THEMALLING CONTRACEPTION

WHICHARETHEREASTHESTANDARDSOFTHESTANDARDS?

THE EREBFC'S ETHICAL DOCUMENTS

Reading time: about 30 min

The "Doc'éthique" sheets are designed to support prior reflection on ethics. Ethics is not a position, a code of good practice or a value judgement. Ethics is a reflective approach highlighting the oppositions between different values and underlining the need to reflect on them in order to make detailed and informed decisions.
The short format of the "Ethics Docs" will thus allow those interested to have a first overview of the questions that arise from the theme treated, but also the researcher wishing to work on this theme to find a first basis to refine his questioning and/or his research theme in ethics.

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"Male contraception will become a moral and social issue, not just a health issue. The aim will be to make men aware of their parental and sexual responsibilities.

[1]

INTRODUCTION

The term contraception refers to reversible measures [2] aimed at preventing the conception of a child during sexual intercourse, regardless of the success rate of the method. The contraceptive issue, as a birth control, is therefore part of a dimension of heterosexual relationships since homosexual relationships do not generate procreative issues within their intimate relationships. Although the burden and risk of pregnancy are borne essentially by the woman, the conception of a human being occurs when an egg meets a spermatozoon, leading to a shared commitment between the partners to conception or contraception.

From then on, a tension arises over the partners' responsibility for contraception: can one partner take on the full decision-making and organisational burden? "*Contraception is nowadays seen as a female prerogative. When the subject is discussed, it is indeed female methods that come to mind. Yet for centuries, birth control seemed to be the responsibility of men until the legalization of the birth control pill. As the process of procreation was medically unknown until the 19th century, the most effective methods of male contraception were those that prevented the gametes from meeting: withdrawal or coitus interruptus, the condom and male sterilisation. To this day, these are exactly the same three methods offered and adapted to men with levels o f effectiveness, for the first two, that do not place them among the most effective contraceptives according to the World Health Organisation (WHO).*" [3]

The French National Authority for Health [HAS] in its summary sheet on male contraception (MC), like the **WHO**, still only mentions **withdrawal, condoms or vasectomy** [4].

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The oldest international research began in the 1950s, but it was not until 1979 that research began on the subject in France [1]. There are currently three main lines of research:

- **Hormonal contraception**. Several hormonal combinations are being studied as well as several means of ingesting it: pill, intramuscular or subcutaneous injections [5]. The advent of a male pill seems to be eagerly awaited, synonymous for some with male-female equality in contraceptive management [6];
- **Non-hormonal contraception.** This research is aimed at influencing sperm production, maturation or function. Studies on inhibitors of proteins involved in meiosis, for example, or on the obstruction of the vas deferens [7]. The "non-hormonal pill" has recently made the headlines [8], although the promises made still seem far from certain. There is also thermal contraception [5].
- **Immuno-contraception**, this time in the form of a vaccine, but research seems to have stalled in recent years [9].

The obstacles that may explain the lack of resources and the slowness of research, compared with the resources and proposals available to women, are many and are not necessarily medical in nature. If indeed there is a lack of knowledge of contraceptive methods among men in general, but also among doctors, societal and even sociological fears quickly appear. The subject of MC thus requires attention at several levels, firstly because the burden of pregnancy will undeniably be borne by the woman, thus establishing an irremediable inequality, but also because of the few studies carried out on the underlying representations of MC, which may interfere with the knowledge of the health professional or induce certain societal behaviours.

Since some contraceptives, such as monthly cycle observation or withdrawal, are not very effective in terms of the percentage of unwanted pregnancies, what is an effective contraception? If the absolute certainty of not procreating were necessary to qualify a contraception as "effective", we would then fall into the field of sterilisation, which is a method that is now definitive. From then on, **contraception implies risk management, which means knowing the advantages and disadvantages of each method in order to be able to choose, according to one's life trajectory,** the method which, at a given moment, seems to correspond the most to the life we want to lead and to the risks we are willing to take.

We will thus examine three dimensions: the couple within which this contraception is played out and the part that the man can play in it, the place of the health professional in this intimacy, and finally society as a whole, in order to bring out the ethical issues that lie behind it.

1- THE COUPLE

THE WOMAN

With the arrival of hormonal contraception in France in 1967, women were able to manage their fertility much more effectively than the previous methods available at the time. This assurance of being able to procreate when one wishes and with whom one wishes brings a new freedom for the woman, transforming her relationship with the man. **While the choice to procreate continues to be decided by both men and women, the decision not to procreate is emancipated from the male agreement** and the now well-known slogan in favour of abortion "my body, my choice" reflects the evolution of female thinking concerning the management of births, the relationship with her body and the place of the male in women's decisions.

Today, 71.8% of French women use a medical contraceptive method [10], the pill being by far the most widely used. **However, worldwide, female sterilisation [11] is the most widely used contraception, ahead of the condom**. Depending on the method used, tubal ligation requires general anaesthesia and several days of convalescence [12].

This contraception and this independence were highly demanded, and although the contribution of better birth management is not questioned, more critical voices are being raised today. Contraceptive failures leading to unwanted pregnancies prevent women from living their sexuality with confidence, leading, despite good contraceptive management, to the fear of an unexpected pregnancy, not to mention the mental burden that this represents on a daily basis.

In France, one third of pregnancies are unwanted [13] **and one woman in three will have a voluntary termination of pregnancy (IVG) in her lifetime** [14]: *"In 2019, France recorded 232,000 IVGs, the highest number since the 1990s. Although young women aged 20 to 29 are the most concerned by abortion, the increase in the rate of recourse has been notable among women in their thirties since the 2010s. The increase is most marked among 30-34 year olds (+3.9 points between 2010 and 2019)."* [15]

[1] Desjeux C., 'Histoire de la contraception masculine. L'expérience de l'Association pour la recherche et le développement de la contraception masculine (1979-1986)", Politiques sociales et familiales, n°100, June 2010, pp. 110-114

[2] According to studies, sterilisation (vasectomy or tubal ligation) is not considered to be a contraceptive because of its difficult reversibility. Others speak of permanent contraception.

[3] Vernier L., "La contraception, une affaire d'homme? Étude quantitative prospective unicentrique au sein de l'Université Catholique de Lille", dissertation for the State Diploma in Midwifery, Université Catholique de Lille, Faculty of Medicine and Maieutics, academic year 2017-2018.

[4] Haute Autorité de Santé, "Male contraception, recommendation of good practices", 17 September 2019

[5] Soufir J.-C. & Mieusset R., "Guide pratique d'une contraception masculine hormonale ou thermique", SALF magazine and Springer-Verlag France, 2012

[6] Kalampalikis N. & Buschini F., "La contraception masculine médicalisée : enjeux psychosociaux et craintes imaginaires", rev. Nouvelle revue de psychosociologie, n°4, 2007, pp. 89-104

[7] Like vasalgel which is currently being studied in India and the USA.

[8] France Inter, "Contraception : une pilule masculine, non-hormonale, efficace à 99% sur les souris", 24 March 2022

[9] Huygue E. & al, "Non-differential male contraception: review of the literature", rev. Progrès en Urologie, 2007, n° 17, pp. 156-164

1 Definition: the female reproductive cell (or gamete)

2 Definition: the human reproductive cell (or gamete)

3 Meiosis: Meiosis is a process of cell division discovered by Edouard Van Beneden (1846-1910) to form reproductive cells, the gametes.

4 The Pearl Index is the tool generally used to develop statistics in clinical contraceptive research.

5 Neuwirth's Law

6 Not all contraceptives have the same assurance of non-conception (see Pearl Index) and misuse of contraception can lead to an unwanted pregnancy despite the high success rate of some contraceptives, as shown for example by missed pills.

7 The management of contraception by the woman requires organisation of medical follow-up (anticipation of appointments, management of the schedule and timetable); a search for information in order to choose her contraception (reimbursement, effectiveness, well-being); the shaping of this contraception (taking the pill or her temperature at a fixed time); and coping with the side effects.

The pill, the most widely used contraception in France today [16], is the subject of severe criticism concerning its side effects on women's daily lives, criticism that the scandals surrounding the 3rd and 4th generation pills have aggravated [17]. "Today, *contraception is "Yes, but". Yes, but, provided that women do not complain too much about the side effects, since there is nothing else to offer them. Yes, but, without relying too much on the man who usually considers that it is up to them to shoulder the burden. Yes, but on the condition that you pay if you want this or that contraception that is easier to bear. Yes, but, on condition that you accept each year examinations that are sometimes intrusive and have no reason to be (such as the vaginal touch that is almost systematically imposed for a prescription or a pill renewal)."* [18]

All of these elements invite us to reexamine the current model in which the mental burden of contraception is borne entirely by the woman. For example, although the condom is used in the majority of early sexual life in France, it is regularly considered in studies as a so-called 'female' contraception insofar as it is the woman, even if she is still a minor, who takes care of the purchase, the provision and the injunction to wear it; an injunction to which the man may or may not agree to conform, thus often carrying the financial burden and the entire procreative responsibility of sexual intercourse on the woman. Furthermore, many studies have shown that condoms are abandoned (even though they are the only method of contraception that protects against sexually transmitted diseases [STDs]) when the pill is used as the preferred method of contraception within the couple. Thus, more than half of women declare that they choose their contraceptive method alone without discussing it with their partner [19], thus illustrating a major ethical dilemma: **does integrating the male into the contraceptive process represent a risk of loss of autonomy for the woman to dispose of her body? Between the woman's desire for freedom and the sharing of responsibilities, where can the man stand?**

THE MAN

As the sexual act is a joint one, should we not talk about contraception including both the woman and the man [3]? What do men have to say about contraception being managed by their partner and is it true that they are satisfied with the current situation? **Today in France, the male role in contraceptive management is more particularly situated at the beginning of sexual life with the use of condoms.** Now very famous, it is used in percentage terms much more than withdrawal and even more than vasectomy, the only three methods recommended by the HAS when other methods have been under study, sometimes for several decades [20]. Vasectomy remains very marginal in our country, unlike in other parts of the world: "*In Quebec, one in five sexually active men has had a vasectomy, and one in three among 45-64 year olds. This method is chosen at least four times more often than tubal ligation. Conversely, in France, women choose to be sterilised five times more often than their male partners.* [22]

Historically, a man was expected not to cause an unwanted pregnancy [23]. This implies the control of his desire with periodic abstinence, which in turn implies a certain knowledge of the female cycle to avoid the fertile period, as well as a dialogue as a couple; and it implies the control of his impulses during withdrawal. In the event of an unwanted pregnancy, the man tended to be blamed for not knowing how to "manage", although the burden and management of pregnancy, and if necessary abortion, was and still is considered a "woman's business". **Wouldn't today's French men like to take responsibility once again for the couple's contraception game?**
? According to a recent study, when asked "Is contraception still a concern for women?", 66% of respondents answered "no", and 95.5% thought that it was "a responsibility to be taken" [24]. However, studies giving the microphone to men on this issue are still too rare. This same study asks about the role of the father, which men seem to feel is "less important than the role of the mother". **If** they don't want children, shouldn't they be more involved? And if we compare this with the answers given above, how can we interpret this contradiction?

Among the motivations that push some men to take an interest in the contraceptive issue, we see the desire not to harm themselves, their partner, the planet or the family unit, as well as a search for security in the area of sexuality and, finally, a search for equity with their partner.

It is in this light that we can read the results of a 2016 study by Santé Publique France [17], which observed that following the "pill crisis" of 2012, women reported more frequent recourse to the use of the male condom as a method of contraception. **Male demands, which seem to be more discreet and less audible to society, still exist** [11], particularly when an unwanted pregnancy has occurred in a couple, or when the woman is no longer taking hormonal contraception and the man wants something other than a condom [21]. "*Men can already take part in the couple's contraception through actions that show their interest, such as accompanying their partner to the doctor, reminding them to take contraception, supporting them in the various decisions concerning contraception, etc.*" [3]

[10] Ministry for Gender Equality, Diversity and Equal Opportunities, "Key figures 2021 edition, "Towards real equality between men and women" ".

[11] Tcherdukian J., "Male contraception: what (r)evolutions?", journal "Progrès en Urologie - FMC", Volume 30, Issue 4, December 2020, pp. 105-111

[12] Site gynandco.fr, "Tubal ligation: a definitive contraception

[13] Bajos N., Moreau C., Leridon, H., & Ferrand, M., "Pourquoi le nombre d'avortements n'a pas baissé en France depuis 30 ans", Population et sociétés, 407, 1-4, 2004

[14] Mazuy M., Toulemon L., & Baril É., "Un recours moindre à l'IVG, mais plus souvent répété", rev. Population Sociétés, 2015

[15] DREES, "232,200 voluntary terminations of pregnancy in 2019, a rate of recourse that reaches its highest level for 30 years".

[16] Santé Publique France, "French women and contraception: first data from the 2016 Health Barometer"

[17] Santé publique France, "Baromètre santé 2016 contraception: Quatre ans après la crise de la pilule, les évolutions se poursuivivent", September 2017

[18] Debusquat S., "Marre de souffrir pour ma contraception. Manifeste féministe pour une contraception pleinement épanouissante", published by Les Liens qui Libèrent, April 2019 - also read on her blog

[19] Viel H., "L'implication des hommes dans la contraception", dissertation for the state diploma of midwifery, University of Caen, School of Midwifery, academic year 2015-2016

[20] HAS, "État des lieux des pratiques contraceptives et des freins à l'accès et au choix d'une contraception adaptée", April 2013

[21] Bonnefond X. & Dardel P., "Le remonte-couilles toulousain, slips chauffants et contraception masculine", JeF Klak, 1 April 2016

[22] Source : Contraceptionmasculine.fr

[23] Le Guen M., Roux A., Rouzaud-Cornabas M., Fonquerne L., Thomé C. & Ventola C., "Fifty years of legal contraception in France: diffusion, medicalisation, feminisation", rev. Population & Sociétés, 2017

[24] Desjeux C., "Histoire et actualité des représentations et pratiques de contraception masculine", rev. Autrepart, number 52; April 2009, pp. 49-63

1 For more information on vasectomy

2 Tubal ligation requires abdominal surgery with general anaesthesia, whereas a vasectomy requires an outpatient procedure with local anaesthesia.

WHAT IS THE FAIRNESS OF BIRTH MANAGEMENT WITHIN THE COUPLE?

Could MC help balance the responsibilities of conception and contraception? And how do women respond to men's willingness to invest in this area? In a study from over a century ago in China, Scotland and South Africa, 80% of women said they would tend to trust their partner to manage contraception [25]. More than a century later, recent studies show that this is not yet the case.

The irresponsibility of men seems to be one of the major accusations and reflects a lack of trust by part of the female population towards their partners. A fortiori, when a woman meets a man and he assures her that she cannot have children (contraception, vasectomy or sterility), how can she rely on his simple statements? Similarly, to what extent can a man blindly trust his contraceptive partner without fearing the risk of a "baby in the back"?

Is trust the key to contraceptive management, an indispensable element of shared responsibility within the couple? Does trusting one's sexual partner mean entrusting the responsibility for contraception to the other? Can "trusting" by letting the other manage the entire contraceptive process not also be seen as giving in to the easy way out and privileging one's own freedom and health to the detriment of the partner who takes on all the responsibility and the difficulties that go with it? Couldn't each person's responsibility also be envisaged in certain cases as a double contraception?

Finally, **some women, despite trusting their partner, will put forward a certain desire for independence**: contraception is their personal responsibility and the reminder to take their partner's contraception can make them feel assisted. Through their dialogue as a couple, these women establish "rules" and define the form of their partner's investment [24]. This dynamic allows the couple to discuss each other's place and is another example of shared responsibility while respecting the space for freedom within the couple.

"I did it for myself first, to control the danger I was carrying in a relationship. Because it's a real danger: I'm not the one who will carry the child, I'm not the one who will go and do an abortion if necessary. (...) There is a strong stake in the relationship, [...] there is a common reflection on contraception, and on what we do together: how and why?
[21]

2- PROFESSIONALS IN THE FIELD

THE PRESCRIPTION OF CONTRACEPTION

In France, it is general practitioners and gynaecologists as well as midwives who have been given the power to supervise and control contraception in order to "*reconcile the demands of feminists and the concerns of the most conservative*", making them "*the legitimate experts in the field of birth control*". [26]

From being a couple's affair, medicalised contraception is becoming a matter of women's health, since the majority of contraceptive prescribers are now women, involuntarily removing the man from the contraceptive decision-making process in most cases. The role of the health professional in charge of the contraceptive issue is major, both in his ability to understand the situation of the woman - who is often the only one to consult - and in the selection of the contraception he will propose. The HAS has listed the obstacles to the choice of contraception adapted to the patient on the part of health professionals and they are numerous [27]. It emerges that **the training of prescribing health professionals is inseparable from the possibility for citizens to access legally available techniques.** Some of the methods under study are still not recommended by the HAS but are used by the population and therefore require professionals to be informed in order to support and discuss them with their patients.

Professionals' preconceptions also have an impact on consultations: sometimes mistrust of men, shifting the question of trust within the couple to the trust that the female doctor will give to the male partner: "*Many female doctors hide certain contraceptives from their patients because they say to themselves 'I wouldn't trust men on this subject, so I don't recommend it*'" [28]; or a general refusal to prescribe them among male professionals, questioning their representation of "masculine nature" [3]. **Professionals' fears in this area are not always medical** (possible fear of undermining masculinity: virility, libido and any other representation of what constitutes this masculinity), but rather societal, or even anthropological (upheaval of customs against the idea built up over the years of the woman as the main actor in birth control), and these different dimensions increase the extent of the difficulty of the subject.

[25] Glasier A.F., Anakwe R., Everington D., Martin C.W., Van der Spuy Z., Cheng L., Ho P.C., Anderson R.A., "Would women trust their partners to use a male pill?", rev. Human Reproduction, Volume 15, Issue 3, 1 March 2000, pp. 646-649

[26] Ventola C., "Le genre de la contraception : représentations et pratiques des prescripteurs en France et en Angleterre", Cahiers du Genre, n°60/2016

[27] HAS, "Contraceptive methods: Focus on the most effective methods available", March 2013

To find out more, here are the recommendations of good practice from the HAS to doctors "Contraception: prescriptions and advice to women".

School nurses, university medical services and pharmacists can renew contraception. Source

56.9% of obstetric gynaecologists, 83.5% of doctors practising medical gynaecology[1], 45% of general practitioners (60% of whom are on medical benches)[1] and 95.5% of midwives are women. Source

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Could a place be given in the teaching of future health professionals to distance themselves from their gender representations in order to enable them to question the images they may have of contraception? Would this help them to better manage their patients' contraceptive requests? And for the prescribing professionals: is this place at the heart of the couple's intimacy well proportioned? What place in this woman/woman pairing is there for the male partner, who is nevertheless central to the management of births? Are women prescribers aware of this involuntary sidelining of the male partner? Conversely, do male prescribers also ask themselves this question? Do male gynaecologists still feel legitimate in the face of a female population claiming their contraceptive freedom, which is sometimes constructed in opposition to the male opinion? What effective freedom of information and choice do patients have when the professional has little training on the subject?

PERMANENT CONTRACEPTION: WHAT SPECIFIC ETHICAL DILEMMAS FOR CAREGIVERS?

The law of 4 July 2001 gave a legal framework to definitive contraception (DC) in France. Previously, DC was regularly practised, but was considered as a physical mutilation, except in cases of real medical justification and not simply for contraceptive purposes. The CCNE considered the issue of CD in 1996 when it was not authorised in France and stated the major advantage for those who choose it: "*the absence of constraint for the user, once sterilisation has been carried out, and its low cost compared to other fertility control techniques*" [29]. **Sterilisation is the method par excellence for permanently stopping fertility, when other contraceptives only render infertility for a given period of time, momentarily stopping the procreative capacity. If there is a human right to procreate, can we consider that with the legalisation of CD, a right not to procreate now exists?** [1]

Although vasectomy has been legalized for twenty years now, there is a significant difference between Western countries in the percentage of men who have undergone vasectomy. In 2013 it represented for example 21% of men in Great Britain against 0.8% of men in France [30]. If we now compare male and female CD in France, in 2018 female CD is estimated at 25,000 tubal ligations versus 8,000 vasectomies, and this number rose to "*40,000 in 2016 with tubal ligation by tubal obturation which was stopped in 2017.*" [31] Although sterilisation is performed more on women, both men and women describe a difficult pathway to CD. A first explanation lies in the doctor's right to refuse to perform this surgery. **Another reason is the lack of information generally provided on the subject, especially during university studies** [32].

The refusal of professionals may also be motivated by an ethical conflict: according to Beauchamps and Childress' tools, this "inner conflict" experienced by some professionals underlines the **questioning of present and future beneficence, in the name of potential future harm if the person were to regret her choice.** "*There is a gap between the terms of the law, which authorise a woman to request permanent contraception regardless of her age and history, and the attitudes of doctors, who give indications according to professional criteria that are often personal and therefore vary according to the operator. Another argument is the fear of the risk of regret, which is all the higher the earlier the age of the procedure. [*31] How can we as professionals avoid basing ourselves solely on our personal knowledge or values when deliberating whether or not to grant a man's request for a CD? Some clinics have chosen to consider requests in a collegial manner, as in an article presented by a team in Nantes for CD requests from women under 35 years of age [31]. [3]

The person is required to wait 4 months to reflect on the decision. This is the longest reflection period required by law for a medical procedure. By way of comparison, a period of only 15 days is required for cosmetic surgery [33], while England does not require any reflection period for vasectomy [26]. This shows both the particular place that France gives to the question of reproduction but also the concern that the legislator may have had in giving individual freedom outside the field of purely curative action. As there is little information available on vasectomy, men who come to the practice to request a CD are generally already very sure of themselves. **In this respect, the 4-month reflection period for men is often perceived as a brake.**

For its part, the HAS proposes a memo sheet of recommendations for good practice [34] and reminds us that "*the law does not stipulate any condition of age, number of children or marital status*". So a young, single person with no children can access the CD, at least that is what the law says. But how can the request of a young man under 35 who has no children be granted? Since men are not regularly ordered to procreate and can freely assure that they do not want children, how can we explain the difficult access to vasectomy for those who request it? What does the low percentage of French men who have undergone vasectomy tell us about our society?

[28] Binge Audio, "Male contraception: it's the men's turn", with Cécile Ventola author of the thesis "Prescribe, proscribe, let choose: Autonomy and rights of users of health systems in France and England through the prism of male contraception", Series "Balls on the table" hosted by Victoire Tuaillon, 7 June 2018

[29] CCNE, "Opinion 50. Report on sterilisation as a permanent method of contraception", 3 April 1996

[30] Delvienne JC, "Place du recours à la vasectomie en Hauts-de-France : Le regard des médecins généraliste", thesis of general medicine, Faculty of Medicine of Amiens, 2020

[31] Branger B., Dabouis G., Berthiau D., Durand, G., Barre, M. & David, P., "Démarche éthique dans les demandes de contraception définitive de femmes majeures de moins de35 ans sans handicaps et sans problèmes médicaux majeurs",
HAL Open Sources, 7 July 2020

[32] Rostam C., "La vasectomie, une contraception occultée", Vocation Sage-femme magazine n° 126, May-June 2017

[33] Code de la santé publique, "Section 2: Délai de réflexion. (Articles D6322-30 to D6322- 30-1)" to be consulted on Legifrance

[34] HAS, "Sterilisation for contraceptive purposes in men and women", 17 September 2019

[1] It should be noted that during these irreversible surgical procedures, a sample of gametes is systematically taken and preserved in flakes in case of regret.

[2] ESSURE - registered trademark

[3] The HAS reminds us that the rate of regret after surgery is only 1 to 2%. Source

WHAT RESEARCH ON MALE CONTRACEPTION?

Currently, the budget for MC research is estimated to be no more than 10% of the total WHO budget for contraceptive research [36]. While 13 new contraceptives have been launched since the Second World War, we are still at the same 4 proposals for men. This major delta is already an ethical problem in itself and raises questions of justice and societal restraint. How can this imbalance be explained?

According to Christophe Desjeux, *"perceiving men as irresponsible is a historical and cultural construction"*. Although research into male contraception is still in its infancy, several factors should be considered [24] :

- **Research in the 1930s was favourable to FC** and gynaecologists had easy access to so-called female hormones through materials (placentas, ovaries, urine, etc.) collected by the medicalised structures and operating in an organised network. These arrangements did not exist for CM. **Research on male hormones was used in the German army during the Second World War in** order to *"have an army of powerful and efficient men"*. This study was stopped at the end of the war and the development of a research dynamic on the male body and its hormonal functioning was fragmented and reduced in time.
- **The development of a CM does not meet the economic stakes of pharmaceutical laboratories**: either it competes with CF, or it will remain marginal. Innovative methods (thermal and subcutaneous hormonal) therefore remain largely unknown, which limits demand.
- **The CM should be included in the concerns of the funders** (CNRS, DGRST, Ministry of Health) to advance research on the combination of progestins and testosterone.
- Finally, **the negative representations and the influence of the media on the irresponsibility of men**, "too soft", widely relayed by certain doctors, do not encourage more research on MC.

"The development of the hormonal pill was funded by feminists (Margaret Sanger) who campaigned for an effective method independent of the sexual act. There has never been an equivalent demand from men." [37] Between a pharmaceutical industry with little interest in MC, insufficient training of health professionals on the subject, societal obstacles and low demand from patients with very limited or non-existent information, the conditions do not seem to be right for a considerable increase in scientific research resources in this field.

3- FROM THE ADOLESCENT TO THE CITIZEN INCLUDED IN SOCIETY

WHAT EDUCATION FOR BOYS ON CONTRACEPTION AND SEXUALITY?

French law has required sexuality education since 2001, with three sessions each year per middle and high school level [38]. However, in 2016, the High Council for Equality between Women and Men (HCE) revealed in a survey that 25% of elementary schools, 11% of high schools and 4% of middle schools declare that they have not implemented any action or session on sexuality education [39] and the schools that have implemented sessions rarely reach the 3 annual sessions. In the face of studies showing that young people are not aware of their bodies, contraception and their proper use despite the lessons given at school, the question arises as to the art and manner of teaching it so that young people retain this important information for their sexual lives. The HAS has published on its website a list of obstacles to contraception described by schools [20] and lists both logistical and funding problems for interventions carried out in schools, as well as a lack of evaluation of these measures, the quality of which is probably very uneven.

There seems to be a discrepancy among male adolescents concerning contraception for girls and for themselves: *"We talk about all the female contraception, the insertion of the IUD and everything. When we talk about vasectomy, in the imagination, it's castration, having your testicles removed, and they're all shaking their heads "Ah, but that's so horrible! Whereas with the IUD, it's radio silence!"* [21] **These lessons are usually the responsibility of the biology teacher, but is he or she best able to explain anything other than the biological technique of reproduction or contraception?**

[35] Bernard V., Bouvattier C., Christin-Maitre S., "Therapeutic issues in male fertility", rev. Annales d'endocrinologie, volume 75, January 2014, pp. 13-20

[36] Rouanet C., "La contraception masculine, c'est (encore) pour bientôt", dissertation for the state diploma in midwifery, University of Lille, Midwifery School of the CHU of Lille, 2021

[37] Le Monde, "Today, the control of contraception by doctors is being debated", 26 September 2017

[38] Initial law n° 2001-588 of 4 July 2001. Updated law: n°2021-1109 of 24 August 2021 - art. 33. To be consulted on Legifrance

[39] France Inter, "Enquête - What happened to the compulsory sex education courses enshrined in law in 2001?", 20 November 2019

"Male reproductive health has long been neglected despite accounting for half of all cases of couple infertility. However, in recent years, a better understanding of the endocrine physiology underlying testicular development and spermatogenesis has led to the development of new therapeutic strategies for the management of male infertility on the one hand and the development of effective male contraception on the other.

[35]

DID YOU KNOW?

Andrology focuses on the physiology and pathology of the male reproductive system. It is in some ways the equivalent of the gynaecologist for women. This medical speciality is concerned with the anatomical, biological and psychological elements that contribute to the proper functioning of the male genital system. The discipline encompasses several branches: endocrinology, urology, the vascular aspect, but also the biological and biochemical aspect, for sperm anomalies.

Urology, a much more developed specialty than andrology, deals with pathologies of the male genital tract. In 2020, there were 1,448 urologists practising in France and far fewer andrologists. The profession is 92% male. Sources

1 According to the association Nous Toutes: *"Respondents who attended at least 7 years of secondary school received an average of 2.7 sessions of sexuality education throughout their schooling, instead of the minimum 21 sessions required by law."* Source

2 *"No respondent answered correctly on withdrawal, on condoms and vasectomy, a majority did not get the right answers ... 80% of the answers were wrong on condoms."* Source: see [3]

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DID YOU KNOW?

The "Contraception and preconceived ideas" site, run by the National Association of Abortion and Contraception Centres (ANCIE), offers materials for teachers and associations including a short film and an intervention preparation sheet entitled: "Contraception is for girls and boys!

"From puberty onwards, sometimes even earlier, women are alerted about their fertility; their bodies become the subject of all the attention of the medical profession, gynaecologists in particular. [...] (When you wear the heated underwear) every day, you start to manipulate something in your body that you weren't manipulating, that is, you pull up your testicles. You become aware of something you're not used to as a guy at all. For me, it was the first time [...] that a doctor touched my sex, that he really looked, that he got down to my sex and looked." [21]

1 It should be noted, however, that condoms can be reimbursed by social security under certain conditions. This scheme is not well known by the population, particularly young men. Source

2 From now on, the first consultation on sexual health, contraception and STD prevention has been extended to young men under the age of 26. Source: Ameli.fr, "Contraception", 17 March 2022 Source

As one Planned Parenthood professional explained: "*[Reproduction] is separate from sexuality. You talk about reproduction, but as a conceptual thing. There are chicks - and with guys it's even worse because they won't suffer the consequences - who are very surprised that they can get pregnant at first sex!*" [21] **Will the boys who are less used to talking about these intimate subjects feel sufficiently comfortable with their teacher, who supervises them all year? These discussions can be an opportunity to open up the subject of contraception to more general themes that will enable young men to reflect on the place they want to take in society**: "*In this way, we have the opportunity to accompany the change in morals in terms of equality between men and women in the family, professionally, personally, etc." [3].* [3] We can try to awaken an understanding of the experiences of the other sex, which will allow for better communication within the couple later on.

Some would like to see sexuality education for boys take on an even broader dimension: "*The question of male contraception must be linked to a more general issue, that of male domination. Criticism includes the recognition of privileges. It is not the expression of a domination that is exercised directly, (...) it is rather the benefit of a privilege. One of the privileges is that of not having to worry about contraception, and this is indeed the expression of a relationship of domination. [21]* **The question could be put to them as follows: what, as a young man, do I need to worry about in my sexuality? Is it legitimate for me not to care? What specific knowledge should I have to be able to deal with it myself?**

CONTRACEPTIVE EDUCATION IN A MEDICAL SETTING?

Today in France, women are the object of all medical attention from the time they reach puberty: **from the first contraceptive prescription, young women are socialised into their bodies through gynaecological medical surveillance** [40]. This is one of the explanations for the "French contraceptive scheme" in which the pill is prescribed so much: regular prescription renewals are an opportunity for a preventive check-up with breast palpation and the usual smear test. Female contraception, with the 3rd and 4th generation pills, has gradually moved towards bio-medicalisation, which does not only deal with purely medical issues but also allows the woman's body to be improved: improvement of the skin, reduction of the volume of menstruation, hormonal treatment of the menopause, etc. **Between real benefits for her health and all kinds of injunctions on the female body, the medical follow-up of women is the archetype of a new way of considering the body and its care. This institutional care has led to effective social management of the biological body, making women socially responsible for contraception, which they know and master through repeated learning from health professionals** [41].

For men, nothing of the sort. There are no recommended regular appointments with the doctor for contraceptive prescriptions or health monitoring, to the extent that some doctors regret that they no longer have the opportunity to see men after they come of age and before any real health concerns arise. Could a strongly recommended appointment at the age of majority in a doctor's surgery enable young men to have a first contact with a professional in the field and teach them that going to the andrologist is not necessarily synonymous with infection or infertility? But also, **what transmission of knowledge between male friends or from father to son exists today? Aren't men being prejudiced by having so little space in the public and medical space to discuss these issues and get information?**

"According to this (essentialist) view, women would be more naturally competent and responsible to take charge of contraception because of their gestational potential. Conversely, since they do not have this gestational potential, men are naturally incompetent or irresponsible in contraceptive matters. This view is all the stronger given that the context of the organisation of sexual and reproductive health services in France is gendered and is mainly aimed at women. [40] **Would the integration of men into the French contraceptive system modify the injunction to motherhood and certain representations of women?** Could the search for a CM that respects men's comfort be good news for women? **The approach to the male body and the management of his sexuality raises the following question: apart from the use of hormonal contraception justifying medical monitoring, does a woman's sexual health require such monitoring and would her knowledge of contraception be affected?**

CONTRACEPTION, A CIVIC COMMITMENT?

Choosing whether or not to have a child is an individual decision, taken alone or within a couple. At first sight, it seems obvious today that the State or the community does not intervene in this decision beyond ensuring the freedom of citizens to conceive or not. **Yet this individual choice has a lasting impact on the society in which we live and conditions the natural renewal of the population.**

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The current debates on retirement age remind us that demographics and the median age of the population have a major impact on our economy and long-term policy decisions. **The unborn child will not only be someone's child, but a future citizen who will participate in the life of the community**. However, it is the couple who conceive the child who take responsibility for loving and raising it.

We can thus see a tension emerging around the management of births between individual will and community management. **Are we aware that our choices to conceive or use contraception are civic commitments? To what extent should my individual choice be in line with or against community issues, like those couples who do not want to procreate because of global overpopulation or, conversely, who are concerned about the "renewal of the French population"?** And to what extent can the state prohibit a population from having children (extermination of minority populations, massive sterilisations), limit the number of children per woman (as in China), encourage procreation through birth control policies (as in France at the beginning of the century) or produce a 'superior race' (Nazi Germany)? **A balance between these two forces is necessary because history has shown us the worst atrocities in this area.** [42-43]

A society would not exist without its individuals, so **the responsibility for contraception lies primarily with us**, and health professionals are only an intermediary who sometimes make us forget this responsibility. **This is one of the consequences of delegated biopolitics** [44]**: each individual can do what he or she wishes with his or her body as long as he or she presents himself or herself before a representative of the medical and nursing profession.** If this doctor-patient relationship becomes the nerve centre of birth control, through the delegation of the body politic to health professionals, it is above all a societal issue. As we all live in society, it is interesting for us to be aware of the impact of our individual decisions on contraception and the political weight they represent. The WHO regularly reminds us of the positive influence of contraceptive use in the fight against poverty, for women's health and against the precariousness of children, contributing to a more equitable world in health and social justice. [45-46] And we can ask ourselves: as a citizen, what kind of society do I want to build? What commitment do I have for the world of tomorrow? **How can my management of contraception commit me as a citizen?**

CONCLUSION

Between the sensational press articles promising the advent of hormonal MC and the difficulty men have in accepting to talk about this subject, which is often considered "taboo", discussing MC requires some distance. **The lived realities of couples are always more diverse and complex than what the studies describe. As this is an intimate subject, it is not easy for researchers to obtain participants who are sure that they fully describe their sexual reality, and this is understandable.** Biases are however clearly identifiable, such as the fact that the majority of studies on contraception, even when they are only interested in female methods, do not question the women's partners. Those that do ask about the role of men are rare, and questioning female partners is not systematic either. Little space is also given to questioning the current French contraceptive model, as well as the place of health professionals at the heart of the couple. The lack of public or intimate space available to men on this subject is problematic, to say the least, and this does not seem to bother the majority of them. But is this true? How many studies and research studies give them a voice on the subject?

Women, after having claimed complete control over contraception, now find themselves with the heavy mental burden of its responsibility. They now want their male partners to be involved. **Some people are keen to see in the MC the advent of a real societal change heralding effective equality between men and women.** But contraception in its current use "does *not have the power to subvert the gender hierarchy. Indeed, its use not only does not disrupt but reinforces the construction of a female identity still based on maternity. [*13] The subject of the CM is thus underpinned by a broad questioning of the image and identity of women, as well as of men. Is real equality between men and women in the field of contraception possible? **Physiological equality does not exist, but equity, i.e. a responsibility proportionate to each person's situation, can be encouraged and promoted.** The question is to know where to place the cursor so that contraception becomes an area of couple life where benevolence towards the other and towards oneself is superior to the simple management of risk and the search for the least adverse effect.

Finally, the ethical issues of MC cannot be approached solely from the prism of male-female equality, since contraception involves us as citizens. **The central role of the health professional can make us forget that this body of ours is first and foremost our own responsibility, at the risk of looking at the contraceptive issue solely from a medical point of view, obscuring broader and deeper societal issues.**

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[44]

See also on the subject Mona Chollet, "Reinventing love - How patriarchy sabotages heterosexual relationships", Zones, 2021

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> Theme 02 "Early life".

> Sub-theme "Contraception and sterilisation

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