sexual risk behaviours (Cooper et al., 2015; Senn et al., 2016; Voisin et al., 2014). Communities in which violence in the family is acceptable experience increased likelihood of such violence (Pinchevsky and Wright, 2012). These studies are examples from an evidence-base that has begun to point strongly towards the association between community violence, peer acceptance of norms as well as acceptance of certain sexual behaviours with sexual health and wellbeing outcomes within communities. Indeed, a systematic review of the relationships between neighbourhood characteristics and 'intimate partner violence' (a common term used in the USA to refer to what more commonly referred to in the UK as domestic abuse), found 'ample evidence to indicate that some aspects of neighbourhood may be risk markers or risk factors for IPV' (Beyer et al., 2013, p. 41). However, other systematic reviews, examining risk and protective factors for sexual violence, have concluded there is little evidence on how community level factors are associated with sexual violence (DeGue et al., 2014; Tharp et al., 2013), and have noted that there are no included studies from Europe, and all studies are cross-sectional, highlighting an important gap in evidence. We would argue that qualitative work is needed to begin to bridge this gap and illuminate experiences *in places* (Popay et al., 2003), particularly experience of sexual health in relation to masculinity constructions.

1.2. Masculinities and sexual health

We sought to explore masculinity constructions within and across areas of high deprivation, in order to focus on local gender dynamics and the importance of experiences *in places* (Manzo, 2005), for the way these influence sexual health understandings and behaviours.

Connell defines 'hegemonic masculinity' as 'the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women' (Connell, 1995, p. 77). For a brief theoretical overview of hegemonic masculinity, and its relationship with other masculinities (e.g., protest masculinity, hypermasculinity) see Jewkes et al. (2015a, 2015b), or for more detail see Connell (1995). Here, we emphasise three points, which are particularly pertinent to our study: firstly, masculinity is embodied, structurally positioned *and* 'performed' (Archer and Yamashita, 2003); secondly, masculinities are relational – hegemonic masculinity is 'a particular form of masculinity in hierarchical relation to a certain form of femininity and to nonhegemonic masculinities' (Connell and Messerschmidt, 2005), and thirdly; gender does not operate on its own but in relation to other social dynamics such as class, race and sexuality (Connell and Messerschmidt, 2005). As Courtenay has stated, the 'social structuring of ethnicity, sexuality and class is intimately and systematically related to the social structuring of gender and power (Courtenay, 2009). Thus, efforts to improve sexual health and wellbeing should be premised upon the understanding of gender as 'a way of structuring social practice' and 'unavoidably involved with other social structures' (Connell, 1995, p. 75).

Berg and Longhurst's review, 'Placing Masculinities and Geography', provides an excellent overview of the masculinities and geography research from its beginnings, so we opt not to rehash that here (Berg and Longhurst, 2003). We do draw attention to the lack of studies that bring together a focus on masculinities, place and sexual health. So on the one hand, spatial studies have explored relationships between area- and individual-level risks and individual HIV status (Feldacker et al., 2010); how the built environment influences young people's sexual risk behaviours (Burns and Snow, 2012); and where and how to place STI screening services (Balfe et al., 2010; Goldenberg et al., 2008). On the other, studies have focused on masculinities but not sexual health, such as those exploring rural and urban influences on masculinities and gender practices (Bye, 2009; Lysaght, 2002; Ni Laoire C and Fielding, 2006). Lysaght's study, for example, revealed the performative character of dominant and subordinate masculinities in Belfast, focusing on the way that spatial context affects the performance of gender identities (Lysaght, 2002). A scoping review (McDaid et al., 2012) underpinning our research, identified specific research gaps relating to intervention studies with adult heterosexual men from deprived areas.

Causal pathways link structural factors and sexual health and wellbeing outcomes; hence, for example, tackling gender inequalities can improve equitable interpersonal relationships (Taufkobong et al., 2016) or reduce sexual risk behaviours (Gupta et al., 2008). To develop effective interventions, particularly those designed to improve gender relations so as to impact on sexual health outcomes, we require further research to identify 'causal or contextual factors that are malleable and have greatest scope for change', as well as the level at which intervening is possible within existing systems (Wight et al., 2016, p. 2).

2. Methods

Individual semi-structured interviews and focus group discussions were conducted with men and women living within the same geographical localities, as described in more detail below. We anticipated that men, and women, might be more willing to talk about some sensitive issues, or personal experiences (e.g., experiences of domestic abuse,

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