Looking at Men's Sexual and Reproductive Health Needs

Although policymakers are beginning to focus on men's roles as fathers and husbands, little attention is being paid to men's sexual and reproductive health needs. Available data illustrate that those needs are substantial and long-term: For much of their lives, men need a range of medical and, in particular, educational and counseling services to protect their own health and well-being, as well as to equip themselves to be good partners and fathers. There are real barriers, however, toward meeting men's needs, including the lack of awareness that their needs exist.

By Adam Sonfield

As part of this year's deliberations over extending and amending the 1996 law that revamped the nation's welfare system, policymakers and advocates are beginning in earnest to focus on men in their capacities as husbands, fathers and financial providers. President Bush and congressional conservatives—seeking to use welfare policy to reinforce "traditional family values" among both welfare recipients and the general public—are placing a high priority on programs to promote responsible fatherhood and encourage marriage. Progressives—advocating that welfare policy focus more on alleviating poverty—are calling for greater attention to moving unemployed men into jobs.

Largely missing from discussions about men's roles, in both the welfare context and elsewhere and from both political perspectives, is attention to men's sexual and reproductive health needs. There is little recognition that meeting those needs could improve men's health and well-being, while simultaneously bolstering their ability to be good partners, fathers and breadwinners. Perhaps, this is not surprising: Historically, when policymakers and advocates have discussed sexual and reproductive health, they have focused on women. Only recently have they turned their attention to men at all, and even then, such efforts have typically been designed to solve what were seen as "women's problems": unintended pregnancy, sexually transmitted diseases (STDs), domestic violence and single parenthood.

There is now a body of research, however, that documents that men, throughout their lives, have important sexual and reproductive health needs of their own. To effectively meet those needs, work must be done to better define the set of medical, educational and counseling services that men require and to determine how and by whom these services should be delivered. At the same time, policymakers, advocates, providers and men themselves must be made aware that men have sexual and reproductive health needs and that meeting men's needs would have considerable social benefits.

Gauging Men's Needs

Although men's sexual and reproductive health needs have not been a major area of study, their extent can be assessed to some degree by looking at key indicators of men's sexual behaviors and their consequences.

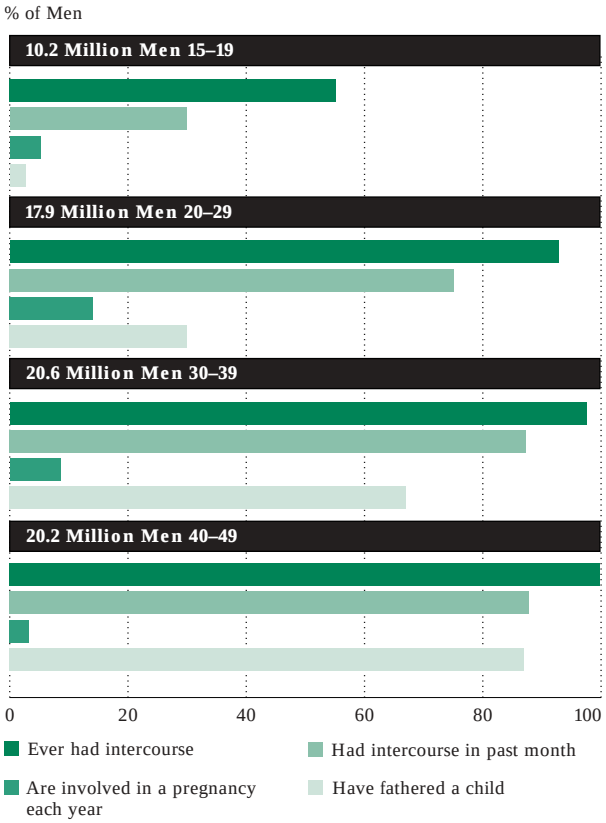
Sexual behavior. Of the almost 69 million American men in their peak reproductive years (ages 15–49), 62 million have had sexual intercourse, including more than half of adolescent men and at least nine in 10 adult men (see chart, page 8). For most of them, sex is currently part of their lives: Three-quarters of men in their 20s, and close to nine in 10 in their 30s and 40s, have had sex in the past month.

On average, American men today begin having sexual intercourse by age 17 and are sexually active for 10 years before marriage (see chart, page 9). Almost one-quarter initiate sex by age 15, including 42% of poor men and 53% of black men. Even before first having intercourse, many men participate in oral sex and other activities that involve similar sexual and reproductive health considerations, such as STDs.

Sexually transmitted diseases. One serious potential consequence of sexual activity for men is contracting or transmitting an STD. Rates of STDs in the United States are high, particularly among young, poor and minority men. One in six men aged 15–49, about 11 million, have genital herpes—an incurable viral infection—including 25% of poor men and 31% of black men. Reported rates of chlamydia and gonorrhea—treatable bacterial infections—are highest among younger men, peaking at 500–600 new cases per year per 100,000 men in their early 20s. Both diseases are especially prevalent among black men: For example, gonorrhea is reported in black men more than 40 times as often as in white men. An estimated 50% of chlamydia cases and 30% of gonorrhea cases are not reported, in part because men often experience no symptoms. Even when men do not experience the often-painful symptoms of these STDs, they still may become sterile,

KEY INDICATORS

Men's behaviors, and hence their needs, change over the course of their lives.



Source: The Alan Guttmacher Institute (AGI), *In Their Own Right: Addressing the Sexual and Reproductive Health Needs of American Men,* New York: AGI, 2002, page 88.

face heightened vulnerability to HIV infection and unwittingly transmit infections that could endanger their partner's pregnancies and future health and fertility.

The most dangerous STD, of course, is HIV. Eight in 10 Americans living with HIV are men—a number that may be as high as 600,000. While only 13% of men are exposed to HIV through heterosexual activity, that proportion has grown substantially in recent years. Furthermore, those men who contract HIV through injection drug use or by having sex with other men may still transmit it to their female partners.

Pregnancy, childbearing and abortion. Another potential consequence of men's sexual behavior is their partners' pregnancies, either planned or unplanned. Men aged 25–49 are involved in 3.7 million pregnancies each year (excluding pregnancies that result in miscarriage), resulting in 2.8 million births (about 1.1 million of which are unplanned) and 800,000 abortions (also typically from unplanned pregnancies). Men of this age group report that 21% of births are mistimed and 17% are not wanted at all (see chart, page 9). Men younger than 25 are involved in an additional 1.7 million pregnancies, resulting in 1.1 million births (many of which are unplanned) and 600,000 abortions.

While only one-quarter of men today father a child by age 25, half do so by age 29; by age 33, half of men want no additional children. Fatherhood comes earlier for certain groups, including low-income men, minorities and those with less education (53% by age 25 and 75% by age 30 among men without a high school degree).

Risk and prevention. Existing data provide insight into the extent to which men are protecting themselves against the negative outcomes of sexual activity. The risk of contracting an STD, for example, is tied to having multiple partners. The proportions of sexually experienced men who have had two or more partners in the past year are especially high—four or five in 10—among never-married (and divorced) men in their teens, 20s, 30s and 40s. Married or cohabitating men are much less likely to report having recent multiple partners.

The risk of contracting or transmitting an STD is also closely associated with the use of condoms. Condom use, by itself or in combination with a female contraceptive method, decreases with age, from 60% among sexually active adolescents to 16% among men in their late 30s (see table, page 10). This decrease is largely the result of men's entering more established relationships. Compared with condoms, hormonal female methods of contraception may be seen by couples as being more reliable in preventing pregnancy, less intrusive to sexual pleasure and spontaneity, and more appropriate for a relationship based on trust and monogamy. Thus, married or cohabiting men in each age group are about half as likely as other men to use condoms. From the perspective of protecting against unintended pregnancy, overall contraceptive use (male and female methods) remains high among men of all ages (80–87%), although it is lower among married men (who may be planning fatherhood) than among those who are not.

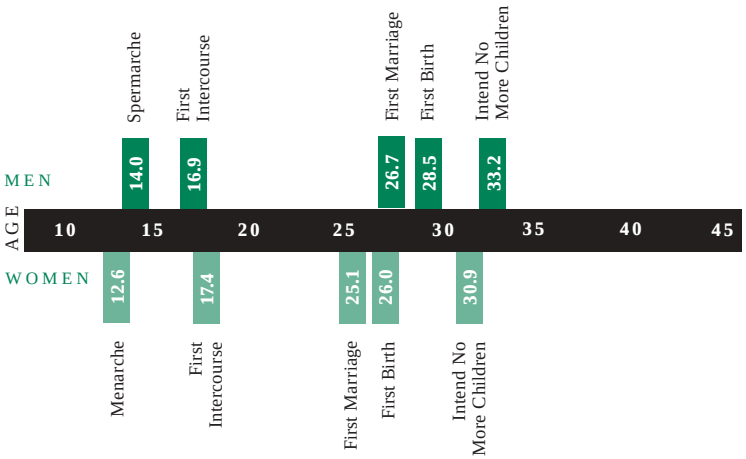
Meeting Men's Needs

While these indicators suggest that men have significant sexual and reproductive health needs, two overarching questions remain: What services are needed, and by whom and in what settings should these services be provided? Currently, there is no generally accepted set of sexual and reproductive health services for all men, although organizations as diverse as the American Medical Association, EngenderHealth and The Urban Institute have developed prototype sets, particularly for certain target groups.

Conceptually, men's needs are simple: Men, as women, need to avoid the potential negative consequences and achieve the desired, positive outcomes of their sexual

Life Events

On average, men spend 10 years being sexually active before marriage–two more than women.



Source: AGI, *In Their Own Right*, page 8.

and reproductive behavior. Men need to prevent unintended pregnancies, within or outside of marriage. They need to protect themselves and their partners against acquiring STDs, including HIV, and they need to be screened and, if necessary, treated for such diseases. Furthermore, men need to be able to father children when they and their partners choose, overcome fertility problems and help ensure that their partners' pregnancies are healthy. More generally, men need the self-esteem, self-awareness and skills to avoid violent and coercive relationships; to engage sexually in ways that are respectful of themselves and their partners; and to be part of strong, fulfilling relationships that can help them meet their other objectives.

What is striking is that—at least in their teen and young-adult years—few of men's sexual and reproductive health needs require medical intervention per se, with the exception of STD screening and treatment. Instead, younger men primarily need information, counseling and skills-building services that can help them to resist peer pressure; make informed, positive decisions; take responsibility for their actions; and communicate effectively with their partners about personal and sexual matters. As men grow older, they are more likely to need medical reproductive health care, such as infertility services, vasectomy, and diagnosis and treatment for cancers of the reproductive tract. However, the situation would change radically with the introduction of a new male contraceptive or prophylactic method that requires medical attention.

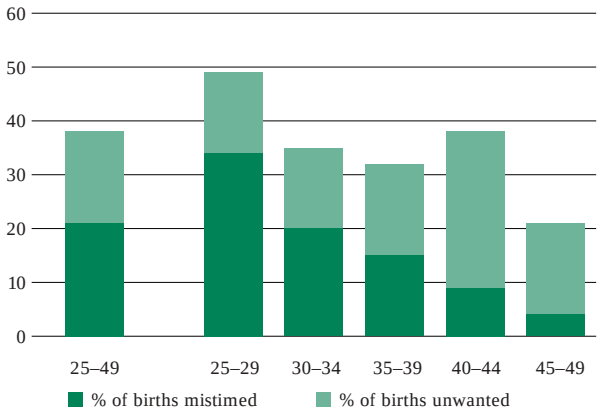
Determining who should provide men with these services and in what settings could prove to be a considerable challenge. Typically, boys and young men receive information and basic education on sexual and reproductive health from their parents and their teachers; however, available data paint a decidedly mixed picture. Only six in 10 men aged 15–18 report discussing AIDS with their parents, and just four in 10 have talked with their parents about STDs or birth control. Although virtually all men aged 15–19 receive some sexuality education in school, for three in 10, instruction comes after they have begun having intercourse. To fill the gaps in their knowledge, boys and men of all ages turn to their peers, who often have inaccurate information. In recent years, many have also turned to the Internet, although identifying trustworthy information is often difficult.

Community-based organizations, such as churches and youth groups, are emerging as important sources not only of information, but also of the critical counseling and skills-building services that men need on issues of sexuality, relationships, marriage and parenting. Some family planning clinics have been reaching out to men, particularly to the partners of their female clients. Although these facilities have a long history of providing both medical and counseling services, many men may see them as being only for women, and some providers may not be comfortable serving men. Furthermore, STD clinics should be considered as part of the equation, as these facilities have experience addressing sexual health matters, and many men seem comfortable seeking out services in such settings. However, STD clinics tend to have a narrow focus, serve men more often for treatment than prevention and may bear a stigma for other men.

Obviously, physicians can also play a critical role, not just as medical providers, but as educators and counselors. However, while urologists and other physicians may be adept at certain areas of male sexual and repro-

Unplanned Births

As men age, they are involved in fewer mistimed and more unwanted births.



Source: AGI, *In Their Own Right*, page 48.

PERCENT OF SEXUALLY ACTIVE MEN WHO USED A CONTRACEPTIVE METHOD IN THE PAST MONTH

	Vasectomy	Condom only	Condom plus other method	Other method	No method
All					
15–19	0	40	20	20	20
20–24	0	21	18	43	18
25–29	3	20	14	50	13
30–34	5	15	7	54	19
35–39	20	11	5	48	16
Married/cohabitating					
20–24	0	14	8	46	32
25–29	4	17	11	52	16
30–34	6	12	6	56	20
35–39	21	11	4	47	17
Not in a union					
20–24	0	26	24	41	9
25–29	0	27	24	44	5
30–34	2	28	8	47	15
35–39	12	17	15	47	9

Source: **AGI,** *In Their Own Right,* **pages 83, 84 and 86.**

ductive health, such as diagnosing and treating prostate cancer and performing vasectomies, the fact remains that there is no analog for men to the obstetrician-gynecologist. Pediatricians and primary care physicians treat large numbers of men for their general health needs, but they may not have the necessary training or comfort-level to provide men with the comprehensive sexual and reproductive health services they need.

Stumbling Blocks

Clearly, much work remains to be done. Those who are interested in meeting men's needs—the advocates, health care providers, teachers and counselors—must come to some consensus on what services are needed and how best to provide them, both now and in the future. Men's own preferences, including those of specific racial, ethnic, age and social and economic groups, need to be taken into account. Medical providers and other professionals who become involved will require substantial additional training from medical schools, professional associations and other institutions.

Policymakers also will have a role to play. One obstacle that may require their intervention is men's general lack of access to health care. More than one-third of men aged 18–44 do not have a regular doctor, and one-third have not seen a doctor in the past year. In addition, men are less likely than women to have health insurance, primarily because they are less likely to be enrolled in Medicaid. One-quarter of men aged 15–49—including 37% of men in their early 20s—have no health coverage of any kind; these rates are substantially higher among poor and minority men. Even those who are insured may not have access to the services they need, because counseling and skills-building services require substantial amounts of time to provide and are unlikely to be covered by either private or public insurance.

Furthermore, public programs that address reproductive health have traditionally focused on serving women. In some cases, government funding may be earmarked for or otherwise limited to female services. For example, in March of this year, the federal Centers for Medicare and Medicaid Services rejected a California proposal to pay for antibiotics for the sexual partners of women on Medicaid with chlamydia. Because the treatment would be for men without Medicaid coverage, the policy would be against Medicaid rules, despite the benefit in reducing women's high reinfection rates. Aside from overcoming these types of hurdles, new funding may also be needed for public programs, health care providers, schools and community-based organizations.

Perhaps the most difficult obstacle, however, is that service providers, policymakers and the general public have little awareness of the scope of men's sexual and reproductive health needs, much less an understanding of the importance of addressing them. This lack of awareness and understanding has helped to create other obstacles to meeting men's needs and has limited efforts to effect change. Raising awareness is the first step toward providing men with the care they need.

Attention to men's needs should also be leveraged to improve sexual and reproductive health services for women. The information, counseling and skills-building that men need are just as vital for women but, until recently, they have been overshadowed by women's substantial need for medical reproductive services. Calling attention to men's need for nonmedical services also promises to broaden the scope and improve the quality of services available to women.

Overall, meeting the sexual and reproductive health needs of men in their own right—helping them make informed decisions and act responsibly in their own lives, for their own sake—should inevitably result in lower rates of STDs and unintended pregnancy, better parenting, and healthier and more satisfying personal and family relationships. Ultimately, this will redound not only to men's benefit but also to the benefit of women, families, communities and society at large.

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