



***IN THEIR
OWN RIGHT***

***ADDRESSING THE SEXUAL
AND REPRODUCTIVE HEALTH
NEEDS OF MEN WORLDWIDE***

THE ALAN GUTTMACHER INSTITUTE

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TABLE OF CONTENTS

	<i>Executive Summary</i>	<i>4</i>
<i>Chapter 1</i>	<i>Why Focus on Men?</i>	<i>6</i>
<i>Chapter 2</i>	<i>Factors That Shape Men's Sexual and Reproductive Lives</i>	<i>12</i>
<i>Chapter 3</i>	<i>Men 15–24: Becoming Independent and Initiating Sexual Relationships</i>	<i>18</i>
<i>Chapter 4</i>	<i>Men 25–39: Marrying and Becoming Fathers</i>	<i>26</i>
<i>Chapter 5</i>	<i>Men 40–54: Approaching the End of Fathering</i>	<i>34</i>
<i>Chapter 6</i>	<i>Sexually Transmitted Infections and Condom Use</i>	<i>40</i>
<i>Chapter 7</i>	<i>Sexual and Reproductive Health Information and Services for Men</i>	<i>46</i>
<i>Chapter 8</i>	<i>Summing Up</i>	<i>54</i>
	<i>Appendix Tables</i>	<i>58</i>
	<i>References and Notes</i>	<i>68</i>

EXECUTIVE SUMMARY

Chapter 1: Why Focus on Men?

Men and women are indispensable partners in sexual relationships, marriage and family building. Still, the sexual and reproductive health needs of men beyond their roles as women's partners have received little attention. Sexually transmitted infections (STIs), including HIV/AIDS, and unplanned pregnancies can devastate the lives of both men and women, and can have negative consequences for families and communities. Addressing the sexual and reproductive behaviors and health of men creates a win-win situation: The more informed and more effective men become in living safer sexual and reproductive lives, the better it will be for them and for their partners and children.

In Their Own Right: Addressing the Sexual and Reproductive Health Needs of Men Worldwide aims to take some steps in that direction by providing an overview of men's sexual and reproductive behavior worldwide and drawing out the health and program implications of that information. Focusing on men 15–54 years old in 23 countries that represent all regions of the world, the report examines men's needs for health information and related services, and identifies obstacles that prevent men from receiving those services. This executive summary presents some of the report's key findings.

Chapter 2: Factors That Shape Men's Sexual and Reproductive Lives

A wide range of societal and individual factors shapes, and often constrains, men's aspirations and behavior as partners, husbands, fathers and sons.

■ Poverty and poor work prospects can undermine men's traditional roles as providers and can make them

fatalistic about the consequences of risky behavior.

■ Male life expectancy is declining in Sub-Saharan Africa but increasing in the rest of the world; reduced prospects for a long life can reduce motivation to protect one's health.

■ Urbanization can weaken the supports of traditional community life, especially when it separates poor men from their families, but can also create the desire for smaller families.

■ Educational attainment is increasing in all developing regions, but job prospects are not improving at the same pace, and large proportions of young men cannot find full-time paying jobs.

■ Increased education and the mass media can offer people new information and ideas, and greater opportunities, but the media can also present poor and young people with visions of consumerism and modern lifestyles that are beyond their reach.

■ Social and cultural changes in developing countries promise young men a greater sense of autonomy, but economic changes can undermine their ability to become self-sufficient and independent.

Chapter 3: Men 15–24: Becoming Independent and Initiating Sexual Relationships

Many men 15–24 are in school or acquiring job-related training and work experience, and most still live with their family. Searching for sexual pleasure and intimacy or facing pressure to prove they are adults, men commonly begin their sexual lives during adolescence.

■ In almost all countries, the majority of men 20–24 report having had sexual intercourse before their 20th birthday.

■ Some 5–35% of men aged 20–24 first had sex before their 15th birthday.

■ Among unmarried men aged 15–24 who have ever had sex, 2–6 in 10 had two or more partners in the past year.

■ In most Sub-Saharan African countries, fewer than half of sexually active men 15–24 use a contraceptive method or rely on their partner's method, compared with 63–93% in industrialized countries and parts of Latin America and the Caribbean.

■ Marriage is rare among adolescent men and uncommon among men in their early 20s.

■ Few men in their teens or early 20s have become fathers.

Chapter 4: Men 25–39: Marrying and Becoming Fathers

The late 20s and 30s are when many men begin to settle down. Most men at these ages marry or enter a union, and start building families.

■ Marriage, including cohabitation and consensual union, is common among men in their late 20s and almost universal among those in their 30s; however, the more educated men are, the longer they defer marriage.

■ Most men 25–39 had one sexual partner, who may be their spouse, in the past year; 15–65% of unmarried men had more than one partner and 7–36% of married men had one or more extramarital partners.

■ Contraceptive prevalence among men in their late 20s and 30s is lower in Sub-Saharan Africa than in other regions, reflecting these men's continued desire for children.

■ The more educated men are, the more likely they are to have discussed family planning with their partner.

■ In both developing and developed countries, half of men become fathers by their mid-to-late 20s.

Chapter 5: Men 40–54: Approaching the End of Fathering

The vast majority of men in their 40s and early 50s are married and have had the number of children they want. Many have experienced the breakup of marriage, some are living with or supporting children from earlier marriages, and some are entering new marital relationships.

- Almost all men aged 40–54 have married—some more than once.
- Some 4–23% of married men 40–54 have had one or more extra-marital partners in a recent 12-month period.
- Men 50–54 in Sub-Saharan Africa want and have many more children than do those in other developing regions.
- In most developing countries, the majority of men in their early 50s have had more children than they want.
- In countries with moderate or high levels of contraceptive use among men 40–54, methods used by women (especially female sterilization) predominate in developing countries, whereas male and female methods are equally relied on in industrialized countries.
- Vasectomy is extremely rare in all but a few industrialized countries and in China.

Chapter 6: Sexually Transmitted Infections and Condom Use

STIs are a personal, public health and economic issue of serious concern throughout the world, and have health consequences for men, women and children.

- The prevalence of curable STIs is higher in Sub-Saharan Africa and in Latin America and the Caribbean than in other regions.

- Sub-Saharan Africa, where heterosexual intercourse is the main way that HIV/AIDS spreads, has the highest HIV prevalence in the world.

- The proportion of men 15–54 who know that condom use is a way of preventing HIV/AIDS varies widely in developing countries—from 9% in Bangladesh to 82% in Brazil.
- Fewer than one-third of men in many developing countries know that two ways of avoiding STIs are condom use and either abstinence or having only one, uninfected partner.
- Condom use is increasing in some developing countries and is higher among more educated men and those living in urban areas than among less-educated and rural men, respectively.
- Men with an STI use various strategies to avoid infecting their sexual partners, but some do not even inform their partner.

Chapter 7: Sexual and Reproductive Health Information and Services for Men

At different stages of their lives, men need and often want reliable and accessible information and services that can help them lead healthy sexual and reproductive lives, but they are short-changed in this regard, especially in developing countries.

- Among all men 15–54 in Sub-Saharan Africa and in Latin America and the Caribbean, 4–18% had two or more partners in the past year and did not use a condom the last time they had intercourse.
- Some 20–46% of men 25–54 in Sub-Saharan Africa and 15–30% of those in Latin America and the Caribbean do not want a child soon or do not want any more children but are not protected against unplanned pregnancy.

- Different components of the ABC approach (abstinence until marriage, being faithful to one partner and condom use) are relevant for different groups of men—in particular, B and C for men with multiple partners.

- Creative program responses to address men's special needs are being developed in various parts of the world, but these are mostly small-scale with limited reach.
- In industrialized countries, poor and uninsured men face significant barriers to accessing men's services.
- In developing countries, the expansion of programs to address men's sexual and reproductive health needs, while continuing to address women's needs, will require increased donor funding.

Chapter 8: Summing Up

Sexual and intimate relationships and a stable family life are important goals for most men worldwide. Broadening primary health care services and providing more information to meet men's needs for medical and counseling services relevant for their sexual and reproductive health would demonstrate responsiveness to the vital interdependence that exists between men's well-being and that of their wives, children and societies. Despite many barriers and the lack of assistance from government or community institutions, men are making considerable efforts to protect their and their partners' sexual and reproductive health. Much more could be achieved if appropriate information, support and services were more readily available to them. The gains—for men in their own right, and for their sexual partners and families—could be inestimable.



Chapter 1

Why Focus on Men?

Men and women are indispensable partners in sexual relationships, marriage and family building. And all people—men and women alike—benefit from health information and services that enable them to live healthy and fulfilling lives. Men who know how to protect their and their partner's sexual and reproductive health are likely to be better husbands and fathers than are men who lack this knowledge. Still, the sexual and reproductive health needs of men beyond their roles as women's partners have received little attention. The family planning, public health and contraceptive research communities have finally learned to regard and treat women as individuals, not just as wives and mothers. This report aims to take some initial steps toward doing the same for men, by providing an overview of their sexual and reproductive behavior and drawing out the health and program implications of that information. It examines men's needs for health information and related services, and identifies obstacles that prevent men from receiving those services.

Women's need for sexual and reproductive health care services has long received more attention than has men's. The reasons for this imbalance are understandable: Only women become pregnant and bear children, and the number, timing and safety of pregnancies and births are directly relevant to women's health and well-being. Moreover, because most of the available contraceptive methods are designed for use by women, related systems of service provision target women.

Research on sexual and reproductive health has also focused mainly on women. Since the mid-1970s, a series of national fertility and family planning surveys conducted worldwide has examined women's sexual and reproductive health behaviors.¹ Until comparable national surveys of men began

in the 1990s, most of the little that was known about men's roles in sex and reproduction came from the accounts supplied by women.

The case for including attention to men became starkly apparent in the mid-1980s, with the onset of the AIDS epidemic. Early attempts to understand and contain the disease made it clear that better knowledge of men's sexual behavior was required. Yet, men's health care needs and the significance of men's roles go far beyond HIV/AIDS. Other sexually transmitted infections (STIs) and unplanned preg-

The sexual and reproductive health needs of men beyond their roles as women's partners have received little attention.

nancies can devastate the lives of men and women, and can have negative consequences for families and communities—both direct (by affecting people's health) and indirect (by affecting socioeconomic conditions). These problems will never be addressed adequately if women alone receive information and health services.

Underscoring the need to increase attention to men, the 1994 United Nations International Conference on Population and Development (ICPD) stressed "male responsibilities and participation" in sexual and reproductive health. The conference's 20-year Programme of Action calls for leaders to "promote the full involvement of men in family life and the full integration of women in community life," ensuring that "men and women are equal partners."² In particular, "efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior,

including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; [and] prevention of unwanted and high-risk pregnancies."³

What Are Men's Needs?

Information about and services for the prevention, diagnosis and treatment of STIs are clearly necessary for men's health. In addition, some men over the course of their lives will need information about and services for the diagnosis and treatment of infertility, sexual dysfunction or cancers of the reproductive system.

Men have their own perspectives and preferences regarding fatherhood and about how many children they want. But men need to take into consideration their partners' preferences and the health benefits of planning pregnancies. Unintended pregnancies may result in the birth of a child the couple is unprepared to care for, or in an abortion, which, in many developing nations, is often an unsafe and sometimes a life-threatening procedure. Clearly, the health risks that unsafe abortions or closely spaced births pose to women can also affect their partners emotionally and economically.

Accordingly, men need more—and more accurate—information on all aspects of sexual and reproductive health. Improving men's knowledge and skills is essential to increasing the likelihood that men will engage in protective behaviors to benefit their own health and that of their partner. Furthermore, providing ways of facilitating more open and equitable communication within couples is crucial to ensuring that sexual and reproductive decisions can be reached with input from both partners.⁴

A focus on men promises broader benefits as well. Research has shown that throughout the world, the attitudes and behaviors of some men seriously

jeopardize the health of women. A review of 35 surveys covering a wide range of countries found that one-fifth to more than one-half of women interviewed had ever been physically abused by an intimate male partner.⁵

Men can be frustrated by their inability to satisfy normative masculine ideals of strength, competence and control, and this frustration can lead to recklessness, the abandonment of expected male responsibilities, sexual promiscuity, violence, drug use and other self-destructive behaviors,⁶ particularly among the young. Some young men facing bleak prospects in their lives may react by avoiding marriage or by rejecting the responsibilities of fatherhood.⁷ A better understanding of the context of men's lives could guide the development of programs that encourage safer, more supportive and more protective behavior.

At the same time, evidence in this report will show that many men are striving with considerable success to fulfill and sometimes expand their roles and responsibilities and to avoid potentially negative consequences of their sexual activity—primarily unintended pregnancies and STIs—despite receiving little guidance or support. These men, too, will benefit from information and services to help them protect themselves and their partners even more effectively.

What About Women?

Some women's health and rights advocates are apprehensive that increased attention to men's health needs will draw attention away from women and their continuing struggle for personal and social equity. In particular, they fear that if service providers pay more attention to men's sexual health concerns, already scarce health care resources will be diverted from programs addressing women's needs. The harsh reality that the burden of ill

health associated with sexual and reproductive behaviors is borne largely by women, especially in developing countries, cannot be denied. And there is no doubt that the financial and human resources currently in place in developing nations are insufficient to meet the still enormous unmet and continuing needs for sexual and reproductive health services for women.

In the end, it may be counterproductive to weigh the sexual and reproductive health needs of women against those of men, because the destinies of both partners are intimately related. Men who are better able to prevent unintended pregnancy and to prevent and obtain treatment for STIs also contribute to their partners' sexual health. However, until they are in their late 30s, men generally require fewer intensive clinical reproductive health services than women. Additionally, because men's greatest need is to become better informed about the risks associated with certain sexual and reproductive behaviors and how to avoid such risks, meeting men's needs should not absorb much of the available health care resources.

Even so, a key societal goal must be to allocate more resources to meeting the sexual and reproductive health needs of both women and men. As reflected in the ICPD Programme of Action, doing so will help build a healthier and more equitable world. Like women, men are more likely to respond to health messages about sex and reproduction if they believe that these messages reflect their own best interests. They are also more likely to be good partners and parents if they feel that their involvement counts, and that their participation is respected. Treating men in their own right creates a win-win situation: The more informed and more effective men become in living safer sexual and reproductive lives, the better it will

be for them and for their partners and children.

A Guide to the Report

This report was written to provide policymakers, health care providers and educators with the basic information needed to design information and services that will improve the sexual and reproductive health conditions of men worldwide. It is intended as a companion to similar comparative international reports published by The Alan Guttmacher Institute in the past 15 years, all of which have focused on various aspects of the sexual and reproductive lives of adolescent and adult women of childbearing age.⁸ Each report was prepared in the belief that in order to develop policies and programs that effectively address people's needs, it is necessary to document as fully as possible what is known about their situation. Surveys of men conducted in the past decade provide data that make this report possible now.

The report focuses on 23 countries in five regions. Surveys of men have not been carried out in every country. Data from Sub-Saharan Africa and Latin America and the Caribbean are the most extensive, whereas comparable information from Asia, the Middle East and North Africa is much less complete. In particular, data from China and India—the two most populous countries in the world—are very limited. As a result, the findings cannot be generalized to the entire world.

Nevertheless, the report presents a profile of the sexual, marital and fathering behavior of men in 39 developing countries and six industrialized countries that represent each major world region. To streamline the presentation of information from such a large number of countries and to provide a sharper focus to the body of the report, we chose to organize the discussion

around a subset of 23 countries. These 23 “focus” countries, selected to be as regionally representative as possible, are Burkina Faso, Ethiopia, Nigeria, Uganda and Zimbabwe (Sub-Saharan Africa); Bangladesh, China, India, Nepal and the Philippines (Asia); Egypt, Morocco and Turkey (the Middle East and North Africa); Brazil, the Dominican Republic, Mexico, Nicaragua and Peru (Latin America and the Caribbean); and Great Britain, Italy, Japan, Sweden and the United States (the industrialized nations).

The report takes a life-stages approach.

In this report, we define men’s reproductive age span as 15–54, on the basis of the data available and because fathering rarely occurs beyond age 54 in most parts of the world. The report is organized around three important stages in men’s sexual and reproductive lives: youth; marriage and starting a family; and raising children and completing family building. During this 40-year period, almost all men have intercourse for the first time, marry and become fathers, and reach the point in their lives when they decide they do not want any more children.

In Sub-Saharan Africa, Latin America and the Caribbean, and the United States, about 6–10 years elapse between the age at which men initiate intercourse and the age at which they first marry (Chart 1.1).⁹ This period represents one of vulnerability, during which many men will be unmarried but sexually active—often with more than one partner—thereby raising their risks of acquiring an STI (including HIV) or of being involved in an out-of-wedlock pregnancy.

Following marriage, most men will become fathers. 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 men

decide that they have had all the children they want. At this point, many men enter a second period of vulnerability: Although they remain capable of fathering children, large proportions want no more children and need to avoid causing another pregnancy.

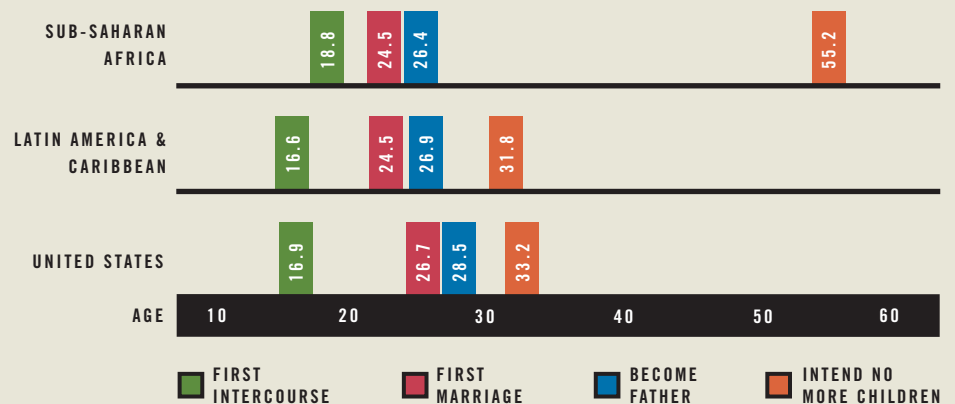
Structure of the report. The report first outlines the economic and social conditions that shape, and often constrain, men’s sexual, marital and reproductive behavior—the same conditions that likely determine the health and human resources available to respond to the sexual and reproductive health needs of men and women (chapter 2). The next three chapters profile the sexual, marital, contraceptive and fathering behaviors of men, focusing on sexual initiation among men aged 15–24 (chapter 3), entry into marriage among men aged 25–39 (chapter 4) and fatherhood among men aged 40–54 (chapter 5). After addressing issues that involve men of all ages—STIs,

particularly HIV/AIDS, and use of the condom to prevent these infections (chapter 6), and men’s needs for sexual and reproductive health services (chapter 7)—the report concludes with a discussion of the program and policy implications raised by the findings (chapter 8).

Although the report covers a wide range of issues affecting men’s sexual and reproductive lives, it provides only an introduction to these issues. There are still large gaps, for example, in what we know about the motivations behind much of men’s sexual behavior, their attitudes to fatherhood and their experiences with the condom. A great deal of research is needed to fill in the broad outlines presented in this report. In the meantime, however, it is not too soon to consider and begin addressing the sexual and reproductive health needs of men worldwide—in their own right and to the ultimate benefit of everyone.

CHART 1.1

Median ages at which men reach four key stages in their sexual and reproductive lives



NOTE: Marriage includes cohabitation and consensual union.

SOURCE: REFERENCE 9.

- Young men typically begin their sexual lives in their mid-teens and marry and become fathers in their mid-to-late 20s.
- U.S. men marry and become fathers about two years later than do men in Latin America and the Caribbean and in Sub-Saharan Africa.
- Men in Sub-Saharan Africa continue to want to have children until a much later age than do men in Latin America and the Caribbean and in the United States.

Principal Sources of Information

The main sources of information used in this report were quantitative data from nationally representative surveys of men and a growing body of qualitative studies on male attitudes, values and behavior in the area of sexual and reproductive health. We focused on the current situation of men aged 15–54 and, when feasible, analyzed trends in behavior by comparing the experience of older and younger men interviewed in the same survey or by studying data from surveys conducted at two different times.

The quantitative studies, most of which were Demographic and Health Surveys (DHS) and the European Fertility and Family Surveys (FFS), varied somewhat across countries but provided comparable data on men's sexual and reproductive behaviors. In most countries, surveys were conducted between the mid-1990s and 2000; however, in some countries, the only available national study was from the early 1990s. Because the surveys that started in the 1990s were developed in response to the HIV/AIDS epidemic, they focused on men's sexual behavior, condom use, knowledge of sexually transmitted infections and HIV, and risk and protective behaviors. Nevertheless, these surveys also covered some broad aspects of men's reproductive behavior, such as union formation, fatherhood, pregnancy prevention and fertility preferences.

The Alan Guttmacher Institute produced unpublished tabulations of the following nationally representative sample-surveys that include all men 15–54, unless indicated otherwise:

- DHS: Sub-Saharan Africa, 1994–2001; Senegal, 1997 (men 20–54); Latin America and the Caribbean, 1996–2000; Bangladesh, 1999–2000 (married men 15–54); Kazakhstan, 1999; Nepal, 2001 (ever-married men 15–54); Pakistan, 1990–1991 (married men 15–54); Egypt, 1992 (married men 20–54); Morocco, 1992 (men 20–54); and Turkey, 1998 (married men 15–54)

- FFS: Hungary, 1993 (men 20–44); Italy, 1996 (men 20–49); and Sweden, 1993 (men 20–44)

- National Population and Reproductive Health Survey, China, 1997 and 2001 (men 15–49)

- Male Reproductive Health Survey, Uttar Pradesh (India), 1995–1996 (married men 15–54)

- National Family Health Survey (NFHS-2), India, 1998–1999

- Young Adult Fertility and Sexuality Survey (YAFS-2), Philippines, 1994 (men 15–24)

- Status of Women and Fertility Survey, Philippines, 1994 (married women 15–39 and their partners)

- Encuesta de Comunicación en Planificación Familiar (ENCOPLAF), Mexico, 1996 (single men 15–24 and married men 15–60)

- Encuesta de Salud Reproductiva con Población Derechohabiente (ENSARE), Mexico, 1998 (men 12–59)

- CONASIDA Comportamiento Sexual en la Ciudad de México, Mexico City, 1992–1993 (men 15–60)

- National Survey of Sexual Attitudes and Lifestyles (NATSAL), Great Britain, 1990 (men 16–54)

- Japan National Fertility Survey (JNFS), Japan, 1997

- HIV and Sex in Japan (HIVSEX) Survey, Japan, 1999 (men 18–54)

- NHK Survey of Sex in Japan, 1999 (men 16–69)

- Current Population Survey (CPS), United States, 1970–2000

- National Survey of Families and Households (NSFH), United States, 1992–1994

- National Survey of Adolescent Males (NSAM), United States, 1995 (men 15–24)

- National Survey of Men (NSM), United States, 1991 (men 20–39)

- National Health and Social Life Survey (NHSLs), United States, 1992

- Survey of Income and Program Participation (SIPP), United States, 1992

The qualitative studies offered a wider understanding of aspects of men's sexual and reproductive lives that were not well documented in the quantitative studies. In general, we used data from qualitative research conducted in countries for which quantitative survey data were available. For countries where certain topics (e.g., abortion) were poorly covered, we used any relevant studies that were available.

Additional sources of information were the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization, the United Nations Development Programme and the United Nations Population Division, as well as data from censuses, international research and health organizations active in various aspects of service provision and advocacy.

Coverage of National Surveys

Although we aimed at covering industrialized and developing countries worldwide and at including all men of reproductive age, coverage was limited by the availability of information.

The survey data from countries in Sub-Saharan Africa and in Latin America and the Caribbean were the most geographically representative and the most extensive. Although one populous Latin American country, Mexico, was not part of the DHS, we included it by using data from a nationally representative survey of all men of reproductive age, together with comprehensive data from a survey of all men in Mexico City—the most modernized area of the country, where approximately 15% of the population of Mexico lives.

Surveys of men's sexual and reproductive behavior and health also have been carried out in many European countries, mainly by the Family and Fertility Survey division of the United Nations Economic Commission for Europe. By including such survey data for three countries and data from other surveys for three additional countries, we covered six industrialized nations that represent major developed subregions of the world: Great Britain (western Europe); Hungary (central Europe); Italy (southern Europe); Japan, a non-European industrialized country; Sweden (northern Europe); and the United States (North America).

Geographic representation of the two remaining world regions—Asia and the Middle East and North Africa—was less complete than that of the other regions. Data for Asia were also limited in depth: For example, those for China lacked many measures, and key information was missing on the sexual activity of unmarried men. The data for India came mainly from a survey in one state, Uttar Pradesh, which is home to 16% of India's population; however, the state is one of the country's poorest, and the survey interviewed only married men. Furthermore, national surveys in Bangladesh, Nepal and Pakistan interviewed only married men, and the only nationally representative surveys of men in the Philippines were conducted among married and unmarried men aged 15–24 and among husbands of women aged 15–39. In the Middle East and North Africa, too, information on the sexual and reproductive behavior of men was limited: Only national surveys of married men were available for Egypt and Turkey, and although surveys in Morocco covered all men, unmarried men were not asked certain questions.

This report presents some information for 82% of men aged 15–54 in Asia, 78% in Sub-Saharan Africa, 63% in Latin America and the Caribbean, and 44–47% in industrialized nations, the Middle East and North Africa. It presents substantial information for about

77% of men aged 15–54 in Sub-Saharan Africa, 60% in Latin America and the Caribbean, 44–48% in industrialized countries, the Middle East and North Africa, and only 9% in Asia.

Given these levels of coverage, the findings cannot be generalized to the entire world. Nevertheless, coverage is strongly representative for Sub-Saharan Africa, quite representative for Latin America and the Caribbean, and moderately representative for the industrialized countries. For the Middle East and North Africa, coverage is weak to moderate, because although slightly more than two-fifths of this region's population is included, the data are mainly for married men. Representativeness is weakest for Asia: Geographic coverage is narrow, data on unmarried men are lacking and data on married men are limited.

Finally, most of the surveys included in this report cover only the noninstitutionalized population and are not representative of other subgroups of men, such as those in the military, those in prison, displaced men, migrants and men living in refugee camps or on the street.

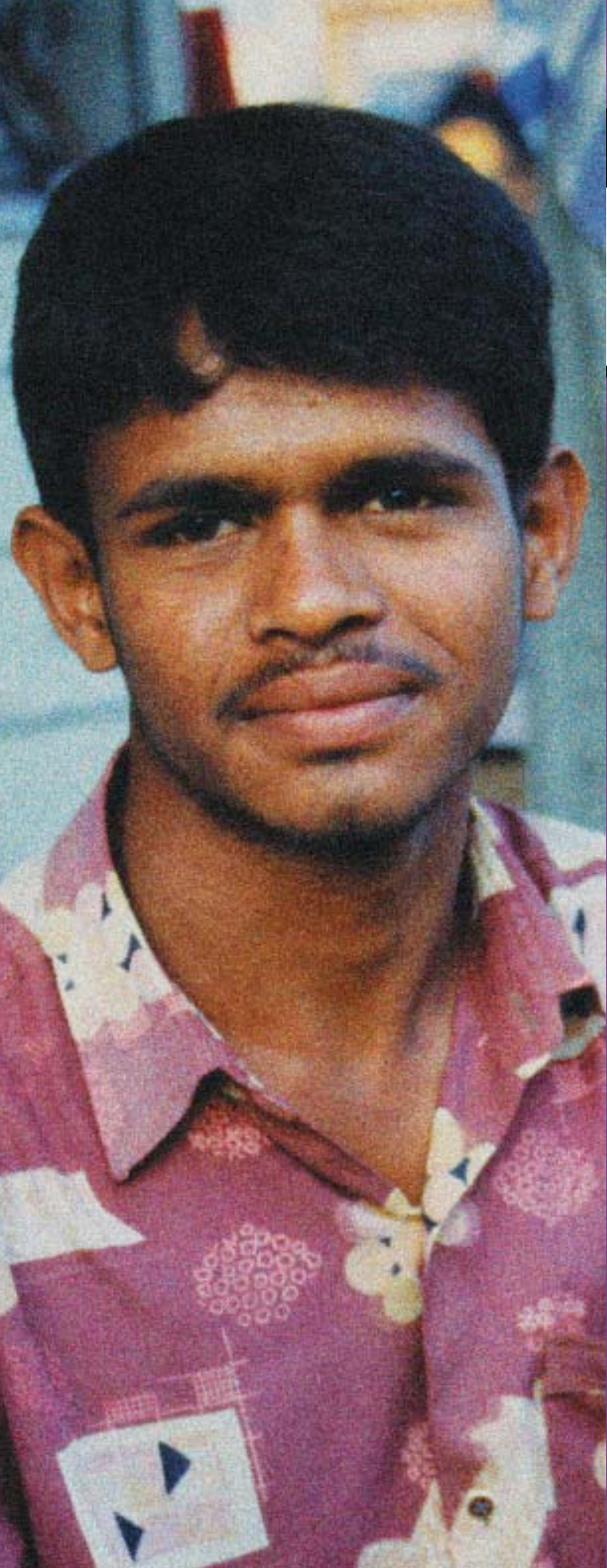
Data Limitations

The data on men's sexual and reproductive health are affected by certain data quality problems and limitations.

Men tend to exaggerate the number of sexual partners they have or have had¹ or provide inconsistent reports about their sexual experiences.² Some men underreport the number of children they have fathered, especially if they do not live with them.³ Additionally, reports from each partner on the couple's contraceptive use often do not agree: Men and women probably report their own use more accurately than they report their partner's, and they may sometimes report use with an extramarital partner.⁴ In settings where some women use a method without their partner's knowledge, men may underreport their partners' contraceptive use.⁵

In some regions, particularly Sub-Saharan Africa, respondents often cannot recall when certain events, such as first sexual intercourse, first union and first experience of fatherhood, occurred. Consequently, high proportions in these regions may give socially expected ages.⁶

In this report, we define men's reproductive age span as 15–54, although not all national surveys interviewed men in this age-group. In contrast to the situation for women, identifying a precise event that marks puberty for men and defining the upper age limit of men's reproductive years are difficult. Our definition is based on the data available, but it is also justified by patterns measured in this study: Survey data for all regions except Sub-Saharan Africa show only small increases in average family size between ages 45–49 and 50–54.⁷ In Sub-Saharan Africa, however, increases of 1–2 children between these ages are typical, suggesting that male fertility continues to increase at older ages. Furthermore, available analyses show that male fertility peaks in the late 30s; in high-fertility societies in which polygyny is common, it peaks in the mid-40s and can remain high during men's 50s and 60s.⁸



Chapter 2

Factors That Shape Men's Sexual and Reproductive Lives

- *Poverty and poor work prospects can undermine men's traditional roles as providers and can make them fatalistic about the consequences of risky behavior.*
- *Male life expectancy is declining in Sub-Saharan Africa but increasing in the rest of the world; reduced prospects for a long life can reduce motivation to protect one's health.*
- *Urbanization can weaken the supports of traditional community life, especially when it separates poor men from their families, but can also create the desire for smaller families.*
- *Educational attainment is increasing in all developing regions, but job prospects are not improving at the same pace, and large proportions of young men cannot find full-time paying jobs.*
- *Increased education and the mass media can offer people new information and ideas, and greater opportunities, but the media can also present poor and young people with visions of consumerism and modern lifestyles that are beyond their reach.*
- *Social and cultural changes in developing countries promise young men a greater sense of autonomy, but economic changes can undermine their ability to become self-sufficient and independent.*

Men's sexual and reproductive lives do not occur in a vacuum. Rather, a wide range of societal and individual factors shapes, and often constrains, men's aspirations and behavior as partners, husbands, fathers and sons. Moreover, the broader context of men's sexual and reproductive lives is a world increasingly characterized by rapid social, cultural and economic change.

Some global developments have the potential to alter the sexual and reproductive aspirations and behavior of men as well as women. For example, urbanization and modernization contribute to changes in family structure. Lengthier schooling often results in postponement of marriage and family building to later ages for both men and women. Increased hopes for a better standard of living or declining prospects of employment may also affect the timing of marriage and childbearing. The emergence of HIV/AIDS undoubtedly affects people's perceptions of the risks associated with sexual activity, although the extent to which perceptions change is likely to vary widely, depending on the prevalence of the disease and the level of public attention to its adverse effects on health. Furthermore, increased advocacy and demand for women's equality often challenge the way in which men behave.

Poverty Characterizes Many People's Lives

Gaping regional differences in income are stark indicators of inequality worldwide. The average annual per capita income in the industrialized focus countries (\$26,462) is 20 times that in Sub-Saharan Africa (\$1,277), 10 times that in Asia (\$2,647) and roughly five times that in the Middle East and North Africa (\$4,718) and Latin America and the Caribbean (\$5,895).¹ Incomes also differ widely within regions and within countries:

For example, within Latin America and the Caribbean, per capita income is less than \$1,500 in Haiti and about \$9,000 in Mexico. In 1998 in the United States, the richest 1% of the population owned 38% of the country's net wealth, whereas the bottom 80% owned 17%.²

Access to resources, such as clean water and sanitation, is an important determinant of the quality of living conditions. Fewer than 10% of households in many countries in Sub-Saharan Africa have piped water, compared with 32–69% of households in Latin America and the Caribbean and

Separation from their families and freedom from traditional cultural controls... may prompt some men to engage in unsafe sexual relationships.

100% of households in Japan.³ Electricity is available in fewer than 20% of households in 15 of the 22 Sub-Saharan African countries covered in this report.⁴ Rural households are much less likely than urban ones to have access to these features of modernization.

Poverty places a heavy burden on many fathers, husbands and sons, because in most societies men are expected to be the major providers in the family. Some poor men might ask themselves: "If I cannot provide for myself, should I have a family?" or "If I cannot provide for my dependents, am I a man?"⁵

Socioeconomic Change Can Undermine Men's Traditional Roles

Some studies suggest that changing labor market conditions in many developing countries are affecting not only men's economic roles but also their position within the family.⁶ These eco-

nomical changes can have particularly serious social and cultural ramifications for men. As a result of globalization, skilled men may be deprived of their jobs, and unskilled men may find it harder to become employed, thereby reducing their ability to fulfill their traditional role as providers.⁷ At the same time, new employment patterns often increase women's work opportunities, earning capacity and power within the family, again potentially threatening traditional masculine roles. Women's improved schooling and growing employment levels—trends most societies support—require that men question and change their views and behaviors regarding traditional gender roles.

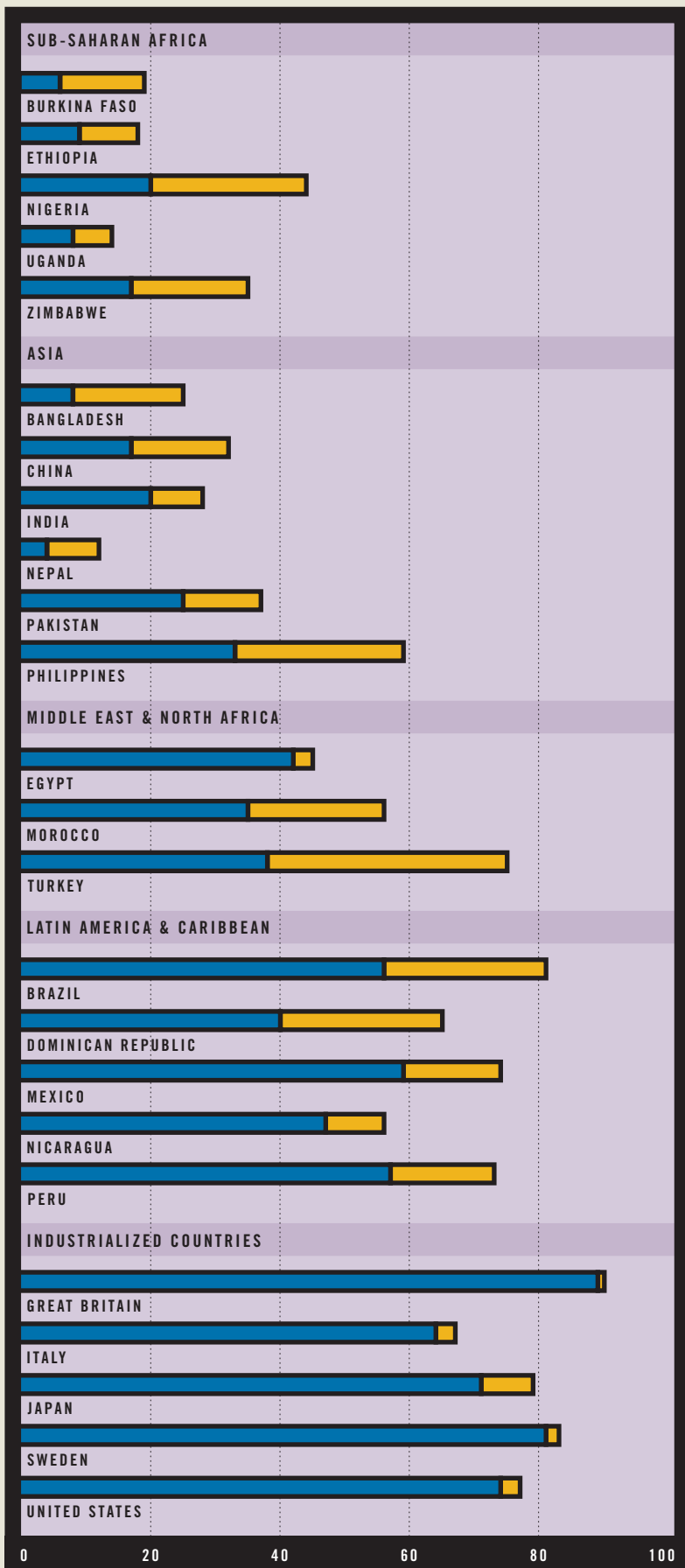
Many men (especially young men) in both developing and industrialized countries have no paid work, and those living in the world's most economically deprived regions commonly leave home to seek jobs. Separation from their families and freedom from traditional cultural controls on their behavior can cut men off from community support and influence, and may prompt some men to engage in unsafe sexual relationships before or outside marriage (see box on page 22).

Male Life Expectancy Varies Widely

Life expectancy is a summary measure that reflects the gap in living conditions between rich and poor countries. In Sub-Saharan Africa, average life expectancy at birth for males is as low as 37–39 years in Malawi, Mozambique, Zambia and Zimbabwe and as high as 56 years in Ghana. By comparison, life expectancy is in the mid-to-high 70s in most industrialized countries.⁸

In most of the Sub-Saharan African countries hard hit by the HIV/AIDS epidemic, life expectancy for men declined between 1985 and 2000. For example, in Zimbabwe, where

CHART 2.1
Percentage of people living in urban areas



■ % IN 1970 ■ INCREASE, 1970-2000

one-third of the adult population is estimated to have HIV/AIDS,⁹ male life expectancy fell by 37%.¹⁰ In contrast, during the same period, male life expectancy increased by seven or more years in industrialized countries and in many countries of Asia, the Middle East and North Africa, and Latin America and the Caribbean.

Reduced prospects for a long life—a function not only of the extent of the AIDS epidemic, but also of persistent poverty, violence, poor health and malnutrition—can affect men's attitude toward how carefully they live their lives. Diminished certainty about whether they will live to an old age leads some young men to consider the rewards of careful behavior insufficient motivation to avoid risky behaviors. Studies conducted in the United States suggest that in impoverished communities with above-average mortality rates among young men, the adoption of risky behaviors like drug use, excessive drinking, reckless driving, weapon carrying and unsafe sexual practices both contribute to and reflect lower overall survival rates.¹¹

Another general measure of social well-being is the proportion of years of life lost to premature death or spent with a disability (disability-adjusted life-years, or DALYs) that can be attributed to certain behaviors. In 2000, traffic accidents, violence, war and self-inflicted injuries accounted for 13% of DALYs among men in Sub-Saharan Africa, compared with 7–9% in Latin America and the Caribbean, India, China and the industrialized countries.¹²

- The population of developing countries became more urban between 1970 and 2000.
- However, in some developing countries, the population is still largely rural.

SOURCE: APPENDIX TABLE 1, COLUMNS 2 AND 3.

Men are more likely than women to engage in risky behaviors. For example, in all world regions, the proportion of total DALYs lost because of alcohol use is 4–11 times as high among men as among women. And in Sub-Saharan Africa, the Middle East, India and China, the proportion of DALYs attributable to drug use is nine times as high among men as among women.¹³

An Increasing Proportion of People in Developing Regions Now Live in Urban Areas

The growing proportion of people living in urban areas (Chart 2.1)¹⁴ represents one of the most important factors shaping the quality of life in developing regions over the past 30 years. The process is driven mainly by poverty: Poor rural people move to urban areas in search of jobs and a better life. Although conditions in urban slums are often very bad, many migrants believe that cities offer better opportunities to earn money, and that being forced to live without shelter, clean water, electricity or transportation represents only a temporary phase until they find a better future.

Migration often weakens the family support systems found in rural areas and undermines intergenerational relationships that traditionally teach and enforce social and community norms, including those of sexual and reproductive behavior.¹⁵ The experience of moving to a large town or city undoubtedly influences men's sexual behavior. During the early stages of urbanization, male migrants often tend to outnumber female migrants. Young men living away from family and community members who would normally monitor and constrain their sexual behavior are especially likely to engage in unsafe sex, or sex with multiple partners.¹⁶ Similarly, some married men who seek jobs in cities become involved in extramarital relationships¹⁷ while still occasionally visiting home to see the

families they are trying to support.

Urbanization also changes men's family-building aspirations and behavior. In Burkina Faso and Ethiopia, for example, men in their late 20s and 30s living in rural areas say they want seven children, whereas those living in urban areas want four.¹⁸ Urban parents raising large families in poor countries often experience difficulties that do not arise in rural areas: All food must be purchased rather than grown; their children need increased schooling to be able to find work in urban areas; and women are less able to combine work and child care than they are in agricultural areas. These considerations probably strengthen cooperation between husbands and wives about the contraceptive use needed to have smaller families; they could, however, also increase conflict over desired family size and contraceptive use if each partner's aspirations change at a different speed.¹⁹

Young Men Stay in School Longer Today Than They Did in the Past

Educational levels among men in developing countries have increased considerably over the past 20–30 years. In countries as far apart as Nigeria and Mexico, for example, 6–7 in 10 men in their early 20s have completed primary school, compared with only 2–3 in 10 men aged 40–54 (Chart 2.2, page 16).²⁰

As education in urban areas has increased, levels of schooling in rural areas have often remained unchanged over the past 20–30 years.²¹ Educational levels among young men are substantially higher in urban than in rural areas.²²

Increased educational attainment, which often leads to the desire for a more modern lifestyle, tends to raise the average age at which young people marry and first have a child, as more educated couples decide to wait until they are economically established

before starting families. However, aspects of economic modernization and social secularization may also be correlated with earlier sexual onset before marriage, which is believed to be the case in some Asian countries.²³

Modernization Often Affects the Cultural Values Shaping People's Lives

As people become more “modern” in their lifestyles through exposure to urban life, increased schooling and new ideas, they typically want consumer goods like radios and televisions. Radio ownership is high in

Urbanization...changes men's family-building aspirations and behavior...Urban parents raising large families...often experience difficulties that do not arise in rural areas.

Egypt and Morocco and in Latin America and the Caribbean, but is uneven in Asia and Sub-Saharan Africa.²⁴ Ownership of a television is less common,²⁵ partly because it is a more expensive item and partly because it requires a reliable source of electricity.

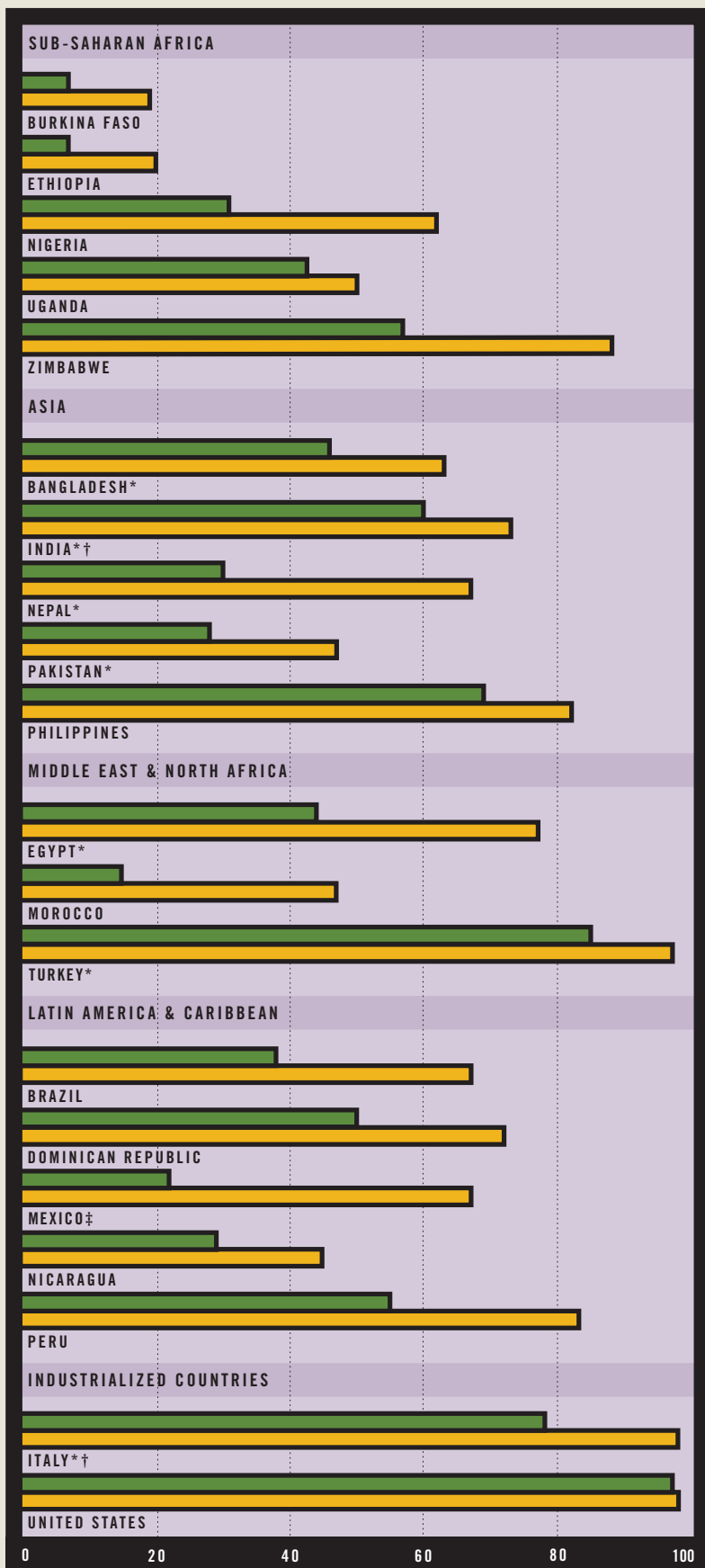
Television and radio deliver news and information from all over the world. Television also carries advertisements that not only present seductive images of elite lifestyles,²⁶ but also often emphasize individualistic, consumer-oriented values. These messages may further affect people's life aspirations and foster the desire for smaller families.

Changing Cultural Values Affect Young People in Particular

Rapid social and cultural change affects young people particularly. Regional studies in Sub-Saharan Africa

CHART 2.2

Percentage of older and younger men with seven or more years of schooling



describe the erosion of traditional rites of passage into adulthood and the weakening of the role of the community elders charged with passing on the group's cultural wisdom about sexuality and family life.²⁷ Poverty and desperation may lead young people to have sex with older partners for money—for example, to pay for schooling—or for gifts.²⁸ Young people have increasing freedom, face growing exposure to sexual risk and, compared with older generations, often develop stark differences in values over issues such as the acceptability of premarital sex²⁹ and selection of one's own husband or wife. Although many social and cultural changes lead young men to seek greater independence from family and community control, their economic status usually does not match their aspirations to greater autonomy.

- Men who turned 20 in the 1990s had more schooling than men who turned 20 two or more decades ago.
- However, in some developing countries, many men 20–24 still have little education.

*Men who have completed at least primary school. †Based on men 40–49 and 20–24. ‡Based on married men 40–54 and all men 20–24.

SOURCE: APPENDIX TABLE 1, COLUMNS 4 AND 5.

Men Are Often Involved When Their Partners Have an Abortion

Induced abortion plays a role in some couples' attempts to regulate their family size. Because it is women who undergo abortion—clandestinely, in some parts of the world—it is difficult to assess men's role in abortion: in the decision-making, the events leading up to the actual procedure and postabortion care. However, several studies of women obtaining abortions in developing countries provide some glimpses into men's involvement.

In a survey conducted in India, where abortion is legal, women ending an unwanted pregnancy reported first discussing the possibility with their husbands, most of whom supported the decision to have an abortion and helped in obtaining the procedure.¹ Another study in India found that all the husbands of women obtaining a legal abortion had participated in the decision-making, helped to locate the provider, arranged transportation, paid for the service and provided postabortion care.² However, compared with the women, the men were less likely to say that the reason for the decision was because they did not want another child (20% vs. 42%), but as likely to say that they could not afford another child (74% vs. 70%).

In Bangladesh, where menstrual regulation up to 10 weeks after the last missed period is a legal method of ending a pregnancy, only 52% of married men know that this means of fertility regulation is available, compared with almost 80% of married women, even though Bangladeshi women are required to have their husband's permission before menstrual regulation is performed. In the early 1980s, 27% of women who were denied such a procedure did not have permission from

their partner; by the end of the decade, this proportion decreased to only 4%. The fees for the procedure are usually paid by women's husbands, brothers or fathers.³

In Vietnam, where abortion is legal, a study of women having abortions found that partners almost always are involved in the decision-making process. The main grounds for having an abortion are related to economic and health-related issues. Men's major reasons for opposing the decision are ethical doubts and the desire for a son.⁴

In Colombia, only four in 10 women obtaining abortions in a Bogotá clinic each year are accompanied by their partner.⁵ Fifty-two percent of the women served by this clinic say that their husbands expressly told them to go ahead with the procedure, and 8% that their partners made it clear that they were uninterested in the pregnancy.⁶ Men who accompany their partners are less likely than those who do not to be in a casual or unstable relationship with the women. Many women characterize the partners who do not accompany them as uncommunicative and uninterested in the fact that they were pregnant.

Some men also play a role in postabortion care, but not as many as would like to do so. A study in five Kenyan hospitals in which more than one in three admissions to the gynecologic ward were for complications of induced abortion found that only 14% of the partners of women with complications had received any information on their wife's condition; 94% said they would have liked to receive such information.⁷ In Egypt, the husbands of women admitted to a hospital for complications of unsafe abortion were counseled separately about their wives' need for family planning, rest and adequate nutrition. However, the counselors sometimes neglect-

ed to give the same information to wives, so that husbands' counseling replaced, rather than reinforced, attention to wives.⁸

Many Women End a Pregnancy Because of Unstable Relationships

In many countries, being in a troubled or fragile relationship ranks high among the reasons women give for seeking an abortion. It was the leading reason in Honduras in 1992–1993, and the second most commonly cited reason in Nigeria in 1996 and in the United States at the end of the 1980s.⁹ The proportion of women seeking abortions because of troubled relationships reached 20–42% in four countries: Chile (in 1988), Honduras (in 1992–1993), Mexico (in 1967–1991) and Nigeria (in 1996).

Many women seeking an abortion say their primary reason is that they do not want to be a single mother.¹⁰ This response suggests several underlying situations: The pregnancy resulted from an extramarital relationship or from a relationship between unmarried people; the man may have threatened to abandon the woman if she had the baby; and the breakup of a relationship may have been imminent.

Two-thirds or more of women obtaining abortions in Belgium, Canada, Finland, France, New Zealand, Norway, Scotland, Spain and the United States are unmarried.¹¹ In hospital-based studies, unmarried women account for six in 10 women having clandestine abortions or suffering abortion complications each year in Brazil, Guinea, Kenya, Mali, Mozambique and Nigeria.¹² In Tanzania, roughly three-quarters of women seeking abortion are unmarried, and one-half of adolescent women seeking abortion have been in the relationship for less than one year.¹³



Chapter 3

Men 15–24: Becoming Independent and Initiating Sexual Relationships

- *In almost all countries, the majority of men 20–24 report having had sexual intercourse before their 20th birthday; in a few countries, substantial proportions of men in their early 20s were still sexually inexperienced by age 20.*
- *Some 5–35% of men aged 20–24 first had sex before their 15th birthday.*
- *Among unmarried men aged 15–24 who have ever had sex, 2–6 in 10 had two or more partners in the past year.*
- *In most Sub-Saharan African countries, fewer than half of sexually active men 15–24 use a contraceptive method or rely on their partner's method, compared with 63–93% in industrialized countries and parts of Latin America and the Caribbean.*
- *Marriage is rare among adolescent men and uncommon among men in their early 20s.*
- *Few men in their teens or early 20s have become fathers.*

Men aged 15–24 share certain characteristics: Very few are married or have become fathers, many are in school or acquiring job-related training and work experience, and most still live with their family—more than nine in 10 adolescents and 7–8 in 10 men in their early 20s.¹

Worldwide, some commonly recognized indicators of when a young man has become an adult are that he has finished school, started a job, started a family (and left his family of origin), or assumed some economic responsibility for his parents or other family members. In some developing countries today (as in the past in many industrialized countries), most men finish school and start to work while they are still adolescents. In contrast, in most industrialized countries (and increasingly in developing countries), many men in their 20s are still pursuing their education, do not yet have full-time jobs and still live with their parents. The period during which men can be considered young is lengthening in Europe and in some high-income Asian countries.²

Young Men Are Often Unemployed or Have Low-Paying Jobs

Young men often have trouble finding paid work. For example, among 15–24-year-olds, rates of unemployment (defined as the proportion of men who say they have no work and are searching or are available for work) are 29% in Sri Lanka; 30% in Greece; 33% in Italy; 34–35% in Jamaica, Egypt and Morocco; and 56% in South Africa.³ However, many young men have occasional jobs in the unreported (informal) labor sector of many countries' economies and are thus not counted in official labor statistics. These men may wash cars, load and unload trucks, run errands and messages, sell goods on the street or scavenge in garbage dumps.

International economic and development agencies identify poor education and high rates of joblessness and underemployment among young men as some of the most serious problems facing the world today.⁴ Poor or nonexistent opportunities for higher education and training, along with high rates of unemployment and underemployment

Compared with their fathers, young men in Sub-Saharan Africa [and in industrialized countries] apparently are beginning their sexual lives somewhat earlier.

among the young in many developing countries, are major factors driving the rural exodus seen around the world. These factors also propel many young men to seek work in other countries, even though most industrialized countries are reluctant to receive unskilled immigrants. Settings in which many young men face bleak life prospects are considered breeding grounds for internal conflict,⁵ political and societal alienation, and even terrorism.

Educational levels have risen in almost every part of the world in recent decades. As a consequence, school attendance plays an increasingly important role in young men's lives. In Latin America and the Caribbean, Great Britain and the United States, many young men are combining school and employment. However, in some countries, sizable proportions are involved in neither activity (Chart 3.1, page 20).⁶ In developing countries, many young men reporting no major activity may have informal jobs; in both developing and industrialized countries, many of those who are in this situation probably are unable to find any work.

Young Men Learn About Sex from a Variety of Sources

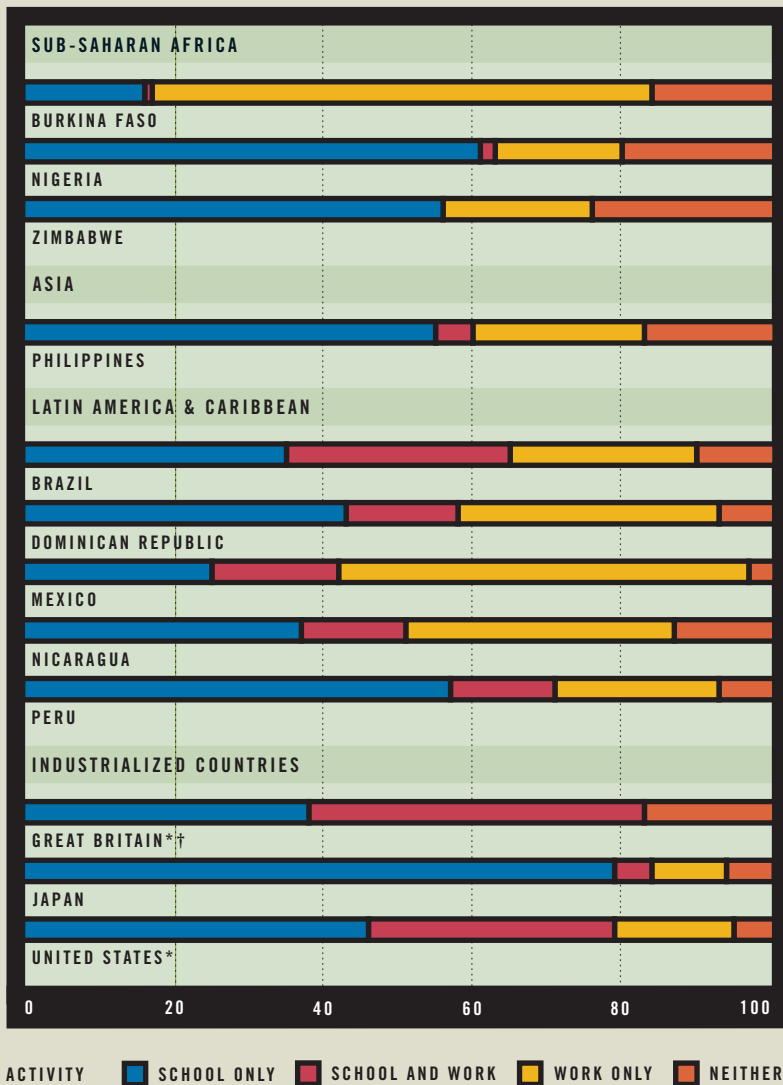
Most men probably learn about sex from their friends and on the street, rather than from parents or at school. Except in countries where the majority of teenage men are still in school and where sex education has been part of the school curriculum for many decades⁷—for example, Sweden⁸—sexual learning probably occurs mainly through the exchange of information between boys and young men. One reason is that parents are often ill equipped to talk to their children about sexual matters, or they are reluctant to do so because of fear that talking about sex may increase curiosity or imply an approval for their children to engage in intercourse prematurely.

Sex education, when provided comprehensively and early enough, will equip young people to live healthy sexual lives. However, very few countries introduce family life or sex education at the elementary school level. Although, in comparison, more countries offer sex education in secondary schools, large proportions of adolescents in many developing countries do not attend school beyond the elementary level. Therefore, only in developed countries in which a very high proportion of young people go to secondary school is there a chance that most young men will receive some school-based sex education. In addition, conservative or strongly religious countries, in both the developing and the developed world, frequently oppose school-based sex education programs.

Many Young Men Begin Their Sexual Lives During Adolescence

Substantial proportions of young men start having sexual intercourse during their teenage years. Typically, 3–7 in 10 men in their early 20s say they first had sexual intercourse before age 18.⁹ And up to 10% of men aged 20–24

Percentage distribution of men 15–19, by school and work activity



*Based on men 16–19. †“School and work” refers to work of 10 or more hours a week, regardless of school attendance.

SOURCE: APPENDIX TABLE 1, COLUMNS 15–18.

- In most developing countries, more than half of adolescent men attend school.
- Substantial proportions of teenage men work, whether or not they are in school.
- In some countries, a sizable minority of adolescent men are neither in school nor working.

say they first had sex before they were 13, and 5–35%, before they were 15 (Chart 3.2). Overall, the majority (52–92%) of men in this age-group in all but two focus countries (Ethiopia and the Philippines) report having had

intercourse before their 20th birthday.¹⁰ Still, a considerable proportion of young men in some focus countries are sexually inexperienced at age 20, ranging from 8% in Nicaragua to 68% in the Philippines.¹¹

The median age at first intercourse among men aged 20–24 ranges from 15.8 to 17.5 in Latin America and the Caribbean; in industrialized countries, it ranges from 15.9 to 17.5. Sexual debut in Sub-Saharan Africa tends to occur somewhat later, at a median age between 15.7 and 21.6.¹²

In Asia, the few national surveys that have been conducted, as well as some smaller-scale studies, suggest that first intercourse in the region occurs considerably later than in Sub-Saharan Africa, Latin America and the Caribbean, and industrialized countries, where typically 6–9 in 10 men in their early 20s have had first sex before age 20.¹³ For example, a series of youth surveys in the 1990s found that among men aged 20–24, 24% in Taiwan, 33% in the Philippines, 43% in Nepal, 49% in Hong Kong and 57% in Thailand had had sexual intercourse before age 20.¹⁴

In Japan in 1997, only 32% of men aged 18–19 and 62% of those aged 20–24 had ever had sexual intercourse.¹⁵ Furthermore, 60% of Japanese men aged 18–19 and more than half of those aged 20 report having only male friends.¹⁶ In the state of Orissa in India, the median age at first sex among men 18–35 is 24; it is as late as 28 among men aged 18–35 whose education is beyond the secondary level. And despite the pattern of late marriage in this state, only 27% of men report having had premarital sex.¹⁷

In Indonesia, urban men with a high school education are somewhat less likely than less-educated, rural men to have experienced sexual intercourse before age 20. By contrast, in Taiwan, Thailand and the Philippines, this association is reversed.¹⁸ In Indonesia—a predominantly Muslim country in which most urban schools are segregated by sex—it is perhaps less easy for young men to develop

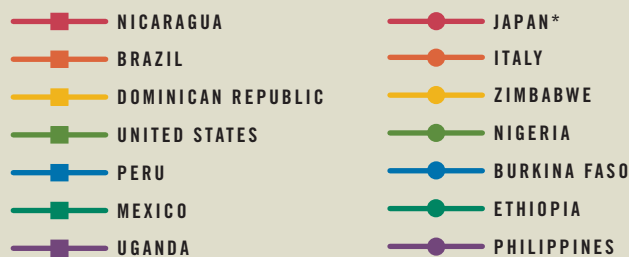
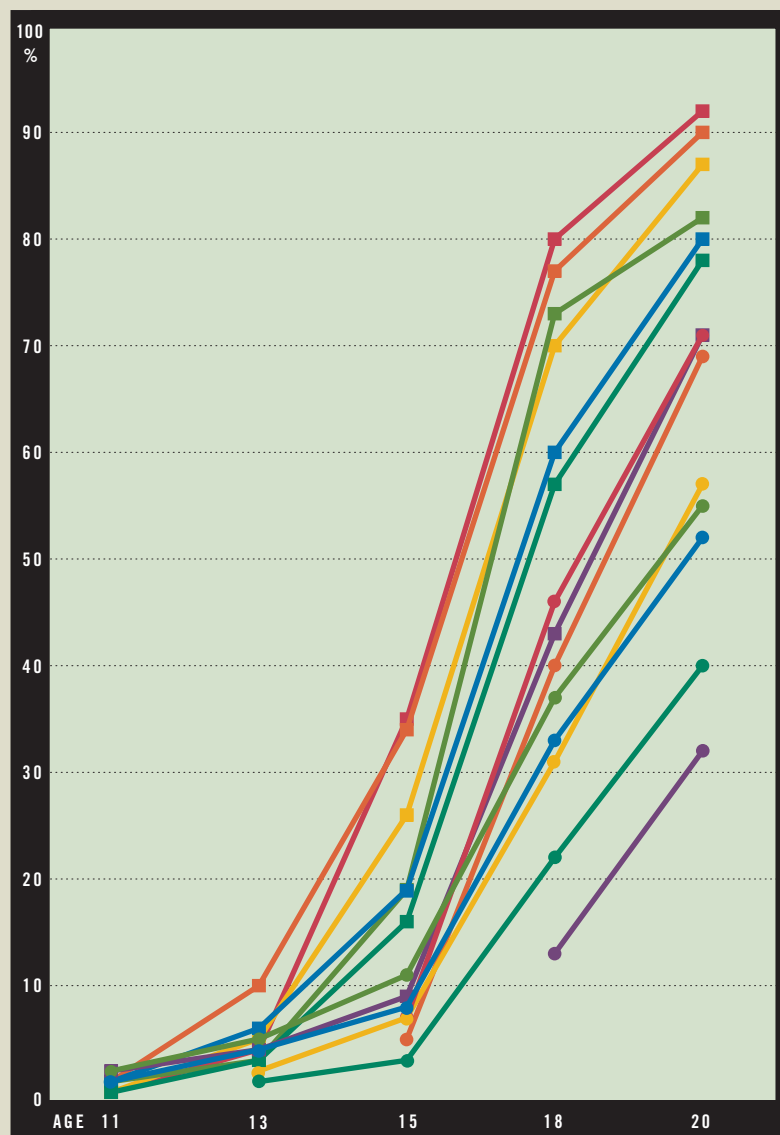
relationships with young women.

The reasons that men's age of sexual debut varies across and within countries and regions are not fully understood. Factors include the degree of cultural conservatism in customs and views regarding young men's sexual behavior, the extent of social control exerted by the family and community, young men's own preference to delay sexual activity, the availability of sexual partners for young men, and variations across and within countries in the degree to which sexual experience is underreported.

Compared with their fathers, young men in Sub-Saharan Africa apparently are beginning their sexual lives somewhat earlier, but this trend is less evident in Latin America and the Caribbean. In industrialized countries, young men also tend to begin their sexual lives earlier than did their fathers.¹⁹

Young men in many cultures face pressure to initiate intercourse early simply to prove that they are adults.²⁰ The search for sexual pleasure and intimacy is another powerful motivation for young men to begin their sexual lives,²¹ prompting some young men to visit sex workers. In India, for example, some studies indicate the first sexual experience of many young men is with a commercial sex worker.²² Curiosity is another common reason that young men give for having engaged in their first episode of heterosexual intercourse. This reason is reported by young men in countries as disparate as Great Britain and Thailand.²³

The sexual experiences of an unknown proportion of young men in every part of the world are with another man. In the United States in 1995, 5% of men aged 15–19 said they had ever engaged in any sexual activity (e.g., masturbation or anal intercourse) with a man.²⁴ Young men who have



*Based on men 20–29.

SOURCE: REFERENCE 10.

- In almost all countries, the majority of men 20–24 had sexual intercourse before their 20th birthday.
- The proportion of men who have had intercourse increases most rapidly between ages 15 and 18.

sex with men are stigmatized to varying degrees, depending on a society's religious and cultural values, as well as its openness to sexuality in general.²⁵

Unmarried Sexually Experienced Men Have Intercourse Sporadically

Young men who have ever had intercourse do not necessarily have intercourse regularly. Only one-half of sexually experienced single men aged 15–24 in 17 of the 45 countries covered in this report said they had had intercourse in the past three months; in Ethiopia and Niger, fewer than one in five said they had done so. In the United States, eight in 10 unmarried sexually experienced young men had had sex in the past three months.²⁶ By comparison, according to national surveys in 10 focus countries, 8–34% of unmarried sexually experienced men in their teens and early 20s had no sexual relationships in the past

Table 3a. Percentage distribution of unmarried sexually experienced men 15–24, by number of partners in the past year

REGION AND COUNTRY	0	1	2	≥3	TOTAL
SUB-SAHARAN AFRICA					
Burkina Faso	17	43	20	20	100
Ethiopia	32	50	10	8	100
Nigeria	18	42	16	24	100
Uganda	34	46	15	5	100
Zimbabwe	20	58	18	4	100
LATIN AMERICA & CARIBBEAN					
Brazil	12	31	23	34	100
Dominican Republic	13	28	24	35	100
Peru	18	38	21	23	100
INDUSTRIALIZED COUNTRIES					
Great Britain	8	58	18	16	100
United States*	8	41	15	36	100

*Based on men 20–24. SOURCE: REFERENCE 27.

year (Table 3a).²⁷ Possible reasons for this variation in sexual activity are that some single young men have short-term relationships that are separated

by periods without a girlfriend, and that some men live or work away from home and have intercourse only with their girlfriends when they return.

MIGRANT MEN

Migration and Mobility Can Increase Sexual Health Risks for Men

Population movements involving migrants, refugees, displaced persons and men employed in long-distance transportation or shipping help to drive the spread of HIV/AIDS and other sexually transmitted infections (STIs). Male migrants often spend extended periods without their wives and children, and usually with male peers. Separation from families, release from traditional constraints on sexual behavior and the anonymity of city life all serve to support a commercial sex industry and to foster casual sexual relationships, which help spread infection. Out of loneliness, boredom and need, men away from home are vulnerable to risky sexual relationships.¹

Men of all backgrounds who are away from home for long periods use the services of female sex workers and other women, who also may work and live far from their home communities. Furthermore, these men and women tend to change their place of work quite frequently. But as sex workers and their clients return home and resume sexual relationships with regular partners, they create the potential for a “double diffusion” of disease.²

Long-distance truck drivers are particularly vulnerable to contracting and transmitting STIs: Truck stops are magnets for commercial sex workers and for local residents seeking to earn money by having sex with men passing through.³ Lacking medical services and fearing deportation or prosecution

if they seek preventive care or treatment, many transient workers, illegal migrants, urban migrants and sex workers who have STIs are untreated.

In most countries, locations containing high concentrations of male transients are often associated with a thriving commercial sex industry. These hot spots include transit areas; workplaces employing large numbers of transient workers; rural trading centers;⁴ ports and harbors; mining, lumber, industrial, plantation and construction sites; sites along transport routes; truck stops; and border crossing points. Because of the sexual networks created, these hubs have STI prevalence rates that are well above national averages.

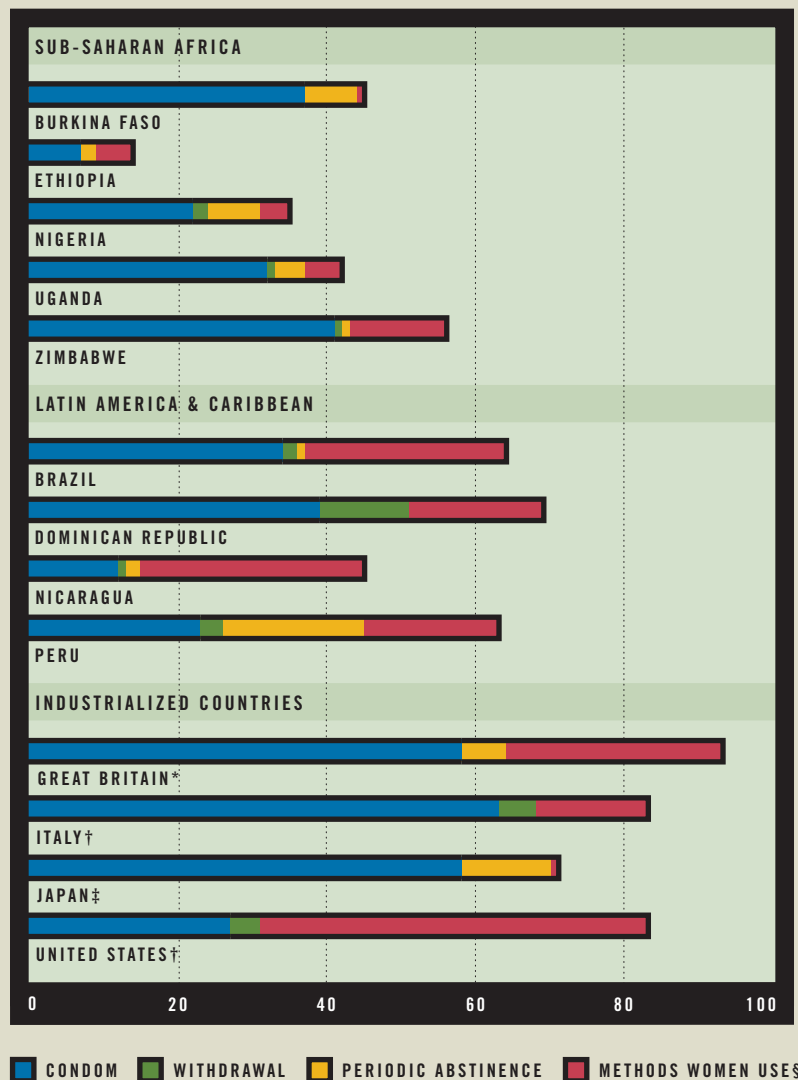
Some Young Men Have Many Sexual Partners

Some 28–58% of sexually experienced single men 15–24 report having had sex with only one partner in the past year; in Sub-Saharan Africa, the proportion ranges from 42% to 58% (Table 3a).²⁸ However, 2–3 in 10 men aged 15–24 in Ethiopia, Uganda, Zimbabwe and Great Britain and 4–6 in 10 in Burkina Faso, Nigeria, Brazil, the Dominican Republic, Peru and the United States had two or more partners in the past year.

Patterns of multiple or short-term sexual relationships—and periods without partners—reflect a number of situations common in youth. In many societies, it is considered acceptable and even admirable for young men to have many partners. Some young men may be able to develop the skills and may have the resources needed to establish or sustain a long-term relationship with a young woman. Others may lack such skills or resources. Some men, fearing the pressure to marry, shy away from anything but short-term relationships, while others have occasional “one-night stands,” or go to brothels when they have some money, have been egged on by their peers or have been drinking.

Contraceptive Prevalence Among Young Men Varies Widely

In Sub-Saharan African focus countries except Zimbabwe and in Nicaragua, fewer than 50% of sexually active men aged 15–24 report that they or their partners are using a method of pregnancy prevention (Chart 3.3).²⁹ In some countries of Latin America and the Caribbean—Brazil, the Dominican Republic and Peru—more than six in 10 men rely on a method (63–70%). Contraceptive prevalence is higher in the industrialized focus countries than in developing focus countries: More than seven in 10 sexually active men 15–24 in Great Britain, Italy, Japan



*Based on men 16–24. †Based on men 20–24. ‡Based on men 18–24. §Pill, injectable, implant, IUD, spermicide, diaphragm or female sterilization. NOTES: Sexually active men are those who had intercourse in the past three months (one month in Italy and the United States). In Great Britain and Japan, “periodic abstinence” includes use of withdrawal.

SOURCE: APPENDIX TABLE 2, COLUMNS 22–25.

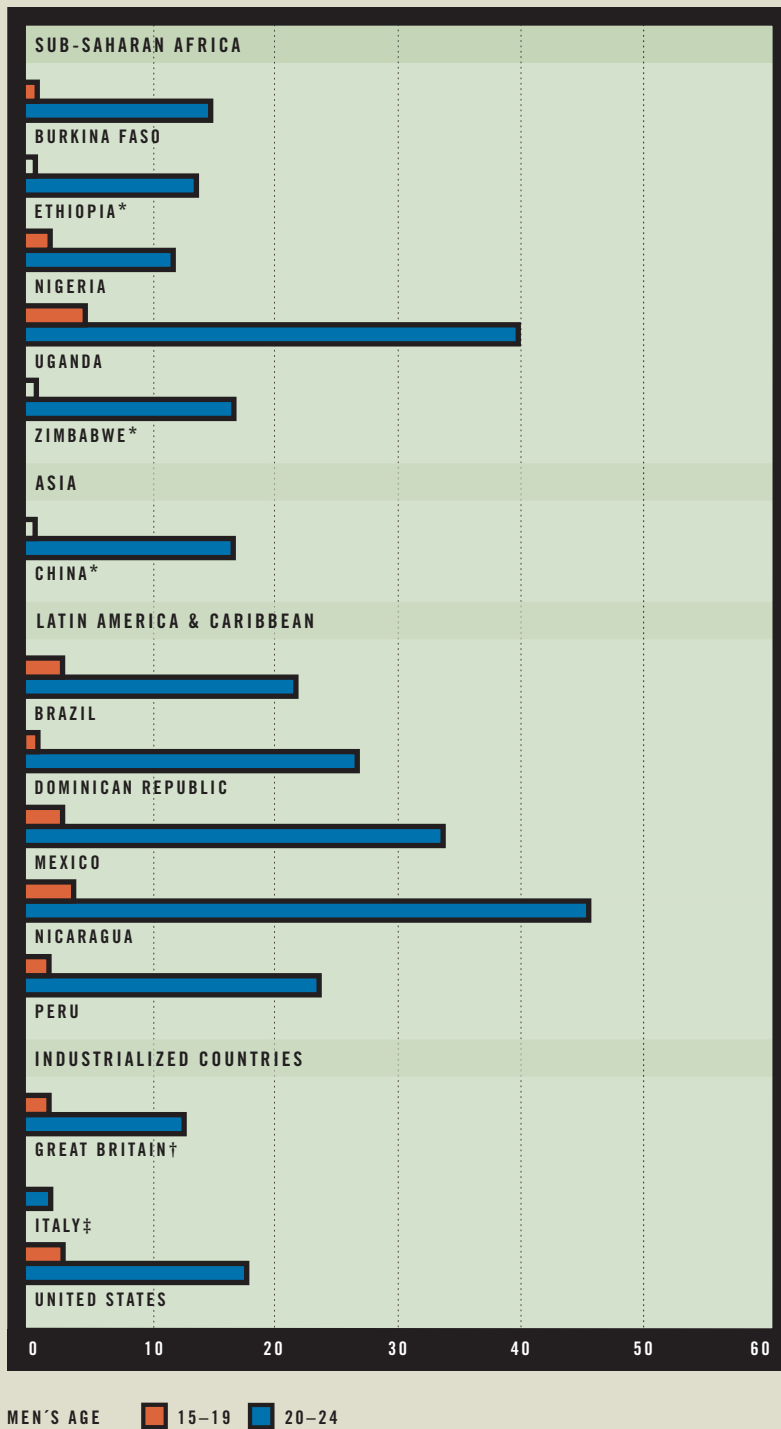
- Proportions of sexually active young men who use, or whose partners use, a contraceptive method are higher in industrialized countries and in Latin America and the Caribbean than in Sub-Saharan Africa.
- In most Sub-Saharan African and industrialized countries, the condom is the predominant method used by men 15–24.

and the United States report using a contraceptive or relying on the method used by their partners (71–93%).

Large proportions of men in the focus countries of Sub-Saharan Africa (44–87%) and in those of

Latin America and the Caribbean (30–75%) use no form of contraception,³⁰ although an unknown proportion of these men may be trying to father a child or may have a partner who is already pregnant.

Percentage of men 15–19 and 20–24 who have ever fathered a child



*Fewer than 0.5% of men 15–19 fathered a child. †Based on men 16–19 and 20–24. ‡Men 15–19 are those 20–24 who became fathers by age 20.

SOURCE: APPENDIX TABLE 2, COLUMNS 17 AND 18.

- Very small proportions of adolescent men have fathered a child; fatherhood becomes more common at age 20–24.
- An exceptionally high proportion of men 20–24 in Nicaragua and Uganda are fathers.
- Fatherhood among men in their early 20s is much more common in Great Britain and the United States than in Italy.

Condoms Are the Most Commonly Used Contraceptive

Sexually active men 15–24—most of whom are unmarried—report using condoms for pregnancy prevention much more frequently than they report any other male method (Chart 3.3).³¹ Male methods other than the condom include withdrawal (practiced very uncommonly in most countries) and vasectomy. The use of vasectomy is virtually nonexistent among young men, because most will want to become fathers one day.

In the developing focus countries, the more schooling young men 20–24 have had, the more likely they are to be using condoms for pregnancy protection (Table 3b).³² Less-educated sexually active young men may not be able to afford condoms and might want to have children. In contrast, young men with more years of schooling may be more likely to have the know-how and money to be able to obtain condoms, as well as the desire to postpone fathering children until they are more established. Young men with more schooling are also more likely to be living in towns and cities, where condoms are more easily available.

Most Young Men Are Not Yet Married

Small proportions of teenage men in all regions of the world have married or lived in a cohabiting or consensual union with a woman.³³ In many developing countries, one-fifth to one-third of men aged 20–24 have been married.³⁴ In contrast, about 2–5 in 10 adolescent women have been married—mainly to men aged 20 or older. In many countries, the proportion of women in their early 20s who have ever married is two or three times that of men (Table 3c).³⁵

A large proportion of unmarried young men continue to live with their family of origin into their 20s. For

example, in the focus countries, about one-half to four-fifths of men 20–24 are still living with their parents.³⁶ This does not necessarily indicate that these young men are economically dependent on their parents. Rather, it may reflect the social reality that even financially independent young men tend to remain with their family of origin until they marry.

Few Young Men Have Become Fathers

Fatherhood is rare among men 15–19 and is uncommon even among men 20–24 (Chart 3.4, page 24).³⁷ In all focus countries except Uganda, Mexico and Nicaragua, 2–27% of men aged 20–24 have become fathers. It is possible that reported levels of fatherhood among young men are low because some men do not know that they have fathered a child, do not choose to report the fact (perhaps because they

Table 3b. Percentage of sexually active men 20–24 currently using condoms for pregnancy prevention, by education

REGION AND COUNTRY	<SECONDARY	≥SECONDARY
SUB-SAHARAN AFRICA		
Burkina Faso	28	79
Ethiopia	3	42
Nigeria	13	29
Uganda	20	53
Zimbabwe	25	47
LATIN AMERICA & CARIBBEAN		
Brazil	18	31
Dominican Republic	19	51
Nicaragua	7	11
Peru	4	25
INDUSTRIALIZED COUNTRIES		
Great Britain	42	59
Italy	68	61
United States*	27	27

*Men who have and have not completed high school. NOTE: Sexually active men are those who had intercourse in the past three months (one month in Italy and the United States).

SOURCE: REFERENCE 32.

do not live with the child's mother) or do not want to acknowledge paternity.³⁸ Moreover, the proportion of young men who have made a partner pregnant but do not actually become a father could be substantial in some parts of the world. In a few (mostly industrialized) countries with reliable abortion statistics, about one-quarter to one-half of teenage women who become pregnant (some of whom are the partners of men aged 15–24) end their pregnancies by obtaining an induced abortion.³⁹

Studies from industrialized countries show that men who become fathers while they are adolescents are more likely than men who become fathers at an older age to come from poor backgrounds or from broken families. They are also likely to have low life expectations or to have performed poorly in school.⁴⁰ In Great Britain, almost one-half of men whose first child was born when they were teenagers had not completed high school, compared with one-third of men whose first child was born when they were 25–29.⁴¹

Rapid Social Changes Affect Young Men's Behavior and Needs

Qualitative studies from many parts of the world suggest that most young men who lack exposure to clear and unbiased information about sexuality and protective sexual behavior are ill prepared to navigate their sexual lives without risk.⁴² More than ever before, young men are facing rapid social changes that affect their sexual behavior, such as urbanization (see chapter 2), a decline in traditional and multi-generational families, and increasing pressure on young men to demonstrate their sexual prowess.⁴³ Additional influential factors are modernization and the increasing importance of the mass media. In Asia, modernization and exposure to the mass media are

Table 3c. Percentage of men and women 15–19 and 20–24 who have ever married

REGION AND COUNTRY	15–19		20–24	
	MEN	WOMEN	MEN	WOMEN
SUB-SAHARAN AFRICA				
Burkina Faso	1	35	22	90
Ethiopia	3	30	24	73
Nigeria	3	28	17	64
Uganda	7	32	45	85
Zimbabwe	1	23	24	72
ASIA				
Bangladesh	5	51	32	90
China	1	1	28	47
India	10	36	41	83
Nepal	20	42	61	86
Philippines	2	9	22	44
MIDDLE EAST & NORTH AFRICA				
Egypt	2	16	12	56
Morocco	1	11	11	40
Turkey	4	15	28	62
LATIN AMERICA & CARIBBEAN				
Brazil	4	17	29	53
Dom. Republic	5	27	43	63
Mexico	5	16	38	55
Nicaragua	10	34	56	75
Peru	3	13	31	52
INDUSTRIALIZED COUNTRIES				
Great Britain	1*	2	16	25
Italy	1†	1	5	13
Sweden	0	0	2	7
Japan	0	1	7	14
United States	2	4	30	45

*Based on men 16–19. †Men 20–24 who had married by age 20. NOTE: Marriage includes cohabitation and consensual union.

SOURCE: REFERENCE 35.

believed to be correlated with earlier sexual onset;⁴⁴ in many parts of the world, they are seen to be challenging traditional values regarding sexuality.⁴⁵ Together, these rapid social changes make the provision of information to help men lead healthy sexual and reproductive lives a matter of urgency.



Chapter 4

Men 25–39: Marrying and Becoming Fathers

- *Marriage, including cohabitation and consensual union, is common among men in their late 20s and almost universal among those in their 30s; however, the more educated men are, the longer they defer marriage.*
- *Most men 25–39 had one sexual partner, who may be their spouse, in the past year; 15–65% of unmarried men had more than one partner and 7–36% of married men had one or more extra-marital partners.*
- *Contraceptive prevalence among men in their late 20s and 30s is lower in Sub-Saharan Africa than in other regions, reflecting these men's continued desire for children.*
- *The more educated men are, the more likely they are to have discussed family planning with their partner.*
- *In both developing and developed countries, half of men become fathers by their mid-to-late 20s.*

The late 20s and 30s are when many men begin to settle down. Most men at these ages have jobs, and many have married. Work and marriage are often related: Most societies believe that it is not good for a man to marry until he has a job and can support a wife and family, and the responsibilities of marriage and family make work an imperative for most men.

This report uses the term “marriage” to describe a man’s entry into any type of marriage or union—legal marriage (monogynous or polygynous), consensual union, cohabitation or visiting union. However, men and the societies in which they live may view various types of union differently in terms of the strength of the emotional bond between partners and between couples and their children, the permanence of the union, the degree of exclusive loyalty and the sense of responsibility to a partner and any children she may have. The type of marriage also affects whether men actually live with their wives, men’s role in raising their children, their economic responsibility for their families and the amount of time they spend with their families.

In many countries of northern and western Europe, cohabitation is becoming almost as common as legal marriage, especially among younger couples. These societies generally view cohabiting relationships and the offspring of such unions with the same levels of approval and recognition as those accorded formally married couples and their children. In the United States and many countries of southern and eastern Europe, cohabiting unions are also becoming more common,¹ although there is less agreement about the social desirability of this type of union.

In some countries in Latin America and the Caribbean, consensual unions are very common. In Peru, for example, 44% of married men 25–39 are in

a consensual union; in Nicaragua and the Dominican Republic, the proportions are 51% and 62%, respectively.² In Asia and in the Middle East and North Africa, formal marriages are the most common form of union.

In Sub-Saharan Africa, most couples are married in a traditional marriage ceremony or in a combination of traditional and either civil or religious marriage ceremonies. In many countries in the region, polygynous marriages are common. However, there is evidence that the practice is starting to decline in some countries.³

Most Men 25–39 Have Married

By the time men are 25–29, they have typically entered marriage, although the proportions who have done so vary widely—from 26–39% in Morocco, Italy and Japan to 80–87% in Uganda, China, Nepal, Nicaragua and Sweden (Chart 4.1, page 28).⁴ When men are

Table 4a. Percentage of men 25–29 who were first married by age 25, by education

REGION AND COUNTRY	<SECONDARY	≥SECONDARY
SUB-SAHARAN AFRICA		
Burkina Faso	54	23
Ethiopia	66	44
Nigeria	69	28
Uganda	85	64
Zimbabwe	55	57
MIDDLE EAST & NORTH AFRICA		
Morocco	44	14
LATIN AMERICA & CARIBBEAN		
Brazil	61	47
Dominican Republic	65	37
Nicaragua	81	71
Peru	62	47
INDUSTRIALIZED COUNTRIES		
Italy*	11	15
Sweden*	86	65

*Men with less than and at least high school education.

SOURCE: REFERENCE 7.

Table 4b. Average age gap between men and the women they marry

REGION AND COUNTRY	AGE GAP (YRS.)
SUB-SAHARAN AFRICA	
Burkina Faso	8.6
Ethiopia	5.1
Nigeria	6.9
Uganda	4.3
Zimbabwe	4.6
ASIA	
Bangladesh	6.8
China	1.7
India	4.7
Nepal	3.3
MIDDLE EAST & NORTH AFRICA	
Egypt	5.7
Turkey	3.0
LATIN AMERICA & CARIBBEAN	
Brazil	3.0
Dominican Republic	3.5
Mexico	2.2
Peru	2.5
INDUSTRIALIZED COUNTRIES	
Great Britain	2.8
Italy	3.2
Sweden	2.2
United States	2.7

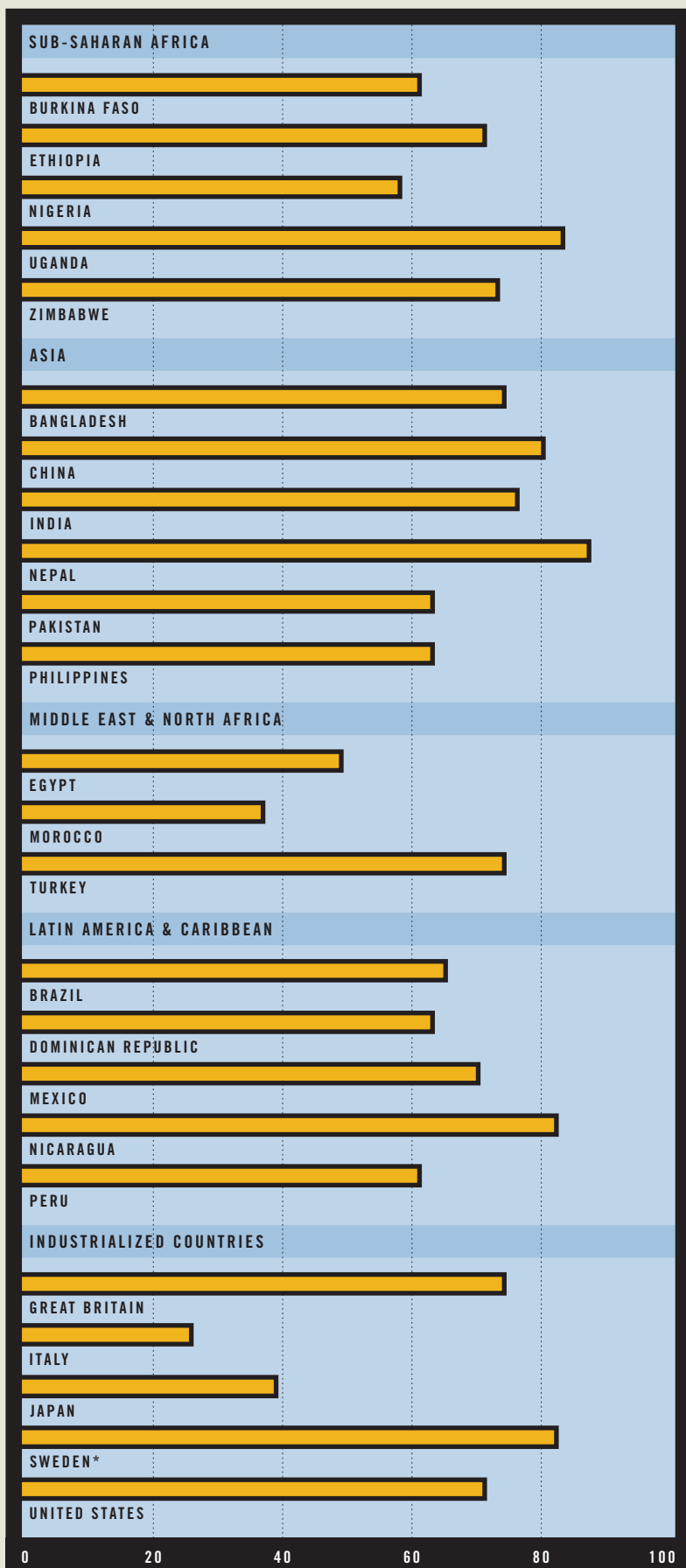
SOURCE: REFERENCE 8.

in their 30s, marriage of some form is almost universal—8–9 in 10 men aged 30–39 in nearly all focus countries have married. Nevertheless, one in four men of this age in Morocco, Italy and Japan remains single.⁵

In a few countries in Sub-Saharan Africa—for example, Kenya—men are marrying somewhat later than they used to: In this region, the median age at marriage is 26.2 among men now in their late 20s, compared with 24.2 among men now in their early 40s. This trend is not apparent in focus countries in Latin America and the Caribbean, and in industrialized focus countries.⁶

In developing countries, men with more education tend to delay marriage.

CHART 4.1
Percentage of men 25–29 who have ever married



The association between increased schooling and later marriage is more pronounced in four of the five focus countries of Sub-Saharan Africa, in Morocco and in the Dominican Republic than in other focus countries (Table 4a, page 27).⁷

Men Usually Marry Younger Women

In all focus countries of Sub-Saharan Africa, in some of Asia and in Egypt, the average age difference between men and the women they marry is 4–9 years. By comparison, the age difference is 2–3 years in most other focus countries (Table 4b, page 27).⁸

In conservative cultures, men prefer to marry young women because husbands are expected to have more experience than their wives and to be able to exert authority over them. In addition, in countries that have a strong preference for men to marry virgins, men would rather have a young bride because of her increased likelihood of having had no previous sexual partners. There are also understandable reasons why young women (and their parents) might consider older men more desirable as husbands. Older men are more likely than younger men to have established themselves and to have a job, and their earnings are usually higher.

A wide age gap between a man and his wife can skew the balance of power and can foster unequal gender relations in a marriage, including

- Most men in their late 20s have married.
- Proportions of men 25–29 who have married are much lower in Egypt, Morocco, Italy and Japan than in other countries.

*Based on men 27–29. NOTE: Ever-married men include those who have ever cohabited or been in a consensual union.

SOURCE: APPENDIX TABLE 3, COLUMN 2.

Table 4c. Percentage distribution of sexually experienced unmarried men 25–39, by number of partners in the past year

REGION AND COUNTRY	0	1	2	≥3	TOTAL
SUB-SAHARAN AFRICA					
Burkina Faso	20	39	17	24	100
Ethiopia	30	55	6	9	100
Nigeria	17	37	21	25	100
Uganda	43	35	18	4	100
Zimbabwe	18	58	17	7	100
LATIN AMERICA & CARIBBEAN					
Brazil	8	36	22	34	100
Dominican Republic	9	26	25	40	100
Peru	19	31	16	34	100
INDUSTRIALIZED COUNTRIES					
Great Britain	15	59	15	11	100
United States*	21	39	14	26	100

*Based on men 20–39.

SOURCE: REFERENCE 12.

decision-making about contraception,⁹ condom use¹⁰ and the number of children to have.¹¹

Most Sexually Active Men Had Only One Partner in the Past Year

In all focus countries except those in Latin America and the Caribbean, more than one-half of sexually experienced single men aged 25–39 report having had no partner or having had intercourse with only one woman in the past year; 15–46% report having had two or more partners (Table 4c).¹² In the three focus countries of Latin America and the Caribbean, 50–65% of sexually experienced single men aged 25–39 have had two or more partners in the past year.

By comparison, the majority of married men in the focus countries say they did not have any extramarital partners in the past 12 months (85% or more in almost all countries).¹³ However, 7–36% have had extramarital sexual partners¹⁴—a range somewhat lower than that of unmarried men reporting two or more partners.

In seven focus countries, 7–15% of married men had one or more extramarital partners in the past 12 months. In Nigeria and the Dominican Republic, the proportion was 24–36%. (Table 4d).¹⁵

Multiple partnerships among single men and extramarital relationships among married men partly reflect the widespread double standard regarding expectations of sexual fidelity for men and for women. Other factors also play a role. For example, in some poor countries, men might spend long periods of the year working away from home (see box on page 22)—a separation that can foster infidelity. In some regions, the practice of lengthy postpartum abstinence leads some fathers to look for another sexual partner during that period.¹⁶ Postpartum abstinence is practiced for up to 15 months in some Sub-Saharan African countries, and its duration is particularly long in West Africa. In other regions, the period of postpartum abstinence is much shorter—about 2–6 months typically.¹⁷

Patterns of Contraceptive Use Vary Widely

Even though having children is a central part of the lives of many men aged 25–39, many married couples want to plan the timing of births, and most men who are sexually active and single do not yet want to become fathers. For these reasons, many men in this age-group are using some method of family planning or are relying on their partners' use of a method. Because a condom used to prevent pregnancy also prevents disease transmission, couples who depend on this method are also protecting themselves against sexually transmitted infections, particularly HIV.

Levels of contraceptive use and the type of method used by sexually active men 25–39 vary widely from one part of the world to another (Chart 4.2, page 30).¹⁸ Some of the variation in levels of contraceptive use is understandable in light of the widely differing number of children that men in various parts of the world say they want. Overall, men

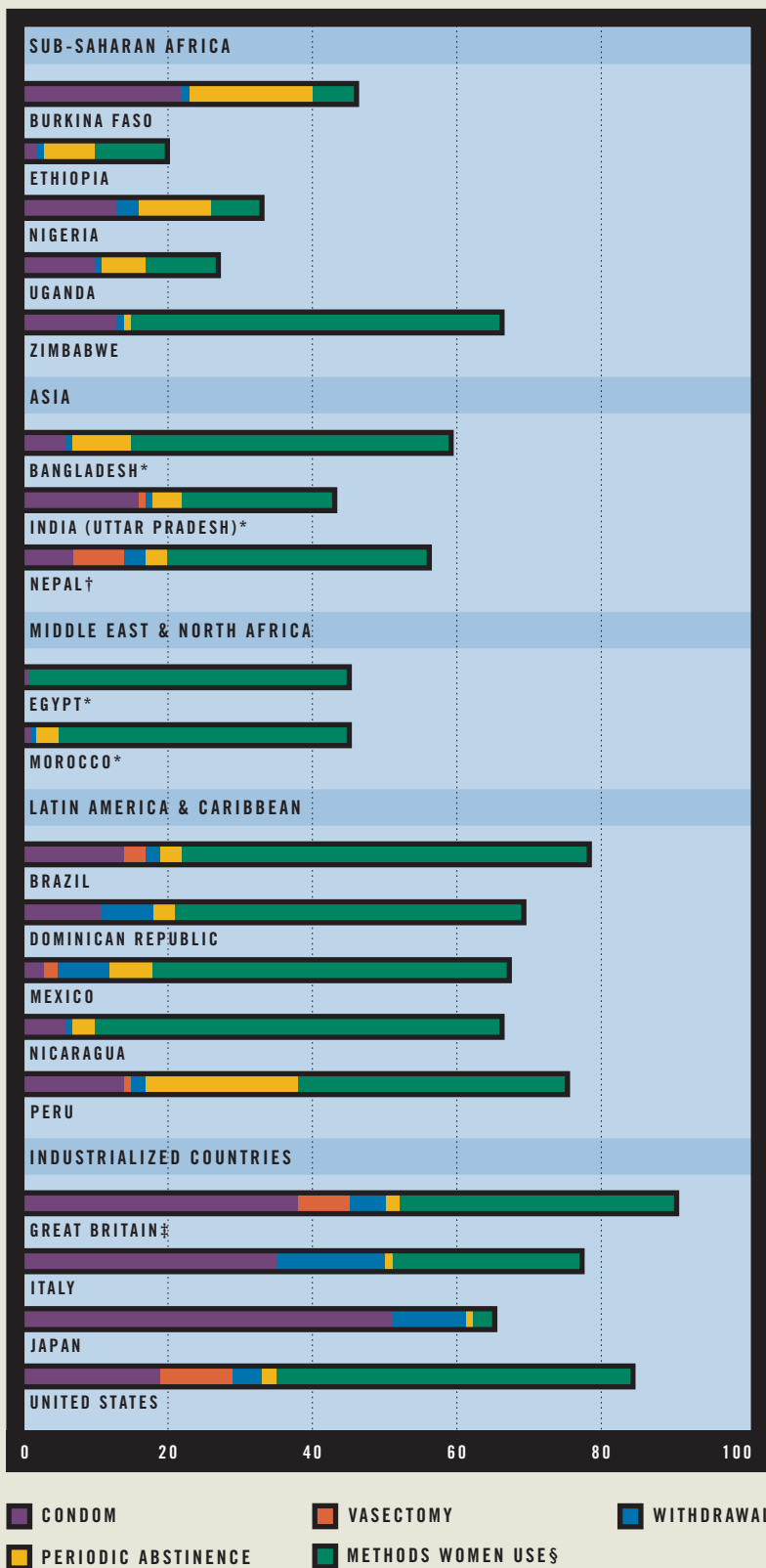
Table 4d. Percentage distribution of married men 25–39, by number of extramarital partners in the past year

REGION AND COUNTRY	0	1	≥2	TOTAL
SUB-SAHARAN AFRICA				
Burkina Faso	90	6	4	100
Ethiopia	93	5	2	100
Nigeria	76	12	12	100
Uganda	86	11	3	100
Zimbabwe	85	14	1	100
LATIN AMERICA & CARIBBEAN				
Brazil	88	6	6	100
Dominican Republic	64	18	18	100
Peru	85	8	7	100
INDUSTRIALIZED COUNTRIES				
United States*	91	5	4	100

*Based on men 20–39.

SOURCE: REFERENCE 15.

CHART 4.2
Contraceptive prevalence among sexually active men 25–39



*Based on married men 25–39. †Based on ever-married men. ‡Based on all men, regardless of sexual activity. §Pill, injectable, implant, IUD, spermicide, diaphragm or female sterilization. NOTE: Sexually active men are those who had intercourse in the past three months (one month in Italy and the United States).

SOURCE: APPENDIX TABLE 3, COLUMNS 15–19.

in Sub-Saharan Africa typically want 5–8 children, those in Latin America want between two and three¹⁹ and those in industrialized countries want no more than two.²⁰ Accordingly, one would expect lower levels of contraceptive use in Sub-Saharan Africa, and higher levels in Latin America and in industrialized countries.

This is indeed what one finds. Among sexually active men 25–39, contraceptive use to prevent pregnancy is relatively low in most of the Sub-Saharan African focus countries, and is moderate to high in most of the countries in Latin America and in the industrialized countries.²¹ (Zimbabwe's atypically high level of contraceptive use is partly because men in this country want smaller families than do men in many other countries in Sub-Saharan Africa.²²)

In the focus countries of Sub-Saharan Africa (except Zimbabwe), condom use and periodic abstinence together account for most contraceptive use among men 25–39 and their partners (Chart 4.2).²³ However, in Latin America and the Caribbean, the use of female methods (the pill and other hormonal methods, the IUD, spermicides, the diaphragm and female sterilization) greatly exceeds that of male methods (condoms, withdrawal and vasectomy). In all the industrialized focus countries except the United States, male methods predominate among men 25–39.

- Levels of contraceptive use among sexually active men 25–39 and their partners are higher in industrialized countries and in Latin America and the Caribbean than in other regions.
- Men 25–39 in Asia, the Middle East and North Africa, and Latin America and the Caribbean rely on methods used by women more commonly than do men elsewhere.

Percentage of married men 25–39 who reportedly have discussed family planning with their partner

Considerable proportions of men 25–39 and their partners do not practice contraception at all (20–79% in the focus countries).²⁴ Men’s late 20s and 30s are when they are most likely to be involved in family building. Some men 25–39 with no contraceptive protection, therefore, have partners who are already pregnant, are trying to become pregnant, or recently gave birth and are temporarily infecund.

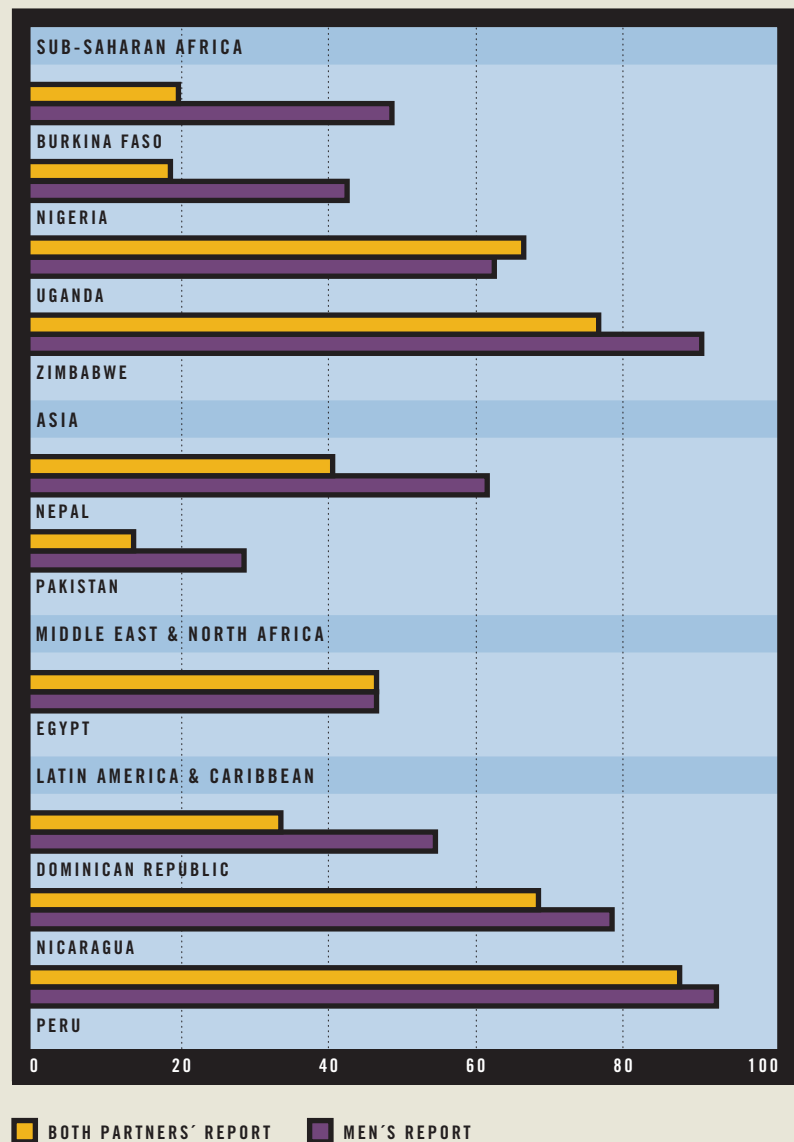
Men are generally believed to assume less responsibility for family planning than are women. This perceived difference is sometimes used as an argument for not involving men in family planning promotion.

However, the findings from studies on men aged 25–39 do not support this claim: If periodic abstinence is viewed as a method equally shared by both sexes, only in Zimbabwe, the focus countries of Latin America and the Caribbean (but not in Peru) and the United States are female partners of men 25–39 responsible for the greater share of total contraceptive use (Chart 4.2).²⁵

In some regions of the world—especially those where men want larger families than do women²⁶—and in cultures in which men are suspicious that women’s access to contraceptive methods will allow their wives to be secretly unfaithful, there is still some resistance to family planning.²⁷ But men’s attitudes are quickly changing, especially where gender roles are changing and where the desire for smaller families is economically based²⁸ or poverty-driven.²⁹

Partner Discussion About Family Planning Is by No Means the Rule

Some, but not all, men aged 25–39 discuss contraception with their partners (Chart 4.3).³⁰ The proportion of couples in which both partners report that they have discussed family planning is low in Burkina Faso, Nigeria

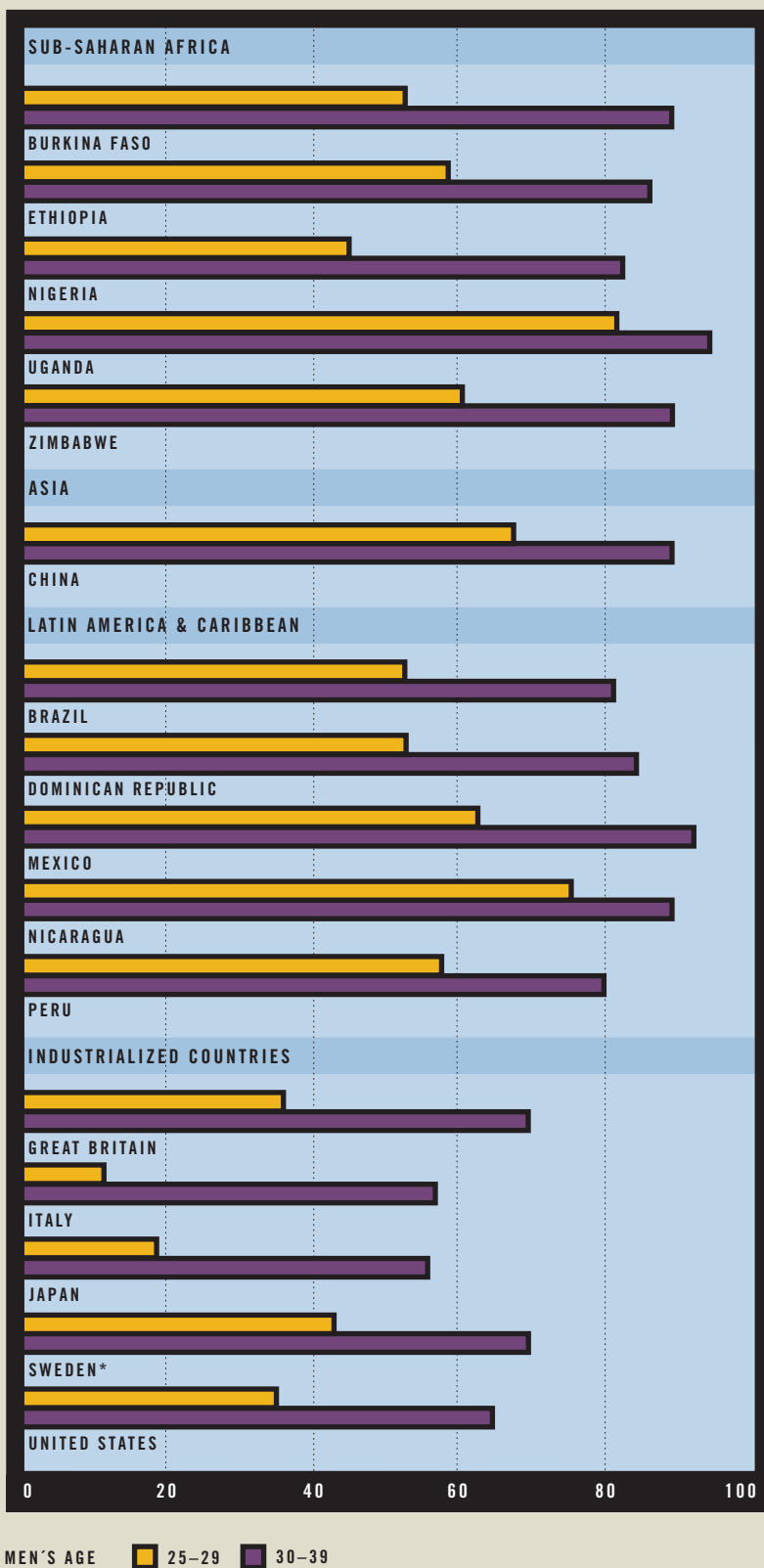


NOTE: Married men include those cohabiting or in a consensual union.

SOURCE: APPENDIX TABLE 3, COLUMNS 24 AND 25.

- In general, a higher proportion of men than of couples claim they have discussed family planning.
- Among all countries, discussion is most common in Peru, where periodic abstinence (which requires couples to talk about the woman’s menstrual cycle) is a popular family planning method.
- In Sub-Saharan Africa, discussion is most common in Zimbabwe, where men rely more on female contraceptive methods than they rely on others.

Percentage of men 25–29 and 30–39 who have ever fathered a child



MEN'S AGE ■ 25–29 ■ 30–39

*Based on men 27–29 and 33–34.

SOURCE: APPENDIX TABLE 3, COLUMNS 12 AND 13.

- Fatherhood among men 25–39 is more common in developing countries than in industrialized countries.
- In developing countries, 80–95% of men in their 30s are fathers.

and Pakistan—parts of the world where contraceptive use is also low. Reports of such a discussion are moderately common in Nepal, Egypt and the Dominican Republic, and more frequent still in Uganda, Zimbabwe, Nicaragua and Peru.³¹

However, in most focus countries, a somewhat higher proportion of men than of couples (by 5–29 percentage points) consider that they have talked to their partners about family planning.³² This discrepancy suggests that women and men have rather different ideas about what constitutes a conversation on this topic. This difference appears not to exist in Egypt; it is narrowest in Peru, where use of periodic abstinence is common and couples have to talk about when the woman is having her period, and they have to do so every month.

The more schooling couples have, the more likely they are to talk about family planning (Table 4e).³³ Men and women who are educated beyond primary school level are more likely to have the confidence to discuss family size and family planning on an equal basis with their partners, and more likely to want smaller families, than are individuals who are illiterate or who have only a few years of schooling.

But the assumption that couples will talk to each other about family planning is not universal. A study in a rural area of Kenya, for example, found that it is generally difficult for couples there to broach the subject. Women do not want to talk about family planning with their husbands unless the couple has achieved its desired family size and desired numbers of sons and daughters. Until then, women tend to worry that such a discussion might reflect badly on their social status, marital security, well-being and relationship with their husband.

Additionally, men are concerned

Table 4e. Among married couples in which the man is 25–39, % with both partners reporting having discussed family planning, by couple's education

REGION AND COUNTRY	<SECONDARY*	≥SECONDARY†
SUB-SAHARAN AFRICA		
Burkina Faso	18	85
Nigeria	11	41
Uganda	65	90
Zimbabwe	68	84
ASIA		
Nepal	38	61
Pakistan	11	38
LATIN AMERICA & CARIBBEAN		
Dominican Republic	26	55
Nicaragua	65	77
Peru	79	94

*Either partner has received less than secondary education. †Both partners have received at least secondary education.

SOURCE: REFERENCE 33.

that they could be suspected of wanting to marry another wife or having an extramarital relationship. Discussions about family planning in this rural part of Kenya are more likely when both spouses are well educated, have achieved their desired family size and have access to family planning services and information.³⁴

As might be expected, in some Sub-Saharan African countries where discussion about family planning is relatively rare, the proportion of couples in which both partners correctly identify each other's attitude toward this topic is low. One or both partners often do not know whether the other partner approves of family planning or are wrong in their assessment.³⁵ In some Sub-Saharan African focus countries, there also tends to be wide disagreement within the couple about the number of children they want. For

example, in Burkina Faso, Ethiopia and Nigeria, 53–56% of couples disagree over their ideal family size by two or more children. Such disagreement is lower but still moderately common in Latin America and the Caribbean, less frequent in some Asian countries and much rarer in the industrialized countries.³⁶

Fatherhood Is Common in Men's Late 20s and 30s

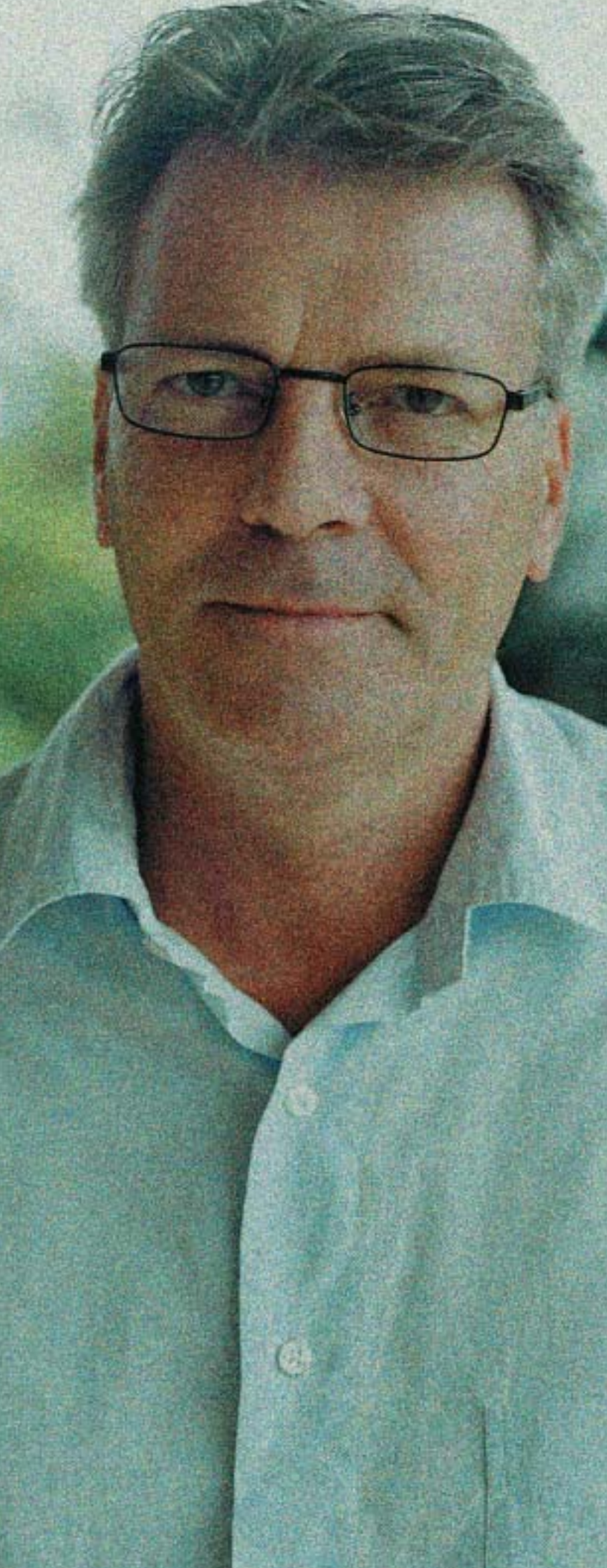
In most of the developing focus countries, half or more of men aged 25–29 and the vast majority of those aged 30–39 have fathered a child (Chart 4.4, page 32).³⁷ By comparison, the transition to fatherhood in industrialized countries is not as rapid: It is slowest in Italy (where 11% of men 25–29 have fathered a child), followed by Japan (19%), the United States (35%) and Great Britain (36%), and fastest in Sweden (43%). A study in Italy concludes that late marriage and men's delay in achieving economic independence are the two main factors responsible for the later age at which they become fathers.³⁸

In most developing countries, the age at which half of men 25–39 have had their first child is 24–27. In contrast, in the industrialized countries, the median age ranges from 24 to 30.³⁹ In developing regions, men in their late 20s have had an average of one child, and those in their early 30s have had 2–3 children. In industrialized countries, men in their 30s have had an average of one child.⁴⁰

A small proportion of never-married men aged 25–39 in Sub-Saharan Africa have fathered a child (3–8% in the focus countries except Uganda). The situation is similar in Latin America and the Caribbean (about 6–8%) and in the industrialized nations (4% in Great Britain, Sweden and the United States).⁴¹

In most countries in Sub-Saharan Africa, men aged 25–39 in rural areas want larger families than their urban counterparts, sometimes by as many as 2–3 children.⁴² Accordingly, rural men in this age-group have had at least one more child, on average, than men living in towns and cities.⁴³ In rural areas, children's labor in the fields and the home contributes to the family's well-being, whereas in urban areas, the need to educate children so that they can become economically productive means that children use scarce family resources in the first two decades of their lives, rather than working and contributing to the family income.

A sizable minority of fathers do not live with their children—1–3 in 10 men aged 25–39 and 1–2 in 10 men aged 30–39. In all countries, this situation is more common among men living in urban areas than among those living in rural areas,⁴⁴ as men move from their rural homes to look for work. Other reasons that men do not live with their children include marital breakup, the custom of sending some rural children to school in urban areas and child fostering—a common arrangement in parts of West Africa. The main reasons that some men in the United States do not live with their children are that the children were born outside of marriage, and that the parents are divorced or separated and the mother has custody. One in 10 men in their 30s in the United States has had at least one child with whom he is not living.⁴⁵



Chapter 5

Men 40–54: Approaching the End of Fathering

- *Almost all men 40–54 have married—some more than once.*
- *Some 4–23% of married men 40–54 have had one or more extramarital partners in a recent 12-month period.*
- *Men 50–54 in Sub-Saharan Africa want and have many more children than do those in other developing regions.*
- *In most developing countries, the majority of men in their early 50s have had more children than they want.*
- *In countries with moderate or high levels of contraceptive use among men 40–54, methods used by women (especially female sterilization) predominate in developing countries, whereas male and female methods are equally relied on in industrialized countries.*
- *Vasectomy is extremely rare in all but a few industrialized countries and in China.*

Most men in their 40s and early 50s are probably as established in their work lives as they will ever be.

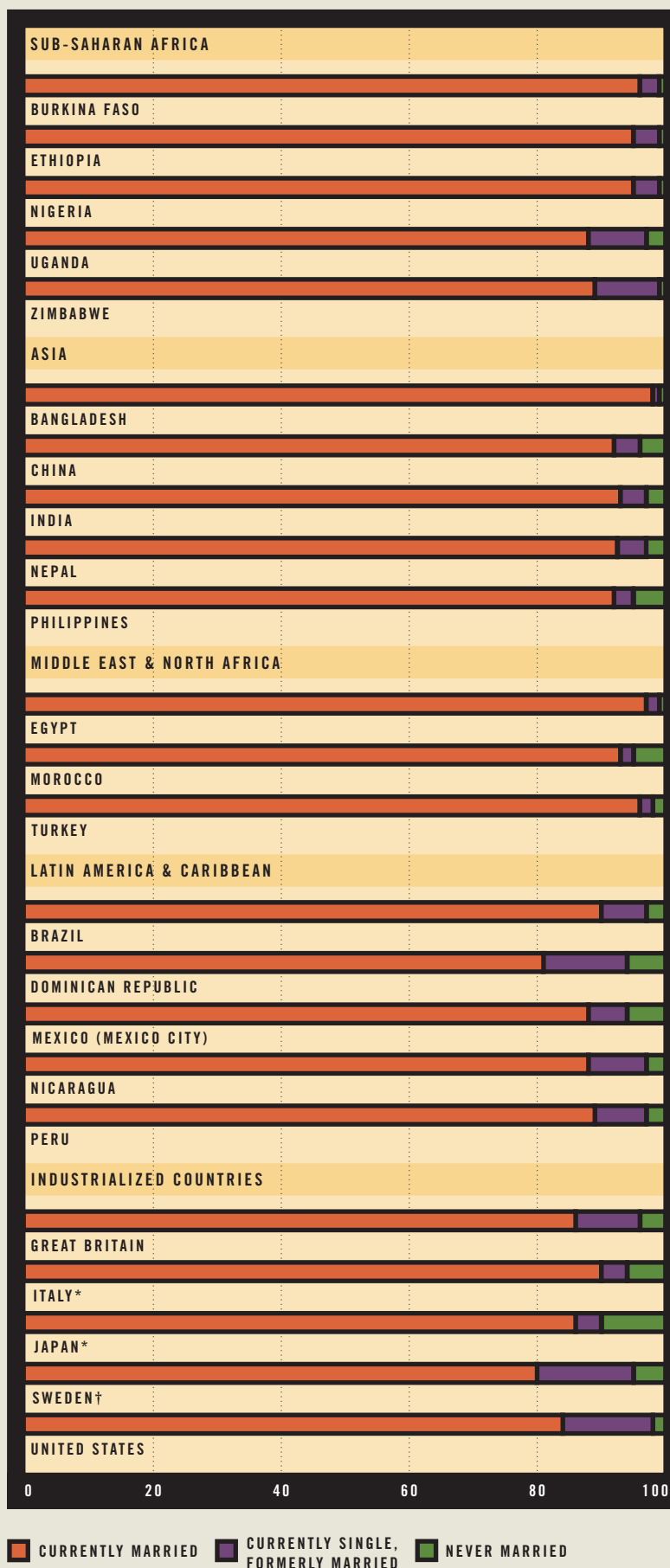
However, many men this age have experienced the breakup of marriage. Especially in developing countries with a low male life expectancy, the 50s will represent some men’s final years.

Most 40–54-year-old men continue to have active sexual lives. Their role as fathers covers many different situations: Some still have young children; some are fathers of teenagers and others may have children who are about to leave or have already left home. In addition, some men are living with or supporting children from earlier marriages, and some are entering new marital relationships.

Almost All Men 40–54 Have Married

The vast majority of men in their 40s and early 50s are married (Chart 5.1);¹ some of these men have married more than once. Only 1–6% of men aged 40–54 in developing countries and 2–10% in industrialized countries have never married.² Most of the men who are currently unmarried (2–13% in the focus countries) were married at one time. A substantial proportion of men 40–54 in Sub-Saharan Africa are in polygynous unions—that is, they have two or more wives. This proportion tends to be lower in eastern and southern Africa (10–20%) than in western Africa (25–40%—Table 5a, page 36).³

- Almost all men in their 40s and early 50s are married; some may be in a second or third marriage.
- Proportions of men 40–54 who have never married or were previously married and are now single are higher in Latin America and the Caribbean and in industrialized countries than in other regions.



Legend: ■ CURRENTLY MARRIED ■ CURRENTLY SINGLE, FORMERLY MARRIED ■ NEVER MARRIED

SOURCE: APPENDIX TABLE 4, COLUMNS 2 AND 3.

*Based on men 40–49. †Based on men 43–44. NOTE: Married men include those cohabiting or in a consensual union.

Some Men Have Extramarital Relationships

The proportion of married men in their 40s and early 50s who have had intercourse with a woman outside marriage in the past year varies widely around the world (Table 5b),⁴ from 4% in Burkina Faso to 14–15% in Zimbabwe and Peru, and 20–23% in the Dominican Republic and Nigeria.⁵ The extramarital partners might be steady partners, sex workers or “one-night stands.”

A sense of sexual entitlement probably encourages some men to display their virility or wealth by having extramarital relationships. For example, in Japan, married older men and young women sometimes engage in *enjo kosai*, or “compensational” dating, during which sex is exchanged for money or clothes;⁶ in some parts of Sub-Saharan Africa, married older men known as “sugar daddies” give gifts or money to the much younger women

Table 5a. Percentage of married men 40–54 in polygynous unions, Sub-Saharan Africa

COUNTRY	%
Benin Republic	40
Burkina Faso	44
Cameroon	27
Central African Republic	15
Chad Republic	34
Côte d'Ivoire	25
Ethiopia	16
Gabon	14
Ghana	19
Guinea	45
Kenya	16
Malawi	15
Mali	37
Mozambique	18
Niger	32
Nigeria	28
Senegal	37
Tanzania	13
Togo	34
Uganda	24
Zambia	16
Zimbabwe	11

SOURCE: REFERENCE 3.

Table 5b. Percentage distribution of married men 40–54, by number of extramarital partners in the past year

REGION AND COUNTRY	0	1	≥2	TOTAL
SUB-SAHARAN AFRICA				
Burkina Faso	96	2	2	100
Ethiopia	91	8	1	100
Nigeria	77	14	9	100
Uganda	93	6	1	100
Zimbabwe	85	12	3	100
LATIN AMERICA & CARIBBEAN				
Brazil	89	6	5	100
Dominican Republic	80	11	9	100
Peru	86	7	7	100
INDUSTRIALIZED COUNTRIES				
United States*	93	5	2	100

*Based on men 40–49.
SOURCE: REFERENCE 4.

with whom they are having sex.⁷

Some married men who leave home to look for work may become involved in sexual relationships with other women, while continuing to support the families they left behind (see box on page 22). In addition, in countries where postpartum abstinence is commonly practiced, men whose wives have recently given birth sometimes engage in sexual relationships with other women during the postpartum period.⁸

Most Men 40–54 Are Fathers, and Many Have Large Families

By their 40s and early 50s, almost all men are fathers. The proportion of men this age who have not had a child is only 1–8% in all of the developing focus countries except the Dominican Republic (where the proportion is 12%) and 11–18% in the industrialized focus countries.⁹ Some men who are not fathers are probably childless by intention; others may be infertile or married to women who are infertile.

Men remain capable of fathering children longer than women are able to

bear children. Hence, men may continue fathering children in their 40s and early 50s, as well as at older ages. Indeed, men this age tend to have partners younger than themselves: Roughly four-fifths of those in Sub-Saharan Africa, and more than one-half in Latin America, have wives who are at least five years their junior.¹⁰

Men aged 50–54 in the Sub-Saharan African focus countries have had 8–10 children, on average. In contrast, those in the focus countries in Asia (excluding China), the Middle East and North Africa, and Latin America and the Caribbean have had 4–6 children. In the industrialized focus countries and in China, men have had an average of two children by their early 50s.¹¹

In most of the developing focus countries, men in their early 50s have had more children than they want. In Uganda, Bangladesh, Egypt, Morocco,

A sense of sexual entitlement probably encourages some men to display their virility or wealth by having extramarital relationships.

Turkey, Mexico, Nicaragua and Peru, they have had about two more than they wanted, and in Zimbabwe, Nepal and Brazil, one more. However, in Ethiopia, Nigeria and the Dominican Republic, men report wanting more children than they actually have (Chart 5.2).¹²

In general, educational attainment is negatively associated with the number of children fathered. In the focus countries in Sub-Saharan Africa, men aged 40–54 with fewer than seven years of schooling have had 6–9 children, whereas those with at least seven years

of schooling have had 4–8.¹³ Similarly, in Latin America and the Caribbean, less-educated men have had 4–6 children, and men with more education, 3–4. In the industrialized focus countries, the relationship between men's education and the number of children fathered is much weaker—a reflection of the general desire for small families in these countries.

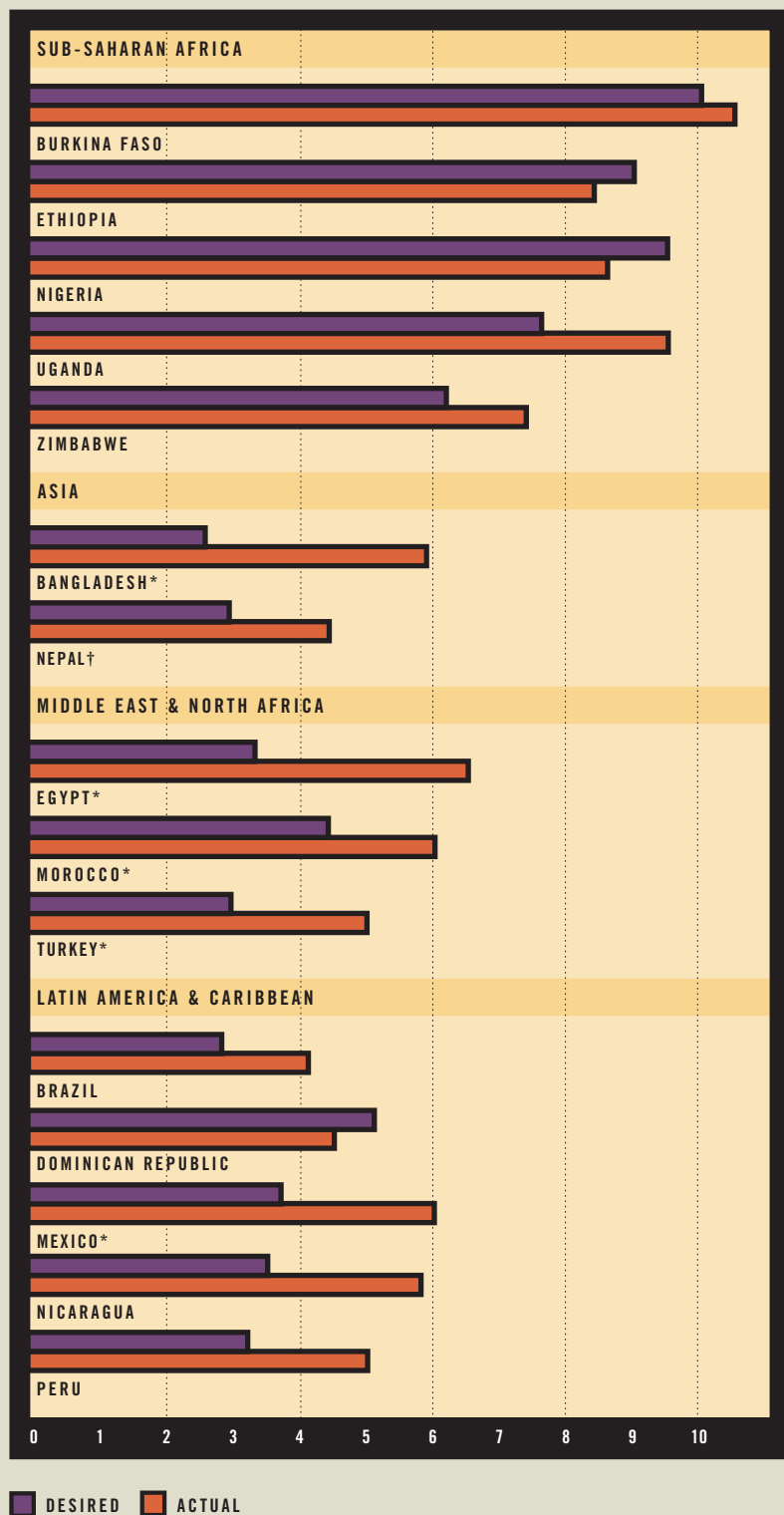
Men who have received more schooling are likely to have smaller families, because they marry later (Table 4a, page 27),¹⁴ they want fewer children, they are more likely to rely on a method of contraception and they are more likely to have educated wives who also prefer a small family. Furthermore, children may be less central to the lives of more educated couples and less important as a source of support in older age.

Most Men in Their 40s and Early 50s Want No More Children

In all regions except Sub-Saharan Africa, most men in their 40s and early 50s consider that they have come to the end of their family-building years. In Bangladesh, Uttar Pradesh (India), Nepal, Egypt, Turkey, most of the focus countries in Latin America and the Caribbean, and all of the industrialized focus countries, at least eight in 10 men aged 40–54 say they do not want any more children. However, in Sub-Saharan Africa—the region with the largest desired family size—smaller proportions of men this age report they have had all the children they want, ranging from 19% in Burkina Faso to 57% in Zimbabwe.¹⁵

Sexually Active Men 40–54 Have Varying Patterns of Contraceptive Use

In the Latin American and Caribbean focus countries and in the industrialized focus countries, 61–80% of sexually active men in their 40s and early



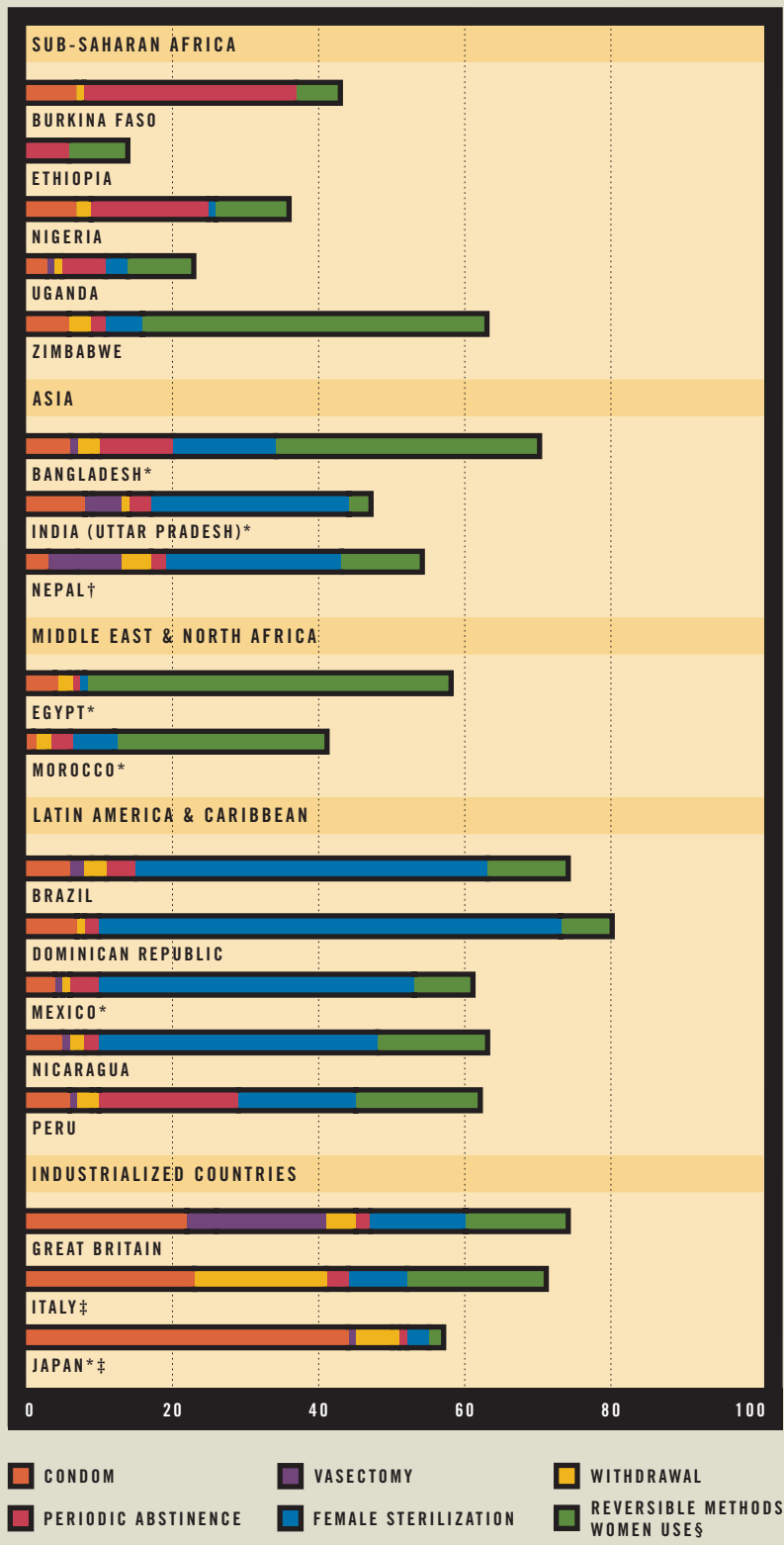
■ DESIRED ■ ACTUAL

*Based on married men. †Based on ever-married men.

SOURCE: APPENDIX TABLE 4, COLUMNS 7 AND 8.

- Men in their early 50s in Sub-Saharan Africa want and have many more children than do men in all other developing regions.
- In developing regions other than Sub-Saharan Africa, men 50–54 typically want 3–4 children but have 4–6.

CHART 5.3
Contraceptive prevalence among sexually active men 40–54



*Based on married men. †Based on ever-married men. ‡Based on men 40–49. \$Pill, injectable, implant, IUD, spermicide or diaphragm. NOTE: Sexually active men are those who had intercourse in the past three months (one month in Italy and the United States).

SOURCE: APPENDIX TABLE 4, COLUMNS 14–19.

- Latin America and the Caribbean has among the highest levels of contraceptive use in the world, and female sterilization predominates in this region.
- Condom use among men 40–54 is highest in industrialized countries.

50s rely on a contraceptive method. In most of the remaining countries, about half or more sexually active men 40–54 or their partners use no method at all.¹⁶ The exceptions are Zimbabwe, Bangladesh and Egypt, where particularly high proportions of men rely on female methods and contraceptive prevalence is about 60% or higher.

Male and female methods are equally important in Great Britain, whereas periodic abstinence is widely practiced in Burkina Faso, Nigeria and Peru. In Japan and Italy, the use of male methods—particularly the condom and withdrawal—exceeds that of female methods (Chart 5.3).¹⁷

Condoms are rarely used as a method of family planning by men 40–54 in most developing focus countries (1–7%), especially in three countries where at least one in 10 men this age engages in extramarital sexual activity (Nigeria, the Dominican Republic and Peru).¹⁸ This discrepancy suggests that not only the men, but also their wives and extramarital partners, are at high risk of contracting sexually transmitted infections, perhaps unknowingly. (See chapter 7 for a more detailed discussion of men’s unmet need for condoms to prevent sexually transmitted infections.)

The use of modern contraceptive methods (including condoms) is much higher among more educated men and their partners than among less-educated men in all the focus countries except the Dominican Republic.¹⁹ The differential by men’s educational levels is narrowest in China, the Dominican Republic, Bangladesh and Zimbabwe. It is widest in Burkina Faso, Guinea, Niger and Zambia.²⁰

Why Do Some Older Men Not Rely on a Contraceptive Method?

In most of the developing focus countries, the proportion of men not relying on a contraceptive method is higher

among 40–54-year-olds than 30–39-year-olds,²¹ even though many men in the older age-group have expressed the desire to have no more children.²² A number of factors might explain this situation: Some older men may not be using a method because their wives are pregnant or are trying to become pregnant, and others may have wives who are no longer fertile; older men may be less well informed than younger men about the availability of contraceptive methods; and older men may hold more traditional cultural values that are opposed to family planning.²³

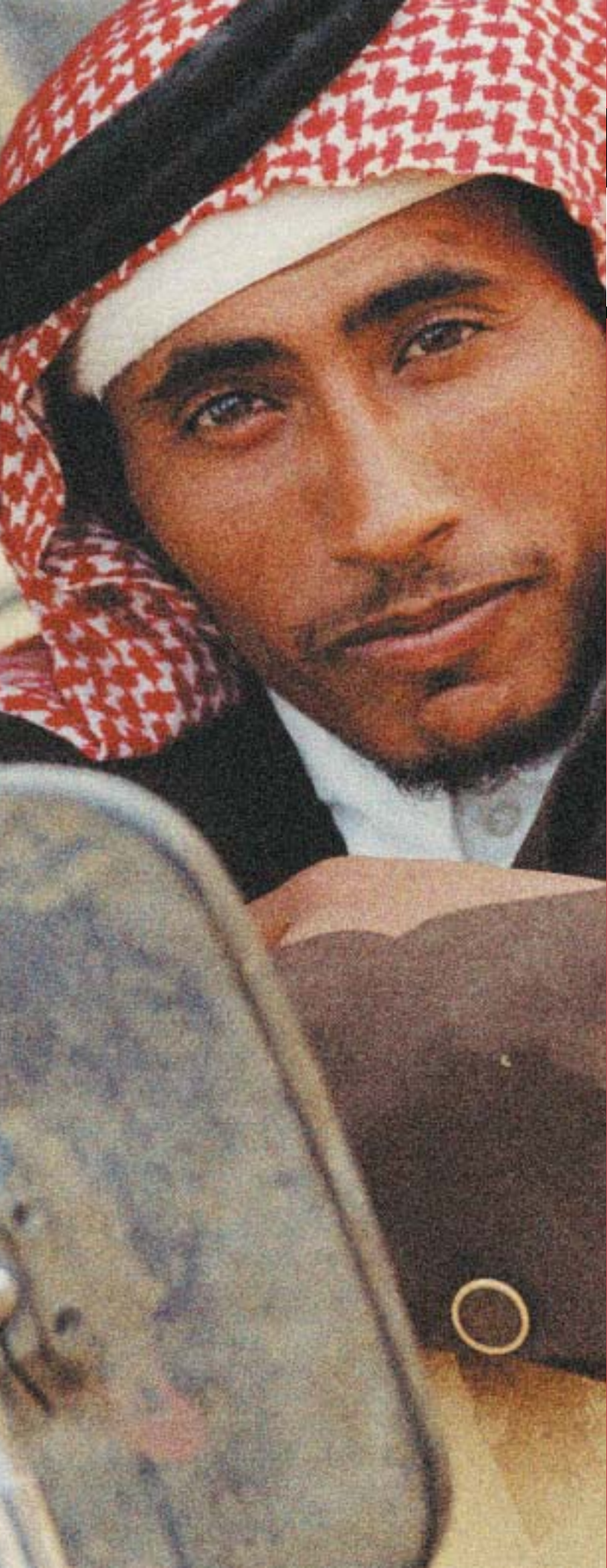
Reliance on Vasectomy Is Rare in All but a Few Countries

Approximately 43 million men around the world (compared with 180 million women) have undergone voluntary sterilization,²⁴ even though vasectomy is far easier to perform than female ster-

ilization, especially using a recently developed no-scalpel technique.²⁵ In some countries where a large proportion of men aged 40–54 have had all the children they want, many of their partners have become sterilized (in four of the five focus countries in Latin America and the Caribbean).²⁶ However, the use of vasectomy is non-existent or uncommon among men in their 40s and early 50s in every focus country except Nepal, Great Britain and the United States.²⁷ The prevalence of male sterilization is highest in parts of western Europe and in North America and China, whereas in much of Africa, eastern Europe and Latin America, it rarely exceeds 1%.²⁸

Low rates of vasectomy can be attributed to many factors: the existence of gender discrimination that places most of the responsibility for fertility control on women; the greater

motivation among women than among men to avoid unwanted pregnancy because it is women who get pregnant; the belief held by some men that sterilization leads to a loss of virility; the lack of public information about the simple surgical technology now available;²⁹ the reluctance of national family planning programs to establish male sterilization services and to publicize them adequately;³⁰ and the reluctance of some providers to provide vasectomy.³¹ In India, some women do not want their husbands to be sterilized because they believe the operation will weaken the husband physically and limit his ability to work.³²



Chapter 6

Sexually Transmitted Infections and Condom Use

- *The prevalence of curable sexually transmitted infections (STIs) is higher in Sub-Saharan Africa and in Latin America and the Caribbean than in other regions.*
- *Sub-Saharan Africa, where heterosexual intercourse is the main way that HIV/AIDS spreads, has the highest HIV prevalence in the world. The prevalence of viral STIs other than HIV/AIDS is unknown.*
- *Both bacterial and viral STIs can increase a person's likelihood of contracting or transmitting HIV; STIs (including HIV/AIDS) can cause infertility and premature death among men and women.*
- *The proportion of men 15–54 who know that condom use is a way of preventing HIV/AIDS varies widely in developing countries—from 9% in Bangladesh to 82% in Brazil.*
- *Fewer than one-third of men in many developing countries know that two ways of avoiding STIs are condom use and either abstinence or having only one, uninfected partner.*
- *Condom use is increasing in some developing countries and is higher among more educated men and those living in urban areas than among less-educated and rural men, respectively.*
- *Men with an STI use various strategies to avoid infecting their sexual partners, but some do not even inform their partner.*

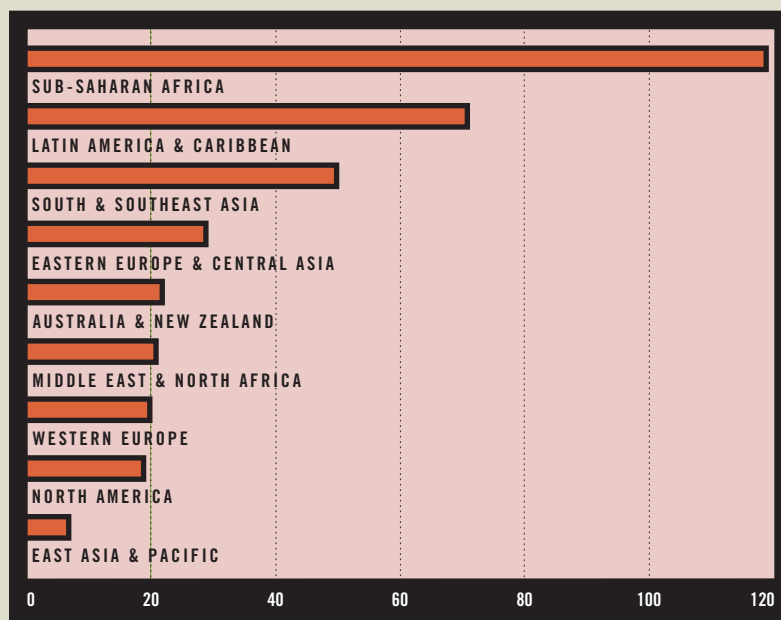
Estimated annual prevalence of curable STIs among men and women 15–49

Sexual intercourse without the protection of a condom can result in the spread of a sexually transmitted infection (STI) if one of the partners is already infected. STIs are a personal, public health and economic issue of serious concern throughout the world. In 2000, there were 2.9 million deaths from AIDS (of which more than 2.3 million occurred in Sub-Saharan Africa)—1.5 million among men and 1.4 million among women.¹ And as a result of STIs and HIV/AIDS, men worldwide lost an estimated 50 million years of productive life in 2000.²

HIV/AIDS Is Widespread in Some Parts of the World

The major STI of viral origin in the world today is infection with human immunodeficiency virus (HIV). By the end of 2002, 39 million adults and three million children were living with HIV/AIDS.³ The focus countries in Sub-Saharan Africa have the highest estimated adult prevalence of HIV/AIDS (5–34%), followed by those in Latin America and the Caribbean (0.2–2.5%) and industrialized focus countries (less than 1%). In Asian focus countries, the adult prevalence is very low—typically 0.1% or less.⁴ However, almost 1% of adults in India have HIV/AIDS, and although the current prevalence among adults in China is very low (0.1%), projections anticipate a rapid spread of HIV in this country.⁵

Half of the world's adults currently living with HIV/AIDS are men (Table 6a, page 42).⁶ The proportion varies from region to region, as do the principal ways in which the infection is transmitted: In Sub-Saharan Africa, HIV is spread mainly through heterosexual activity, whereas in Asia, Latin America and the industrialized regions (North America, western Europe, and Australia and New Zealand), it is typically spread through male homosexual activity and injection-drug use.



INFECTIONS PER 1,000 POPULATION

NOTES: Curable STIs are trichomoniasis, chlamydia, gonorrhea and syphilis. Regions are those defined by the World Health Organization.

SOURCE: REFERENCE 11.

- Sub-Saharan Africa and Latin America and the Caribbean have the highest rates of curable STIs in the world.

The age of people who have HIV/AIDS also varies by world region. In the hardest hit region—Sub-Saharan Africa—an estimated 10 million 15–24-year-olds and almost three million children younger than age 15 are living with HIV/AIDS, together accounting for almost half the total number of infected people. In contrast, in the whole of Asia and in the Pacific, about two million people aged 15–24 are estimated to be living with HIV/AIDS—17% of the total.⁷

Some few men in most developing countries have never heard of STIs or HIV/AIDS; the proportion is particularly high in Bangladesh and Nepal (44% and 26%, respectively).⁸ Men around the world therefore view their potential risk of becoming infected with the virus very differently. However, the

prevalence of HIV/AIDS in the country in which men live appears not to affect their perceptions of their actual risk. For example, 21% of men aged 15–54 in Burkina Faso, 14–15% in Brazil and Peru, and 5% in Nigeria think they are moderately or very vulnerable to this disease.⁹ In Zimbabwe, where 34% of adults live with HIV/AIDS, 12% of men aged 15–54 believe they are at moderate or high risk of contracting the virus, compared with 32% of men in Nicaragua, where fewer than 1% of the adult population are infected.¹⁰

Two Other Viral STIs Are Widespread

The two other common viral STIs are those caused by human papillomavirus (HPV) and herpes simplex virus type 2, or genital herpes. No viral STI can cur-

Table 6a. Estimated number of adults and children with HIV/AIDS, percentage of infected adults who are men and main modes of transmission

REGION	NO. (MILLIONS)	% OF INFECTED ADULTS WHO ARE MEN	MODES OF TRANSMISSION
WORLD	41.86	50	
Sub-Saharan Africa	29.40	42	H
South & Southeast Asia	6.00	64	H, I
Latin America	1.50	70	M, I, H
East Asia & Pacific	1.20	76	I, H, M
Eastern Europe & Central Asia	1.20	73	I
North America	0.98	80	M, I, H
Middle East & North Africa	0.55	45	H, I
Caribbean	0.44	50	H, M
Western Europe	0.57	75	M, I
Australia & New Zealand	0.02	93	M

NOTES: Regions are those defined by the World Health Organization. Modes of transmission are ranked by proportions of HIV infections they cause. H=heterosexual intercourse. I=transmission by injection-drug use. M=transmission among men who have sex with men.

SOURCE: REFERENCE 3.

men.¹¹ All of these infections are treatable if they are diagnosed and the appropriate drugs are available.

In 1999, the combined prevalence of these four curable STIs was highest in Sub-Saharan Africa, at an estimated annual rate of 119 per 1,000 men and women aged 15–49—more than twice as high as the prevalence in South and Southeast Asia (50 per 1,000). The rate in Latin America and the Caribbean was the second highest in the world—71 per 1,000 (Chart 6.1, page 41).¹² The reasons for these wide regional variations are not fully understood. Possible factors include differences in patterns of sexual behavior, poverty and the inadequacy of health care services.

rently be cured, but drug regimens can alleviate or delay the worst symptoms.

HPV is an infection of the skin and mucous membranes; most strains are harmless, but several are strongly associated with the development of anal and genital cancer in men and women, and cervical cancer in women. The body clears most HPV infections naturally, and some medical treatments can alleviate or remove genital warts and precancerous lesions caused by the virus.

Genital herpes can be spread by skin-to-skin contact (without penetrative sex) at any time when blisters or other symptoms are present. There are no estimates of how prevalent HPV and genital herpes are worldwide.

Millions of Men Are Infected with Curable STIs

The World Health Organization estimates that in 1999, there were 340 million new cases of the four leading bacterial and parasitic STIs: trichomoniasis, chlamydia, gonorrhea and syphilis. Almost half of these new infections (164 million) were among

Table 6b. Percentage of sexually active men 15–54 reporting condom use in successive national surveys, and annual change between surveys, by marital status

REGION AND COUNTRY (SURVEY DATES)	EARLIER SURVEY	LATER SURVEY	ANNUAL CHANGE*
Unmarried men			
SUB-SAHARAN AFRICA			
Benin (1996, 2001)	33.4	42.1	1.7
Ghana (1993, 1998)	21.4	32.0	1.8
Kenya (1993, 1998)	29.3	42.7	2.2
Tanzania (1996, 1999)	19.5	27.4	2.6
Uganda (1995, 2000)	29.3	56.8	5.5
Zimbabwe (1994, 1999)	45.3	50.8	1.1
LATIN AMERICA & CARIBBEAN			
Dominican Republic (1996, 1999)	30.3	46.5	5.4
Haiti (1994, 2000)	25.6	28.4	0.5
Married men			
SUB-SAHARAN AFRICA			
Benin (1996, 2001)	6.2	8.7	0.5
Ghana (1993, 1998)	11.1	8.6	-0.5
Kenya (1993, 1998)	6.8	7.8	0.2
Tanzania (1996, 1999)	4.9	9.3	1.5
Uganda (1995, 2000)	2.5	4.6	0.4
Zimbabwe (1994, 1999)	6.2	5.7	-0.1
LATIN AMERICA & CARIBBEAN			
Dominican Republic (1996, 1999)	3.4	2.8	-0.2
Haiti (1994, 2000)	6.4	6.4	0.0

*In percentage points. NOTE: Condom use refers to use as a contraceptive method only. Nonfocus countries are included because information on trends in condom use, as reported by men, is available in only a few countries.

SOURCE: REFERENCE 19.

Percentage of men 15–54 who named condom use and either abstinence or having only one partner as ways of preventing HIV/AIDS

STIs Have Serious Health Consequences for Men, Women and Children

STIs facilitate the transmission of HIV in both men and women, but the risk of contracting STIs and HIV is greater for women, because of the characteristics of the cells that form the lining of the vagina. However, women are less likely than men to experience symptoms from certain infections—for example, chlamydia and gonorrhea¹³—and therefore less likely to seek treatment if infected and more likely to have serious consequences.

Some STIs can cause adverse outcomes for pregnant women and their fetuses or newborns, such as ectopic pregnancy, miscarriage, stillbirth, stunted fetal development and mother-to-child infections. For men, untreated STIs can result in blisters and sores, fever, inflammation of the urethra and difficulty in urinating. Some STIs can cause infertility in both men and women. Certain types of HPV have been linked to cervical, anal and genital cancer.

Having Multiple Partners and Not Using Condoms Increase the Risk of Contracting STIs

Although men (and women) can become infected with HIV and other STIs in a variety of ways, sexual intercourse confers the greatest risk of contracting and transmitting infection. The risk is especially high when men or women have unprotected intercourse (vaginal or anal) with many sexual partners within a short period. The more sexual partners a person has, the greater the chance that at least one of them carries an STI.

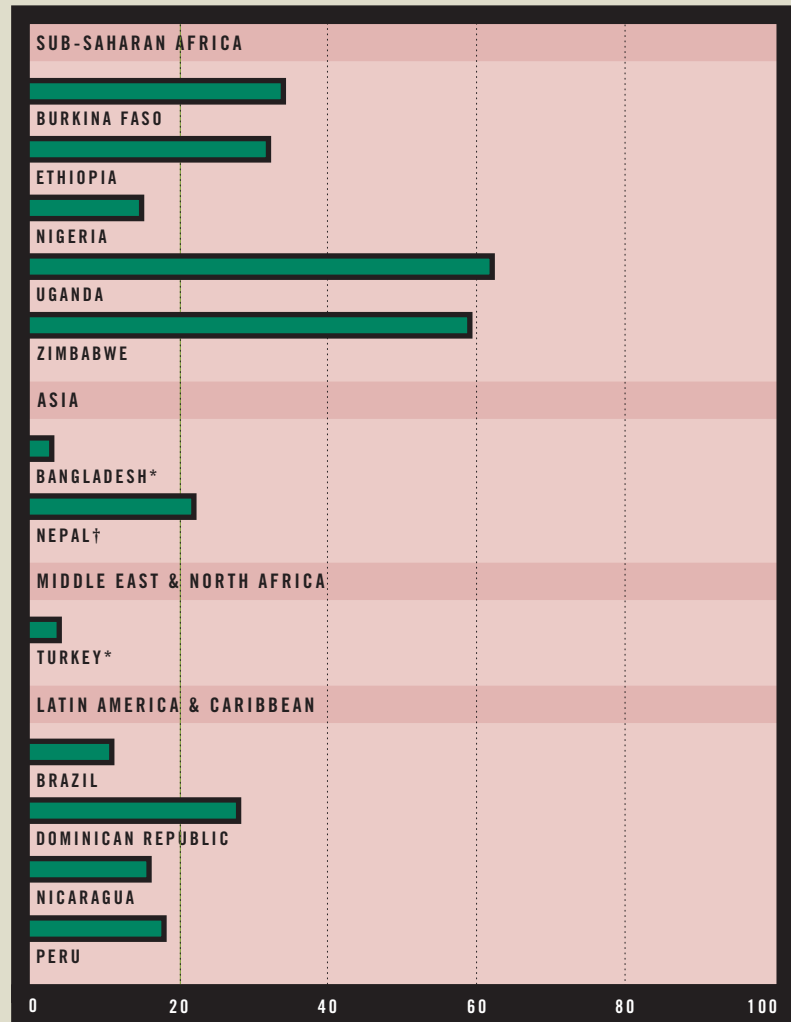
The reuse of injection needles during medical treatment, injection-drug use, blood transfusion and the mutual exchange of blood through scarification or circumcision can also contribute to the transmission of HIV.¹⁴ The relative

importance of these routes is unknown. However, expert opinion today is that sexual intercourse remains the main means of transmission.¹⁵

The only known ways of preventing the sexual transmission of HIV/AIDS are consistent and correct condom use,¹⁶ abstinence and having intercourse with only one, uninfected sexual partner—the ABC of HIV prevention (abstinence, being faithful to one partner and con-

dom use). Some men do not even know that condom use is a method of preventing HIV infection: Only 9% of men 15–54 in Bangladesh are aware of this safety measure, compared with 20–29% in Mozambique, Niger, Nigeria and Turkey; 71–77% in Malawi, Tanzania, Uganda, Zimbabwe and the Dominican Republic; and 82% in Brazil.¹⁷

In some countries, even smaller proportions of men are aware of two of

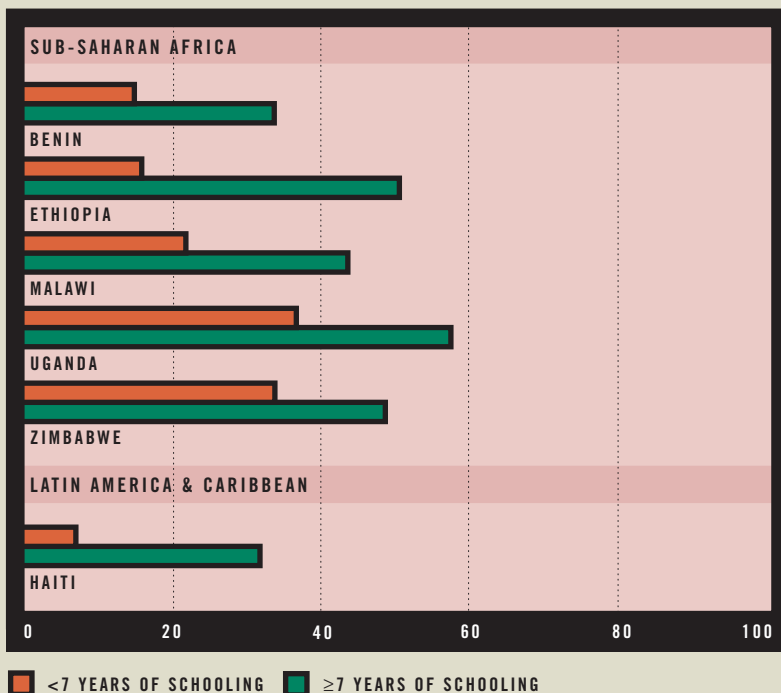


*Based on married men. †Based on ever-married men.

SOURCE: APPENDIX TABLE 5, COLUMN 4.

- Of all countries, Uganda and Zimbabwe have the highest proportions of men 15–54 who know that condom use and either abstinence or having only one partner are two means of preventing HIV/AIDS.

Percentage of unmarried sexually active men 15–54 who used a condom for STI prevention at last intercourse, by duration of schooling



NOTES: Sexually active men are those who had intercourse in the past three months. Benin, Malawi and Haiti are included with three Sub-Saharan African focus countries because only these countries had relevant data when we prepared this report.

SOURCE: REFERENCE 20.

- Unmarried men with seven or more years of schooling use condoms for STI prevention more commonly than do those with less schooling.
- Among unmarried men with little schooling, condom use for STI prevention is moderately high in Uganda and Zimbabwe—two countries particularly hard hit by the AIDS epidemic.

the ABC strategies. Other than Uganda and Zimbabwe—two countries with very high prevalence rates of HIV/AIDS—one-third or fewer of men 15–54 in developing focus countries know about both condom use and either abstinence or fidelity. Particularly low proportions of men in Bangladesh (3%), Turkey (4%), Brazil (11%) and Nigeria (15%) have this knowledge (Chart 6.2, page 43).¹⁸

Condom Use Is on the Rise

In certain countries of Sub-Saharan Africa and the Caribbean—particularly the Dominican Republic, Ghana,

Kenya and Uganda—condom use has recently increased among sexually active single men, who represent one of the groups at greatest risk of contracting STIs. In contrast, among married men, rates of condom use have increased only slightly in some countries, even declined in others and not changed in Haiti (Table 6b, page 42).¹⁹

In five Sub-Saharan countries and in Haiti, condom use specifically for the prevention of STIs is higher among sexually active men who have had at least seven years of schooling than among those with a lower educa-

tional level (Chart 6.3).²⁰ Condom use for STI protection is also more common in urban areas than in rural areas (not shown), which may reflect the increased likelihood that men living in towns and cities can get hold of condoms, as well as the increased likelihood that urban men are educated.

Infected Men Resort to Various Measures to Reduce Transmission

Once infected with an STI (including HIV), some men conceal this fact from their partner: In some developing countries, at least three in 10 men 15–54 who had an STI in the past year did not tell their partners; in Benin and Peru, six in 10 did not.²¹

Whether or not they inform their partners, many men who have an STI take action to avoid spreading the infection. In Brazil and Peru, for example, about two-fifths of such men aged 15–54 said they avoided having intercourse while they were infected, and in the Dominican Republic, more than one-half said they did so.²² Roughly one in 10 infected men in a few countries reported that they continued to have intercourse but used a condom,²³ and almost four in 10 in a few Sub-Saharan African countries reported that they had taken some kind of medicine,²⁴ although it is not possible to determine whether the drug was appropriate for their particular infection. However, one-third of infected men in Nigeria and Peru, and almost one-half in Burkina Faso—but only one in 10 in the Dominican Republic—said they did nothing to avoid infecting their partner.²⁵ In several countries, small proportions said that their partner already had an STI.²⁶

When used correctly and consistently, male condoms have been found to be 97% effective at protecting couples against unintended pregnancy.¹ Moreover, an expert panel concluded in 2000 that regular and correct use of the male condom significantly reduces the risk of contracting HIV in men and women, and the risk of transmission of gonorrhea from women to men. The panel's report emphasized that "the absence of definitive conclusions reflected inadequacies of the evidence available and should not be interpreted as proof of the adequacy or inadequacy of the condom to reduce the risk of [other sexually transmitted diseases]."² In addition, the findings of subsequent scientific reviews conducted by the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Agency for International Development, as well as guidelines and statements issued by CDC, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization, emphasize that correct and consistent use of latex condoms can reduce the risk of transmission of HIV and all other sexually transmitted infections (STIs), and that condoms remain the best defense in preventing HIV/STIs.

Condoms Are Highly Effective in Slowing HIV Spread

In the early 1980s, when evidence of HIV/AIDS first gained recognition, most cases of AIDS in industrialized countries were among men having sex with men and those involved in injection-drug use. As the disease made its way into the wider population and

as condoms were used more commonly among men having sex with men, the proportion of HIV infections due to heterosexual activity began to increase, and that due to male homosexual activity, to decrease.³

Increased adoption of the condom helped to reduce HIV/AIDS levels in urban gay communities in North America and western Europe between 1987 and 2000.⁴ However, some men having sex with men—especially young men in industrialized countries who have grown up with the availability of life-prolonging treatments for AIDS—are becoming less vigilant in protecting themselves from all STIs through regular condom use.⁵

An Asian country that has been particularly successful in encouraging condom use is Thailand. The Thai government launched a national campaign in the late 1980s in an attempt to attain 100% condom use among commercial sex workers. As a result, the level of condom use increased in sex establishments, the incidence of STIs in these establishments decreased⁶ and the prevalence of HIV in specific target populations decreased. Condom use may have prevented more than two million HIV infections in Thailand between 1989 and 1995.⁷

Many Men View Condoms Unfavorably

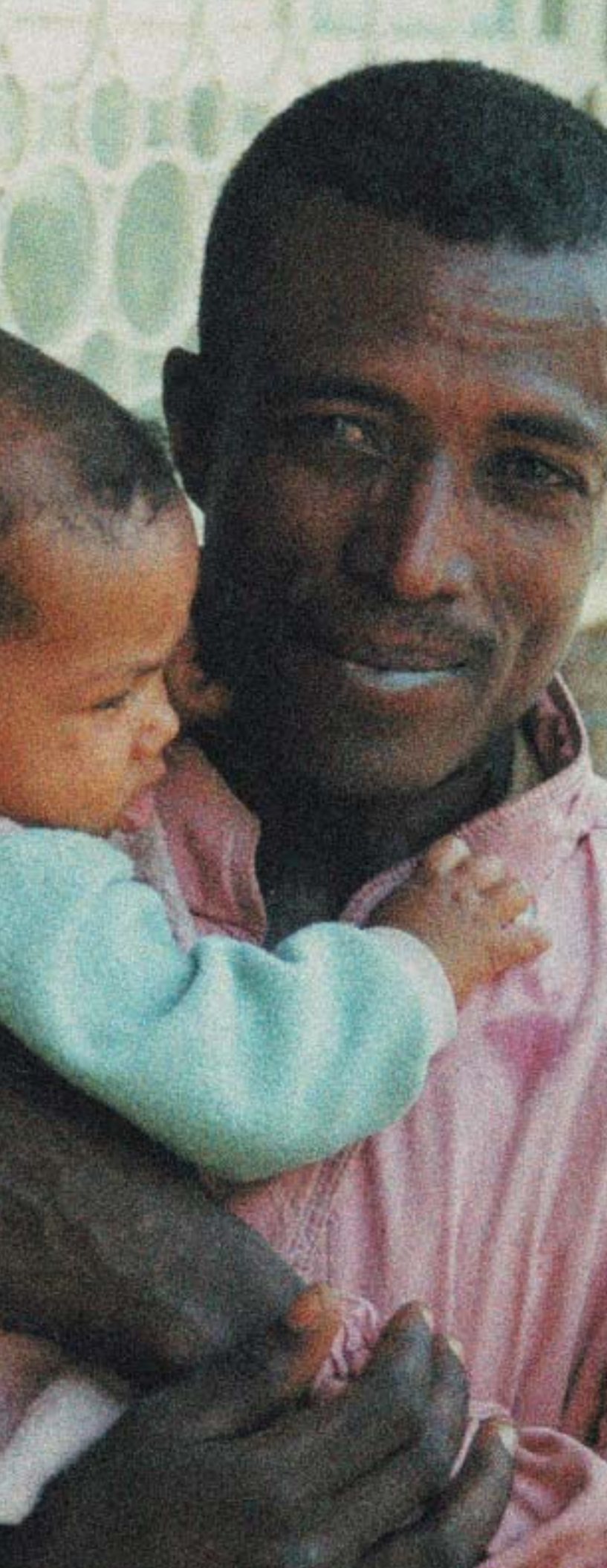
Some common complaints about condoms are that they reduce sexual sensation and pleasure;⁸ interrupt sex and are embarrassing to use;⁹ and affect men's ability to obtain

and maintain an erection.¹⁰ In some countries, fear is fueled by rumors that condoms have been pierced with minute holes to render them useless¹¹ or have been impregnated with the AIDS virus.¹²

In many parts of the world, men are more likely to use condoms with prostitutes and extramarital partners¹³ than with their wives or regular partners. As a consequence, condom use is associated with promiscuity. This stigma often makes it difficult for either partner to suggest condom use. Doing so might be interpreted as an indication that a partner has been unfaithful or suspects the other of infidelity.¹⁴ In situations in which gender relations are highly unequal, women often find it difficult to insist that a partner use a condom¹⁵—for example, if they suspect that he has other partners or that he has an STI.

Supplies of Condoms Are Inadequate

Condoms are not available or accessible in many parts of the world, especially to young men with limited resources. Hence, in some settings, men may be prepared—indeed, anxious—to use condoms but unable to obtain them. Today, an estimated 6–9 billion condoms are distributed each year for family planning and for STI prevention,¹⁶ but many more (perhaps 19–24 billion a year¹⁷) are needed to protect populations from unplanned pregnancies, HIV and other STIs.¹⁸



Chapter 7

Sexual and Reproductive Health Information and Services for Men

- *Men want and need reliable and accessible information and services that can help them lead healthy sexual lives, but they are shortchanged in this regard, especially in developing countries.*
- *Among all men 15–54 in Sub-Saharan Africa and in Latin America and the Caribbean, 4–18% had two or more partners in the past year and did not use a condom the last time they had intercourse.*
- *Some 20–46% of men 25–54 in Sub-Saharan Africa and 15–30% of those in Latin America and the Caribbean do not want a child soon or do not want any more children but are not protected against unplanned pregnancy.*
- *Different components of the ABC approach (abstinence until marriage, being faithful to one partner and condom use) are relevant for different groups of men—in particular, B and C for men with multiple partners.*
- *Creative program responses to address men’s special needs are being developed in various parts of the world, but these are mostly small-scale with limited reach.*
- *In industrialized countries, poor and uninsured men face significant barriers to accessing men’s services.*
- *In developing countries, the expansion of programs to address men’s sexual and reproductive health needs, while continuing to address women’s needs, will require increased donor funding.*

Men need and often want a wide range of sexual and reproductive health support, information and services at different stages of their lives. In richer industrialized countries, spurred on by concerns about HIV/AIDS, there have been increased efforts to provide men with sexual and reproductive health information, although large gaps remain. In developing countries, modernization has often resulted in the breakdown of cultural traditions and community institutions that were once responsible for inducting young people into their sexual and marital lives. Modernization has also brought new awareness of and need for information and services, and sometimes new health risks—for example, the more rapid spread of sexually transmitted infections (STIs). Unless the disappearing traditional sources of information and guides to conduct are replaced, many young men will grow up without the skills and knowledge they need to face a world in which gender roles are changing, STIs are common and the desire for small families is growing.

Men Need Information About Sexuality and Relationships

Worldwide, what is perhaps most important—especially for young men—is the availability of good, clear, non-judgmental information on a wide range of subjects, including the physiology of reproduction, healthy sexual relationships, skills to communicate with partners on sexual and reproductive matters, protection against STIs, contraception, condom use and abortion. However, many parents feel ill equipped to teach their children about these issues,¹ and the responsibility is often left to schools, churches and other institutions.

Sex education remains a controversial and divisive social issue in most parts of the world. Opponents of sex education assert that it encourages

young people to have sex, but studies have conclusively demonstrated that this is not the case.² The typical school-based curriculum of many countries contains useful information about the differences between male and female reproductive systems, but it usually does not provide the opportunity for young men to ask questions without embarrassment about the

Men need and often want a wide range of sexual and reproductive health support, information and services at different stages of their lives.

issues that really concern them in adolescence—for example, “Am I normal if I masturbate?” and “Is my penis the right size?”³ In many developing countries, there is no sex education in schools; in some countries, sex education starts too late to be helpful. Furthermore, many young people leave school before receiving it, and some men do not attend school at all.

Before puberty, young people need to know about the physical and hormonal changes that are going to transform their bodies and their sexual and emotional feelings. Once they become sexually active, men need a thorough understanding of their risks of contracting STIs and of unintentionally making their partner pregnant. They also need to know how to prevent these outcomes by using condoms effectively or by reaching an agreement with their partner about the use of an effective contraceptive method. For men to be able to talk to their partners about STI protection and contraception, they need communication skills, as well as information about the dangers and health problems that some women experience in pregnancy and childbirth—information that will

better prepare men to support their partners. And men need and want the knowledge and life skills that will help them become good fathers.

Adult men, too, often need basic sexual and reproductive health information, as well as a more specific understanding of their bodies. For example, many men in India (and also elsewhere) 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.⁴

Men Also Need Clinical Services

STI services. Many men need access to effective testing for STIs (including HIV/AIDS) and treatment. In Benin, Ethiopia, Gabon, Malawi, Uganda and Zimbabwe, more than two-thirds of all men 15–19 (and similar proportions of teenage women) who have never been tested for HIV say they would like to be, and very small proportions of men 15–19 have ever been tested for HIV—only 1% in Ethiopia, 3–4% in Benin, Uganda and Zimbabwe, and 7–9% in Malawi and Gabon.⁵

Some men who become infected with STIs try to treat themselves. Some buy the correct drugs but take them in an incorrect manner, which is dangerous because leaving STIs partially untreated can lead to serious complications.⁶ Others seek care from pharmacists;⁷ patent medicine dealers, some of whom sell useless remedies; herbalists; and providers of traditional health care, who have had no formal training.⁸ Some men in developing countries say they prefer these sources because they are affordable.⁹ In small-scale studies conducted in Tanzania, Kenya and Zambia, men have claimed that traditional healers are more respectful and less judgmental than private doctors or health care workers in family planning clinics.¹⁰

Men who had two or more sexual partners in a recent one-year period and who did not use a condom at last intercourse can be considered to have an unmet need for STI prevention. The proportion of all men 15–54 with this type of unmet need is higher in Latin America and the Caribbean (11–18%) than in Sub-Saharan Africa (4–10%). In five of the nine focus countries, men who have an unmet need for condoms for STI protection are more likely to be single than married, especially in the Dominican Republic—14% vs. 4% (Table 7a).¹¹ In Zimbabwe and Ethiopia, those in need are more likely to be married than single, and in Nigeria, they are equally likely to be unmarried as they are married. Men in the United States also have considerable levels of unmet need for STI prevention: Of all men aged 18–54, 8% are in need and unmarried and 4% are in need and married.

In some respects, this measure of unmet need is a minimal one: It does not take into consideration the possibility that some of the men with multi-

ple partners who used a condom at last intercourse did not use it consistently throughout the year or did not always use it correctly. Furthermore, some men may have only one partner, but that partner may not be monogamous. In other respects—if all the partners of a man with multiple partners are uninfected, or if men selectively use the condom with high-risk partners (but not with their spouse)—this measure will overstate unmet need for STI prevention.

Family planning services. In every focus country except Burkina Faso, Ethiopia, Nigeria and Uganda, men 15–24 say they want no more than four children and, more typically, 2–3.¹² Furthermore, the ideal family size of men 15–24 is smaller than that reported by men 25–39, and even smaller than that reported by men in their early 50s. In the industrialized focus countries, men of all ages want very small families—typically no more than two children.¹³ If they are to realize these aspirations, men and their partners (especially in Sub-Saharan Africa) will

Table 7a. Percentage of all men 15–54 who had two or more partners in the past year and did not use a condom at last sex, by marital status

REGION AND COUNTRY	SINGLE	MARRIED	TOTAL
SUB-SAHARAN AFRICA			
Burkina Faso	3	1	4
Ethiopia	1	4	5
Nigeria	5	5	10
Uganda	6	1	7
Zimbabwe	2	6	8
LATIN AMERICA & CARIBBEAN			
Brazil	8	5	13
Dom. Republic	14	4	18
Peru	7	4	11
INDUSTRIALIZED COUNTRIES			
United States*	8	4	12

*Men 18–54.

SOURCE: APPENDIX TABLE 5, COLUMNS 16 AND 17.

have to practice family planning at higher levels and more effectively than did their parents, many of whom have had more children than they wanted (Chart 5.2, page 37).¹⁴

Levels of unmet need for family planning are highest in the focus countries of Sub-Saharan Africa: Among all men aged 25–54, 20–46% do not want a child soon or do not want any more children but have no contraceptive protection (Chart 7.1).¹⁵ Men's unmet need for contraception is also considerable in four focus countries of Latin America and the Caribbean—15–30%. Although men in industrialized countries have higher contraceptive prevalence levels than those in developing countries, some still have an unmet need for family planning: In the United States, 3% of men 20–39 are sexually active, want no more children and are not using a method of contraception (a more narrowly defined group than for other countries, because men who do not want a child soon are not included

EFFECTIVE PROGRAMS TO CONTROL SEXUALLY TRANSMITTED INFECTIONS (STIs)

Services targeted at reducing the spread of STIs depend on the following features:¹

- a well-functioning primary health care structure;
- a reliable drug supply;
- clinics for diagnosis and treatment;
- methods of notifying sexual partners of STI patients, so that they, too, can be tested and treated;
- counseling to help infected people understand their illness, take medication correctly and prevent future infections;
- training for health care practitioners involved in STI services and counseling;
- readily and cheaply available condom supplies;
- mass media communications about STIs to encourage infected people to seek treatment, to promote the use of condoms and to support mutual monogamy; and
- surveillance systems to identify the most prevalent STIs and to track the effectiveness of antibiotics used to treat them.

and because of the more restricted age-range); in Italy, this proportion is 11% among men 25–49.

Men’s involvement in helping narrow the gap between their aspirations about family size and the couple’s level of contraceptive protection could be strengthened in light of the fact that condom use can play a major role in family planning. And apart from being the only effective contraceptive method appropriate for men of all ages, condoms provide protection against both unplanned pregnancy and STIs.

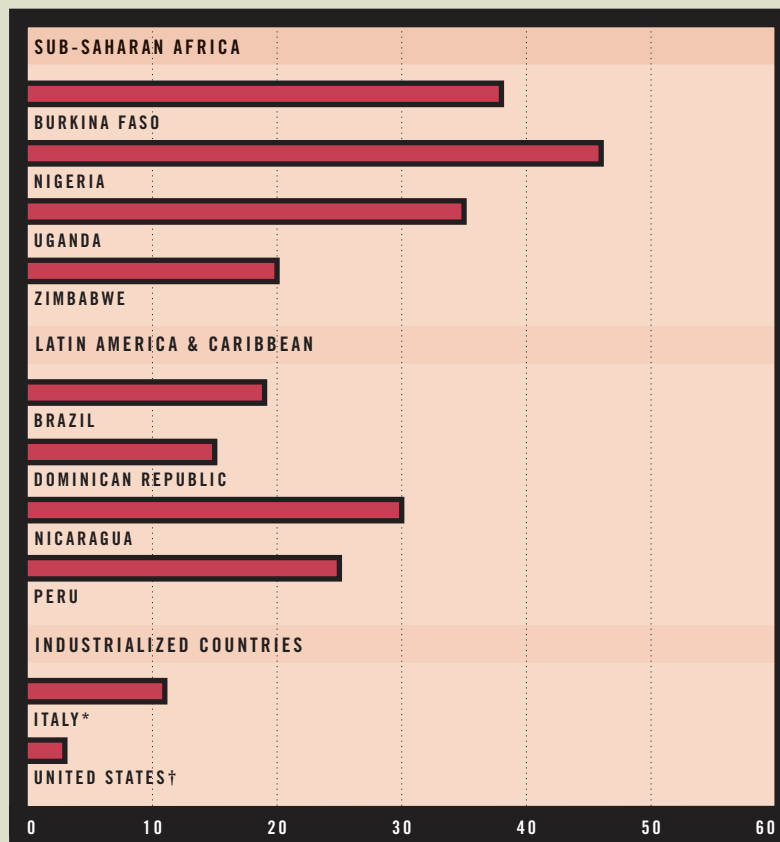
Men Require Specific Services if They Are to Adopt the ABC Strategy

In every region except East Asia and the Pacific, and eastern Europe and central Asia, HIV/AIDS has spread primarily through unsafe sex (mainly heterosexual, but also homosexual to some degree—Table 6a, page 42).¹⁶ Hence, urging men to abstain from intercourse if they are unmarried, or to adopt protective behaviors if they are sexually active (staying faithful to a partner and using condoms) to slow the epidemic is a logical policy response. These strategies form the basis of the ABC (abstinence until marriage, being faithful to one partner and condom use) campaign that the U.S. Agency for International Development is currently recommending to prevent HIV/AIDS and other STIs.

Sexual abstinence until men marry, or the return to celibacy if unmarried men have already had sexual intercourse, is obviously the most effective strategy, if adhered to faithfully. However, this strategy is problematic, given the realities of men’s lives. Such an approach would have to compete with the natural human drive for sexual pleasure and intimacy, as well as with strong cultural pressure on young men to prove their manhood by being sexually active. Still, this approach may be relevant in some contexts and for very young adolescents.

CHART 7.1

Percentage of all men 25–54 who want to delay or avoid having a child and are not relying on a contraceptive method



*Based on men 25–49. †Based on men 20–39. NOTE: In Italy and the United States, unmet need is for men who want no more children.

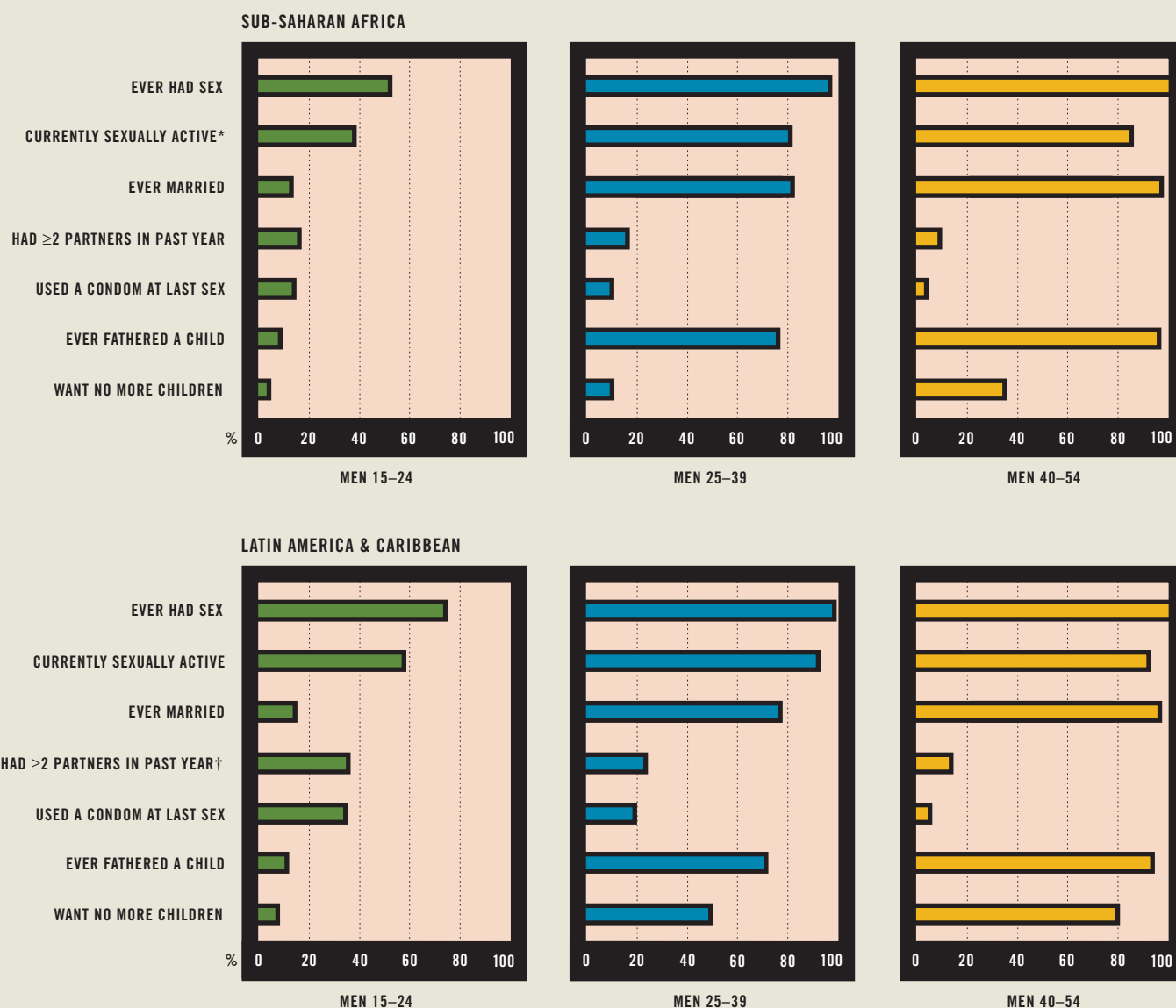
SOURCE: APPENDIX TABLE 5, COLUMN 18.

- Among all regions, the unmet need for family planning is greatest in Sub-Saharan Africa.
- In all countries except the Dominican Republic, Italy and the United States, one-fifth or more of all men 25–54 do not want a child but are not protected by a modern method.

Abstinence until marriage and return to celibacy have little relevance for young men who are already sexually active and choose to remain so. This situation represents that of the large majority of men. At least half of men 15–24, and almost all of those aged 25 and older in Sub-Saharan Africa and in Latin America and the Caribbean—the regions for which relevant information exists—have had sexual intercourse (Chart 7.2, page 50).¹⁷ In the United States, 55% of

men 15–19 and 90% of those 20–24 are already sexually experienced.¹⁸ Starting in men’s mid-20s, most sexual activity is within the context of marriage, and only among men 15–24 is most sexual activity extramarital.

Most men are at low risk of contracting an STI because they have had no or only one sexual partner in the past year. In Sub-Saharan Africa, the proportion who had no or only one partner in the past year increases from an average of 83% of all men aged



*Not including Senegal. †Not including Nicaragua. NOTES: Averages are for all countries in the two regions and are weighted by size of male population. Latin America and the Caribbean does not include Mexico. Sexually active men are those who had intercourse in the past three months. Ever-married men include those who have ever cohabited or been in a consensual union.

SOURCE: REFERENCE 17.

15–24 to 90% of men 40–54; in Latin America and the Caribbean, the corresponding increase is from 64% to 86%¹⁹ (In the United States, 75% of men 15–19 and 88% of men in their 40s had one partner or none at all in a given 12-month period.²⁰) These figures suggest that the likelihood that men have two or more sexual partners is somewhat greater in Latin America and the Caribbean than in Sub-

Saharan Africa. However, in both these regions, the B and C components of the ABC campaign would be a high priority for the 17–36% of men aged 15–24, the 17–23% of men aged 25–39 and the 10–14% of men aged 40–54 who report that they had two or more sexual partners in the past year (Chart 7.2).²¹

Besides the STI and pregnancy prevention information and services

implied in the ABC approach, most men need and often want to know about their partner's health risks during pregnancy and childbirth, and about the steps they might take to help their partners receive appropriate care if health emergencies arise. In countries where abortion is legally restricted or unsafe, men can play a crucial role in protecting their partner's health. Moreover, men need the kind of infor-

mation and support that will help them provide their children with guidance, love and security. The target population for this kind of information includes young men who will soon be fathers and men aged 25 and older (the majority of whom have already had a child).

Some Agencies Are Developing Special Services for Men

In both developed and developing countries, a number of national and international organizations are designing pilot projects to address men's sexual and reproductive health needs.²² Most experimental programs tend to target boys and young men. A few programs are being added to existing reproductive health services; others are being conducted within existing youth or community-based schemes, and some are freestanding or made available in industry-based health facilities.²³ However, experimental educational and service projects are necessarily small-scale and hence serve small numbers of male clients.

Services are often offered in settings where men tend to gather (e.g., schools, youth clubs, worksites, truck stops, sporting events and military barracks). Outreach services use a variety of approaches: Some train health care providers and community and social workers to understand and respond to men's particular needs; others distribute condoms or introduce the social marketing of contraceptive supplies. Some develop mass media activities or education programs likely to appeal to men. Successful programs include those aimed at making vasectomy more accessible and more acceptable,²⁴ and at providing STI services to high-risk men.²⁵

Another type of demonstration project focuses on issues of gender equity and the cultural constructs of masculinity that often hamper men's search for good sexual and reproductive health.²⁶ These projects aim to

Table 7b. Percentage of gross domestic product (GDP) and per capita spending on health care services, by region and by income level

REGION AND INCOME LEVEL	% OF GDP SPENT ON HEALTH CARE		PER CAPITA SPENDING (U.S. \$)*
	PUBLIC SPENDING	PRIVATE SPENDING	
REGION			
South Asia	0.9	3.8	87
Sub-Saharan Africa	1.7	2.6	89
East Asia & Pacific	1.7	2.4	151
Middle East & North Africa	2.3	0.3	228
Eastern Europe & Central Asia	4.0	1.6	326
Latin America & Caribbean	3.2	3.3	452
European Union	6.7	2.3	2,045
United States	5.8	7.2	3,950
INCOME LEVEL			
Low	1.2	3.1	74
Lower-middle	2.3	2.5	190
Upper-middle	3.4	2.9	549
High	6.0	3.7	2,587
*Adjusted for relative value of local currency (purchasing power parity). NOTE: Regions and income levels are those defined by the World Bank.			
SOURCE: REFERENCE 33.			

modify men's sexual and gender-related attitudes, values and behaviors in ways that will promote their own reproductive health and assure greater equity between women and men in decision-making over a range of issues, such as when intercourse occurs, how many children to have, contraception and abortion. Programs of this type are implemented in counseling sessions, focus groups and consciousness-raising exercises with boys, men and couples.

Finally, advocacy projects to promote awareness of the need for male sexual and reproductive health services are aimed at a range of audiences: policymakers,²⁷ the general public, the mass media,²⁸ religious leaders and relevant health care providers.

Lessons Can Be Learned From Pilot and Experimental Projects for Men

There is a growing consensus on a number of broad recommendations emanating from the experiences of a wide range of demonstration projects

for men. Services should be accessible, welcoming, sensitive to men's needs and consonant with existing community values; programs should seek men out where they tend to congregate; and projects must be carefully tailored to meet the special needs of young men, poor and minority men, older men, and gay and bisexual men. Additionally, male-oriented programs should consider the broader needs of boys and men for education and jobs, and should help men change harmful expressions of their masculinity and sexuality in the context of the larger social, cultural and economic conditions that shape their behavior.²⁹

Pages 52–53 list a full range of information and service programs that should ideally be available for men, regardless of where they live. Most involve information, the development of personal skills and behavioral counseling—services that may be provided at relatively little additional cost at existing primary health care centers. The framework also details some of

A MODEL SET OF SEXUAL AND REPRODUCTIVE HEALTH INFORMATION AND SERVICES FOR MEN

Although there is no generally accepted standard set of sexual and reproductive health information and services for all men, several organizations have begun to develop prototype sets of services for different target groups. The set presented below is based mainly on existing models and aims to present a comprehensive framework of the needs of all men.¹ It is by no means definitive, but is intended to stimulate discussion and advance efforts toward a set of services that has the support of a cross-section of all who work in men's sexual and reproductive health. However, any prototype set of services will need to be tailored to meet the needs of particular groups—for example, young men, disadvantaged men and men who engage in high-risk behaviors. The five service categories reflect differences in sources and types of services, even though there is some overlap.

Information

- Basic sex and reproductive health education

Normal anatomy and pubertal development, social and emotional development, reproductive biology, changes in sexual function during the reproductive life span, sexual identity and orientation

- Genital health and hygiene

Penile hygiene, how to perform a testicular exam, prostate cancer awareness

- Healthy relationships

Stages in romantic relationships; when sexual involvement is appropriate; forms of sexual expression; sexual coercion, abuse and violence; domestic violence; statutory rape awareness; the influence of alcohol and other drugs on sexual behavior

- Pregnancy prevention

Costs and consequences of pregnancy, contraceptive methods (including abstinence and

condoms), effectiveness of contraceptives

- Sexually transmitted infections (STIs), including HIV

Definitions, symptoms, transmission, diagnosis, treatment, prevalence, consequences, prevention techniques

- Fatherhood

Paternal and maternal rights and responsibilities, prenatal health, childbirth, child development and health, well-child care, paternity establishment, child support, visitation, single fathers' support groups, parenting behaviors that promote healthy adolescent adjustment

- Where and how to obtain other services

Genetic counseling, mastectomy partner counseling, services for those with disabilities, services for those experiencing or perpetrating sexual abuse

Skills

- Pregnancy and STI prevention and sexual health skills

Self-advocacy, risk assessment and avoidance, decision-making, setting and achieving goals, resisting peer pressure, communicating with and listening to partners, selecting partners and avoiding unhealthy relationships, distinguishing between consent and coercion, violence prevention, partner intimacy, negotiating sexual activity, safer sex and setting limits, how to use contraceptives (including the condom) properly, recognizing STI symptoms, how to obtain services and more information

- Fatherhood skills

Parenting, life skills (e.g., securing a job, housing, medical care), training and opportunities for self-sufficiency, communication with child's mother, health guidance on why and how to talk to one's children regularly about health-related behaviors (including sexual health), involvement in child's health and well-child care services

Counseling

- Self-concept

Self-esteem, sexual identity and orientation, gender roles, personal potential, awareness of vulnerability, confidence in the future, sense of control over one's life and decisions, nurturance

- Life events and decision-making

Relationships with sexual partners, the male partner's role in pregnancy, delivery, abortion, adoption, the postpartum period, hysterectomy, decision-making regarding contraceptive method and sterilization (male or female)

- Values and motivation

Respect for others; role expectations; setting and achieving life goals; parenting as a life goal; values regarding parenthood; values regarding "being a man"; support groups for young fathers; value of healthy lifestyle, sexuality and relationships; mutual fidelity; concern for partner's health; women's and men's role in contraceptive practice and pregnancy

Preventive Health Care Services

- Sexual and reproductive health history

Sexual activity and behavior; use of condoms and contraceptives; sexual orientation; number of partners in the past six months; history of exchanging sex for money or drugs, injecting drugs, engaging in sex with other males, having a partner at risk of contracting an STI, having an STI, being involved in pregnancy, being sexually abused, or perpetrating sexual abuse or domestic violence; desires or concerns about fatherhood

- Cancer evaluation screening

Family history screening for prostate, testicular, colon and skin cancer

- Substance abuse screening

- Mental health assessment

Routine physical

Blood pressure, lipid profile, heart and lung exam, breast exam, urine sample, urinary difficulties, nutrition and diet, development assessment

Premarital blood test

Links to the provision of appropriate additional services or referral if needed

Clinical Diagnosis and Treatment

Testing for STIs, including HIV (determined by the individual's risk factors and performed in conjunction with pretest and posttest counseling); diagnosis; treatment; counseling; partner notification; partner referral

Diagnosis of and treatment for sexual dysfunction (impotence, premature ejaculation, disorders of the reproductive system, lesions of the genital tract, hernias and varicocele)

Fertility evaluation

History, semen analysis, paternity blood test, infertility services

Contraceptive services

Vasectomy

Treatment for urologic disease, vasectomy reversal

the more costly medical, testing and diagnostic services that men need, particularly in such areas as STI prevention and treatment, screening for prostate and testicular cancer, infertility services, programs addressing sexual dysfunction and vasectomy services for men who want no more children.

Resources Are Severely Inadequate

It is clearly essential to broaden the quality and quantity of information, medical services (particularly for STI screening and treatment) and contraceptive supplies (particularly of condoms) available to men, and doing so will require increased donor funding. The overwhelming inadequacy of sexual and reproductive health care programs for men and women in many poor countries is illustrated by high levels of infant mortality; maternal morbidity and mortality; unplanned pregnancy; clandestine abortion; and unwanted births among women of childbearing age. What, then, are the realistic chances that these same poor countries will be able to provide the reproductive health services that both men and women need?

The availability of any medical service depends on the supply of appropriately trained doctors, nurses and health care workers, and on the ability of individuals and the public sector to pay for health care. With the exceptions of China, Egypt, Turkey, Brazil, the Dominican Republic and Mexico, the developing focus countries suffer from a serious shortage of doctors—they have one doctor for every 1,000–50,000 people, compared with one for every 200–600 in industrialized focus countries.³⁰

In many developed countries, the scarcity of medical staff specifically trained to address men's needs for information and services in the area of sexual and reproductive health is a major barrier to serving men. Issues of

inadequate health insurance coverage—for example, among poor men in the United States—and the lack of a consensus on what constitutes basic sexual and reproductive services for men are further barriers.³¹

In low-income countries, total annual spending on health services is no more than \$74 per capita, compared with \$3,950 in the United States (Table 7b, page 51).³² Much of these outlays come out of people's pockets, rather than from public spending, thereby imposing yet another limit on what people in low-income countries can realistically afford to pay for the sexual and reproductive health services they might need.

Some additional funding assistance for sexual and reproductive health programs is already on the way in the form of international pledges of \$3.4 billion made to the Global Fund to Fight AIDS, Tuberculosis & Malaria—a special program that was launched at the United Nations in 2000.³³ Nevertheless, it is uncertain whether the momentum for meeting the far higher overall monetary goals of this global appeal will continue. Rich industrialized countries are all feeling the pinch from the recent global economic downturn, and there is no way of predicting what the scale of future contributions to this new fund, or to broader sexual and reproductive health interventions, will be.



Chapter 8

Summing Up

Sexual and intimate relationships and a stable family life are important goals for most men worldwide. Love, marriage and fatherhood contribute greatly to men's well-being and happiness, as well as to the future of societies. Yet, sexual relationships can carry risks of sexually transmitted infections (STIs)—particularly HIV/AIDS—and unplanned pregnancies. Achieving and maintaining healthy sexual relationships requires minimizing these risks and appropriately managing their potentially grave outcomes.

While many men worldwide are doing a good job in protecting their sexual and reproductive health, some are not. Most men begin to have sexual intercourse in their mid-to-late adolescence but do not settle down into marriage until their mid-20s or later. During the intervening years, the majority of young men in Sub-Saharan Africa and in Latin America and the Caribbean (more than four-fifths and roughly two-thirds, respectively) have no or only one partner in a typical year (Chart 7.2, page 50).¹ Most men in their late 20s and older get married and have children, and the majority of married men have sex only with their wives in a given year—64–93% of married men 25–39 and 77–96% of married men 40–54 (Table 4d, page 29, and Table 5b, page 36).²

The curiosity, bravura and peer pressure that drive some men to seek multiple sexual partners are largely characteristics of unmarried young men. The proportion of men who had more than one partner in the past year declines noticeably with age—from 17% among men 15–24 to 10% among men 40–54 in Sub-Saharan Africa, from 36% to 14% in Latin America and the Caribbean (Chart 7.2, page 50),³ and from 25% to 12% in the United States.⁴

Condom use is rising in many countries in Sub-Saharan Africa (Table 6b, page 42).⁵ However, among the focus

countries in Sub-Saharan Africa and in Latin America and the Caribbean, about one-half to three-quarters of sexually active men aged 15–24 who had multiple partners did not use a condom the last time they had intercourse, and the proportion is even higher among men aged 25–54; proportions are also high among U.S. men of similar ages.⁶ In addition, the extent to which men who rely on condoms use them consistently or correctly is not known. Promoting consistent and correct use of condoms among

Despite widespread recognition that men need better information and health services...the political will to translate advocacy into action has so far been seriously absent.

sexually active men with multiple partners is therefore an important priority.

Sexually active young men are taking a large share of responsibility for contraception (in the form of condom use and withdrawal) in all regions, and especially in industrialized countries (Chart 3.3, page 23).⁷ Worldwide, hardly any teenage men and relatively small proportions of men in their early 20s have become fathers—a finding indicating that young men and their partners succeed, to a great extent, in avoiding unplanned births. However, sizable proportions of men 25–54 in developing countries, particularly in Sub-Saharan Africa, who say they do not want a child now or in the near future do not use—and their partners do not use—any modern method of contraception (Chart 7.1, page 49).⁸ Furthermore, a large proportion of married men aged 25–39, particularly of those in Sub-Saharan Africa, report that they have not discussed family

planning with their partners.⁹

In developing countries, men often lack the most basic elements of sexual and reproductive health care—affordable and accessible supplies of condoms and effective STI testing and treatment services. Yet, in the many countries that are deficient in good, reliable information and services to address men's sexual and reproductive health concerns, men often succeed in protecting their and their partners' health. It is therefore not farfetched to anticipate the valuable role that expanded support and improved services for men could play in reinforcing the efforts they are already making to protect their sexual and reproductive health. What is needed to move quickly to this next step?

Men's Needs Are Being Recognized, but Are Not Being Met

Despite widespread recognition that men need better information and health services if they are to lead healthier sexual and reproductive lives, there has been little effort to provide or develop such information and services. Throughout the world, a number of obstacles stand in the way of addressing men's needs.

First, the political will to translate advocacy into action has so far been seriously absent. There has been very little effort to identify and implement practical ways of helping men understand that safer sex is in their own best interests. Although a number of pilot programs for men have been tried, most have not been rigorously evaluated, and few have been expanded to reach a wider client base.

Second, while there has been strong rhetoric at international conferences and in policy discussions urging countries to pay more attention to men's needs, the allocation of funding and the training of health care providers and educators have not followed.

Third, specific logistic challenges

face countries that want to move from rhetoric and broad recommendations to specific programs, and from pilot projects to services available at the national level: Who are the health care providers and educators who could be tapped to offer the services that men need? Are these professionals sufficient in number, and are they properly trained to undertake necessary activities? If not, how can this training be funded and implemented? What other institutions—nursing and medical schools, regular schools and colleges, private companies, nongovernmental organizations, religious groups—can be enlisted in activities that would lead to increased training in men's service provision? Moreover, creating more open societies in which men can naturally and comfortably manage their own sexual and reproductive health represents a complex cultural challenge in many parts of the world.

The inadequacy of resources, particularly in developing countries, to meet men's sexual and reproductive health needs is troubling because in the many roles that men have—as sexual partners, husbands, fathers and often gatekeepers for their families to the outside world—they play an integral part in influencing and determining not just their own sexual and reproductive health but also that of their wives and the well-being of their families. Thus, improved sexual and reproductive knowledge and health services for men have the potential to create such wide beneficial ripple effects for their families and communities that the wisdom and cost-effectiveness of helping men can scarcely be in doubt.

The Millennium Development Goals Do Not Specifically Mention Men

The eight Millennium Development Goals (MDGs), spelled out at the Millennium Summit of the United Nations in September 2002, are highly relevant as determinants of policy and

funding for all aspects of socioeconomic development, particularly in the developing world. The MDGs are therefore also pertinent to the prospects of improving attention to men's sexual and reproductive health.

The MDGs are very broad-reaching and important: to eradicate extreme poverty and hunger; to achieve universal primary education; to promote gen-

[Men] play an integral part in influencing and determining not just their own sexual and reproductive health but also that of their wives and the well-being of their families.

der equality and empower women; to reduce child mortality; to improve maternal health; to combat HIV/AIDS, malaria and other diseases; to ensure environmental sustainability; and to build a global partnership for development).¹⁰ Yet, it is striking that the MDGs do not mention the need for attention to STIs other than HIV/AIDS. This omission should be rectified, given the known links between STIs and spread of HIV. Additionally, family planning should surely receive greater prominence, given the importance of the prevention of unplanned pregnancies to the health and well-being of women and children, and to the economic well-being of men and their families.

Men receive no special mention in any of the MDGs. For example, the third goal states the need to increase the proportion of women employed in the nonagricultural labor sector, but there is no reference to efforts to reduce male unemployment in any part of the world. This omission needs to be addressed, given the links revealed by research in both developing and industrialized countries between men's

uncertain and often bleak economic status and their likelihood of engaging in unsafe behaviors—from drug and alcohol misuse to weapon carrying, fighting and unprotected sex.

In future years, the MDGs and donor contributions to the Global Fund to Fight AIDS, Tuberculosis & Malaria are likely to increase support for HIV/AIDS programs. However, funds for family planning and other areas of reproductive health may decline. Because sexual and reproductive health services, including HIV/AIDS programs, are so highly interrelated, it is difficult to account separately for donor assistance directed to any single component of services. As a consequence, family planning and reproductive health programs, including services specifically for men, may be obliged to work much more closely with HIV/AIDS services than they ever have before.

Much More Research Is Needed

By making evident the gaps in information about men's sexual and reproductive health, this report highlights the need for further work. Information is particularly lacking on men's attitudes toward sex, marriage and reproduction, as well as their motives for some behaviors—for example, frequenting sex workers without using condoms in settings where STIs (including HIV/AIDS) are prevalent. And in populous areas of the world—especially much of Asia, the Middle East and North Africa—we still know very little about men's sexual and reproductive behavior and needs. Given what we have learned about the links between men's education and their sexual and reproductive behavior, there is a great need for more research into the cultural, social and economic factors associated with men's sexual and reproductive behaviors, in all parts of the world.

The accuracy of available information on sexual behavior, such as the

number of partners and age at first sex, needs to be tested through methodological studies. Few published studies exist on the extent to which men use condoms correctly and consistently; documenting these aspects of condom use matters greatly in the search for effective methods of disease prevention. Men's role in decision-making regarding pregnancy (including choosing an abortion), their role during the prenatal period and their role in raising their children, as well as whether and how these roles are changing, are also essentially undocumented.

Some counterintuitive findings remain perplexing. For example, sexual initiation among men occurs earlier in Latin America and the Caribbean than in Sub-Saharan Africa,¹¹ and multiple sexual relationships are apparently more common in Latin America and the Caribbean.¹² But why is HIV/AIDS so much less prevalent in most of this region? How much of the difference

The gains [from providing appropriate information, support and services to men]—for men in their own right, and for their sexual partners and families—could be inestimable.

can be attributed to the fact that condom use is higher in Latin America and the Caribbean, especially among younger men?¹³ What other risk factors, currently unknown or poorly documented, might vary across (and possibly within) these world regions?

Compared with most other Sub-Saharan African countries, Zimbabwe has far higher levels of contraceptive use and lower desired and achieved family sizes.¹⁴ But why has the success of Zimbabwe's family planning

program not translated itself in any perceivable way into an increased involvement of men and greater attention to STI prevention—initiatives that might have helped stem the HIV/AIDS epidemic in that country?

Moreover, given the greater resources for health programs in industrialized countries compared with those in other countries, what are the factors preventing more from being done to meet men's needs for sexual and reproductive health information and services in these more affluent regions, and to integrate men into existing health services?

Men Must Overcome Many Barriers

This report has provided a great deal of information about the particular conditions of men's lives and behaviors that can jeopardize their sexual and reproductive health. The findings suggest that the impact of structural factors, such as poverty and poor education, overlaps and interacts with the impact of individual and cultural factors, such as the sense of a male sexual prerogative, men's reluctance to talk about sex, and their reluctance, embarrassment or fear surrounding condom use or vasectomy.

On the one hand, most societies give more freedom to men than to women in how they conduct their sexual lives. On the other hand, men in many cultures learn that they should not express their emotions freely. In some parts of the world, men play an authoritarian role in their families, which affects the nature of their relationships with their wives and children. And some men learn from childhood that conflict within the family or community must be resolved through violence. Given these often demanding expectations of appropriate masculine behavior, it should hardly be surprising that some men find it difficult to talk to their partners about personal sexual and reproductive issues.

Intercourse, sexual frequency, normal sexual functioning, sexual pleasure, contraception, STI prevention, the desired number of children, the pressures involved in having to support a family—these are all topics that many men would probably like to discuss with their partners but are unable to, because doing so would be contrary to usual or expected behavior, or because they lack the basic knowledge or confidence to do so. Creating mechanisms and settings for men—especially adolescents and young men—to express themselves comfortably about these issues could go a long way to helping them protect their sexual and reproductive health, as well as that of their partners. Beyond that, broadening primary health care services and providing more information to meet men's needs for medical and counseling services relevant for their sexual and reproductive health would demonstrate responsiveness to the vital interdependence that exists between men's well-being and that of their wives, children and societies.

Helping Men Promises Gains in Health For All

Because the world is such a complex and politically and economically uncertain place, it would be unwise to make overarching and overambitious recommendations about possible ways of helping men help themselves. Yet, even the smallest steps can yield rich dividends. Given the amount that men are already doing to protect their own and their partners' sexual and reproductive health—with little apparent assistance from government or community institutions—it is reasonable to predict that much more could be achieved if appropriate information, support and services were more readily available to them. The gains—for men in their own right, and for their sexual partners and families—could be inestimable.

APPENDIX TABLE 1: DEMOGRAPHIC, ECONOMIC AND LIVING CONDITIONS IN 45 COUNTRIES

Region, country and survey year	MEN 15–54	LEVEL OF URBANIZATION		EDUCATION		MALE LIFE EXPECTANCY AT BIRTH		PHYSICIAN ACCESS	INCOME	
	No. (in 000s), 2002	% of population urban		% of men with ≥7 years of schooling		% of men 20–54 with ≥10 years of schooling	1985	2001	Persons per physician, 1990–1999 ¹	Per capita GDP, 2000 (U.S. \$) ²
		1970	2000	20–24	40–54					
	1	2	3	4	5	6	7	8	9	10
Sub-Saharan Africa										
Benin Republic, 2001	1,624	17	42	33	16	14	46	49	16,667	990
Burkina Faso, 1998–1999	2,625	6	19	19	7	9	49	46	33,333	976
Cameroon, 1998	3,847	20	49	66	40	28	52	54	14,286	1,703
Central African Republic, 1994–1995	907	30	41	43	13	16	44	43	25,000	1,172
Chad Republic, 1996–1997	1,931	12	24	26	10	9	36	49	33,333	871
Côte d'Ivoire, 1998–1999	4,430	27	46	38	30	27	49	48	11,111	1,630
Ethiopia, 2000	15,721	9	18	20	7	9	38	44	25,000	668
Gabon, 2000	306	31	81	77	58	41	47	48	5,263	6,237
Ghana, 1998	5,273	29	38	76	65	53	52	56	16,667	1,964
Guinea, 1999	2,103	14	33	32	21	17	38	43	6,667	1,982
Kenya, 1998	8,216	10	33	82	66	38	59	47	7,692	1,022
Malawi, 2000	2,770	6	25	53	33	11	45	37	50,000	615
Mali, 1995–1996	2,761	14	30	20	11	3	46	50	20,000	797
Mozambique, 1997	4,579	6	40	16	8	6	44	37	u	854
Niger, 1998	2,664	9	21	21	6	8	41	45	25,000	746
Nigeria, 1999	29,436	20	44	62	31	41	50	51	4,762	896
Senegal, 1997	2,461	33	47	29	20	18	45	52	12,500	1,510
Tanzania, 1999	8,997	7	33	70	40	29	45	52	25,000	523
Togo, 1998	1,165	13	33	51	22	18	52	52	12,500	1,442
Uganda, 2000–2001	13,774	8	14	50	43	21	44	43	25,000	1,208
Zambia, 1996	2,596	30	40	63	60	29	50	37	14,286	780
Zimbabwe, 1999	3,237	17	35	88	57	49	62	39	7,143	2,635
Asia										
Bangladesh, 1999–2000	40,767	8	25	63 ³	46 ³	42 ⁴	52	59	50,000	1,602
China, 1997	412,955	17	32	u	u	u	66	69	595	3,976
India, 1998–1999	305,219	20	28	74 ³	59 ^{3,6}	35 ^{7,8}	55	62	2,083	2,358
Kazakhstan, 1999	4,791	50	56	59	67	47	63	59	283	5,871
Nepal, 2001	6,258	4	12	67 ³	30 ³	39 ⁴	51	59	25,000	1,327
Pakistan, 1990–1991	38,399	25	37	47 ³	28 ³	26 ⁴	54	61	1,754	1,928
Philippines, 1994	21,781	33	59	82	69	u	61	65	9,091	3,971
Middle East & North Africa										
Egypt, 1992	20,397	42	45	77 ³	44 ³	40 ⁹	58	66	495	3,635
Morocco, 1992	8,960	35	56	47	15	26	61	67	2,941	3,546
Turkey, 1998	20,397	38	75	97 ³	85 ³	49 ⁴	64	69	826	6,974
Latin America & Caribbean										
Bolivia, 1998	2,248	41	63	86	52	44	51	62	1,961	2,424
Brazil, 1996	52,294	56	81	67	38	38	61	59	787	7,625
Dominican Republic, 1999	2,534	40	65	72	50	37	67	71	463	6,033
Haiti, 2000	2,132	20	36	60	18	22	49	48	12,500	1,467
Mexico, 1996	28,811	59	74	67	22 ¹⁰	20	65	69	855	9,023
Nicaragua, 1997–1998	1,363	47	56	45	29	24	59	67	1,163	2,366
Peru, 1996	7,485	57	73	83	55	54	60	68	1,075	4,426
Industrialized countries										
Great Britain, 1990	16,537	89	90	u	u	100 ¹¹	72	75	609	23,509
Hungary, 1993	2,835	49	64	87 ³	80 ^{3,14}	42 ^{9,15}	66	67	280	12,416
Italy, 1996	15,934	64	67	98 ³	78 ^{3,6}	57 ^{9,15}	72	75	181	23,626
Japan, 1997	34,705	71	79	u	u	u	75	78	508	26,755
Sweden, 1993	2,372	81	83	u	87 ^{3,14}	83 ¹⁷	74	77	322	24,277
United States, 1995	82,958	74	77	98	97	87 ⁷	71	74	408	34,142

1. The most recent survey available during this period was used. 2. Adjusted for relative value of local currency (purchasing power parity). 3. Men who have completed at least primary school. 4. Men with at least some secondary school education. 5. Based on men 15–54. 6. Based on men 40–49. 7. Men who have completed at least high school. 8. Based on men 20–49. 9. Men who have completed at least secondary school. 10. Based on married men. 11. Based on men 16–54. 12. Based on men 16–19. 13. Men who work 10 or more hours per week, regardless of school attendance. 14. Based on men 40–44. 15. Based on men 20–44. 16. Men who are unemployed, do housework, or engage in other or unknown activities. 17. Based on men 28–44.

NOTES: GDP=gross domestic product. Columns 11–14 are based on household data, unless indicated otherwise. u=unavailable.

SOURCES: For all columns lacking a citation, the reference is: The Alan Guttmacher Institute (AGI), unpublished tabulations of Demographic and Health Surveys (DHS) or of other relevant surveys (see Data Sources, p. 10). **Column 1:** United Nations (UN), *World Population Prospects: The 2000 Revision, Annex Tables*, New York: UN, 2001. **Columns 2 and 3:** UN, *World Urbanization Prospects 1999*, New York: UN, 1999. **Columns 4 and 5:** Philippines: Tabulations of the 1990 Census of Population and Housing provided by C. Raymundo, University of the Philippines, Manila, Philippines; *United States:* AGI, unpublished tabulations of the 2000 Current Population Survey (CPS). **Column 6:** Philippines: Tabulations of the 1990 Census of Population and Housing provided by C. Raymundo, University of the Philippines, Manila, Philippines; *Mexico:* AGI, unpublished tabulations of the 1998 Encuesta de Salud Reproductiva con Población Derechohabiente; *United States:* AGI, unpublished tabulations of the 2000 CPS. **Columns**

INDICATORS OF MODERNIZATION				EDUCATION/EMPLOYMENT STATUS			
% of households with				% of men 15–19			
Piped water	Electricity	Television	Radio	In school only	In school and working	Working only	Neither
11	12	13	14	15	16	17	18
8	15	11	54	u	u	u	u
4	7	6	58	16	1	67	16
8	41	16	53	53	2	36	8
2	3	3	45	38	6	42	13
3	2	2	29	35	20	37	8
28	48	29	66	31	4	52	13
5	13	2	21	u	u	u	u
40	74	50	73	80	4	6	10
17	43	21	50	49	1	32	19
3	16	9	56	37	10	44	9
23	15	13	63	61	2	15	23
3	5	2	55	u	u	u	u
5	6	8	56	26	0	49	24
5	7	3	31	47	4	13	36
5	7	5	33	14	1	66	19
10	45	26	62	60	2	17	20
31	32	21	67	u	u	u	u
3	8	2	43	26	6	54	14
4	15	13	51	63	5	22	11
1	9	6	52	u	u	u	u
18	17	17	44	53	1	23	23
20	38	25	52	56	0	20	24
5	32	18	32	u	u	u	u
43 ⁵	98 ⁵	u	u	u	u	u	u
39	60	35	38	u	u	u	u
50	97	92	41	75	2	5	18
35	25	13	44	u	u	u	u
18	61	27	35	u	u	u	u
42 ⁵	58 ⁵	37 ⁵	u	56	5	23	17
81	98	89	82	u	u	u	u
42	49	59	85	u	u	u	u
55	u	91	u	u	u	u	u
32	71	62	85	58	16	18	7
69	94	68	88	35	30	25	10
18	u	71	65	43	15	35	7
11	32	23	47	66	u	26	8
37 ⁵	97 ⁵	86 ⁵	u	25	17	55	3
49	70	56	78	37	14	36	13
56	67	68	85	56	14	22	7
u	u	u	u	38 ¹²	45 ^{12,13}	u	17 ¹²
u	u	u	u	u	u	u	u
u	u	u	u	u	u	u	u
100 ⁵	100 ⁵	100 ⁵	u	79	5	10	6 ¹⁶
u	u	u	u	u	u	u	u
u	u	u	u	46 ¹²	33 ¹²	16 ¹²	5 ¹²

7 and 8: Central African Republic, Côte d'Ivoire, Mali, Niger, Senegal, Bangladesh, China, Egypt, Great Britain and Italy: UN, *World Population Prospects 2000, Volume 1, Comprehensive Tables*, New York: UN, 2002; all other countries: U.S. Bureau of the Census, *International Data Base*, <<http://www.census.gov/ipc/www/idbnew.html>>, accessed Dec. 5, 2001. **Column 9:** Ethiopia, Gabon, Guinea, Malawi, Nigeria, Uganda, India, Morocco, Philippines, Bolivia, Great Britain and United States: UN Development Programme (UNDP), *Human Development Report 2000*, New York: UN, 2000, pp. 190–193; all other countries: UNDP, *Human Development Report 2001*, New York: UN, 2001, pp. 158–161. **Column 10:** UNDP, *Human Development Report 2002*, New York: Oxford University Press, 2002, pp. 149–152. **Columns 11–13:** Philippines: National Statistics Office, Philippines, *1990 Census of Population and Housing, Report No. 3: Socio-Economic and Demographic Characteristics*, Manila, Philippines: National Statistics Office, 1992. **Columns 15–18:** Zimbabwe: AGI, unpublished tabulations of the 1994 DHS.

APPENDIX TABLE 2: EDUCATION, MARITAL STATUS AND SEXUAL AND REPRODUCTIVE CHARACTERISTICS OF MEN 15–24 IN 45 COUNTRIES

Region, country and survey year	MEN 15–24											
	No. (in 000s), 2002	EDUCATION			MARITAL STATUS		SEXUAL EXPERIENCE					
		% of men 15–24 with ≥7 years of schooling			% of men ever married ¹		% of men ever had sex		Median age at 1st sex		% of men 20–24 who had 1st sex	
	Total	Urban	Rural	15–19	20–24	15–19	20–24	20–24	40–44	before age 18	before age 20	
	1	2	3	4	5	6	7	8	9	10	11	12
Sub-Saharan Africa												
Benin Republic, 2001	577	39	56	25	1	25	51	89	17.3	18.5	59	80
Burkina Faso, 1999	1,276	19	55	7	1	22	28	71	19.7	20.3	33	52
Cameroon, 1998	1,633	61	78	48	4	28	48	91	17.0	18.4	63	85
Central African Rep., 1994	379	33	52	12	8	46	52	94	17.0	18.0	65	88
Chad Republic, 1997	802	22	48	10	6	44	36	78	18.4	18.6	45	67
Côte d'Ivoire, 1998	1,840	37	58	20	2	21	56	89	17.5	19.5	54	83
Ethiopia, 2000	6,423	17	70	7	3	24	15	53	21.6	20.1	22	40
Gabon, 2000	113	72	78	46	4	29	78	96	15.7	17.4	85	94
Ghana, 1998	2,175	75	88	68	3	26	19	67	19.5	19.5	30	55
Guinea, 1999	853	30	46	17	2	20	51	84	17.5	20.1	56	77
Kenya, 1998	3,687	69	89	64	1	23	54	91	15.9	16.8	71	84
Malawi, 2000	1,214	43	69	37	4	42	61	93	17.7	18.5	53	77
Mali, 1996	1,180	20	44	6	5	29	37	79	18.7	20.7	38	64
Mozambique, 1997	1,887	15	35	5	4	58	66	95	16.8	17.6	61	87
Niger, 1998	1,151	19	50	7	4	42	26	66	20.3	20.2	26	47
Nigeria, 1999	12,429	65	84	56	3	17	27	64	19.5	20.1	37	55
Senegal, 1997	999	29 ⁷	44 ⁷	10 ⁷	u	8	u	69	19.0	21.1	38	56
Tanzania, 1999	3,841	56	65	52	4	33	57	90	17.5	17.9	57	81
Togo, 1998	487	48	70	33	2	18	43	85	u	u	u	u
Uganda, 2000	2,501	44	74	36	7	45	39	87	18.4	18.5	43	71
Zambia, 1996	1,150	55	75	38	1	32	66	89	16.0	17.3	70	83
Zimbabwe, 1999	1,466	84	98	77	1	24	29	76	19.5	20.0	31	57
Asia												
Bangladesh, 2000 ⁸	15,147	64 ⁹	u	u	5 ¹⁰	32 ¹⁰	u	u	u	22.9	u	u
China, 1997 and 2001	107,284	u	u	u	1 ¹¹	28 ¹¹	u	u	u	u	u	u
India, 1998–1999	102,435	83 ¹⁴	86 ¹⁴	70 ¹⁴	10 ¹⁰	41 ¹⁰	u	u	u	17.4 ¹⁵	u	u
Kazakhstan, 1999	1,505	99	98	99	0	34	33	84	18.6	19.5	40	69
Nepal, 2001 ¹⁶	2,416	50 ⁹	u	u	20 ¹⁰	61 ¹⁰	u	u	u	19.2	u	u
Pakistan, 1991 ⁸	14,876	50 ⁹	u	u	6 ¹⁷	30 ¹⁷	u	u	u	u	u	u
Philippines, 1994	8,111	77	84	69	2	22	12	41	u	u	13	32
Middle East & North Africa												
Egypt, 1992 ⁸	7,476	79 ⁷	u	u	2 ¹⁸	12 ¹⁸	u	u	u	u	u	u
Morocco, 1992	3,197	47 ⁷	64 ⁷	22 ⁷	1 ¹⁹	11 ¹⁹	u	u	u	u	u	u
Turkey, 1998 ⁸	6,718	96 ⁹	u	u	4 ²⁰	28 ²⁰	u	u	u	u	u	u
Latin America & Caribbean												
Bolivia, 1998	856	86	93	64	5	34	41	89	17.0	17.4	63	79
Brazil, 1996	17,165	67	75	38	4	29	64	94	16.2	16.5	77	90
Dominican Republic, 1999	879	73	83	57	5	43	48	94	16.6	16.2	70	87
Haiti, 2000	939	42	70	21	3	30	52	87	15.9	16.9	71	82
Mexico, 1996	10,032	66	72	54	5 ²⁰	38 ²⁰	25	82	17.5	18.0	57	78
Nicaragua, 1998	573	47	64	20	10	56	58	96	15.8	15.4	80	92
Peru, 1996	2,691	84	93	60	3	31	46	89	17.4	16.6	60	80
Industrialized countries												
Great Britain, 1990	3,772	u	u	u	1 ²¹	16	u	u	17.0	18.0	64	83
Hungary, 1993	704	87 ^{7,9}	91 ⁷	79 ⁷	7 ²³	25	78 ²³	87	17.0	17.5	49	78
Italy, 1996	3,250	98 ^{7,9}	99 ⁷	98 ⁷	1 ²³	5	69 ²³	81	17.5	17.2	40	69
Japan, 1997	7,831	99	u	u	0.4	7	32 ²⁴	62	18.8 ²⁵	19.8 ²⁶	46 ²⁵	71 ²⁵
Sweden, 1993	534	u	u	u	0.1	2	u	u	u	u	u	u
United States, 1995	20,220	98 ⁹	u	u	2	30	55	90	15.9	17.1	73	82

1. Ever-married men include those who have ever cohabited or been in a consensual union. 2. Sexually active men are those who had intercourse in the past three months (one month in the Philippines, Mexico, Hungary, Italy and the United States). 3. Based on the number of partners in the past year. 4. Based on men who had intercourse in the past three months (one month in Hungary, Italy and the United States); all men, regardless of sexual activity, in China; and sexually experienced men in Mexico. 5. Column 21 may not be the total of columns 22–25 because it includes men relying on traditional methods. 6. Pill, injectable, implant, IUD, spermicide, diaphragm or female sterilization. 7. Based on men 20–24. 8. Based on married men, except for columns 1, 5 and 6. 9. Men who have completed at least primary school. 10. Survey year, 1991. 11. Survey year, 1997. 12. Calculated from both 1997 and 2001 surveys. 13. Survey year, 2001. 14. Based on men 15–29. 15. Based on married men in Uttar Pradesh only. 16. Based on ever-married men, except for columns 1, 5 and 6. 17. Survey year, 1998. 18. Survey year, 1996. 19. Survey year, 1994. 20. Survey year, 1990. 21. Based on men 16–19. 22. Based on men

16–24. 23. Men aged 20–24 who had engaged in the behavior by age 20. 24. Based on men 18–19. 25. Based on men 20–29. 26. Based on men 40–49. 27. Based on men 18–24. 28. Men relying on withdrawal or periodic abstinence.

NOTES: In calculations of median age at first sex, men who never had sex ranked higher than the oldest sexually experienced men. Data in columns 9 and 10 are from two cohorts of the same survey. u=unavailable.

SOURCES: For all columns lacking a citation, the reference is: The Alan Guttmacher Institute (AGI), unpublished tabulations of Demographic and Health Surveys (DHS) or of other relevant surveys (see Data Sources, p. 10). Column 1: United Nations (UN), *World Population Prospects: The 2000 Revision, Annex Tables*, New York: UN, 2001. Column 2: *United States*: AGI, unpublished tabulations of the 2000 Current Population Survey. Column 5: Bangladesh, India, Nepal, Pakistan, Egypt, Morocco, Turkey, Mexico, Sweden: United Nations Population Division, *Database on Marriage Patterns* (Pop/1/DB/2000/3); Japan:

SEXUAL ACTIVITY		FATHERHOOD		CONTRACEPTIVE KNOWLEDGE		CONTRACEPTIVE USE						
% of never-married men sexually active ²		% of unmarried sexually experienced men 15–24 with ≥2 partners ³	Mean no. of children desired, men 15–24	% of men who are fathers		% of men 15–24 who know about		% of sexually active men ⁴ 15–24 currently using				
15–19	20–24			15–19	20–24	Condoms	Other modern methods	Any method ⁵	Condoms	Withdrawal	Periodic Abstinence	Other modern methods ⁶
13	14	15	16	17	18	19	20	21	22	23	24	25
33	59	29	6.0	2	18	93	72	53	38	4	8	2
21	48	39	6.2	1	15	89	59	45	37	0	7	1
37	72	61	6.0	3	22	91	69	62	33	3	24	1
42	76	u	6.8	5	38	92	61	22	11	1	8	0
26	46	53	11.0	3	27	61	36	18	9	1	6	2
45	66	46	5.3	3	27	96	68	60	43	0	12	4
7	21	18	4.9	0.3	14	61	72	13	7	0	2	5
59	80	31	5.0	7	30	99	76	71	52	2	13	3
13	34	23	3.9	1	13	92	73	47	29	4	6	9
40	56	37	5.4	2	16	82	60	44	36	2	5	1
38	65	45	3.7	1	18	97	88	60	39	0	17	3
36	49	15	3.8	3	33	94	92	35	27	2	1	4
21	49	31	7.0	0.2	19	84	63	37	30	1	4	1
50	68	60	5.9	4	41	64	51	10	5	0	1	1
14	23	46	9.1	1	23	78	76	19	14	1	1	3
16	42	40	6.4	2	12	74	56	36	22	2	7	4
u	u	u	6.2 ⁷	u	u	93 ⁷	73 ⁷	u	u	u	u	u
43	66	35	4.6	1	24	87	68	28	24	0	2	2
26	55	32	4.4	1	15	96	79	58	40	1	13	3
17	40	20	4.7	5	40	97	87	42	32	1	4	5
44	60	43	5.2	1	32	95	73	35	26	2	3	2
16	42	22	3.7	0.3	17	u	90	56	41	1	1	13
u	u	u	2.3	u	u	96	100	u	u	u	u	u
u	u	u	u	0.2 ¹²	17 ¹²	u	u	11 ¹³	10 ¹³	0.2 ¹³	0.3 ¹³	u
u	u	u	u	u	u	u	u	u	u	u	u	u
23	66	38	2.9	0.2	20	84	82	71	52	2	3	12
u	u	u	2.5	u	u	99	100	u	u	u	u	u
u	u	u	3.9	u	u	u	79	u	u	u	u	u
3	9	u	3.2	u	u	79	27	u	u	u	u	u
u	u	u	3.1 ⁷	u	u	47 ⁷	94 ⁷	u	u	u	u	u
u	u	u	2.6 ⁷	u	u	u	u	u	u	u	u	u
u	u	u	2.6	u	u	82	96	u	u	u	u	u
29	70	50	2.6	3	29	90	86	56	22	3	23	9
44	72	58	2.3	3	22	99	98	64	34	2	1	27
31	74	59	3.2	1	27	98	98	70	39	12	0	18
30	54	28	3.2	1	21	95	92	49	26	9	11	3
16	23	u	2.6	3	34	90	88	25	9	2	2	11
40	72	u	2.6	4	46	97	93	45	12	1	2	30
32	68	44	2.4	2	24	95	94	63	23	3	19	18
32 ²¹	53	34 ²²	u	2 ²¹	13	u	u	94 ²²	58 ²²	u	6 ^{22,28}	29 ²²
u	54	u	1.9 ⁷	3 ²³	13	u	u	80 ⁷	20 ⁷	4 ⁷	0 ⁷	56 ⁷
u	49	u	2.1 ⁷	0 ²³	2	u	u	83 ⁷	63 ⁷	5 ⁷	0 ⁷	15 ⁷
u	u	34	1.9	u	u	u	u	73 ²⁷	58 ²⁷	u	12 ^{27,28}	1 ²⁷
u	u	u	u	u	u	u	u	u	u	u	u	u
46	55	51 ⁷	2.3 ¹⁴	3	17	u	u	83 ⁷	27 ⁷	4 ⁷	0 ⁷	52 ⁷

Japan Census 2000, <<http://www.stat.go.jp/english/data/nenkan/zuhyou/bo213000.xls>>, accessed June 30, 2003; *United States*: AGI, unpublished tabulations of the 1995 National Survey of Adolescent Males (NSAM). **Column 6:** *Bangladesh, India, Nepal, Pakistan, Egypt, Morocco, Turkey, Mexico, Sweden*: United Nations Population Division, *Database on Marriage Patterns* (Pop/1/DB/2000/3); *Japan*: Japan Census 2000, <<http://www.stat.go.jp/english/data/nenkan/zuhyou/bo213000.xls>>, accessed June 30, 2003; *United States*: AGI, unpublished tabulations of the 1991 National Survey of Men (NSM). **Column 7:** *United States*: AGI, unpublished tabulations of the 1995 NSAM. **Column 8:** *United States*: AGI, unpublished tabulations of the 1991 NSM. **Column 9:** *Japan*: AGI, unpublished tabulations of the 1999 NHK Survey of Sex in Japan. **Column 10:** *Uttar Pradesh (India)*: AGI, unpublished tabulations of the 1995–1996 Male Reproductive Health Survey; *Japan*: AGI, unpublished tabulations of the 1999 NHK Survey of Sex in Japan. **Columns 11 and 12:** *Japan*: AGI, unpublished tabulations of the 1999 NHK Survey of Sex in Japan. **Column 13:** *United States*: AGI, unpublished tabulations of the 1995 NSAM. **Column 15:** *Dominican*

Republic: AGI, unpublished tabulations of the 1996 DHS; *Japan*: AGI, unpublished tabulations of the 1999 NHK Survey of Sex in Japan. **Column 16:** *Japan*: AGI, unpublished tabulations of the 1999 NHK Survey of Sex in Japan; *United States*: AGI, unpublished tabulations of the 1995 NSAM. **Column 17:** *Tanzania*: AGI, unpublished tabulations of the 1996 DHS; *United States*: AGI, unpublished tabulations of the 1995 NSAM. **Column 18:** *Tanzania*: AGI, unpublished tabulations of the 1996 DHS; *United States*: AGI, unpublished tabulations of the 1992 Survey on Income and Program Participation. **Columns 21–25:** *United States*: AGI, unpublished tabulations of the 1991 National Survey of Men.

APPENDIX TABLE 3: MARITAL STATUS AND SEXUAL AND REPRODUCTIVE CHARACTERISTICS OF MEN 25–39 IN 45 COUNTRIES

Region, country and survey year	MEN 25–39		MARITAL STATUS				SEXUAL ACTIVITY		FATHERHOOD				
	No. (in 000s), 2002	% of men ever married ¹		Median age at 1st marriage ¹		% of married men 25–39 with ≥1 extramarital partners ^{1,2}	% of unmarried sexually experi- enced men 25–39 with ≥2 partners ³	Median age became father, men 25–39	Mean no. of children desired, men 25–39			% of men who are fathers	
		25–29	30–39	25–29	40–44				Total	Rural	Urban	25–29	30–39
1	2	3	4	5	6	7	8	9	10	11	12	13	
Sub-Saharan Africa													
Benin Republic, 2001	569	67	92	24.4	24.0	29	33	26.2	7.6	8.9	5.9	61	89
Burkina Faso, 1998–1999	921	61	94	25.1	25.4	10	40	27.1	6.4	7.0	4.3	53	91
Cameroon, 1998	1,454	58	88	26.1	24.7	41	64	27.4	7.0	7.7	5.8	50	83
Central African Republic, 1994–1995	332	77	93	23.3	22.9	u	u	24.3	7.7	8.7	6.3	71	89
Chad Republic, 1996–1997	737	75	97	22.7	23.0	15	48	25.5	13.8	15.1	10.9	66	93
Côte d'Ivoire, 1998–1999	1,600	46	84	26.3 ⁸	24.6	29	56	28.5	5.8	7.0	4.3	44	86
Ethiopia, 2000	5,982	71	93	23.2	23.7	7	15	26.5	6.5	6.9	4.3	59	87
Gabon, 2000	114	61	90	24.7	22.9	53	27	25.6	5.6	6.8	5.2	62	88
Ghana, 1998	2,010	58	90	25.8	25.1	24	24	28.3	4.5	5.1	3.6	45	86
Guinea, 1999	799	50	88	26.1 ⁸	26.8	30	39	27.2	6.8	7.9	4.9	52	83
Kenya, 1998	3,069	65	93	26.2	24.2	20	40	26.7	3.9	4.2	3.5	57	90
Malawi, 2000	1,030	86	98	22.7	22.3	15	13	24.2	4.8	4.9	4.2	82	95
Mali, 1995–1996	1,063	68	91	24.5	25.8	9	40	26.1	7.6	8.3	6.2	62	87
Mozambique, 1997	1,754	88	97	21.3	22.1	49	43	24.0	7.2	8.2	5.2	72	89
Niger, 1998	1,012	84	96	22.5	21.2	7	41	25.3	10.8	11.7	7.7	71	92
Nigeria, 1999	11,022	58	89	25.7	24.8	24	46	28.4	7.3	7.9	5.9	45	83
Senegal, 1997	944	36	73	29.2 ⁸	26.2	u	u	u	6.9	8.1	5.6	u	u
Tanzania, 1999	3,447	80	94	23.4	24.3	29	34	25.6	5.4	5.9	4.3	66	91
Togo, 1998	444	60	89	25.1	24.5	21	40	27.0	5.2	6.0	4.0	54	84
Uganda, 2000–2001	2,124	83	95	21.9	22.6	14	22	22.6	5.8	6.1	4.4	82	95
Zambia, 1996	986	77	95	23.4	23.8	22	43	24.7	5.7	6.6	4.8	73	92
Zimbabwe, 1999	1,207	73	93	24.3	24.1	15	25	26.2	3.8	4.2	3.4	61	90
Asia													
Bangladesh, 1999–2000 ⁹	16,314	74 ¹⁰	95 ¹⁰	u	23.4	u	u	u	2.3	2.4	2.2	u	u
China, 1997 and 2001	178,288	80	94	u	u	u	u	24.0 ¹¹	u	u	u	68 ¹²	90 ¹²
India (Uttar Pradesh), 1995–1996 ^{9,13}	122,433 ¹⁴	76 ^{10,14}	94 ^{10,14}	u	20.1	u	u	u	u	u	u	u	u
Kazakhstan, 1999	1,831	75	91	23.7	23.5	11	41	26.1	3.3	3.5	3.1	62	87
Nepal, 2001 ¹⁶	2,428	87	96	u	u	u	u	u	2.7	2.8	2.2	u	u
Pakistan, 1990–1991 ⁹	14,111	63 ¹⁷	87 ¹⁷	u	24.8	u	u	u	4.2	4.2	4.0	u	u
Philippines, 1990 ⁹	8,583	63	87	u	u	u	u	u	u	u	u	u	u
Middle East & North Africa													
Egypt, 1992 ⁹	7,706	49 ¹⁸	88 ¹⁸	u	26.2	u	u	u	3.1	3.3	2.8	u	u
Morocco, 1992 ⁹	3,623	37 ¹⁹	75 ¹⁹	u	25.1	u	u	u	3.3	3.7	2.9	u	u
Turkey, 1998 ⁹	8,291	74 ²⁰	93 ²⁰	u	22.9	u	u	u	2.6	2.7	2.6	u	u
Latin America & Caribbean													
Bolivia, 1998	884	67	89	23.7	23.6	13	45	25.7	3.0	3.1	2.9	62	86
Brazil, 1996	20,959	65	89	24.3	24.0	12	56	27.1	2.6	2.7	2.6	53	82
Dominican Republic, 1999	1,024	63	92	26.3	24.8	36	65	27.0	3.7	3.8	3.7	53	85
Haiti, 2000	778	48	86	26.0 ⁸	24.5	32	37	28.0	3.1	3.4	2.8	47	83
Mexico, 1998	11,972	70 ²⁰	88 ²⁰	24.4	23.0	u	u	25.3	3.7 ²¹	4.0 ²¹	3.5 ²¹	63	93
Nicaragua, 1997–1998	520	82	95	21.2	22.5	u	u	23.2	3.2	3.4	3.0	76	90
Peru, 1996	3,008	61	85	25.1	25.0	15	50	26.3	2.6	2.9	2.5	58	80
Industrialized countries													
Great Britain, 1990	6,607	74	91	24.0	24.0	2	27	29.0	u	u	u	36	70
Hungary, 1993	1,089	68	88	23.2	22.7	u	u	24.1	0.7	0.6	0.7	47	79
Italy, 1996	6,741	26 ¹⁷	74 ¹⁷	28.7 ⁸	24.8	u	u	u	1.4	1.4	1.3	11	57
Japan, 1997	13,736	39	74	u	27.7 ²¹	u	28 ²³	28.7	2.3	2.4	2.2	19	56
Sweden, 1993	916	82 ²⁴	90 ²⁵	21.6 ²⁴	21.9 ²⁵	u	u	30.0 ²⁶	1.3 ²⁶	1.1 ²⁶	1.4 ²⁶	43 ²⁴	70 ²⁵
United States, 1991	31,027	71	90	u	23.7	8	41	28.5	2.5	u	u	35	65

1. Ever-married men include those who have ever cohabited or been in a consensual union; married men include those cohabiting or in a consensual union. 2. Based on the number of extramarital partners in the past year. 3. Based on the number of partners in the past year. 4. Based on men who had intercourse in the past three months (one month in Hungary, Italy and the United States); all men, regardless of sexual activity, in China, the Philippines and Great Britain; married men in Bangladesh, Uttar Pradesh (India), Pakistan, Egypt, Morocco, Turkey and Mexico; and ever-married men in Nepal. 5. Column 14 may not be the total of columns 15–19 because it includes men relying on traditional methods. 6. Pill, injectable, implant, IUD, spermicide, diaphragm or female sterilization. 7. Based on couples (those married, cohabiting or in a consensual union) in which the man is 25–39. 8. Based on men 30–34. 9. Based on married men, except for columns 1–3. 10. Survey year, 1991. 11. Survey year, 2001. 12. Calculated from both 1997 and 2001 surveys. 13. Refers to Uttar Pradesh only, except for columns 1–3. 14. Refers to the whole of India. 15. Ever discussed unwanted pregnancy. 16. Based on ever-married men, except

for columns 1–3. 17. Survey year, 1998. 18. Survey year, 1996. 19. Survey year, 1994. 20. Survey year, 1990. 21. Based on married men. 22. Based on men's reports of partner's preference. 23. Based on men 25–34. 24. Based on men 27–29. 25. Based on men 33–34. 26. Based on men 27–29 and 33–34. NOTES: In calculations of median ages at which men first married and became a father, never-married men and men who were not fathers ranked higher than the oldest married men and oldest fathers, respectively. We could not calculate median ages at which men 25–29 first married in the United States, because more than 50% never married; we could not calculate the median age at which men 25–39 became a father in Italy, because more than 50% were not fathers. Data in columns 4 and 5 are from two cohorts of the same survey. u=unavailable. SOURCES: For all columns lacking a citation, the reference is: The Alan Guttmacher Institute (AGI), unpublished tabulations of Demographic and Health Surveys (DHS) or of other relevant surveys (see Data Sources, p. 10). Column 1: United Nations (UN), *World Population Prospects: The 2000 Revision, Annex*

CONTRACEPTIVE USE

FAMILY PLANNING

% of sexually active men ⁴ 25–39 currently using						% of couples differing in desired family size by ≥2 children ⁷	% of couples reporting each other's attitude toward family planning (%) ⁷			Both partners report discussing family planning (%) ⁷	Married men 25–39 report discussing family planning (%) ¹
Any method ⁵	Condoms	Vasectomy	Withdrawal	Periodic abstinence	Other modern methods ⁶		Both partners correct	One or both partners incorrect	One or both partners do not know		
14	15	16	17	18	19	20	21	22	23	24	25
43	17	0	7	12	5	58	27	22	51	28	56
46	22	0	1	17	6	53	27	13	59	20	49
46	17	0	3	20	4	52	20	19	61	26	52
22	4	0	1	11	2	61	20	20	60	44	u
18	3	0	1	12	1	79	14	12	74	12	37
45	17	0	2	17	9	48	31	18	52	27	42
21	2	0	1	7	10	56	u	u	u	u	u
65	33	0	5	18	7	56	28	20	52	55	70
39	14	0	3	9	12	36	54	12	34	51	67
30	20	0	1	6	3	63	18	29	53	8	28
66	15	0	1	20	29	32	60	20	20	69	84
36	10	0	2	1	21	36	70	17	13	67	82
25	10	0	1	7	5	59	18	17	65	22	46
11	2	0	0	2	6	69	18	16	66	14	33
18	4	0	0	2	8	70	20	11	69	15	37
34	13	0	3	10	7	56	24	14	62	19	43
u	u	u	u	u	u	53	25	12	63	32	31
42	15	0	5	5	14	38	50	19	32	48	63
49	19	0	4	15	6	54	28	17	55	41	65
30	10	0	1	6	10	36	70	17	13	67	63
42	12	0	5	7	15	47	55	18	27	56	75
66	13	0	1	1	51	37	82	8	10	77	91
62	6	0	1	8	44	13	u	u	u	u	u
u	6 ¹¹	6 ¹¹	0.2 ¹¹	0.3 ¹¹	u	u	u	u	u	u	u
43	16	1	1	4	21	u	u	u	u	u	21 ¹⁵
63	13	1	3	2	45	37	55	26	20	39	61
56	7	7	3	3	36	12	76	11	13	41	62
15	4	0	2	3	6	34	26	22	52	14	29
47	u	u	u	u	u	u	u	u	u	u	u
47	1	0	0	0	44	21	69	18	13	47	47
46	1	0	1	3	40	29	u	u	u	u	83
69	15	0	20	2	32	18	69	13	17	u	u
66	8	0	2	32	23	36	64	16	21	73	85
78	14	3	2	3	56	27	u	u	u	u	u
70	11	0	7	3	48	36	61	19	20	34	55
51	14	0	10	6	20	29	52	11	37	60	73
67	3	2	7	6	49	u	u	u	u	u	62
67	6	0	1	3	56	35	76	13	12	69	79
75	14	1	2	21	37	24	80	12	8	88	93
90	38	7	5	2	38	u	u	u	u	u	u
75	10	0	4	4	58	5 ²²	u	u	u	u	u
77	35	u	15	1	26	6 ²²	u	u	u	u	u
68	51	0	10	1	3	u	u	u	u	u	u
u	u	u	u	u	u	u	u	u	u	u	u
84	19	10	4	2	49	19	u	u	u	u	u

Tables, New York: UN, 2001. **Columns 2 and 3:** Bangladesh, China, India, Nepal, Pakistan, Egypt, Morocco, Turkey, Mexico and Italy: United Nations Population Division, *Database on Marriage Patterns* (Pop/1/DB/2000/3); Philippines: National Statistics Office, Philippines, *1990 Census of Population and Housing, Report No. 3: Socio-Economic and Demographic Characteristics*, Manila, Philippines: National Statistics Office, 1992; *United States:* AGI, unpublished tabulations of the 1992 National Health and Social Life Survey (NHLS). **Column 4:** Mexico: United Nations Population Division, *Database on Marriage Patterns* (Pop/1/DB/2000/3). **Column 5:** United States: AGI, unpublished tabulations of the 1992–1994 National Survey of Families and Households (NSFH). **Column 6:** Dominican Republic: AGI, unpublished tabulations of the 1996 DHS; *United States:* AGI, unpublished tabulations of the 1992 NHLS. **Column 7:** Dominican Republic: AGI, unpublished tabulations of the 1996 DHS; Japan: AGI, unpublished tabulations of the 1999 HIV and Sex in Japan Survey; *United States:* AGI, unpublished tabulations of the 1992 NHLS. **Column 8:** Tanzania: AGI, unpublished tabulations of the 1996 DHS; *United*

States: AGI, *In Their Own Right: Addressing the Sexual and Reproductive Health Needs of American Men*, New York: AGI, 2002, p. 8. **Column 9:** Mexico: AGI, unpublished tabulations of the 1996 Encuesta de Comunicación en Planificación Familiar (ENCOPLAF); *United States:* AGI, unpublished tabulations of the 1992–1994 NSFH. **Columns 10 and 11:** Mexico: AGI, unpublished tabulations of the 1996 ENCOPLAF. **Column 20:** *United States:* AGI, unpublished tabulations of the 1992–1994 NSFH. **Column 12:** Tanzania: AGI, unpublished tabulations of the 1996 DHS; *United States:* AGI, unpublished tabulations of the 1992–1994 NSFH. **Column 13:** Tanzania: AGI, unpublished tabulations of the 1996 DHS; *United States:* AGI, unpublished tabulations of the 1992 NHLS. **Column 14:** Philippines: 1994 Status of Women and Fertility Survey; Mexico: AGI, unpublished tabulations of the 1996 ENCOPLAF. **Columns 15–19:** Mexico: AGI, unpublished tabulations of the 1996 ENCOPLAF. **Column 20:** *United States:* AGI, unpublished tabulations of the 1992–1994 NSFH. **Column 25:** Mexico: AGI, unpublished tabulations of the 1996 ENCOPLAF.

APPENDIX TABLE 4. MARITAL STATUS AND SEXUAL AND REPRODUCTIVE CHARACTERISTICS OF MEN 40–54 IN 45 COUNTRIES

Region, country and survey year	MEN 40–54	CURRENT MARITAL STATUS		SEXUAL ACTIVITY	FATHERHOOD							
	No. (in 000s), 2002	% of men 40–54		% of married men 40–54 with ≥1 extramarital partners ^{1,2}	Mean no. of children, men aged			Mean no. of children desired, men 50–54	Desire no more children (% of men 40–54)	Mean no. of children, men 40–54 with		% of men 40–54 childless
		Married ¹	Single but formerly married ¹		40–44	45–49	50–54			<7 years of schooling	≥7 years of schooling	
	1	2	3	4	5	6	7	8	9	10	11	12
Sub-Saharan Africa												
Benin Republic, 2001	309	92	7	15	7.4	9.5	10.8	15.4	33	9.1	6.5	2
Burkina Faso, 1998–1999	428	96	3	4	6.9	8.6	10.6	10.1	19	8.6	6.0	1
Cameroon, 1998	761	91	8	26	5.6	7.2	7.8	9.8	21	6.8	6.4	7
Central African Republic, 1994–1995	196	82	16	u	6.5	6.5	7.3	10.1	19	6.4	8.8	8
Chad Republic, 1996–1997	393	96	4	8	8.1	9.7	10.7	19.6	6	9.3	7.9	2
Côte d'Ivoire, 1998–1999	990	84	8	22	5.8	6.5	8.8	8.1	32	6.8	7.1	8
Ethiopia, 2000	3,316	95	4	9	5.9	8.0	8.5	9.1	37	7.6	4.2	3
Gabon, 2000	76	82	14	36	6.1	6.3	8.0	8.0	26	5.9	7.1	4
Ghana, 1998	1,088	88	10	24	4.7	5.5	7.3	6.5	45	6.5	5.3	4
Guinea, 1999	450	96	3	17	5.7	7.2	9.2	10.8	10	7.5	5.5	2
Kenya, 1998	1,461	94	5	10	5.6	6.8	8.3	4.3	65	7.4	6.3	3
Malawi, 2000	526	94	6	7	6.6	7.8	9.3	8.0	66	8.0	7.2	1
Mali, 1995–1996	519	97	2	5	6.5	8.0	10.0	11.0	10	8.0	6.4	2
Mozambique, 1997	939	94	6	39	5.8	7.4	8.2	8.4	22	6.9	5.1	1
Niger, 1998	502	98	2	4	7.9	9.2	10.7	14.4	6	9.2	6.8	2
Nigeria, 1999	5,985	95	4	23	6.6	7.9	8.7	9.6	28	8.3	6.3	4
Senegal, 1997	519	92	6	u	u	u	u	8.8	11	u	u	u
Tanzania, 1999	1,709	91	8	27	6.0	7.6	9.1	7.8	37	7.6	6.6	3
Togo, 1998	234	91	7	15	6.9	8.0	9.8	6.4	39	8.4	6.3	2
Uganda, 2000–2001	999	88	9	7	7.3	9.0	9.6	7.7	53	8.8	7.9	4
Zambia, 1996	460	93	6	9	6.2	7.8	9.5	8.3	42	7.9	7.2	1
Zimbabwe, 1999	565	89	10	15	5.2	5.8	7.5	6.3	57	6.6	5.5	2
Asia												
Bangladesh, 1999–2000 ⁶	9,306	98 ⁷	1 ⁷	u	4.2	4.7	5.9	2.6	87	5.2	4.1	1
China, 2001	127,404	92 ⁸	4 ⁸	u	2.0	2.2	2.4	u	u	2.5	1.9	1
India (Uttar Pradesh), 1995–1996 ^{6,9}	80,351 ¹⁰	93 ^{7,10}	4 ^{7,10}	3	4.9	5.0	5.3	u	84	5.4	4.5	3
Kazakhstan, 1999	1,463	90	7	7	2.8	2.9	3.9	3.2	82	4.0	3.1	4
Nepal, 2001 ¹¹	1,415	93 ⁷	5 ⁷	0	4.1	4.5	4.5	3.0	89	4.4	4.2	3
Pakistan, 1990–1991 ⁶	9,412	92 ¹²	4 ¹²	u	u	u	u	4.0	44	u	u	u
Philippines, 1994 ⁶	5,087	92	3	u	u	u	u	u	53	5.7	3.8	4
Middle East & North Africa												
Egypt, 1992 ⁶	5,215	97 ¹³	2 ¹³	u	5.0	5.8	6.6	3.4	78	6.5	4.1	2
Morocco, 1992 ⁶	2,139	93 ¹⁴	2 ¹⁴	u	5.3	6.3	6.1	4.5	55	6.1	4.5	4
Turkey, 1998 ⁶	5,388	96 ¹⁵	2 ¹⁵	u	3.6	4.4	5.1	3.0	87	4.9	3.1	2
Latin America & Caribbean												
Bolivia, 1998	508	88	8	8	4.6	5.2	5.5	3.2	80	5.8	4.3	6
Brazil, 1996	14,170	90	7	11	3.5	3.9	4.2	2.9	83	4.4	2.8	6
Dominican Republic, 1999	631	81	13	20	3.4	4.4	4.6	5.2	76	4.2	3.9	12
Haiti, 2000	415	90	9	22	5.3	6.7	6.4	3.7	65	6.3	4.9	5
Mexico, 1996 ⁶	6,807	88 ¹⁶	6 ¹⁶	u	4.6	5.4	6.1	3.8 ¹⁷	89	5.4	4.0	1
Nicaragua, 1997–1998	270	88	9	u	5.2	5.9	5.9	3.6	74	6.0	4.5	5
Peru, 1996	1,786	89	8	14	4.3	4.9	5.1	3.3	80	6.0	3.7	7
Industrialized countries												
Great Britain, 1990	6,157	86	10	5	1.8	2.1	2.2	u	u	u	u	16
Hungary, 1993 ¹⁸	1,041	84	11	u	1.8	u	u	u	91	2.2	1.7	11
Italy, 1996 ¹⁹	5,943	90	4	u	1.7	1.8	u	u	91	2.1	1.6	15
Japan, 1997 ²⁰	13,139	86	4	u	1.7	1.9	u	2.3	89	u	u	18
Sweden, 1993 ²¹	922	80	15	u	1.9	u	u	u	88	1.9	1.9	17
United States, 1992	31,711	84	14	6	2.0	2.2	2.4	2.6 ²²	89	2.6	2.1	12

1. Married men include those cohabiting or in a consensual union. 2. Based on the number of extramarital partners in the past year (lifetime number in Uttar Pradesh, India). 3. Based on men who had intercourse in the past three months (one month in Hungary, Italy and the United States); all men, regardless of sexual activity, in the Philippines; married men in Bangladesh, Uttar Pradesh (India), Pakistan, Egypt, Morocco, Turkey, Mexico and Japan; and ever-married men in Nepal. 4. Column 14 may not be the total of columns 15–20 because it includes men relying on traditional methods. 5. Pill, injectable, implant, IUD, spermicide or diaphragm. 6. Based on married men, except for columns 1–3. 7. Survey year, 1991. 8. Survey year, 1999. 9. Refers to Uttar Pradesh only, except for columns 1–3. 10. Refers to the whole of India. 11. Based on ever-married men, except for columns 1–3. 12. Survey year, 1998. 13. Survey year, 1996. 14. Survey year, 1994. 15. Survey year, 1990. 16. Refers to Mexico City

only; survey years 1992–1993. 17. Does not include 15% of respondents, who answered “don’t know” or “up to God.” 18. Based on men 40–44, except for column 1. 19. Based on men 40–49, except for column 1. 20. Based on married men 40–49, except for columns 1–3 and 8 (based on all men 40–49). 21. Based on men 43–44, except for column 1. 22. Based on men 40–49.

NOTE: u=unavailable.

SOURCES: For all columns lacking a citation, the reference is: The Alan Guttmacher Institute (AGI), unpublished tabulations of Demographic and Health Surveys (DHS) or of other relevant surveys (see Data Sources, p. 10). Column 1: United Nations (UN), *World Population Prospects: The 2000 Revision, Annex Tables*, New York: UN, 2001. Columns 2 and 3: Bangladesh, China, India, Nepal, Pakistan, Egypt, Morocco, Turkey and Italy: United Nations Population Division, *Database on Marriage Patterns*

CONTRACEPTIVE USE

% of sexually active men³ 40–54 currently using

Any method ⁴	Condoms	Vasectomy	Withdrawal	Periodic abstinence	Partner sterilization	Other modern methods ⁵
13	14	15	16	17	18	19
33	6	0	8	12	0	6
46	7	0	1	29	0	6
34	7	0	5	15	1	5
16	1	0	1	5	2	1
13	1	0	1	9	0	1
27	11	0	2	9	0	5
15	0	0	0	6	0	8
40	14	0	2	17	1	5
31	6	0	2	8	1	14
16	6	0	2	6	0	3
63	5	0	1	19	15	20
34	4	0	2	1	11	13
15	1	0	1	7	1	4
10	0	0	0	2	3	4
12	0	0	0	1	0	6
38	7	0	2	16	1	10
u	u	u	u	u	u	u
38	6	0	3	8	5	12
41	6	0	4	14	0	7
25	3	1	1	6	3	9
39	6	0	4	5	4	15
67	6	0	3	2	5	47
71	6	1	3	10	14	36
u	u	u	u	u	u	u
48	8	5	1	3	27	3
63	13	1	3	2	3	40
54	3	10	4	2	24	11
19	4	0	2	4	7	2
70	u	u	u	u	u	u
58	4	0	2	1	1	50
43	1	0	2	3	6	29
62	9	0	17	2	6	26
53	3	0	2	25	11	10
73	6	2	3	4	48	11
80	7	0	1	2	63	7
39	2	1	7	6	5	17
61	4	1	1	4	43	8
63	5	1	2	2	38	15
62	6	1	3	19	16	17
74	22	19	4	2	13	14
76	8	u	5	2	11	50
70	23	u	18	3	8	19
61	44	1	6	1	3	2
u	u	u	u	u	u	u
u	5	23	u	u	u	u

(Pop/1/DB/2000/3); *Philippines*: National Statistics Office, Philippines, 1990 Census of Population and Housing, Report No. 3: Socio-Economic and Demographic Characteristics, Manila, Philippines: National Statistics Office, 1992; *Mexico City*: AGI, unpublished tabulations of the 1992–1993 CONASIDA Comportamiento Sexual en la Ciudad de México. **Columns 5 and 6**: *United States*: AGI, unpublished tabulations of the 1992–1994 National Survey of Families and Households (NSFH). **Column 7**: *Tanzania*: AGI, unpublished tabulations of the 1996 DHS; *United States*: AGI, unpublished tabulations of the 1992–1994 NSFH. **Column 8**: *United States*: AGI, unpublished tabulations of the 1992–1994 NSFH. **Column 9**: *Tanzania*: AGI, unpublished tabulations of the 1996 DHS; *United States*: AGI, unpublished tabulations of the 1992–1994 NSFH. **Columns 10–12**: *Tanzania*: AGI, unpublished tabulations of the 1996 DHS.

APPENDIX TABLE 5: HIV/AIDS PREVALENCE, SEXUALLY TRANSMITTED INFECTION (STI) AND HIV/AIDS KNOWLEDGE AND PREVENTION, AND UNMET NEED

Region, country and survey year	HIV/AIDS PREVALENCE	STI/HIV/AIDS KNOWLEDGE AND PREVENTION					% of sexually experienced men who ever used a condom for HIV/AIDS prevention	
	Estimated % among adults, 2001	% of men 15–54				15–24	25–54	
		Have heard of STIs or HIV/AIDS	Know condom use prevents HIV/AIDS	Know condom use and either abstinence or monogamy prevent HIV/AIDS	Believe they have moderate/great risk of contracting HIV/AIDS			
	1	2	3	4	5	6	7	
Sub-Saharan Africa								
Benin Republic, 2001	3.6	98	58	31	19	36	21	
Burkina Faso, 1998–1999	6.5	96	56	34	21	52	28	
Cameroon, 1998	11.8	98	52	20	14	58	42	
Central African Republic, 1994–1995	12.9	99	42	22	15	54	31	
Chad Republic, 1996–1997	3.6	92	20	10	24	21	9	
Côte d'Ivoire, 1998–1999	9.7	100	67	31	13	72	46	
Ethiopia, 2000	6.4	96	37	32	u	u	u	
Gabon, 2000	4.2	100	69	27	u	80	68	
Ghana, 1998	3.0	u	39	23	10	u	u	
Guinea, 1999	1.5	97	41	28	9	42	24	
Kenya, 1998	15.0	99	49	12	23	55	35	
Malawi, 2000	15.0	100	71	60	u	u	u	
Mali, 1995–1996	1.7	96	44	10	11	41	20	
Mozambique, 1997	13.0	u	28	11	23	u	u	
Niger, 1998	1.4	95	29	11	7	24	10	
Nigeria, 1999	5.8	94	26	15	5	40	23	
Senegal, 1997	0.5	99 ⁵	51 ⁵	29 ⁵	u	u	u	
Tanzania, 1999	7.8	99	73	50	23	15	13	
Togo, 1998	6.0	99	55	20	16	56	34	
Uganda, 2000–2001	5.0	100	72	62	16	36	17	
Zambia, 1996	21.5	100	49	35	13	25	25	
Zimbabwe, 1999	33.7	99	76	59	12	70	52	
Asia								
Bangladesh, 1999–2000 ⁶	0.02	56	9	3	u	u	u	
China, 2001	0.1	u	u	u	u	u	u	
India (Uttar Pradesh), 1995–1996 ^{6,7}	0.8	u	u	u	u	u	u	
Kazakhstan, 1999	0.04	u	70	38	u	u	u	
Nepal, 2001 ⁹	0.5	74	53	22	u	u	u	
Pakistan, 1990–1991 ⁶	0.1	u	u	u	u	u	u	
Philippines, 2001	0.07	u	u	u	u	u	u	
Middle East & North Africa								
Egypt, 2001	0.02	u	u	u	u	u	u	
Morocco, 2001	0.1	u	u	u	u	u	u	
Turkey, 1998 ⁶	0.01	u	20	4	u	u	u	
Latin America & Caribbean								
Bolivia, 1998	0.1	u	47	28	41	u	u	
Brazil, 1996	0.7	99	82	11	14	u	u	
Dominican Republic, 1999	2.5	100	77	28	4	62	45	
Haiti, 2000	6.1	98	55	25	7	5	4	
Mexico, 1998	0.3	100	u	u	u	92	84	
Nicaragua, 1997–1998	0.2	u	64	16	32	u	u	
Peru, 1996	0.4	97	47	18	15	51	31	
Industrialized countries								
Great Britain, 2001	0.1	u	u	u	u	u	u	
Hungary, 1993	0.1	u	u	u	u	u	u	
Italy, 1996	0.4	u	u	u	u	u	u	
Japan, 1999	0.02	u	u	u	u	26 ^{13,14}	15 ^{13,14}	
Sweden, 2001	0.1	u	u	u	u	u	u	
United States, 1992	0.6	100 ¹⁵	u	u	u	u	u	

1. Unmet need for STI protection is the percentage of men who had two or more partners (or at least one extramarital partner) in the past year and did not use a condom at last intercourse. 2. Based on men who had intercourse in the past three months (one month in the United States); based on ever-married men in Nepal. 3. Married men include those cohabiting or in a consensual union. 4. Unmet need for contraception is the percentage of all men who are sexually active and fecund, and want to delay or avoid having children but are not using a method. Sexually active men are those who had intercourse in the past three months (one month in Hungary, Italy and the United States); refers to ever-married men in Nepal. 5. Based on men 20–54. 6. Based on married men, except for column 1. 7. Refers to Uttar Pradesh

only, except for column 1, which refers to the whole of India. 8. Based on men with STI symptoms. 9. Based on ever-married men, except for column 1. 10. Based on men 25–44. 11. Unmet need is for men who want no more children. 12. Based on men 25–49. 13. Based on men 18–24. 14. Based on condom use at last sex. 15. Based on men 20–39. 16. Based on men 18–54.

NOTE: u=unavailable.

SOURCES: For all columns lacking a citation, the reference is: The Alan Guttmacher Institute (AGI), unpublished tabulations of Demographic and Health Surveys (DHS) or of other relevant surveys (see Data Sources, p. 10). Column 1: Gabon, Guinea, Niger, Bangladesh, Egypt, Kazakhstan, Philippines,

REFERENCES AND NOTES

CHAPTER 1: WHY FOCUS ON MEN?

- World Fertility Surveys, 1974–1983; and Demographic and Health Surveys, 1987–2001.
- United Nations (UN), *Report of the International Conference on Population and Development, Cairo, 5–13 September, 1994*, New York: UN, 1994, paras. 4.24 and 4.29, pp. 30–31.
- Ibid.*, para. 4.27, p. 30.
- Casterline JB, Perez AE and Biddlecom AE, Factors underlying unmet need for family planning in the Philippines, *Studies in Family Planning*, 1997, 28(3):173–191; Wolff B, Blanc AK and Ssekamatte-Ssebuliba J, The role of couple negotiation in unmet need for contraception and the decision to stop childbearing in Uganda, *Studies in Family Planning*, 2000, 31(2):124–137; Casterline JB, Sathar ZA and ul Haque M, Obstacles to contraceptive use in Pakistan: a study in Punjab, *Studies in Family Planning*, 2001, 32(2):95–110; Bloom SS et al., What husbands in northern India know about reproductive health: correlates of knowledge about pregnancy and maternal and sexual health, *Journal of Biosocial Science*, 2000, 32(2): 237–251; Beegle K, Frankenberg E and Thomas D, Bargaining power within couples and use of prenatal and delivery care in Indonesia, *Studies in Family Planning*, 2001, 32(2): 130–146; Gallen ME, Liskin L and Kak N, Men—new focus for family planning programs, *Population Reports*, 1986, Series J, No. 33; Drennan M, Reproductive health: new perspectives on men's participation, *Population Reports*, 1998, Series J, No. 46; and Raju S and Leonard A, eds., *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality*, New Delhi: Population Council, 2000.
- Heise LL, Gender-based violence and women's reproductive health, *International Journal of Gynecology & Obstetrics*, 1994, 46(2):221–229; and Heise LL, Pitanguy J and Germain A, *Violence Against Women: The Hidden Health Burden*, Washington, DC: World Bank, 1994.
- Narayan D et al., *Voices of the Poor: Crying Out for Change*, New York: Oxford University Press, 2000, pp. 109–131; and Dridi D, Les Algériennes n'acceptent plus la tutelle des hommes, *Courrier International*, Apr. 18–24, 2002, pp. 48–49.
- Dolan C, Do weak states undermine masculinities? *Insights*, 2000, No. 35, <<http://www.id21.org/insights/insights35/insights-iss35-art07.html>>, accessed July 4, 2003; Sweetman C, "Sitting on a rock": men, socio-economic change and development policy in Lesotho, in: Sweetman C, ed., *Men's Involvement in Gender and Development Policy and Practice: Beyond Rhetoric*, Working Paper, Oxford, UK: Oxfam, 2001; Redman P, Empowering men to disempower themselves: heterosexual masculinities, HIV and the contradiction of anti-oppressive education, in: Mac an Ghaill M, ed., *Understanding Masculinities: Social Relations and Cultural Trends*, Philadelphia, PA, USA: Open University Press, 1996, pp. 168–181; Panos Institute, The intimate enemy: gender violence and reproductive health, *Panos Briefing*, 1998, No. 27; and Barker G and Loewenstein I, Where the boys are: attitudes related to masculinity, fatherhood and violence toward women among low-income adolescent and young adult males in Rio de Janeiro, Brazil, *Youth and Society*, 1997, 29(3):166–196.
- These reports are available through the Web site of The Alan Guttmacher Institute (AGI), <www.guttmacher.org>.
- Sub-Saharan Africa and Latin America and the Caribbean:** AGI, unpublished tabulations of 1994–2001 Demographic and Health Surveys.

United States: *first intercourse:* AGI, unpublished tabulations of the 1995 National Survey of Adolescent Males; *first marriage:* U.S. Bureau of the Census, Table MS-2, Estimated median age at first marriage, by sex: 1890 to the present, 1999, <<http://www.census.gov/population/socdemo/ms-la/tabms-2.txt>>, accessed Sept. 14, 2000; *become father:* AGI, unpublished tabulations of the 1995 National Survey of Family Growth; *intend no more children:* AGI, unpublished tabulations of the 1992–1994 National Survey of Families and Households.

BOX: DATA SOURCES

- Sanders SA and Reinisch JM, Would you say you "had sex" if...? *Journal of the American Medical Association*, 1999, 281(3):275–277; Brown NR and Sinclair RC, Estimating number of lifetime sexual partners: men and women do it differently, *Journal of Sex Research*, 1999, 36(3):292–297; and Weideman MW, The truth must be in here somewhere: examining the gender discrepancy in self-reported lifetime number of sex partners, *Journal of Sex Research*, 1997, 34(4):375–386.
 - Eggleston E, Leitch J and Jackson J, Consistency of self-reports of sexual activity among young adolescents in Jamaica, *International Family Planning Perspectives*, 2000, 26(2):79–83.
 - Rendall MS et al., Incomplete reporting of men's fertility in the United States and Great Britain: a research note, *Demography*, 1999, 36(1):135–144.
 - Bankole A and Ezeh AC, Unmet need for couples: an analytical framework and evaluation with DHS data, *Population Research and Policy Review*, 2000, 18(6):579–605.
 - Castle S et al., A qualitative study of clandestine contraceptive use in urban Mali, *Studies in Family Planning*, 1999, 30(3):231–248; and Biddlecom AE and Fapohunda BM, Covert contraceptive use: prevalence, motivations, and consequences, *Studies in Family Planning*, 1998, 29(4):360–372.
 - Nigeria National Population Commission, *Nigeria Demographic and Health Survey 1999*, Lagos, Nigeria, and Calverton, MD, USA: National Population Commission and Macro International, 2000; and Meekers, D, Immaculate conceptions in Sub-Saharan Africa: exploratory analysis of inconsistencies in the timing of first sexual intercourse and first birth, *Social Biology*, 1995, 42(3–4): 151–161.
 - Appendix Table 4, cols. 6 and 7.
 - Coleman DA, Male fertility trends in industrial countries: theories in search of some evidence, in: Bledsoe C, Lerner S and Guyer JI, eds., *Fertility and the Male Life-Cycle in the Era of Fertility Decline*, Oxford, UK: Oxford University Press, 2000, pp. 29–60.
- ## CHAPTER 2: FACTORS THAT SHAPE MEN'S SEXUAL AND REPRODUCTIVE LIVES
- Calculated from Appendix Table 1, col. 10.
 - Mishel L, Bernstein J and Schmitt J, *The State of Working America, 2000/2001*, Ithaca, NY, USA: Cornell University Press, 2001, pp. 257–284.
 - Appendix Table 1, col. 11.
 - Appendix Table 1, col. 12.
 - Joint United Nations Programme on HIV/AIDS (UNAIDS) and Panos Institute, *Young Men and HIV: Culture, Poverty and Sexual Risk*, London: Panos Institute, 2001, p. 13.
 - World Bank, Engendering economics, *Develop-*

- ment Brief*, 1995, No. 58; Maina-Ahlberg B, Fuglesang M and Johansson A, *Men, Sexuality and Reproductive Health*, Health Division Issue Paper, Stockholm, Sweden: Swedish International Development Cooperation Agency, 1998, No. 9, p. 3; and Altman D, Sex, politics, and political economy, *Journal of Mundane Behavior*, 2002, 3(1):149–178, <<http://www.mundanebehavior.org/issues/v3n1/altman.htm>>, accessed Oct. 15, 2002.
- Arias O, *Are Men Benefiting from the New Economy? Male Economic Marginalization in Argentina, Brazil, and Costa Rica*, Policy Research Division Working Paper, Washington, DC: World Bank, 2001, No. WPS 2740.
 - Appendix Table 1, col. 8.
 - Appendix Table 5, col. 1.
 - Calculated from Appendix Table 1, cols. 7 and 8.
 - Lindberg LD et al., *Teenage Risk-Taking: A Statistical Portrait*, Washington, DC: Urban Institute, 2000.
 - World Bank, *DALYS Tables*, <<http://devdata.worldbank.org/hnpstats/DALselection.asp>>, accessed Mar. 11, 2003.
 - Ibid.*
 - From and calculated from Appendix Table 1, cols. 2 and 3.
 - Mensch BS et al., The changing nature of adolescence in the Kassena-Nankana district of northern Ghana, *Studies in Family Planning*, 1999, 30(2):95–111.
 - UNAIDS and Panos Institute, 2001, op. cit. (see reference 5).
 - Lubkemann SC, The transformation of transnationality among Mozambican migrants in South Africa, *Canadian Journal of African Studies*, 2000, 34(1):41–63.
 - Appendix Table 3, cols. 10 and 11.
 - Bawah AA et al., Women's fears and men's anxieties: the impact of family planning on gender relations in northern Ghana, *Studies in Family Planning*, 1999, 30(1):54–66.
 - Appendix Table 1, cols. 4 and 5.
 - International Fund for Agricultural Development, *Rural Poverty Report 2001: The Challenge of Ending Rural Poverty*, <<http://www.ifad.org/poverty>>, accessed May 13, 2002.
 - Appendix Table 2, cols. 3 and 4.
 - Xenos P et al., *The Timing of Union Formation and Sexual Onset: Asian Evidence from Young Adult Reproductive Health Surveys*, Honolulu, HI, USA: East-West Center, 2001.
 - Appendix Table 1, col. 14.
 - Appendix Table 1, col. 13.
 - Perkins A, Media influence and differential fertility preference formation of couples in Sub-Saharan Africa, *African Journal of Reproductive Health*, 1998, 2(2):66–81; and Casterline JB, ed., *Diffusion Processes and Fertility Transition: Selected Perspectives*, Washington DC: National Academies Press, 2001.
 - Barker GK and Rich S, Influences on adolescent sexuality in Nigeria and Kenya: findings from recent focus-group discussions, *Studies in Family Planning*, 1992, 23(3):199–210; and Adegoka AA, Pubertal development and traditional support systems in Africa: an overview, *African Journal of Reproductive Health*, 2001, 5(1):20–30.
 - Calvès A-E, Cornwell GT and Enyegue PE, Adolescent sexual activity in Sub-Saharan Africa: do men have the same strategies and motivations as women? Working Papers in African Demography, University Park, PA, USA: Population Research Institute, Pennsylvania State University, 1996, No. AD96-04; Gueye M, Castle S and Konaté MK, Timing of first intercourse among Malian adoles-

cents: implications for contraceptive use, *International Family Planning Perspectives*, 2001, 27(2):56–62 & 70; Rwenge M, Sexual risk behaviors among young people in Bamenda, Cameroon, *International Family Planning Perspectives*, 2000, 26(3):118–123 & 130; Gørgen R et al., Sexual behavior and attitudes among unmarried urban youths in Guinea, *International Family Planning Perspectives*, 1998, 24(2):65–71; Kgosidintsi N, Sexual behavior and the risk of HIV infection among adolescent females in Botswana, Gaborone, Botswana: National Institute of Development, Research and Documentation, 1977; Temin MJ et al., Perceptions of sexual behavior and knowledge about sexually transmitted diseases among adolescents in Benin City, Nigeria, *International Family Planning Perspectives*, 1999, 25(4): 186–190 & 195; and Meekers D and Calvés A-E, Gender differentials in adolescent sexual activity and reproductive health risks in Cameroon, *African Journal of Reproductive Health*, 1999, 3(2):51–67.

29. Speizer IS, Mullen SA and Amégée K, Gender differences in adult perspectives on adolescent reproductive behaviors: evidence from Lomé, Togo, *International Family Planning Perspectives*, 2001, 27(4):178–185.

BOX: MEN AND ABORTION

1. Johnston HB, *Abortion Practice in India: A Review of Literature*, Mumbai, India: Centre for Enquiry into Health and Allied Themes, 2002.

2. Clark S et al., Husbands' and wives' perspectives on recent abortion experiences in India, paper presented at the Regional Conference on Abortion, Cuernavaca, Mexico, Nov. 12–15, 2001.

3. Rob U and Piet-Pelon N, Men and pregnancy termination in Bangladesh, paper presented at the annual meeting of the American Public Health Association, Washington, DC, Nov. 15–19, 2001.

4. Johansson A et al., Men and abortion decisions: a study from Vietnam, Stockholm, Sweden: Karolinska Institute, 1997.

5. Margoth MT, Hombres Colombianos, paper presented at the Regional Conference on Abortion, Cuernavaca, Mexico, Nov. 12–15, 2001.

6. Tolbert K, Morris K and Romero M, Los hombres y la decisión respecto al aborto: hacia una teoría entre las relaciones de género y el aborto, paper presented at the Encuentro de Investigadores sobre aborto inducido en América Latina y el Caribe, Bogotá, Colombia, Nov. 15–18, 1994.

7. Solo J et al., Creating linkages between incomplete abortion and family planning services in Kenya: what works best? New York: Population Council, 1988, p. 22.

8. Abdel-Tawab N, Huntington D and Nawar L, Ethical considerations in studying the effects of counseling the husbands of postabortion patients in Egypt, paper presented at the annual meeting of the American Public Health Association, Indianapolis, IN, USA, Nov. 9–13, 1997.

9. Bankole A, Singh S and Haas T, Reasons why women have induced abortions: evidence from 27 countries, *International Family Planning Perspectives*, 1998, 24(3):117–127 & 152.

10. Ibid.

11. Ibid.

12. Bankole A, Singh S and Haas T, Characteristics of women who obtain induced abortion: a worldwide review, *International Family Planning Perspectives*, 1999, 25(2):68–77.

13. Mpangile GS, Leshabari MT and Kihwele DJ, Induced abortion in Dar es Salaam, United Republic of Tanzania: the plight of adolescents, in: Mundigo A and Indriso C, eds., *Abortion in the Developing World*, London: Zed Books, 1999, pp. 387–403.

CHAPTER 3: MEN 15–24: BECOMING INDEPENDENT AND INITIATING SEXUAL RELATIONSHIPS

1. **Marital status:** Appendix Table 2, cols 5 and 6. **Fatherhood:** Appendix Table 2, cols. 17 and 18. **Education/employment status:** Appendix Table 1, cols. 15–17. **Residence with family:** The Alan Guttmacher Institute (AGI), unpublished tabulations of Demographic and Health Surveys (DHS) or of other relevant surveys (see Data Sources, p. 10).

2. UK National Health Service, *Boys' and Young Men's Health: Literature and Practice Review, An Interim Report*, London: Health Development Agency, 2001; Youth Include, *Facts and Figures*, <<http://www.youthinclude.org/facts.htm>>, accessed Jan. 8, 2003; Jones G and Bell R, *Balancing Act: Youth, Parenting and Public Policy*, Joseph Rowntree Foundation, 2000, <<http://www.jrf.org.uk/knowledge/findings/socialpolicy/590.asp>>, accessed Jan. 8, 2002; Xenos P, How long is Asian adolescence? paper presented at the International Conference on Asian Youth at Risk: Social, Health and Policy Challenges, Taipei, Taiwan, Nov. 26–29, 2001; and IARD, *Study on the State of Young People and Youth Policy in Europe*, Milan, Italy: IARD, 2001.

3. International Labour Office, *Youth and Work: Global Trends*, <<http://www.ilo.org/public/english/employment/skills/youth/download/youthwor.pdf>>, accessed June 27, 2002.

4. Annan K, Needed: two billion jobs, meeting the challenge of youth unemployment, keynote address presented at the annual meeting of the World Bank Group and the International Monetary Fund, Washington, DC, Sept. 25, 1999, <<http://www.worldbank.org/html/extdr/pos99/kasp092599.htm>>, accessed Jan. 17, 2003.

5. Sardesai S and Wam P, Conflict Analysis Framework (CAF): identifying conflict-related obstacles to development, *Conflict Prevention and Reconstruction Unit Dissemination Notes*, Washington, DC: World Bank, 2002, No. 5, p. 2.

6. Appendix Table 1, cols. 15–18.

7. Berne L and Huberman B, *European Approaches to Adolescent Sexual Behavior and Responsibility*, Washington, DC: Advocates for Youth, 1999. Appendix Table 2, col. 11.

8. Darroch JE et al., *Teenage Sexual and Reproductive Behavior in Developed Countries: Can More Progress Be Made?* Occasional Report, New York: AGI, 2001, No. 3, p. 62.

9. Appendix Table 2, col. 11.

10. **Had sex before age 11, 13 and 15:** Mexico: AGI, unpublished tabulations of the 1996 Encuesta de Comunicación en Planificación Familiar; *all other developing countries:* AGI, unpublished tabulations of 1996–2000 DHS; *United States:* AGI, unpublished tabulations of the 1991 National Survey of Men (NSM); *Japan:* AGI, unpublished tabulations of the 1997 Japan National Fertility Survey; *Italy:* AGI, unpublished tabulations of the 1996 Fertility and Family Survey (FFS). **Had sex before age 18 and 20:** Appendix Table 2, cols. 11 and 12.

11. Calculated from Appendix Table 2, col. 12.

12. Appendix Table 2, col. 9.

13. Appendix Table 2, col. 12.

14. Xenos P et al., *An Asian Comparative Description of Events in the Transition to Adulthood*, Population Series Working Paper, Honolulu, HI, USA: East-West Center, 2002, No. 109–13, Table 2, p. 4.

15. Appendix Table 2, cols. 7 and 8.

16. Sata R, Adolescent reproductive health in Japan: demographic and policy dimension, paper presented at the annual meeting of the Population Association of America, Atlanta, GA, USA, May 8–11, 2002.

17. Collumbien M, Das B and Bohidar N, Male sexual debut in Orissa: context, partners and differentials, *Asia-Pacific Population Journal*, 2001, 16(2):211–244.

18. Xenos P et al., *Cross-National Comparison and the Importance of Sub-Groups Within Countries*, Population Series Working Paper, Honolulu, HI, USA: East-West Center, 2001, No. 108–12, Figure 3, p. 16

19. Appendix Table 2, cols. 9 and 10.

20. Rivers K and Aggleton P, *Adolescent Sexuality, Gender and the HIV Epidemic*, London: University of London, 1999; Nzioka C, Perspectives of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections: Kenya, *Reproductive Health Matters*, 2001, 9(17):108–117; and Maina-Ahlberg B, Fuglesang M and Johansson A, *Men, Sexuality and Reproductive Health*, Health Division Issue Paper, Stockholm, Sweden: Swedish International Development Cooperation Agency, 1998, No. 9, p. 3.

21. Nguyen MT, Vu TH and Blanc M-E, Sexual behaviour related to HIV/AIDS: commercial sex and condom use in Hanoi, Viet Nam, *Asia-Pacific Population Journal*, 2002, 17(3):41–52, Table 1, p. 45.

22. United Nations Population Fund (UNFPA), *Adolescents in India: A Profile*, <<http://www.unfpa.org/focus/india/faceofadolescentsprofile.pdf>>, accessed Apr. 8, 2003; and Brown A et al., *Sexual Relations Among Young People in Developing Countries: Evidence from WHO Case Studies*, Geneva: World Health Organization, 2001, p. 12.

23. Forrest S, “Big and tough”: boys learning about sexuality and manhood, *Sexual and Relationship Therapy*, 2000, 15(3):247–261; and Isarabhakdi P, Determinants of sexual behavior that influence the risk of pregnancy and disease among rural Thai young adults, Nakom Pathom, Thailand: Institute for Population and Social Research, 1995.

24. AGI, unpublished tabulations of the 1995 National Survey of Adolescent Males.

25. Tan M, Recent HIV/AIDS trends among men who have sex with men, in: Shiokawa Y and Kitamura T, eds., *Global Challenge of AIDS: Ten Years of HIV/AIDS Research*, Tokyo: Kodansha Press, 1995, pp. 27–34; Murray SO, ed., *Islamic Homosexualities*, New York: New York University Press, 1997; Schmitt A and Sofer J, eds., *Sexuality and Eroticism Among Males in Moslem Societies*, New York: Harrington Press, 1992; and Seabrook J, *Love in a Different Climate: Men Who Have Sex with Men in India*, London: Verso Press, 1999.

26. AGI, unpublished tabulations of DHS and of other relevant surveys (see Data Sources, p. 10).

27. **Developing countries:** AGI, unpublished tabulations of 1996–2000 DHS. **Great Britain:** AGI, unpublished tabulations of the 1990 National Survey of Sexual Attitudes and Lifestyles (NATSAL). **United States:** AGI, unpublished tabulations of the 1992 National Health and Social Life Survey.

28. Ibid

29. Appendix Table 2, cols. 22–25.

30. Calculated from Appendix Table 2, col. 21.

31. Appendix Table 2, cols. 22–25.

32. **Developing countries:** AGI, unpublished tabulations of 1996–2000 DHS. **Great Britain:** AGI, unpublished tabulations of the 1990 NATSAL. **Italy:** AGI, unpublished tabulations of the 1996 FFS. **United States:** AGI, unpublished tabulations of the 1991 NSM.

33. Appendix Table 2, col. 5.

34. Appendix Table 2, col. 6.

35. **Men:** Appendix Table 2, cols. 5 and 6. **Women:** *Sub-Saharan African countries, Brazil, Nicaragua and Peru:* Published reports of 1996–2001 DHS; *China, Philippines, Japan and Italy:* United Nations

(UN) Population Division, *Database on Marriage Patterns* (Pop/1/DB/200/3); *Dominican Republic*: AGI, unpublished tabulations of the 1999 DHS; *all other countries*: UN, *World Marriage Patterns 2000*, New York: Population Division, Department of Economic and Social Affairs, UN, 2001.

36. AGI, unpublished tabulations of 1996–2001 DHS.

37. Appendix Table 2, cols. 17 and 18.

38. Calvès A-E, Premarital childbearing and parenting in Cameroon: who takes care of the kids? paper presented at the annual meeting of the Population Association of America, Chicago, IL, USA, Apr. 2–4, 1998.

39. AGI, *Sharing Responsibility: Women, Society and Abortion Worldwide*, New York: AGI, 1999, Chart 4.6, p. 29.

40. Thornberry TP, Smith CA and Howard GJ, Risk factors for teenage fatherhood, *Journal of Marriage and the Family*, 1997, 59(3):505–522.

41. Clarke L, Condy A and Downing A, *Fathers: A Sociodemographic Profile*, Working Paper, Oxford, UK: Family Policy Studies Centre, 1998, No. 6, Table 4.5, p. 14.

42. Abraham L and Kumar KA, Sexual experiences and their correlates among college students in Mumbai City, *International Family Planning Perspectives*, 1999, 25(3):139–146 & 152; and Amazigo U et al., Sexual activity and contraceptive knowledge and use among in-school adolescents in Nigeria, *International Family Planning Perspectives*, 1997, 23(1):28–33.

43. Rivers K and Aggleton P, *Adolescent sexuality, gender and the HIV epidemic*, London: University of London, 1998; and Nzioka C, Perspectives of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections: Kenya, 2001, *Reproductive Health Matters*, 2001, 9(17):108–111.

44. Xenos P et al., *The Timing of Union Formation and Sexual Onset: Asian Evidence from Young Adult Reproductive Health Surveys*, Honolulu, HI, USA: East-West Center, 2001.

45. Joint United Nations Programme on HIV/AIDS (UNAIDS), *Sex and Youth: Contextual Factors Affecting Risk for HIV/AIDS: A Comparative Analysis of Multi-Site Studies in Developing Countries*, Geneva: UNAIDS, 1999.

BOX: MIGRANT MEN

1. Joint United Nations Programme on HIV/AIDS (UNAIDS) and Panos Institute, *Young Men and HIV: Culture, Poverty and Sexual Risk*, London: Panos Institute, 2001, p. 13.

2. Hugo G, *Population Mobility and HIV/AIDS in Indonesia*, United Nations Development Programme, South East Asia HIV and Development Programme, Nov. 2001, <<http://www.hiv-development.org/publications/Indonesia.htm>>, accessed June 6, 2003.

3. UNAIDS and United Nations (UN) Economic and Social Commission for Asia and the Pacific, *The Assessment and Mitigation of the Impact of Transport Infrastructure and Services on the Spread of HIV/AIDS: An Annotated Bibliography*, New York: UN, 2001; Conover T, Trucking through the AIDS belt, *The New Yorker*, Aug. 16, 1993, pp. 56–75; and Orubuloye IO, Caldwell P and Caldwell JC, The role of high-risk occupations in the spread of AIDS: truck drivers and itinerant market women in Nigeria, *International Family Planning Perspectives*, 1993, 19(2):43–48 & 71.

4. Bloom SS et al., *Community Effects on the Risk of HIV Infection in Rural Tanzania*, Measure Evaluation Working Papers, Chapel Hill, NC, USA: Carolina Population Center, Mar. 2002, <<http://www.cpc.unc.edu/measure/publications/workingpapers/wp0247ab.html>>, accessed Jan. 15,

2003; and Ssengonzi R et al., Spatial networks of sexual partnerships in a rural Ugandan population: implications for HIV transmission, paper presented at the annual meeting of the Population Association of America, New York, Mar. 25–27, 1999.

CHAPTER 4: MEN 25–39: MARRYING AND BECOMING FATHERS

1. Saluter AF and Lugaila TA, Marital status and living arrangements, March 1996, *Current Population Reports*, 1998, Series P-20, No. 496, p. 5; and Macura M, Eastern and Western Europe's fertility and partnership patterns: selected developments from 1987 to 1999, in: Macura M and Beets G, eds., *Dynamics of Fertility and Partnership in Europe: Insights and Lessons from Comparative Research, Volume I*, New York: United Nations (UN), 2002, pp. 2755.

2. The Alan Guttmacher Institute (AGI), unpublished tabulations of 1996–2001 Demographic and Health Surveys (DHS).

3. Timeaus IM and Reynar A, Polygynists and their wives in Sub-Saharan Africa: an analysis of five Demographic and Health Surveys, *Population Studies*, 1998, 52(2): 145–162.

4. Appendix Table 3, col. 2.

5. Calculated from Appendix Table 3, col. 3.

6. Appendix Table 3, cols. 4 and 5.

7. **Italy**: AGI, unpublished tabulations of the 1996 Fertility and Family Survey (FFS). **Sweden**: AGI, unpublished tabulations of the 1993 FFS. **All other countries**: AGI, unpublished tabulations of 1992–2000 DHS.

8. UN, *World Marriage Patterns 2000*, New York: Population Division, Department of Economic and Social Affairs, UN, 2001.

9. Feyisetan BJ, Spousal communication and contraceptive use among the Yoruba of Nigeria, *Population Research and Policy Review*, 2000, 19(1):29–45; Bankole A and Singh S, Couples' fertility and contraceptive decision-making in developing countries: hearing the man's voice, *International Family Planning Perspectives*, 1998, 24(1):15–24; and Bawah AA et al., Women's fears and men's anxieties: the impact of family planning on gender relations in northern Ghana, *Studies in Family Planning*, 1999, 30(1):54–66.

10. Blanc AK and Wolff B, Gender and decision-making over condom use in two districts in Uganda, *African Journal of Reproductive Health*, 2001, 5(3):15–28.

11. Ratcliff AA, Hill AG and Walraven G, Separate lives, different interests: male and female reproduction in the Gambia, *Bulletin of the World Health Organization*, 2000, 78(5):570–577.

12. **Great Britain**: AGI, unpublished tabulations of the 1990 National Survey of Sexual Attitudes and Lifestyles. **All other countries**: AGI, unpublished tabulations of 1996–2000 DHS.

13. Calculated from Appendix Table 3, col. 6.

14. Appendix Table 3, col. 6.

15. AGI, unpublished tabulations of 1996–2000 DHS.

16. Ali MM and Cleland JG, The link between post-natal abstinence and extramarital sex in Côte d'Ivoire, *Studies in Family Planning*, 2001, 32(3):214–219; and Cleland JG, Ali M and Capo-Chichi V, Post-partum sexual abstinence in West Africa: implications for AIDS control and family planning programmes, *AIDS*, 1999, 13(1):125–131.

17. AGI, *Hopes and Realities: Closing the Gap Between Women's Aspirations and Their Reproductive Experiences*, New York: AGI, 1995, p. 30.

18. Appendix Table 3, cols. 15–19.

19. Westoff CF and Bankole A, Reproductive pref-

erences in developing countries at the turn of the century, *Demographic and Health Surveys Comparative Reports*, Calverton, MD, USA: Macro International, 2002, No. 2, Table 8.1, p. 16.

20. United Nations Economic Commission for Europe, *Family and Fertility Surveys, Standard Country Tables*, Table 25, <http://www.unece.org/ead/pau/ffs/f_h_151b.htm>, accessed Apr. 12, 2003.

21. Appendix Table 3, col. 14.

22. Appendix Table 3, col. 9.

23. Appendix Table 3, cols. 15–19.

24. Calculated from Appendix Table 3, col. 14.

25. Appendix Table 3, cols. 15–19.

26. Mason KO and Smith HL, Husbands' versus wives' fertility goals and use of contraception: the influence of gender context in five Asian countries, *Demography*, 2000, 37(3):299–311.

27. Bawah AA et al., Women's fear and men's anxieties: the impact of family planning on gender relations in northern Ghana, *Studies in Family Planning*, 1991, 30(1):54–66.

28. Karra M, Stark NN and Wolf J, Male involvement in family planning: a case study spanning five generations of a south Indian family, *Studies in Family Planning*, 1997, 28(1):24–34.

29. Ndiaye MD, Pauvreté, attitudes et pratiques des hommes en matière de planification familiale: le cas du quartier de Randoulène nord, Thies, Senegal: Association pour la Promotion des Activités de Population-Sénégal, <<http://www.cicred.org/pauvrete/actes/ndiaye.pdf>>, accessed Aug. 7, 2003.

30. Appendix Table 3, cols. 24 and 25.

31. Appendix Table 3, col. 24.

32. Appendix Table 3, col. 25.

33. AGI, unpublished tabulations of 1991–2001 DHS.

34. Fapohunda BM and Rutenberg N, *Expanding Men's Participation in Reproductive Health in Kenya*, Nairobi, Kenya: African Population Policy Research Center, 1999.

35. Appendix Table 3, cols. 21–23.

36. Appendix Table 3, col. 20.

37. Appendix Table 3, cols. 12 and 13.

38. Francovich L, Livi-Bacci, M and Salvini S, Male fertility in Italy, 1995–1996: a delay of fatherhood, paper presented at the annual meeting of the Population Association of America, Chicago, IL, USA, Apr. 2–4, 1998.

39. Appendix Table 3, col. 8.

40. AGI, unpublished tabulations of DHS or of other relevant surveys (see Data Sources, p. 10).

41. *Ibid.*

42. Appendix Table 3, cols. 10 and 11.

43. AGI, unpublished tabulations of DHS or of other relevant surveys (see Data Sources, p. 10).

44. *Ibid.*

45. AGI, *In Their Own Right: Addressing the Sexual and Reproductive Health Needs of American Men*, New York: AGI, 2002, p. 47.

CHAPTER 5: MEN 40–54: APPROACHING THE END OF FATHERING

1. Appendix Table 4, cols. 2 and 3.

2. Calculated from Appendix Table 4, cols. 2 and 3.

3. The Alan Guttmacher Institute (AGI), unpublished tabulations of 1994–2001 Demographic and Health Surveys (DHS).

4. AGI, unpublished tabulations of 1996–2000 DHS.

5. Appendix Table 4, col. 4.

6. Office of the Prime Minister, Japan, Human rights of women, in: *FY 1999 Annual Report on the State of the Formation of a Gender Equal Society and Policies to Be Implemented in FY 2000 to Promote the Formation of a Gender Equal Society*, 2000, <<http://www.gender.go.jp/danijo/english/plan2000/2000/1-3.html>>, accessed Feb. 5, 2003.
7. Luke N, Confronting the myth of “sugar daddies”: linking age and economic asymmetries and risky sexual behavior in urban Kenya, paper presented at the annual meeting of the Population Association of America, Atlanta, GA, USA, May 8–11, 2002.
8. Ali MM and Cleland JG, The link between post-natal abstinence and extramarital sex in Côte d'Ivoire, *Studies in Family Planning*, 2001, 32(3):214–219.
9. Appendix Table 4, col. 12.
10. AGI, unpublished tabulations of 1994–2001 DHS.
11. Appendix Table 4, col. 7.
12. Appendix Table 4, cols. 7 and 8.
13. Appendix Table 4, cols. 10 and 11.
14. AGI, unpublished tabulations of DHS and of other relevant surveys (see Data Sources, p. 10).
15. Appendix Table 4, col. 9.
16. From and calculated from Appendix Table 4, col. 13.
17. Appendix Table 4, cols. 14–19.
18. Appendix Table 4, cols. 4 and 14.
19. AGI, unpublished tabulations of DHS and of other relevant surveys (see Data Sources, p. 10).
20. Ibid.
21. Calculated from Appendix Table 3, col. 14 and Appendix Table 4, col. 13.
22. Appendix Table 4, col. 9.
23. Wolff B, Blanc AK and Ssekamatte-Ssebuliba J, The role of couple negotiation in unmet need for contraception and the decision to stop childbearing in Uganda, *Studies in Family Planning*, 2000, 31(2):124–137.
24. EngenderHealth, *Contraceptive Sterilization: Global Issues and Trends*, New York: EngenderHealth, 2002, p. 17.
25. Ibid., p. 161.
26. Appendix Table 4, cols. 9 and 18.
27. Appendix Table 4, col. 15.
28. EngenderHealth, 2002, op. cit. (see reference 24), Table 2.4, p. 31.
29. Kincaid DL et al., Impact of a mass media vasectomy program campaign in Brazil, *International Family Planning Perspectives*, 1996, 22(4):169–175; and Vernon R, Operations research on promoting vasectomy in three Latin American countries, *International Family Planning Perspectives*, 1996, 22(1):26–31.
30. Aldaz, E, Givaudan M and Pick S, *Creencias, Conocimientos, Actitudes, Motivaciones e Intenciones Conductuales Hacia la Vasectomía en Hombres Mexicanos*, Mexico City: Instituto Mexicano de Investigación de Familia y Población, 1997.
31. Penteadó LG et al., Organizing a public-sector vasectomy program in Brazil, *Studies in Family Planning*, 2001, 32(4):315–328.
32. Kishor S, Macro International, Calverton, MD, USA, personal communication, Oct. 6, 2002.
3. Centers for Disease Control and Prevention (CDC), *HIV/AIDS Surveillance Report*, Atlanta, GA, USA: CDC, 2000, Table 1, p. 5 and Table 25, p. 34.
4. United Nations (UN) Department of Public Information, *Preventing HIV/AIDS*, June 25–27, 2001, <http://www.un.org/ga/aids/ungassfactsheets/html/fsprevention_en.htm>, accessed June 6, 2003.
5. CDC, Increase in unsafe sex and rectal gonorrhoea among men who have sex with men—San Francisco, California, *Morbidity and Mortality Reports*, 1999, 48(3):45–48.
6. Hanenberg RS et al., Impact of Thailand's HIV-control programme as indicated by the decline of sexually transmitted diseases, *Lancet*, 1994, 344(8917):243–245.
7. Joint United Nations Programme on HIV/AIDS (UNAIDS), *STI/HIV: 100% Condom Use Programme for Sex Workers*, 2000, <<http://www.unaids.org/bestpractice/digest/files/condoms.html>>, accessed Mar. 7, 2003.
8. Ghana Social Marketing Foundation et al., *Ghana Youth Reproductive Health Survey Report*, Ghana: Ghana Social Marketing Foundation, 2000, Table 8E, pp. 61–62; and Tamang A, *Sexual Risk-Behavior and Knowledge and Attitudes to Condom Use Among Men in Five Border Towns of Nepal*, Kathmandu, Nepal: Center for Research on Environmental Health and Population Activities, 1998, Table 4.5, p. 19.
9. Ibid.
10. Braeken D, It takes two to tango: young men and condom use, paper presented at the Fourth European Seminar of the European Information Centre, Aids and Youth, Canterbury, UK, July 8–12, 1997.
11. Hulton LA, Cullen R and Khaloko SW, Perceptions of the risks of sexual activity and their consequences among Ugandan adolescents, *Studies in Family Planning*, 2000, 31(1):35–46.
12. Fredrick B, The Alan Guttmacher Institute, New York, personal communication, Mar. 11, 2003.
13. Messersmith LJ et al., Who's at risk? men's STD experience and condom use in southwest Nigeria, *Studies in Family Planning*, 2000, 31(3):203–216; and Adetunji J, Condom use in marital and nonmarital relationships in Zimbabwe, *International Family Planning Perspectives*, 2000, 26(4):196–200.
14. Jadack RA et al., Reasons for not using condoms of clients at urban sexually transmitted diseases clinics, *Sexually Transmitted Diseases*, 1997, 24(7):402–408.
15. Kalichman SC et al., Sexual coercion, domestic violence, and negotiating condom use among low-income African American women, *Journal of Women's Health*, 1998, 7(3):371–378; and Bond V and Dover P, Men, women and the trouble with condoms: problems associated with condom use by migrant workers in rural Zambia, *Health Transition Review*, 1997, 7(Suppl.):S377–S391.
16. UNAIDS, *Condoms and HIV Prevention: World AIDS Campaign 2001*, <<http://www.thebody.com/unaids/wac/condoms.html>>, accessed May 28, 2003; and Ross J and Bulatao R, *Contraceptive Projections and the Donor Gap: Meeting the Challenge, Securing Contraceptive Supplies*, Washington, DC: John Snow, 2001.
17. Gardner R, Blackburn RD and Upadhyay UD, Closing the condom gap, *Population Reports*, 1999, Series H, No. 9; and Chaya N, Amen K-A and Fox M, *Condoms Count: Meeting the Need in the Era of HIV/AIDS*, Washington, DC: Population Action International, 2000.
18. UN Department of Public Information, 2001, op. cit. (see reference 4).
- p. 148.
2. Ibid., Annex Table 3, p. 150.
3. Joint United Nations Programme on HIV/AIDS (UNAIDS), *AIDS Epidemic Update*, 2002, <<http://www.unaids.org/worldaidsday/2002/press/Epiupdate.html>>, accessed Jan. 16, 2003.
4. Appendix Table 5, col. 1.
5. UNAIDS, *HIV/AIDS: China's Titanic Peril: 2001 Update of the AIDS Situation and Needs Assessment Report*, 2002, <<http://www.unaids.org/whatsnew/newadds/AIDSChina2001update.pdf>>, accessed Jan. 14, 2003.
6. UNAIDS, 2002, op. cit. (see reference 3).
7. Ibid.
8. Calculated from Appendix Table 5, col. 2.
9. Appendix Table 5, col. 5.
10. Appendix Table 5, cols. 1 and 5.
11. WHO, *Global Prevalence and Incidence of Selected Curable Sexually Transmitted Infections*, 1999, <<http://www.who.int/docstore/hiv/GRSTI/002.htm>>, accessed July 7, 2002.
12. Ibid.
13. Lande R, Controlling sexually transmitted diseases, *Population Reports*, 1993, Series L, No. 9.
14. Gisselquist D et al., Let it be sexual: how health care transmission of AIDS was ignored, *International Journal of STD & AIDS*, 2003, 14(3):148–161; and Gisselquist D and Potterat JJ, Heterosexual transmission of HIV in Africa: an empiric estimate, *International Journal of STD & AIDS*, 2003, 14(3):162–173.
15. Reaney P, Scientists challenge view sex fuels AIDS in Africa, *Reuters NewsMedia*, Feb. 20, 2003, <<http://www.aegis.com/news/re/2003/RE030232.html>>, accessed Feb. 20, 2003; WHO, Expert group stresses that unsafe sex is primary mode of transmission of HIV in Africa, Mar. 14, 2003, <<http://www.who.int/mediacentre/statements/2003/statement5/en/print.html>>, accessed Mar. 28, 2003; and Berkley S, International AIDS Vaccine Initiative, New York, personal communication, Mar. 31, 2003.
16. WHO, *Effectiveness of Male Latex Condoms in Protecting Against Pregnancy and Sexually Transmitted Infections*, 2000, <<http://www.who.int/inf-fs/en/fact243.html>>, accessed Dec. 12, 2002.
17. Appendix Table 5, col. 3.
18. Appendix Table 5, col. 4.
19. The Alan Guttmacher Institute (AGI), unpublished tabulations of 1993–2001 Demographic and Health Surveys (DHS).
20. AGI, unpublished tabulations of 1999–2001 DHS.
21. Calculated from Appendix Table 5, col. 13.
22. Appendix Table 5, col. 8.
23. Appendix Table 5, col. 9.
24. Appendix Table 5, col. 10.
25. Appendix Table 5, col. 11.
26. Appendix Table 5, col. 12.

BOX: CONDOM USE IN THE HIV/AIDS ERA

1. Trussell J and Vaughan B, Contraceptive failure, method-related discontinuation and resumption of use: results from the 1995 National Survey of Family Growth, *Family Planning Perspectives*, 1999, 31(2):64–72 & 93.
2. National Institute of Allergy and Infectious Diseases, *Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention*, Bethesda, MD, USA: National Institute of Allergy and Infectious Diseases, 2001; and Cates W, Jr., The NIH Condom report: the glass is 90% full, *Family*

CHAPTER 6: SEXUALLY TRANSMITTED INFECTIONS AND CONDOM USE

1. World Health Organization (WHO), *World Health Report 2001*, Geneva: WHO, 2001, Annex Table 2,

CHAPTER 7: SEXUAL AND REPRODUCTIVE HEALTH INFORMATION AND SERVICES FOR MEN

1. Miller BC, *Families Matter: A Research Synthesis of Family Influences on Adolescent Pregnancy*, Washington, DC: National Campaign to Prevent Teen Pregnancy, 1998.

2. Joint United Nations Programme on HIV/AIDS (UNAIDS), *Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: A Review Update*, Geneva: UNAIDS, 1997.

3. Raju S and Leonard A, eds., *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality*, New Delhi: Population Council, 2000, p. 57; Laack S, Thoughts about male involvement: Swedish experiences, paper presented at the Youth Sexuality Conference, Arusha, Tanzania, Aug. 13–18, 1995; and Laack S et al., *Report on the RFSU Young Men's Clinic*, Stockholm, Sweden: Swedish Association of Sex Education, 1997.

4. Raju S and Leonard A, 2000, op. cit. (see reference 3), p. 57; and Verma RK et al., *Cultural Perceptions and Categorization of Male Sexual Health Problems by Practitioners and Men in a Mumbai Slum Population*, International Institute for Population Sciences, <<http://www.hsph.harvard.edu/Organizations/healthnet/ASia/suchana/0804/rh052.html>>, accessed June 6, 2003.

5. The Alan Guttmacher Institute (AGI), unpublished tabulations of 1994–2001 Demographic and Health Surveys (DHS).

6. World Health Organization (WHO), *Guidelines for the Management of Sexually Transmitted Infections*, Geneva: WHO, 2001; and Family Health International (FHI), *AIDS Control and Prevention Project, August 21, 1991 to December 31, 1997, Final Report, Volume 1*, December 31, 1997, <http://www.fhi.org/en/HIVAIDS/Publications/Archive/aidscafinalvol1/FHI_AIDSCAP_Fnl_Rprt_Vol1_Prog_Info_Diss.htm>, accessed May 5, 2003.

7. Ghana Social Marketing Foundation et al., *Ghana Youth Reproductive Health Survey Report*, Ghana: Ghana Social Marketing Foundation, 2000, pp. 46–47.

8. *Ibid.*, Table 8E, pp. 46–47; and Green E, The participation of African traditional healers in AIDS/STD prevention programmes, *AIDSLink*, 1995, No. 36, pp. 14–15.

9. Measure DHS+, *Appropriate diagnosis and treatment of STIs, HIV/AIDS Survey Indicators Database*, <http://www.measuredhs.com/hivdata/ind_detl.cfm?ind_id=70&prog_area_id=12>, accessed June 4, 2002; Population Council, Men in Bangladesh, India, and Pakistan: reproductive health issues, news release, 1999, <<http://www.popcouncil.org/mediacenter/newsreleases/ubaidar.html>>, accessed June 4, 2002; and Temin MJ et al., Perceptions of sexual behavior and knowledge about sexually transmitted diseases among adolescents in Benin City, Nigeria, *International Family Planning Perspectives*, 1999, 25(4):186–190 & 195.

10. Population Council, *Male Involvement in RH Issues*, <http://www.popcouncil.org/frontiers/ortabpriefs/male_3.html#whohow>, accessed Oct. 4, 2002.

11. Appendix Table 5, cols. 16 and 17.

12. Appendix Table 2, col. 16.

13. Appendix Table 2, col. 16; Appendix Table 3, col. 9; and Appendix Table 4, col. 8.

14. Appendix Table 4, cols. 7 and 8.

15. Appendix Table 5, col. 18.

16. UNAIDS, *AIDS Epidemic Update*, 2002, <<http://www.unaids.org/worldaidsday/2002/press/Epiupdate.html>>, accessed Jan. 16, 2003.

17. AGI, unpublished tabulations of 1994–2001 DHS.

18. Appendix Table 2, cols. 7 and 8.

19. AGI, unpublished tabulations of 1994–2000 DHS.

20. AGI, 2002, op. cit., (see reference 18).

21. AGI, unpublished tabulations of 1994–2001 DHS.

22. Finger W, Pilot projects increase men's involvement, *Network*, 1992, 13(1):8–9; and Sonenstein FL et al., *Involving Males in Preventing Teen Pregnancy*, Washington, DC: Urban Institute, 1997.

23. AVSC International and International Planned Parenthood Federation/Western Hemisphere Region, *Five Case Studies for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms*, Oaxaca, Mexico: International Planned Parenthood Federation/Western Hemisphere Region, 1999; Johns Hopkins School of Public Health, Center for Communication Programs, *Reaching Men Worldwide: Lessons Learned from Family Planning and Communication Projects, 1986–1996*, Baltimore, MD, USA: Johns Hopkins School of Public Health, Center for Communication Programs, 1997; Program for Appropriate Technology in Health (PATH), *Reproductive Health for Men Programs*, <http://www.path.org/resources/rh_for_men_programs.htm>, accessed Dec. 11, 2001; Pan American Health Organization, *New Project Involves Men in Reproductive Health Program*, <http://www.paho.org/English/DPI/PRESS_000411.HTM>, accessed Dec. 7, 2001; Pathfinder International, Reaching young men with reproductive health programs, in: *Focus/Focus on Young Adults*, <www.pathfind.org/pf/pubs/focus/IN%20FOCUS/ReachingYoungMen.doc>, accessed Dec. 11, 2001; Raju S and Leonard A, 2000, op. cit. (see reference 3); Foreit JR et al., *Estrategias para Involucrar a los Hombres en el Cuidado de la Salud Reproductiva: De la Administración de la Granja a la Administración de la Familia*, Mexico City: Population Council, 1998; United Nations Population Fund (UNFPA), *Male Involvement in Reproductive Health, Including Family Planning and Sexual Health*, Technical Report, New York: UNFPA, 1995, No. 28; and UNFPA, *Partnering: A New Approach to Sexual and Reproductive Health*, Technical Paper, New York: UNFPA, 2000, No. 3.

24. Vernon R, Ojeda G and Vega A, Making vasectomy services more acceptable to men, *International Family Planning Perspectives*, 1991, 17(2):55–60; and Wilkinson D et al., Improving vasectomy services in Kenya: lessons from a mystery client study, *Reproductive Health Matters*, 1996, 4(7):115–121.

25. Yinger N and Murphy E, *Illustrative Indicators for Programming in Men and Reproductive Health*, Washington, DC: PATH, 1999.

26. Piet-Pelon N, Rob U and Khan ME, *Men in Bangladesh, India and Pakistan: Reproductive Health Issues*, New Delhi: Population Council, 1999; Sweetman C, ed., *Men's Involvement in Gender and Development Policy and Practice: Beyond Rhetoric*, Working Paper, Oxford, UK: Oxfam, 2001; and Department of Child and Adolescent Health and Development, WHO, *Working with Adolescent Boys: Programme Experiences, Consolidated Findings from Regional Surveys in Africa, the Americas, Eastern Mediterranean, South-East Asia, and Western Pacific*, Geneva: WHO, 2000.

27. National Asian Women's Health Organization (NAWHO), *Asian American Men's Health Survey: Sharing Responsibility*, San Francisco, CA, USA: NAWHO, 1999; and AGI, 2002, op. cit. (see reference 18).

28. Population Reference Bureau (PRB), *Male Responsibility in Today's Africa*, Washington, DC: PRB, 1996.

29. FOCUS on Young Adults, *Advancing Young Adult Reproductive Health: Actions for the Next Decade*, Washington, DC: FOCUS on Young Adults, 2002; Barker G, *Working with Adolescent Boys: A Review of International Literature and a Survey of Programs Working with Adolescent Boys in Health and Health Promotion*, report to WHO Adolescent Health and Development Programme, Division of Family Health, Geneva, Mar. 1998; WHO, *Programming for Male Involvement in Reproductive Health: Report of the Meeting of WHO Regional Advisers in Reproductive Health, WHO/PAHO, Washington, DC, 5–7 September 2001*, Geneva: WHO, 2002; and UNFPA, 1995, op. cit. (see reference 23).

30. Appendix Table 1, col. 9.

31. AGI, 2002, op. cit. (see reference 18), chapter 6.

32. World Bank, Human Development Network, Development Data Group, *Data Comparative Tables*, <<http://devdata.worldbank.org/hnpstats/DCselection.asp>>, accessed May 23, 2002.

33. Global Fund to Fight AIDS, Tuberculosis & Malaria, *Pledges and Contributions*, May 30, 2003, <<http://www.globalfundatm.org/files/pledges&contributions030530.rtf>>, accessed June 6, 2003.

BOX: EFFECTIVE PROGRAMS TO CONTROL SEXUALLY TRANSMITTED INFECTIONS

1. Lande R, Controlling sexually transmitted diseases, *Population Reports*, 1993, Series L, No. 9.

BOX: A MODEL SET OF SEXUAL AND REPRODUCTIVE HEALTH INFORMATION AND SERVICES FOR MEN

1. American Medical Association, *Guidelines for Adolescent Preventive Services Recommendations*, 2000, <<http://www.ama-assn.org/ama/pub/category/2279.html>>, accessed Feb. 2, 2001; EngenderHealth, *Men's Reproductive Health Services Model*, 2000, <<http://www.engenderhealth.org/ia/www/emrhm0.html>>, accessed Apr. 4, 2001; and Sonenstein FL, ed., *Young Men's Sexual and Reproductive Health: Toward a National Strategy. Framework and Recommendations*, Washington, DC: Urban Institute, 2000.

CHAPTER 8: SUMMING UP

1. The Alan Guttmacher Institute (AGI), unpublished tabulations of 1994–2001 Demographic and Health Surveys (DHS).

2. AGI, unpublished tabulations of 1996–2000 DHS.

3. AGI, unpublished tabulations of 1994–2001 DHS.

4. AGI, *In Their Own Right: Addressing the Sexual and Reproductive Health Needs of American Men*, New York: AGI, 2002, Table 7.1, p. 88.

5. AGI, unpublished tabulations of 1993–2001 DHS.

6. Appendix Table 5, cols. 14 and 15.

7. Appendix Table 2, cols. 22–25.

8. Appendix Table 5, col. 18.

9. Calculated from Appendix Table 3, col. 25.

10. World Health Organization, *Millennium Development Goals*, <<http://www.who.int/mdg/en>>, accessed May 5, 2003.

11. AGI, unpublished tabulations of 1996–2001 DHS.

12. AGI, unpublished tabulations of 1994–2001 DHS.

13. *Ibid.*

14. **Contraceptive use:** Appendix Table 2, col. 21; Appendix Table 3, col. 14; and Appendix Table 4, col. 13. **Family size:** Appendix Table 4, cols. 7 and 8.

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