

# Sexual And Reproductive Health





The international commitment to engage men in sexual and reproductive health (SRH) and its importance in the context of promoting gender equality was affirmed in the International Conference on Population and Development (ICPD) Programme of Action and in the Beijing Platform of Action in 1994 and 1995, respectively (see Box 1). The commitment to include men in SRH formed part of a paradigm shift from a demographic to a more holistic and rights-based understanding of SRH (UNFPA, 2000; Greene et al., 2006).

This shift entailed rooting programmes and policies in human rights and prioritizing individuals and their needs over demographic goals. In many ways, the HIV epidemic was also responsible for increased attention to how gender and other socio-cultural norms influence men's and women's SRH (UNFPA, 2003).

It is now widely acknowledged that engaging men in SRH programmes and policies is necessary both for their own health and well-being, as well as that of women and children. Furthermore, as discussed in the introduction, engaging men and boys in SRH requires addressing the rigid traditional gender norms and power dynamics that underlie their SRH-related attitudes and behaviours and interactions with partners.

Worldwide, boys and men are raised to believe that to be "real" men they need to be strong and in control—particularly with respect to their intimate and sexual relationships. Sexual experience, frequently associated with initiation into manhood, may be viewed by men and boys as a sign of sexual competence or accomplishment, rather than acts of intimacy (Marsiglio, 1988; Nzioka, 2001).

Indeed, although men and women construct their identity through their sexuality and sexual experiences, societal norms regarding both tend to differ. Having multiple sexual partners, for example, may be seen as proof of manhood. Contraception, in turn, may be considered a "woman's concern".

Research undertaken worldwide finds that between 28 per cent and 59 per cent of unmarried sexually experienced young men have had two or more sexual partners during the last year and, of these, 39 to 68 per cent did not use a condom the last time they engaged in intercourse (Guttmacher, 2003). Because it is often men who wield most of the decision-making power<sup>16</sup>, their knowledge and attitude concerning family planning and prevention of STI/HIV can have serious implications for both themselves and their partners.

**Norms that promote the idea of men as being self-reliant and invulnerable may make them hesitant or unwilling to seek help for their SRH needs.** Research has found that men and boys in many settings (North America, parts of Europe, Latin America and parts of sub-Saharan Africa) may delay seeking help longer than women and girls and often will only do so after they have suffered significant personal consequences (Kutcher et al., 1996; Addis and Mahalik, 2003; Hudspeth et al., 2004).

Health professionals may in turn believe that men are disinterested in information and services and focus their efforts on women (WHO, 2000). These norms and barriers to men's help-seeking behaviour may also discourage men from being involved in their partners' health.

<sup>16</sup> This "control" over reproductive decision-making varies across contexts, and seems to be weakening, particularly among young generations and in contexts where women's levels of education and literacy are increasing (UNFPA 2000).

**BOX 1****INVOLVING MEN IN SEXUAL AND REPRODUCTIVE HEALTH:  
AN INTERNATIONAL COMMITMENT**

The 1994 International Conference on Population and Development (ICPD) in Cairo called for a rights-based approach to SRH including a recognition of the active role that men can play with regard to childrearing as well maternal health. The ICPD marked the beginning of an international consensus on how gender norms harm both men's and women's health and impede development, and the need for more systematic attempts to address gender norms in programming and policies.

The "family planning approach," which predominated before ICPD, mainly targeted women and prioritized contraceptive use and fertility as indicators of progress. A prominent aspect of this shift to a broader and more rights-based health agenda has been the evolving dialogue about engaging men in health programming and policies. Below are some excerpts from the Programme of Action which specifically address the need to engage men in the promotion of SRH:

"The objective is to promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles. ICPD Programme of Action (Paragraph 4.25)."

"Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution of family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be

included in education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children. ICPD Programme of Action (Paragraph 4.27)."

"In terms of young men and sexual and reproductive health, the ICPD recognizes that the 'health needs of adolescents as a group have been largely ignored' and that the 'responsible sexual behaviour, sensitivity, and equity in gender relations instilled during the formative years (will) enhance and promote respectful and harmonious partnerships between men and women.' ICPD Programme of Action (Paragraph 7.41 and 7.34)."

The 1995 Fourth Conference on Women in Beijing, China emphasized the need to achieve gender equity in order to improve reproductive health. Below are some excerpts from conference documents which specifically address the need to engage men in the promotion of sexual and reproductive health:

"Encourage men to share equally in child care and household work and to provide their share of financial support for their families, even if they do not live with them; 107(c)."

"...facilitate promotion of programmes to educate and enable men to assume their responsibilities to prevent HIV/AIDS and other sexually transmitted diseases; 108 (e)."

"Design specific programmes for men of all ages and male adolescents, recognizing the parental roles referred to in paragraph 107 (e) above, aimed at providing complete and accurate information on safe and responsible sexual and reproductive behaviour...108(l)"

A number of factors—socio-economic status, age, religion, race, and ethnicity for example—interact with gender to shape male SRH needs and behaviours. In terms of socio-economic status, poverty and poor employment prospects can undermine the ability of men to fulfil their traditional role as providers—some research has found that men may compensate for this perceived loss of "manhood" by having more sexual partners, or by using violence, including sexual violence (see, for example, Silberschmidt, 2001).

Unemployment may also force men (especially young men) to leave their homes and families in search of work. This separation may prompt some to engage in high-risk sexual relationships (Guttmacher 2003; Yang et al., n.d.). Low socio-economic status may also mean that men have limited access to information and services.

In contrast, there is evidence that education and economic security can have a positive impact on SRH behaviours—for example, lengthier schooling and increased prospects for a better standard of living often result in the postponement of marriage and childbearing to later ages for both men and women. Improved schooling and employment levels among women, in particular, can lead to positive changes not only in the perceptions of gender roles, but also in the actual relationships and dynamics between men and women.

Conversely, other studies suggest that, in some situations, the demands of poverty can also lead to greater flexibility with respect to gender roles: An unemployed low-income man, for example, may take on domestic tasks, including child care, so that his partner can work (Barker, 2000). Youth who migrate to cities for work and live away from

rigid family and community controls may be exposed to alternative and more equitable models of male-female relationships and behaviours.

These contrasting examples underscore the fact that there is no formulaic way in which class or other factors influence gender or SRH—rather, it is a confluence of many factors that vary from individual to individual.

In discussing the linkages between gender and SRH, it is also important to think about how men's SRH needs, vulnerabilities and behaviours change over the life cycle. Although SRH is most often associated with adults and adolescents, the norms of male power and risk-taking that lead to SRH vulnerabilities are taught through socialization that begins in infancy and continues throughout childhood. It is therefore necessary that SRH programmes and policies also consider how to engage both parents and children with messages about gender-equity and the importance of sharing life roles and responsibilities.

During adolescence and youth<sup>17</sup>, men's SRH needs and vulnerabilities are influenced by social expectations surrounding their transition from childhood to young adulthood, including sexual debut, marriage, education and work. In Sub-Saharan Africa, Latin America and the Caribbean, and the United States, about 6 to 10 years elapse between the age at which men first have sex and the age at which they first marry. This is a period during

which many men will be unmarried but sexually active—often with more than one partner.

Most men between the ages of 20–24 report having had sex by the age of 20. Comparatively few men in this age range have children, fewer even among men aged 15–19. Many are in school or acquiring work experience or are searching for work, unemployed or working in low-paying jobs. Though young men may have sex with more partners than older men, it is generally more sporadic. In one study undertaken in 17 countries, only one-half of sexually active men between the ages of 15–24 had reported having sex during the last three months (Guttmacher, 2003).

Research has found that peers significantly influence adolescent and young men's behaviours and attitudes particularly with regard to relationships and sex. Surveys have also revealed that adolescent and young men remain largely ignorant of their own or their partner's sexuality, do not discuss health and HIV prevention with partners and have misconceptions about and often limited access to condoms and other contraceptive and prophylactic methods (UNFPA, 2003).

Most men between 25 and 39 years of age have already married at least once and are generally employed. In most countries, employment is seen as a precursor to marriage, without which a man is not considered marriageable. Following marriage, most men will

### BOX 3

#### WHAT IS SEXUAL AND REPRODUCTIVE HEALTH?

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 that are free of coercion, discrimination and violence.

Reproductive health is a state of physical, emotional, mental and social well-being in relation to the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

SOURCE: WHO TECHNICAL CONSULTATION ON SEXUAL HEALTH, JANUARY 2002



<sup>17</sup> "Adolescents" are generally defined as those aged 10–19 and "youth" as those aged 15–24.



become fathers. A study across 10 countries found that 80–90 per cent of men between the ages of 30–39 have married and the vast majority of these have fathered a child (Guttmacher, 2003). Only when they are in their early 30s (in the United States and in Latin America and the Caribbean), and in their mid-50s (in Sub-Saharan Africa), do half of the men surveyed decide that they have had all the children they want. At this point, although many men may remain capable of fathering children, a larger proportion do not want any more children and need the skills and methods to avoid further pregnancies (see Box 6 – Men and Vasectomies, for example).

Almost all men in their 40s or 50s are married while

some are on their second or third marriages. In developing countries only about 1–8 per cent of men in this age range have never had a child and up to 11–18 per cent in industrialized countries (Guttmacher, 2003).

The majority of married men also report that they have had as many children as they want, except those living in Sub-Saharan Africa. As men age, they (and their health care providers) may assume that they no longer have a need for preventive measures and SRH services. However, many older men (and women) may be at risk for STIs/HIV and not realize it. Medical services to treat infertility and impotence or that offer vasectomy and cancer screening also become increasingly important as men age.

### BOX 3

#### WAYS FOR MEN AND BOYS TO BECOME ENGAGED IN SEXUAL AND REPRODUCTIVE HEALTH<sup>18</sup>

- Learn about their bodies and changing SRH needs
- Learn how to talk about sex, sexuality and reproduction in gender equitable and open ways; admit when they have doubts and ask questions about them; get the information they need from good sources
- Seek care/getting regular health checkups, including for STIs
- Share responsibility for family planning, contraception and/or prevention of STIs
- Use contraception consistently (when it has been agreed upon by both partners) and support partner's contraceptive use, including male and/or female condoms
- Plan their families and support their partner's use of Maternal and Child Health services as necessary
- Only engage in sexual relations that are equitably negotiated, mutually desired and non-coercive; focused on giving as well as receiving pleasure
- Reject, avoid and try to prevent all forms of GBV including domestic violence, sexual violence, and harmful practices such as child marriage, bride kidnappings, dowry related violence, honour killings, female genital mutilation/cutting and prenatal sex selection
- Understand their partners' needs regarding SRH and sexual pleasure
- Support partners' decisions regarding their own body
- Support and promote sexual education in their communities

## WHAT ARE MEN AND BOY'S SEXUAL AND REPRODUCTIVE HEALTH NEEDS?

Worldwide, men report needing accurate, clear, and non-judgmental information, including about the physiology of reproduction, healthy and mutually enjoyable sexual relationships, and skills-building on how to communicate with partners about SRH, protection against STIs, contraception, and condom use. It is important to remember, however, that information needs change over the course of a man's life. For example, before puberty boys need to learn about the physical and hormonal changes that are about to transform their bodies and their sexual and emotional

feelings. Young and adult men also need basic SRH information, as well as a more detailed understanding of their bodies and how to give and receive pleasure. For example, many young and adult men (in some settings) may worry about the quantity and quality of their semen, of which they believe they have a limited supply, and some worry about the size and shape of their sexual organs and about their ability to perform sexually. From an early age, boys and younger men also need the opportunity to build skills to help them resist peer pressure and communicate with their partners

<sup>18</sup> This list is adapted from the programming experiences of EngenderHealth and Promundo and is not meant to be exhaustive.

about personal and sexual matters. Older men also need to learn about the changes their bodies will undergo and learn how to accommodate these so as to continue to enjoy fulfilling sexual relations.

Before becoming sexually active, young and adult men need information about the difference between male and female sexual response cycles, how to communicate mutually about sexual needs and preferences, how to effectively use condoms and other methods to prevent STIs and unplanned pregnancies. A common belief among many young men is that they should "know it all" about sexuality and sex, when in fact they are frequently uninformed or misinformed on these matters.

Data from around the world indicates that only 40 per cent of young men have accurate knowledge about HIV and the proportion of men aged 15–54 who know that condoms can prevent HIV varies widely in developing countries—from 9 per cent in Bangladesh to 82 per cent in Brazil (UNAIDS, 2008; Guttmacher, 2003). It is also important, for example, that men are made aware that HIV is more easily transmitted sexually from men to women than from women to men and that their own high-risk behaviours have implications for the health of their partners and families (Link – See HIV section for more information about how to engage men and boys in HIV prevention).

In addition to information, men also need to learn about how to communicate with their partners about STI prevention and contraception, to use methods correctly and consistently, and to deal with unplanned pregnancies. Men also need access to family planning methods, counselling, testing and treatment for STI/HIV and the support and skills related to voluntary partner disclosure and notification. In some settings, men who become infected with STIs (including HIV) may try to treat themselves, seek care from pharmacists, traditional healers, or others who may not have formal training in the treatment of STIs.<sup>19</sup> Research has found that men might prefer consulting with informal practitioners because they are more affordable and/or because they believe that they are more respectful and less judgmental than private doctors or health care workers working out of family planning clinics (Guttmacher, 2003). Later in this section, strategies for ensuring that health professionals, clinics and other service spaces are more welcoming to men, are discussed.

As previously mentioned, many men may view reproduction and family planning as a female responsibility. This is in part owing to norms that emphasize men's sexuality and undervalue responsibility with regards to reproduction and in part to the fact that most contraceptive methods and family planning

programmes and services are female-centred. Research has shown, however, that many men have an unmet need for family planning (UNFPA, 2000).

It is estimated that between 20–46 per cent of men aged 25–54 in Sub-Saharan Africa and 15–30 per cent of those in Latin America and the Caribbean do not want a child soon or at all but are nevertheless not protected against unplanned pregnancy (Guttmacher, 2003). Furthermore, a large proportion of married men aged 25–39, particularly in sub-Saharan Africa, say that they have not discussed family planning with their partners—highlighting the extent to which lack of communication between partners leads to lost opportunities to meet family planning preferences and needs (UN Millennium Project, 2006).

At the same time, it is important that family planning efforts address the dynamics of a couple's reproductive decision-making (UNFPA, 2000). Men may have their own perspectives and preferences regarding fatherhood and how many children they want and they need to be able to balance these with their partners' preferences and the health benefits of planning pregnancies.

Family planning efforts therefore need to include support and skills building aimed at enhancing communication and negotiation between couples as well as information about, and access to, methods. It is important that couples discuss the number and spacing of children and decide together which contraceptive method (or combination of methods) best meets their needs (see, for example, Box 7 Promoting Men's Use of Condoms and Box 6 Men and Vasectomies).

As men grow older, they need to know about vasectomy, the diagnosis and treatment of infertility, sexual function and dysfunction or cancers of the reproductive system. Throughout the life cycle of men, however, the emphasis needs to be on continued safe sexual practices, including correct and consistent condom use, and an understanding of the potential vulnerabilities that exist in all stages of life, whether a man is married or single.

Finally, it is important to remember that many men are already fulfilling (and in some cases expanding) their roles and responsibilities to engage in loving, pleasurable and life-enhancing sexual relations. They are also avoiding the potentially negative consequences of sexual activity—primarily unintended pregnancies and STIs—despite receiving little guidance or support from peers, services or their communities. These men, too, can benefit from information and services that will help them adapt to their changing needs and circumstances and enhance both their own sexual fulfilment and that of their partners.

<sup>19</sup> In the section on HIV, we discuss in more detail the specific considerations and strategies for engaging men in prevention, care and treatment.

## PROGRAMMING FOR ENGAGING MEN AND BOYS IN SEXUAL AND REPRODUCTIVE HEALTH

Historically, most SRH programmes and policies have focused on clinical or service settings. As discussed earlier, however, education and community-level efforts are also necessary to change the behaviour and social norms that stand in the way of promoting SRH.

SRH providers need to be more responsive and spaces more attractive. It is also critical that providers work with men to increase health-seeking behaviours and mobilize peer counsellors and utilize community spaces to promote positive sexual and reproductive behaviours while, at the same time, questioning rigid norms that lead to SRH vulnerability.

### GROUP EDUCATION

Most existing SRH education efforts have centred on condom use, STIs, and HIV with relatively little information paid to men, family planning, and sexual health more broadly. Specific topics which need to be addressed include: male and female anatomy, sexual pleasure, sexual dysfunction, STIs, contraceptive methods, consistent and correct condom usage, shared decision-making and communication among sexual partners. Providers should also encourage discussions around diversity of sexual identities and practices.

Group education should offer a space where men can acquire accurate information. Participants should learn how to care for their own SRH as well as that of their partners. They should learn how to better communicate and share decision-making with women concerning a range of issues—such as if and when intercourse occurs, what each partner likes and doesn't like, how many children to have and when and what contraceptive method to use.

In many settings, SRH education can be a contentious and taboo topic—particularly when it involves boys and young men. Parents, family, teachers, religious leaders and policymakers may be uncomfortable talking about it or even supporting the notion that youth

Schools are a good place to reach large numbers of boys and young men with information about SRH. In many settings, schools already offer health and family life curricula, alongside general information about how to prevent STIs. However, these rarely include critical examinations of gender and sexuality and how these increase the likelihood of acquiring STIs (including HIV), increase the risks of unplanned pregnancy and other SRH-related problems.

To effectively establish, review and adapt curricula requires both advocacy and technical effort. Administrators and educators need to be sensitized to the necessity of including a gender perspective into all programming and to impress upon students the need to take a stand against violence. Programmers should offer students, families, and other stakeholders an opportunity to review material. Images and messages should be vetted to make sure that they do not contain harmful stereotypes while specific activities with respect to gender and masculinity should be added. Moreover, it is important to provide students with an opportunity to ask questions about the SRH issues that really concern them.

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