The Politics of Male Reproductive Health

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Reproduction affects 100 % of the population. Every human being in every society – regardless of gender identity, sexuality, class status, or racial identity – is a result of reproduction, and the majority of individuals will have a child at some point in their lives (e.g. Vespa et al. 2013). Even those who do not want to have children must contend with strong cultural presumptions around parenthood and, if they are heterosexually active, take steps to ensure they do not reproduce. Reproductive technologies have transformed the landscape of reproductive possibilities, even as they remain out of reach for so many. Together, these facts raise crucial questions about the relationship between reproduction, definitions of the ›good life‹, and intersecting inequalities, such as those associated with gender, race, class, and sexuality (e.g. Collins 2015, Ross and Solinger 2017).

Defining Reproduction

Social scientists have engaged in decades of research about a range of reproductive topics, from conception to contraception and various technologies such as *in vitro* fertilization, egg and sperm donation, and surrogacy. About a decade ago, I reviewed this literature for the *Annual Review of Sociology* and was surprised that few scholars offered an explicit definition of what they meant by ›reproduction‹, perhaps assuming it to be a rather straightforward term referring to biological events associated with pregnancy and birth.

However, mapping the constellation of topics that constitute reproductive studies reveals that scholars are studying both the process of having children, from conception through pregnancy and birth, and the obverse: the process of *not* having children. This occurs when individuals use contraception, have an abortion, undergo sterilization, experience infertility, decide to remain childfree, and/or go through menopause. Moreover, reproduction researchers hardly limit themselves to analyses of biology. To the contrary, many of the scholars working in this field are at the forefront of theorizing the relationship between biological and social processes. Thus, I developed a conceptualization of reproduction as »the biological and social process of having or not having children« (Almeling 2015, 430).

In addition, and along with others, such as political scientist Cynthia Daniels (2006) and anthropologist Marcia Inhorn (2009), I noted that previous social scientific research on reproduction has focused overwhelmingly on female reproductive bodies and the reproductive experiences of heterosexual, cisgender women. Many of the authors in this current volume make important contributions to expanding our understanding of how people with various sexual and gender identities define a ›good life‹ when it comes to reproduction. To join that effort, I draw on a decade-long research endeavor devoted to understanding why so little attention had been paid to *male* reproductive health, and the social, clinical, and political consequences that result (Almeling 2020). In what follows, I provide a brief overview of my major findings, which underscore the need for a relational approach to inequality, i.e. examining both those who are disadvantaged as well as those who are advantaged by intersecting social processes around gender, race, class and sexuality.

The Missing Science of Male Reproductive Health[1]

Men going about their daily lives are not subject to endless advice about sperm. They do not encounter books and billboards and warning labels about how their health might affect their children's health. And even when they do contemplate becoming a father, men do not experience anxiety about every last morsel they consume or product they use.

But they could. In recent years, researchers have been amassing evidence that the health of male bodies – including factors such as their age, behaviors, and exposure to toxins – can damage sperm and, in turn, affect their children's health. The headline of one front-page story in the *New York Times* announced that »Father's Age Is Linked to Risk of Autism and Schizophrenia« (Carey 2012). Men who breathe polluted air, drink polluted water, or work with any sort of chemicals – from pesticides to paint thinners – might be damaging their sperm (Kimmins et al. 2024). Collectively referred to as paternal effects, the ›news‹ here is that it is not just women's bodies that affect reproductive outcomes.

Of course, it is women, not men, who are accustomed to hearing endless advice about their reproductive health. It comes to a crescendo during pregnancy. There are long lists of do's and don'ts from clinicians and well-meaning friends, family, co-workers, and sometimes strangers on the street. There are even guidelines about what to do *before* pregnancy to make sure one's body is fully prepared to gestate the next generation

1 *Note on terminology*: Dualistic (or binary) conceptions of sex and gender have been challenged in recent years by intersex and trans scholars and activists, who have offered a range of alternatives for thinking about gender and bodies, from spectrums to fluidity. However, during the period covered by my research (from the late nineteenth century to the early twenty-first century), medical researchers and individuals typically conceived of sex as dualistic, so I refer to ›male bodies‹ and ›men's experiences‹. A more precise rendering would be ›bodies that society has historically defined as a particular kind of body, namely male‹. However, that is unwieldly to write every time, so I would kindly ask readers to keep this preamble in mind whenever I use the words male or men (or female or women). Also, the reader should note that I do not presume any direct, simple, or universal relationship between body parts and gender identity.

(Waggoner 2017). The message is clear: It is women's responsibility to make sure reproduction goes well. And when it doesn't, when there is a miscarriage or a baby arrives in anything but full health, it is often women who bear the blame.

Now that scientists are learning just how important men's health is for reproduction, the question is: What took so long? After more than a century of studying every possible way that women's age and women's behaviors and women's exposures to toxins can affect reproduction, why are we only now learning basic information about how men's health affects reproductive outcomes?

Historical Inattention to Sperm

The gap in knowledge about male reproductive health – and in particular, our dearth of knowledge about sperm – is not natural or inevitable. It can be traced back to the earliest days of medical specialization, when doctors positioned the male body as a neutral medical ›standard‹ and the female body as ›reproductive‹ – leaving us with a missing science of male reproductive health.

During the latter part of the 19th century, when the medical profession began carving up the body into distinct specialties, reproduction could have become the basis of a unified specialty that incorporated both female and male bodies. Instead, gynecology and obstetrics, two of the earliest specialties, focused solely on female reproductive organs (and merged into OB-GYN in the 1920s and '30s). In effect, female reproductive parts and processes were hived off from general medicine and designated a distinct realm of knowledge and treatment.

To this day, women are encouraged to schedule regular medical visits to have their reproductive organs examined. Public health campaigns offer all kinds of advice about women's pre-conception health and age-related fertility. And government labels warn women about toxic chemicals in beverages, medicines and buildings.

In contrast, even as the male body was positioned as the ›standard body‹ for biomedical research throughout the 20th century – the tem-

plate for investigations into the cardiovascular system, the brain, and so on – there was scant research on its reproductive aspects. In part, this is the result of a cultural belief that sex is binary: Traditional views of male and female as distinct and even ›opposite‹ categories meant that since women were defined as reproductive, men were defined as not reproductive.

A clear indication of how difficult it has been to link men's bodies to reproductive health are the attempts to launch a medical specialty called ›andrology‹ – an effort that failed outright in the United States in the 1890s and gained only a bit of traction starting in the 1970s (for more details, see Almeling 2020: Chapters 1 and 2). The topic of male reproductive health continues to hover around the edges of multiple specialties –urology, sexual health, infertility – without serving as the focus of any one in particular. Though men are advised to get regular cancer screenings starting in middle age, there are no recommendations that men have their reproductive organs examined regularly, and almost no public health campaigns mention the significance of men's health for reproductive outcomes.

To be sure, it makes sense that there would be more medical and public health attention to people who can become pregnant, but it does not follow, however, that male reproductive health should receive almost no attention.

These dynamics repeat again and again: There is still no contraceptive pill for men, for example, and their birth control options remain limited to condoms and vasectomy – the same options they had a hundred years ago. Women can hardly pick up a magazine without being reminded about their biological clocks, while most men have no idea that paternal age can affect reproductive outcomes.

The Emerging Science of Paternal Effects

Scientists and clinicians are just now filling in crucial details about how men's health can pose risks for their children. Using the label ›paternal effects‹, they have concentrated on three factors: a father's age at the time

of conception, what he consumes (alcohol, drugs, smoking, diet), and his exposures to toxic substances at home, work and in the environment (see Almeling 2020: Chapters 3 and 4).

Some of these factors appear to influence not only pregnancy outcomes, such as miscarriage and birth weight, but also birth defects, childhood illnesses and even adult-onset conditions. Yet in my research interviewing American men about reproduction, I learned that many remain unaware that a man's health can have implications for his children (see Almeling 2020: Chapters 5 and 6). They might have heard the news that men's behaviors or exposures can affect fertility by reducing sperm count or causing these cells to be misshapen or sluggish. But the emerging science of paternal effects goes further, suggesting that men's health can affect not only the number or shape of sperm but also its genetics.

Take, for example, cigarette smoking: Men who smoke before conception can reduce their sperm count and spur genetic changes inside these cells, especially during the two to three months it takes sperm to grow in the body. If the sperm is then able to fertilize an egg, the resulting child faces a higher risk of cancer (Milne et al. 2012). Writing in the *American Journal of Epidemiology* more than a decade ago, scientists said that men who are planning to have children should be »strongly encouraged to cease smoking«. Yet warnings like these are not reaching the general public, in no small part because of the lack of medical infrastructure focused on male reproductive health.

What to do about the lack of GUYnecology?

The major recommendation that flows from my research is that we should all be paying much more attention to male reproductive health. But just *how* to do that is not at all obvious. Most importantly, there is the question of how to talk about men and reproduction without reifying the gender binary or replicating the typical and problematic approach to women's reproductive health. In the past, reproductive health messaging has usually been directed at individual women, encouraging them to

be as healthy as possible, but this tends to turn reproductive health into a moral issue and stigmatize those who cannot achieve it. It can even result in punishment. Just ask the hundreds of American women – who are disproportionately poor and/or women of color – who have been imprisoned for their behavior during pregnancy (Paltrow and Flavin 2013).

Rather than just adding men to the list of those who can be blamed for reproduction gone wrong, perhaps we could use the new attention sperm health is getting as an opportunity to reconsider all messaging about reproductive health. Public health officials could emphasize that *both* women's and men's health can affect the health of their children, and that any one body's health is not solely a matter of individual control.

Other proactive efforts to figure men into the reproductive equation could happen in a variety of ways:

- Health care providers can disrupt the implicit association of reproductive health with women's health by explicitly offering patients of all gender identities information about the importance of paternal effects.
- Biomedical researchers can work to identify the precise levels of risk posed by male age, behaviors and exposures, alone and in combination.
- Governmental health agencies and professional medical associations can develop materials to educate the public about how men's health can affect children's health.
- Engineers of fertility apps could add notices about the significance of sperm health.
- High school teachers responsible for health classes or sex education can incorporate this information into the curriculum. Indeed, in interviewing 40 American men about reproduction, I learned that high school is often the last time they hear anything at all about their own reproductive systems.

Reframing reproductive health as not just about women would entail nothing less than a paradigm shift, cutting against default assumptions

that reproduction is just a ›women's issue‹ and solely women's responsibility. Rather than placing the onus on individual women to eat right and avoid toxins, maybe officials would redouble their efforts to ensure that *everyone* has access to a healthy lifestyle and that *nobody* is exposed to harmful chemicals.

Paying more attention to male reproductive health could improve men's lives and the lives of their children. And in the best possible scenario, it could provide a much-needed nudge to longstanding efforts to address structural and environmental contributors to disease, like increasing access to quality health care, reducing racial and economic inequalities, and adopting more stringent regulations to protect the air and water, all of which would arguably contribute to a ›good life‹. Indeed, such efforts would benefit *all* bodies, whether they are reproducing or not.

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