



MEN'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

A POSITION PAPER



WHY TALK ABOUT MEN'S SRHR?

Sexual and reproductive health and rights (SRHR) are often seen as the domain of women and girls' health and well-being. Men and boys are considered important in SRHR, but mainly as partners, gatekeepers and policymakers. This paper argues that men and boys have their own sexual and reproductive health issues and concerns. Addressing men's concerns benefits not only themselves, but the rippling effect through their partners and communities allows the achievement of SRHR for all.

“*If we want large numbers of men to support and implement gender equality policy, it will be necessary for that policy to speak in concrete and positive ways, to their concerns, interests, hopes and problems. The political task is to do this without weakening the drive for justice for women and girls that animates current gender equality policy.*”

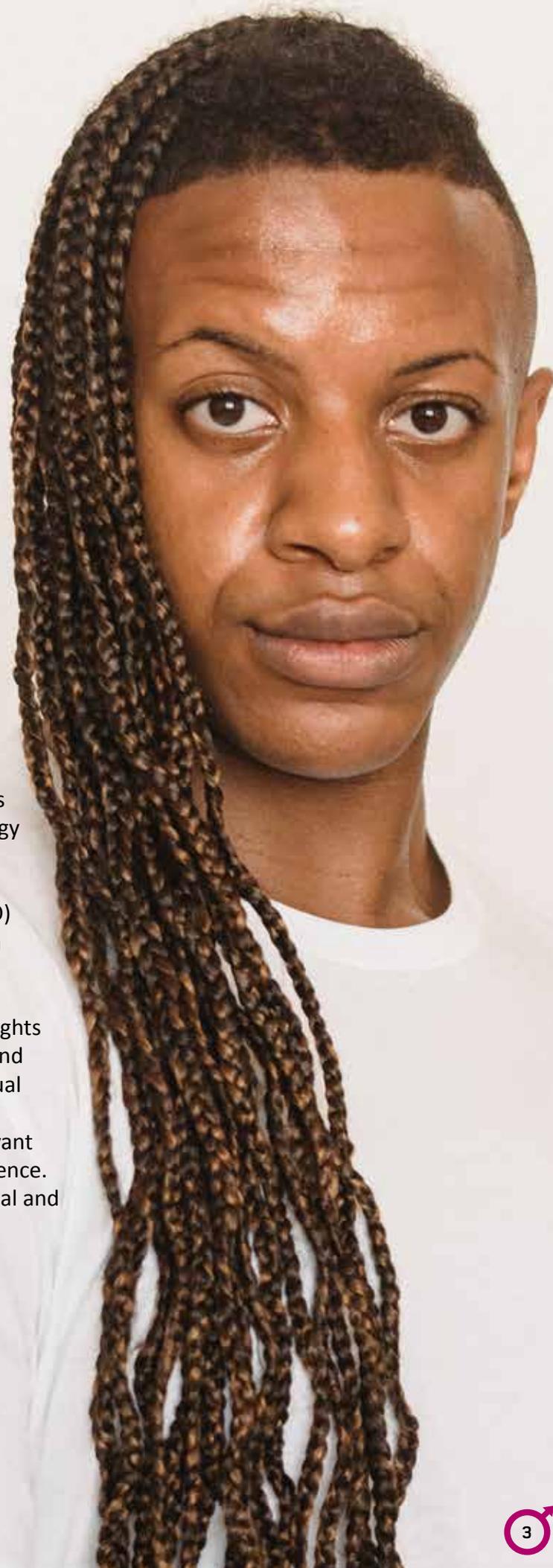
(R.W. Connell, UN advisor)



BACK TO BASICS

WHAT DO WE MEAN BY MEN AND SRHR?

In this paper, 'men' refers to any person who identifies as a man, both cisgender men (born male) or transgender (born female). 'Boys' are young men and included under 'men' unless otherwise stated. While most men have male sexual and reproductive organs, it is important to recognize that gender identity and physiology are not always aligned, so a man may have female sexual or reproductive organs, with implications for his health.¹ In line with the World Health Organization (WHO) definition of health, 'sexual health' is a positive approach to sexuality, sexual relationships and sexual experiences, while 'reproductive health' relates to the reproductive system and its functions and processes. Several human rights agreed under international frameworks apply to sexual and reproductive health (SRH) and should allow each individual to attain the highest standard of reproductive and sexual health, make free and responsible decisions, access relevant services, and be free of discrimination, coercion and violence. Duty bearers should respect, protect, and fulfil such sexual and reproductive rights.



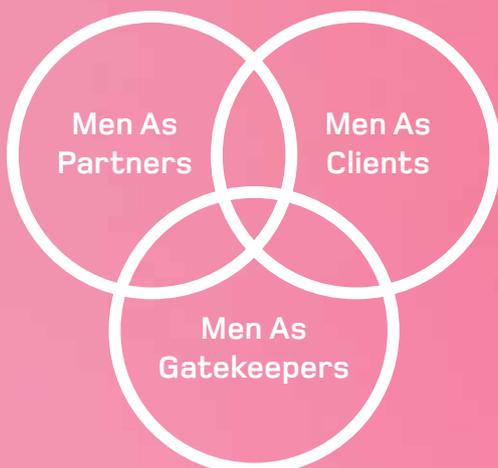
1. The same applies to transwomen with male organs, but that is beyond the scope of this paper

ENGAGING MEN, OR TARGETING THEM?

Historically, reproductive health was concerned with population control, more specifically the control of reproduction and fertility, and attention was focused on the role of women as reproducers. The 1994 International Conference on Population and Development (ICPD) not only introduced a more positive approach, including the right for all to achieve and uphold the best possible sexual and reproductive health but also introduced the concept of engaging men in SRHR. Since then, policies and programmes included men as partners or gatekeepers to improve SRHR outcomes for women. But some argue, the discourse remained focused on destructive norms of masculinity and harmful behaviours of men. In the last decade, men are increasingly recognized as having sexual and reproductive lives themselves, resulting in normative and technical guidance on SRH services and programmes for men and boys as clients, which in turn can make them into agents of positive change for SRHR more broadly.



HOW SRHR PROGRAMMES ENGAGE MEN



WHAT ARE MEN'S SEXUAL AND REPRODUCTIVE HEALTH ISSUES?

What follows are commonly discussed SRH concerns and issues that men, in all their diversity, may experience throughout their lives. As men's SRHR is a burgeoning field, there is still relatively little published research on issues like infertility, sexual function, and the aspects of sexual health. Importantly, sexual and reproductive concerns depend on personal, behavioural and social factors, and differ significantly per sub-group of men.

SEXUALLY TRANSMITTED INFECTIONS AND HIV

The WHO estimates that each year, 184 million men and boys report a sexually transmitted infection (STI), more than half of the total cases. This is probably an underestimate because women are routinely screened for STIs in antenatal clinics, and men tend to avoid health services and prefer self-medication. As a result, the WHO estimates that men and boys lose almost 5 million years of life due to STI-related ill health, besides the direct morbidity and indirect consequences such as infertility (which may result from gonorrhoea or chlamydia) and HIV infection (the risk of which is increased by herpes simplex or syphilis). Some men are more at risk than others. Research indicates that STIs are common among certain (mobile) professions and for younger, poorer, and minority men.

An estimated 750,000 men and boys acquired HIV in 2020, half of the total new infections. As with STIs, men are less likely to be diagnosed in a clinic and receive early treatment, compared to women who are screened for HIV during pregnancy. HIV results in an estimated 48 million years of life lost for men. The quality of life implications of HIV infection may include shame and fear due to social stigma, sometimes reported to result in sexual dysfunction. HIV infection affects some male subpopulations more than others; men who have sex with men are 22 times more likely to acquire HIV than the general male population, according to UNAIDS. Stigma and discrimination (experienced or anticipated) deter many men who have sex with men from seeking HIV diagnosis or treatment. Other vulnerable groups include men who inject drugs, male sex workers, and men who spend time away from their families.

SEXUAL DYSFUNCTION

Sexual dysfunction is defined as any reason a man is unable to participate in sex, recognizing that sexual response depends on psychological as well as somatic processes. A recent study in Italy found that the most common dysfunctions are erectile dysfunction, premature ejaculation, and low libido. Sexual health professionals increasingly recognize the importance of organs other than just genitals for sexual pleasure (or dysfunction). Sexual dysfunction happens in all age groups, but the same Italian study found that younger men are increasingly seeking help for erectile dysfunction, possibly due to public awareness, increasing options for treatment possibilities, or lifestyle. While the major causes of erectile problems for older men are often underlying disease, such as treatment for prostate cancer,

cardiovascular disease or lifestyle (alcohol and smoking), for younger men, psychological and lifestyle factors are found to be relatively more important. In a Belgian study, more than half of gay men living with HIV reported erectile dysfunction, while another study did not find that sexual orientation makes a difference in the prevalence of erectile problems. The impact of sexual dysfunction can be devastating at both the personal and interpersonal levels in terms of reduced sexual pleasure, performance or fertility. Several studies found that cultural notions of masculinity often make sexual dysfunction even harder on men or may result in a vicious cycle of performance anxiety. Sadly, stigma and taboo may prevent them from seeking help even if it is available.

MALE INFERTILITY

Infertility is defined as any disease of the reproductive system resulting in failure to achieve a pregnancy after at least 12 months of regular unprotected sexual intercourse. Infertility is common, affecting around 15% of heterosexual couples globally. Research indicates that male infertility may contribute to half the global cases of childlessness, and the US Centers for Disease Control and Prevention (CDC) estimates that almost 10% of men are infertile. These figures may be underestimates, as male infertility often goes unreported in national health statistics due to stigma and the belief that infertility is exclusively a female issue. Male infertility is associated with a multitude of factors that result in limited quality or quantity of sperm in semen or ejaculate. Medical factors include hormonal imbalances, transport obstruction due to prior infections or surgery, or antibodies to sperm cells. Behaviours such as smoking, alcohol use, and exposure to radiation or chemicals can also affect fertility. As mentioned, sexual dysfunction may result in infertility. Infertility also affects men in same-sex couples and transgender men. The impact of infertility can be severe on men and their families, both psychologically and socially. Infertility may provoke men to undertake risky sexual and health-seeking behaviours.

REPRODUCTIVE CANCERS

Prostate cancer is the most common cancer for men worldwide. According to global cancer statistics, roughly four per cent of men will be diagnosed with it during their lifetime, or roughly 1.1 million each year. This figure does not include men with prostate cancer who die from another disease before they are diagnosed, which happens often. Research shows that almost six million years of life are lost to prostate cancer. Testicular and penile cancer are less common male reproductive cancers, with a lifetime risk of around 1 per thousand (1.4 and 0.9, respectively). While the exact causes of reproductive cancers are poorly understood, genetic and hormonal factors appear associated. Prostate cancer is often diagnosed in men over the age of 40, while testicular cancer is more common among younger men aged 20-35. Survival rates of reproductive cancers are generally good at 95%, but the key to survival is early detection and treatment. Such services are unevenly available in the world, and according to UNFPA, half of the 300,000 deaths from prostate cancer occur in low- and middle-income countries. Despite good survival rates, the impact on health and well-being from these cancers can be serious. Recent research shows sexual relationships can become strained during prostate cancer treatment and that depression and anxiety may result in a lower sex drive and quality of life.

CONTRACEPTION AND CONDOM USE

Family planning remains the domain of women, but male partners are increasingly engaged. Modern contraceptive options available for men are limited to vasectomy (irreversible sterilization) and the condom. Global reporting indicates that one in ten married men use modern contraception, with condom use more common among younger men and vasectomy more common in high-income countries (up to 12% in North America). The uptake of vasectomy is minimal in low- and middle-income countries, mainly due to men's reluctance to use irreversible methods. Novel reversible (hormonal) products are under development, but this is a slow process due to industry concerns about the limited market demand. Men use condoms not just for contraception but also to prevent the transmission of sexually transmitted diseases and HIV. A study of sexually active men across 37 countries found that, on average, 40% of men used a condom during their last sexual encounter, but it is unclear what the main reason for condom use was. Much research has been done into the reasons why men don't accept and use condoms, and these generally point towards cultural disagreement, interference with pleasure or erection, or cost.

SEXUAL AND GENDER-BASED VIOLENCE AFFECTING MEN

Acts of violence inflicted upon an individual because of their gender or sexual orientation can occur in various forms, whether it be physical, sexual, psychological. A recent report identified that a considerable amount of men experience sexual violence. However, boys' and men's sexual victimisation remains poorly documented due to shame, and is poorly researched. Two groups of men and boys appear vulnerable: those in conflict settings and those who don't conform to stereotypes of masculinity. UNHCR reports that 30-40 per cent of adult men experienced sexual violence while in detention in Syria. Some even argue that male conscription into the army and being forced to commit atrocities constitutes gender-based violence. The second group of boys and men, often homosexual or queer, face violence across most societies and cultures. This violence is well-documented. The consequences of violence are physical and psychological, and often long-term. Sexual and gender-based violence against men and boys often goes unreported and unaddressed, as many services exclusively target female victims.



NOT ALL MEN ARE EQUAL: SPECIFIC ISSUES AND SUBPOPULATIONS

Clearly, there are huge differences in the issues and concerns between various subpopulations of men, depending on factors like age, location, culture, sexual orientation or gender expression.

BOYS AND ADOLESCENT MEN

As boys become sexually aware and active, engaging in positive and safe sexual relations may be a challenge. As a result, younger men experience unplanned conception and STIs more commonly than older men. Ideally, young men have access to comprehensive sex education and age-appropriate SRH services. Information from peers is very important and can be useful, but [research](#) indicates that peers may lack knowledge or share similar misconceptions. Societal and cultural norms around masculinity, sexuality and sexual orientation, and gender identity and expression are important during the period of adolescence into manhood.

MIDDLE-AGED AND ELDERLY MEN

A [global study](#) found that sexual desire and activity are widespread among middle-aged and elderly men (age 40-80) and may persist into old age. Sexual dysfunctions were reported, mainly premature ejaculation and erectile dysfunction, and these tended to increase with age. Additionally, the risk of prostate cancer increases with age. The realisation that the world population is ageing resulted in [calls](#) for SRHR policies and programmes to keep up.

MEN WHO HAVE SEX WITH MEN

Homosexual and bisexual men experience specific sexual health challenges. As they become aware of their sexual orientation and attraction, they need a supportive environment, including appropriate information, access to health services and condoms. In reality, many same-sex attracted men face criminalisation at worst, or at best discrimination in healthcare, school and the community. Secondly, men who engage in anal intercourse face a higher risk of anal STIs and HIV, and need appropriate health information and health services to sustain their sexual health. Several [studies](#) report, however, that stigmatising attitudes of health workers (or anticipated stigma) are barriers for men who have sex with men to seek sexual health education, prevention or treatment.

TRANSGENDER MEN

Transgender and gender-expansive youth face similar, if not worse, challenges as they realise and develop their gender identity and orientation and become sexually active. Transgender youth need access to appropriate, inclusive and specialised services, including gender confirmation treatment (hormonal and/or surgical). As adults, transgender men may continue to need specialist, inclusive sexual and reproductive health services, including but not limited to reproductive cancer screening or fertility treatment.

WHY ARE MEN AND BOYS NOT USING SRH SERVICES?

Barriers to access exist at multiple levels, at the personal and health service levels, but also in society at large. The following are some of the main barriers in relation to men's SRHR.

PERSONAL BARRIERS

Lack of awareness is a major barrier to seeking sexual and reproductive health care. Research in [Pakistan](#) and [Zimbabwe](#), for example, found that elderly men were simply not aware of prostate cancer, but would seek screening when informed. Similarly, insufficient or conflicting information may result in low health-seeking behaviour, as was found for men in the [United Kingdom](#) who were uncertain about the symptoms of testicular cancer. Anxieties often prevent men from seeking care, including fear around disclosure or internalised stigma associated with [sexual orientation](#), infertility, sexual dysfunction, or HIV and other sexually transmitted diseases. A lack of priority is another factor that may prevent men from seeking care, especially if the costs are higher than the perceived benefit, as was shown in a [Tanzanian study](#) among men who have sex with men.

HEALTH SERVICE-LEVEL BARRIERS

Sexual and reproductive health services are generally targeted towards women and female-specific health issues, resulting in real or perceived barriers for men and boys. A [Population Council](#) paper warns that when reproductive health spaces are perceived and managed as a "women's space", this perpetuates the notion that women are responsible for contraception and reduces male engagement in family planning. For example, clinic opening hours can be inconvenient for men, and the physical space may not be 'men-friendly'. Crucially, health workers' attitudes are important and prejudice may be the result of the lack of training and sensitization. The gender of the health provider may be a deterrent for some men, but this can be easily addressed through gender-balanced teams. [UNFPA and IPPF](#) recognize that health services barriers are generally worse for adolescent men and those who don't conform to societal expectations about masculinity.

SOCIO-CULTURAL BARRIERS

Religion, geography, and poverty affect men's sexual and reproductive behaviours in various interconnected ways. Socio-cultural factors not only impact how men interact with their partners, practise safer sex and negotiate mutual pleasure, but also if and how men seek SRH services. A connecting link is the notion of masculinity. A [WHO review](#) of interventions for men found that dominant masculine stereotypes such as men not needing help or needing to appear strong, result in harmful and risky sexual practises for themselves and others. Additionally, cis-heterosexual bias in society but also in SRHR policies and services, results in stigma and discrimination against non-conforming men and boys. The recent [Gutmacher-Lancet commission on SRHR for all](#) recommends addressing these social determinants of men's health-seeking.



BUT THERE ARE GOOD PRACTICES AND PROMISING POLICIES

At the global level, the UN 2030 Sustainable Development Goals include universal access to sexual and reproductive health care services for all people, integration of reproductive health into national strategies and programmes, as well as universal access to sexual and reproductive rights. Global organisations like IPPF, MenEngage and Promundo advocate to include men in SRHR policies, and the 2017 Guttmacher-Lancet Commission on SRHR explicitly addressed men and boys. UNFPA and WHO have developed normative guidance, including [service packages for men and boys](#).

At the national level, a good example is Brazil, which developed a National Policy of Integral Health Attention to Men, to address and transform norms of masculinity and improve men's health outcomes. One of five strategies is including men in SRHR, for example, using prenatal visits as a key entry point to engage men and involve them in SRHR services, one-stop-shop services, and the training and sensitisation of health workers.

At the health service level, there are many examples of rights-based, client-centred, and stigma-free approaches to service provision, as promoted in the UNFPA/IPPF service package. These services engage local men to develop packages and address barriers.

Promising examples of how to engage with and reach men include:

- Use of social media, peer outreach and self-care interventions to reach hard-to-engage men e.g. adolescents, men who have sex with men, transmen and male sex workers.
- Special opening hours for working men, or mobile and pop-up clinics, for workplace and school-based interventions.
- 'Men-only' time slots, integrated 'one-stop-shop' services for multiple men's health issues and anonymous services to protect confidentiality.
- Inclusion of male care providers in SRH clinics or training on judgement-free and stigma-free services to men of various identities.



MORE INFORMATION ON MEN'S SEXUAL HEALTH NEEDS, POLICIES, AND PROGRAMMES:

Greene, M.E., Berger, B.O., Hakobyan, L., Stiefvater, E., and Levto, R.G. (2019). Getting to Equal: Men, Gender Equality, and Sexual and Reproductive Health and Rights. Washington, DC: Promundo-US.

IPPF (2009) The Truth About Men, Boys and Sex: A gender-transformative guide

IPPF and UNFPA (2017). Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys. London: IPPF and New York City: UNFPA.

Pascoe, L., & Peacock, D. (2017). Addressing the Health Needs of Men and Boys: An Analysis of National Policies in Eastern & Southern Africa. Commissioned by UNAIDS & WHO. Cape Town, South Africa: Sonke Gender Justice



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