IN THEIR OWN RIGHT

ADDRESSING THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF AMERICAN MEN

THE ALAN GUTTMACHER INSTITUTE

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EXECUTIVE SUMMARY

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In recent years, awareness has grown of the need to address the sexual and reproductive behaviors and health of men. This recognition reflects the advent of HIV and the critical role of condom use in preventing sexually transmitted diseases (STDs), concerns about the role of men in teenage pregnancies and births, and the failure of many divorced and unmarried fathers to fulfill their parental responsibilities. The result has been programs' efforts to bring men—particularly the partners of women clients—into the existing reproductive health system.

Still, the sexual and reproductive health needs of men in their own right—as individuals and not simply as women's partners—have been largely ignored. The family planning, public health and contraceptive research communities have learned to regard and treat women as individuals, not just wives and mothers. It is time to do the same for men: to recognize that their reproductive health is, above all, about their own well-being and their ability to engage in healthy, fulfilling sexual relationships.

In Their Own Right: Addressing the Sexual and Reproductive Health Needs of American Men aims to take some initial steps in that direction by providing an overview of some fundamental patterns in men's sexual and reproductive lives, and their implications for policy and programs. It focuses on men 15–49 years old, because during these years, men typically pass the main sexual and reproductive milestones, from the initiation of sexual activity to marriage and fatherhood. And it underscores both gaps in what is known and obstacles to serving men effectively. This summary presents some of the report's key findings.

Chapter 2: Men 15–19: Initiating Sexual Relationships

Adolescence—the transition between childhood and adulthood—is a time of promise for most young men, a stage at which they want to discover and establish an identity independent of their family. And often, the heart of discovering who they are involves young men's exploration of romantic and sexual relationships. However, there is great variation in when and how safely teenage men experience the transition to sexual activity.

- Fewer than one-quarter of American men are sexually experienced by age 15, but nine in 10 have intercourse before their 20th birthday.
- Poor and minority youth initiate intercourse somewhat earlier than more affluent and white teenagers.
- Slightly more than two in 10 sexually experienced men have had only one partner by their late teens, and about three in 10 have had six or more.
- Sexual activity in adolescence is often sporadic, and many relationships do not last very long.
- Most men use a condom the first time they have intercourse, but condom use subsequently declines and reliance on female methods increases.
- Very few adolescent men are married, and only 3% are fathers. Only 7% of births each year involve teenage men.
- Six in 10 pregnancies involving teenage fathers end in a birth; four in 10 end in an abortion. Thirteen percent of abortions each year involve teenage men.

Chapter 3: Men 20–29: Settling Down

In their 20s, many men first establish an independent place in society. Often, they have completed their education, started working full-time and set up their own households, frequently in the context of marriage or a cohabiting relationship. Nevertheless, many have not yet assumed responsibility for families of their own.

- Twenty-seven percent of men in their early 20s are married or cohabiting, but this proportion doubles by the late 20s.
- Black men are much less likely than white or Hispanic men to marry in their 20s, and poor black men are half as likely as better-off black men to do so.
- Condom use is more common among men not in a union than among those who are cohabiting or married. It is therefore not surprising that men in their early 20s are more likely than those in their late 20s to use condoms.
- One-quarter of men have fathered a child by age 25, and one-half have done so by age 30. Minority men and those with the lowest incomes and least education are the most likely to become fathers in their 20s.

- Men in their 20s account for about half of births and half of abortions in the United States each year.
- Roughly eight in 10 births involving men in their early 20s, and half of those involving men in their late 20s, are nonmarital.

Chapter 4: Men 30–49: Forming Families

Most men in the 30s and 40s have married and become fathers. However, because of separation, divorce, nonmarital childbearing and children's starting to leave home, some men who have had children are not living with them.

- Seven in 10 men in their 30s and eight in 10 of those in their 40s are married or living with a woman.
- In their 30s and 40s, poor men are the least likely to be married and the most likely to be separated or divorced.
- During their 30s and 40s, men's use of condoms for contraception declines, and their reliance on male and female sterilization grows.
- By age 49, the average man has had about two children. In addition, many men are fathers to stepchildren, adopted children or foster children.
- Men in their 30s and 40s account for 44% of births and 34% of abortions each year. The number of men who father children after age 49 is very small.
- Eleven percent of men in their 30s have biological children but do not live with them.

Chapter 5: Sexually Transmitted Diseases and Condom Use

The personal, societal and economic costs of STDs are enormous and growing. The spread of these diseases is determined partly by the level of infection within a community, the ability of infected individuals to obtain treatment and the prevailing patterns of sexual behavior.

- Eight in 10 adults living with AIDS in the United States are men. More than one in 10 men who had AIDS diagnosed in 1999 were exposed to HIV through heterosexual activity.
- Reported rates of chlamydia and gonorrhea reach 500–600 per 100,000 men in their early 20s, levels that are much higher than those of men in their 30s or older.
- Compared with white and Hispanic men, black men have twice as high a level of infection with herpes, and probably have several times the rates of bacterial STDs.
- Nine in 10 men have heard of HIV, AIDS, gonorrhea and syphilis, but far fewer know about genital warts and are aware that chlamydia can infect men. Men's knowledge of effective measures for preventing STDs is sketchy.
- Half of men who use condoms do so for birth control, not STD protection.

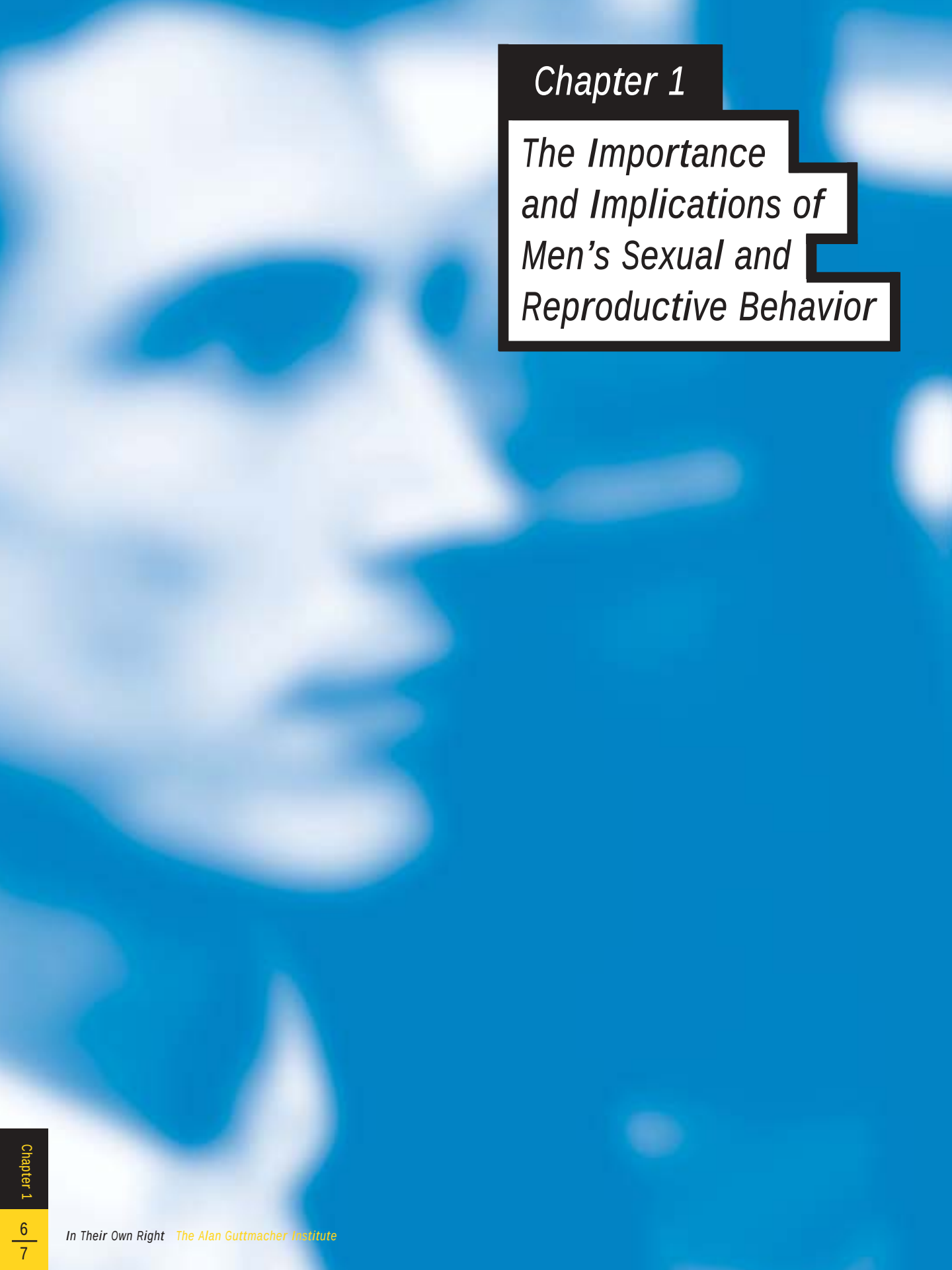
Chapter 6: Sexual and Reproductive Health Information and Services for Men

From adolescence on, most men need information and counseling about sexual and reproductive matters, and they need somewhere reliable to go for related education and health care.

- There is no commonly agreed upon definition of sexual and reproductive health care for men, and many barriers impede the provision of such care.
- Obstacles to care include the tendency of many men not to seek regular, routine checkups; the fact that health insurance often does not cover the services men need; and the high proportions of men—particularly poor men—who do not have health insurance.
- Few health professionals are specifically trained to provide men with sexual and reproductive health education and services.
- The older men get, the more likely they are to need medical sexual and reproductive health services rather than information.
- At all ages, sexually active men, particularly those who do not use a condom and have multiple partners, need regular screening for STDs.

Chapter 7: Summing Up

It is essential to recognize the sexual and reproductive health care needs of American men and to increase their access to services addressing those needs, including counseling, educational and medical services. Movement toward a more holistic and broad-based approach to sexual and reproductive health care for men should enhance their well-being, equip them to make responsible decisions, result in lower levels of STDs and unintended childbearing, and help make men better fathers. Thus, what is increasingly seen as good for men in their own right should turn out to be just as good for women—to the benefit of men and women as individuals, couples, families and society as a whole.



Chapter 1

The Importance and Implications of Men's Sexual and Reproductive Behavior

"The sexual and reproductive health needs of men in their own right, as individuals, have been largely ignored."

Although sex and reproduction involve both men and women, until recently, women's health care needs in these areas received by far the greater share of attention. The reasons for this imbalance are obvious and largely understandable. Only women become pregnant and bear children, and safe pregnancies and the healthiest possible outcomes are essential to the well-being of women, children and families. Equally important, the advent of technologies and services that enable women to plan pregnancies, and to experience the pleasure of sexual intercourse without the fear of unintended pregnancy, has been a historic and liberating development in their lives.

Men have always been freer than women to separate sexual pleasure from reproductive outcomes, with relatively little attention to the consequences of their behavior. In recent years, however, the sexual and reproductive roles of men have received increased public scrutiny,[1] as health professionals and advocates concerned with women's sexual and reproductive health have become aware of the need to address the behaviors and health of their male partners as well.

In part, this recognition reflects the advent of HIV and the growing awareness of the critical role that men's condom use plays in the prevention of sexually transmitted diseases (STDs). It also may reflect increased concerns about teenage pregnancies and births, especially those involving older men, and the failure of large numbers of divorced and unmarried fathers to fulfill their child support obligations and other parental responsibilities.

At the program level, efforts are under way to bring men—particularly the partners of women clients—into the existing family planning and reproductive health care system by offering them contraceptives, testing and treatment for STDs, and other services. Supporters of this approach reason that healthy and well-informed men are the most likely to be responsible sexual partners and good fathers.

Still, the sexual and reproductive health needs of men in their own right, as individuals, have been largely ignored. The family planning, public health and contraceptive research communities have finally learned to regard and treat women as individuals, not just wives and mothers. It is time to do the same for men. This report aims to take some initial steps in that direction by providing an overview of American men's sexual and reproductive behavior, drawing out the health and program implications of that information, and underscoring both gaps in what is known and obstacles to serving men more effectively.

This kind of effort is long overdue for a number of reasons. For decades in the United States, sexual initiation has been taking place earlier, and marriage later; the result is that young men (as well as young women) have a lengthy period of sexual activity before marriage. High divorce rates have created large numbers of midlife bachelors, many of whom are ill equipped to take up new roles under social and sexual conditions that have changed dramatically since they were adolescents. Society now expects men to be more directly involved in the care and upbringing of their children than they were in the past, and men themselves seem to welcome a more active role. Yet more and more children are being born to couples who are not married and who may not live together. How men manage these challenges is critical for their emotional and physical well-being—and for the well-being of their partners and families.

There Are Many Obstacles to Addressing Men's Needs

Several stumbling blocks stand in the way of addressing men's needs:

- Some observers continue to perceive men as basically irresponsible, or to believe that involving them in sexual and reproductive health programs can achieve no useful end.

■ Some health care providers are reluctant to offer services to men—because they lack interest, because appropriately trained staff are not available, or because they are concerned that services for men might divert resources from services for women (especially poor women) and compromise the quality and availability of care.

■ In a vicious circle, the lack of information on male sexual and reproductive health needs and inadequate medical training in this area have contributed to significant gaps in financing for these services.

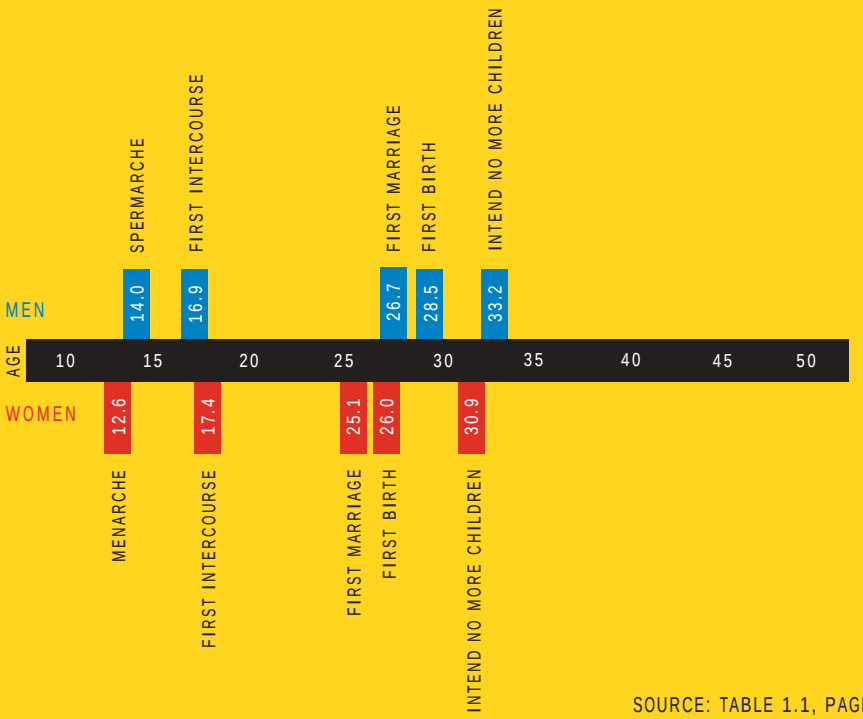
■ Standards of reproductive health care have been developed for women, but no consensus yet exists as to what constitutes good sexual and reproductive health care for men.

■ Men have fewer purely medical reproductive health needs than women do, but historically, family planning and reproductive health programs have been overwhelmingly medical in nature.

Another perspective, however, is that investing resources in providing information and services for men need not jeopardize the availability of services for women. Addressing the sexual and reproductive health needs of men in their own right will ultimately benefit not just men, but also women and families. What is more, men's reproductive health needs typically require less expensive medical care than do women's. And recognizing the importance for men of nonmedical care—including information and counseling on topics such as sexual pleasure and its relationship to contraceptive use, and effective communication and negotiation within relationships—promises to broaden the scope of services available to women as well as men. Rather than redirecting scarce resources away from the provision of care to women, addressing the sexual and reproductive

CHART 1.1

Men and women experience important sexual and reproductive events at similar ages.



SOURCE: TABLE 1.1, PAGE 82.

needs of America's men may well result in more comprehensive care for women, as well as stronger relationships among healthier partners.

Between Ages 15 and 49, Men Typically Experience a Number of Sexual and Reproductive Milestones

This report uses a life-stages framework to follow the lives of U.S. men between the ages of 15 and 49—the years of greatest importance for men's sexual and reproductive behavior.[2] During this 35-year period, men experience puberty (marked by the onset of sperm production), have intercourse for the first time, marry for the first time, become fathers and then see the end of childbearing (Chart 1.1). Many men also experience separation, divorce and remarriage during these years, and some become widowed. At each stage, men are likely to need specific types of information and, in some cases, specialized kinds of health care.

By age 14, half of young men have entered puberty. Are they prepared for this transition, marking the end of childhood and the threshold of adolescence? Shortly before their 17th birthday, half of men have experienced sexual intercourse for the first time. Do they have the information and guidance that will make this a safe and pleasurable experience for themselves and their partners? By age 27, half of American men have married for the first time. Have they acquired the communication skills necessary for a strong relationship?

The timing of these last two transitions reveals a crucial fact: Between first intercourse and first marriage, the typical American man spends around 10 years being single but sexually active—making this an extremely important period in terms of the need for effective protection against STDs and unwanted pregnancies and births.

By their 29th birthday, half of all U.S. men have become fathers for the first time. Do these men have the information and advice they need to prepare them for this important role? By age 33, five in 10 men say they do not want any more children. Do they have the knowledge and services that will enable them to prevent further pregnancies for the rest of their sexually active lives?

Clearly, people rarely fit into frameworks. Men may begin their sexual lives by age 15 or younger, have children before they marry, never marry or form new families well beyond their 40s. Nevertheless, the life-stages framework provides a structure that underscores the implications of men's changing sexual and reproductive lives for their changing information and service needs.

Men's Sexual and Reproductive Behavior Is Influenced by Their Background

The pace and direction of men's progression from adolescence to adulthood are shaped—and sometimes limited—not just by their age or life stage, but also by their racial and ethnic background and their socioeconomic and marital status (see box, page 10). American men are diverse in these key respects (Chart 1.2, page 11).[3]

White men are much less likely than minority men to be poor (Chart 1.3, page 12) and to have a low level of education.[4] As a result, the effects of race and ethnicity in American society are often difficult to disentangle from those of socioeconomic status.[5] This complicates any attempt to assess how each factor is independently associated with variations in men's sexual and reproductive lives. Further complicating our understanding of the role of socioeconomic disadvantage in the sexual and reproductive behaviors of differing racial and ethnic groups is the continuing existence of deep-rooted forms of racial discrimination.

Men's sexual and reproductive behavior is also strongly affected by whether they are single, cohabiting, married, divorced or separated. Accordingly, union status is another factor used to help describe variations in men's sexual and reproductive behaviors, although it may be associated with socioeconomic status.

Other factors, too, likely account for variations in men's sexual and reproductive attitudes and behavior. Personal or community values and religious beliefs grounded in family or social groupings may play an influential role. Community values can be especially important in defining acceptable patterns of behavior, or establishing models of the kinds of relationships between men

and women that are considered normal, respectable or worthy of emulation.

Indeed, numerous stereotypes of masculinity—and of femininity—thrive in America, although they may vary in different communities. Among traits often considered typically masculine are sexual prowess, physical strength, adventurousness and stoicism. Less positively, men are often accused of behaving insensitively in relationships, of being sexual predators or being unwilling to commit to long-term relationships, of resorting to force when frustrated (see box on page 19) or of being "deadbeat dads." This report questions and challenges many of those stereotypes.

The Report Follows Men from Adolescence to Maturity

This report deals separately with men in three successive age-groups: adolescents (15–19), young adults (20–29) and mature adult men (30–49). These age breakdowns do not exactly coincide with the timing of the events shown in Chart 1.1. But each represents at least one important transition—to sexual initiation for most men in adolescence, to cohabitation and marriage for many men in their 20s, and to having and raising children for the majority of men in their 30s and 40s. The choice of these age-groups is also somewhat dictated by the specific age-groups of men covered in the national surveys whose findings form the basis for this report.

For issues not covered by surveys, the report summarizes many other types of social science research to help describe and explain the influences on men's sexual and reproductive behavior. Thus, it brings together for the first time data obtained from a wide range of sources.

After examining the characteristics and behaviors of men in the selected age-groups (chapters 2–4), the report addresses issues that involve men

CATEGORIZING MEN BY THEIR BACKGROUND CHARACTERISTICS

Marital and Union Status

Data are presented on both current legal marital status and current union status. When viewed according to marital status, men are categorized as married; divorced, separated or widowed (often combined and described as formerly married); or never-married. Union status is a wider definition that also includes cohabitation, or living together; union status is obtained only by some surveys. Cohabitation can overlap two of the marital status categories, since cohabiting individuals can be either never-married or formerly married.

Race and Ethnicity

Government agencies typically classify Americans into one of five major racial and ethnic groups, each of which encompasses quite diverse subgroups. But because the sample sizes in national surveys are usually not large enough to provide adequate representation of smaller groups, or of subgroups within categories, this report focuses only on the three largest groups: non-Hispanic white, non-Hispanic black and Hispanic. In most analyses, men classified as Asian or Pacific Islander or as Native American are combined with the white population.

Poverty Status

In this report, men are classified as poor if their family income is less than 100% of the federal poverty level ($16,450 for a family of four in 1998), low-income if it is 100–199% of poverty, moderate-income if it is 200–349% of poverty and better-off if it is 350% of poverty or higher. These categories were chosen for the following reasons: The first two (comprising 10% and 15% of American families, respectively) are often used in determining eligibility of government benefits. The second two (comprising 25% and 50% of families) allow a more detailed examination of the impact of income than would have been possible by combining them into a single group.

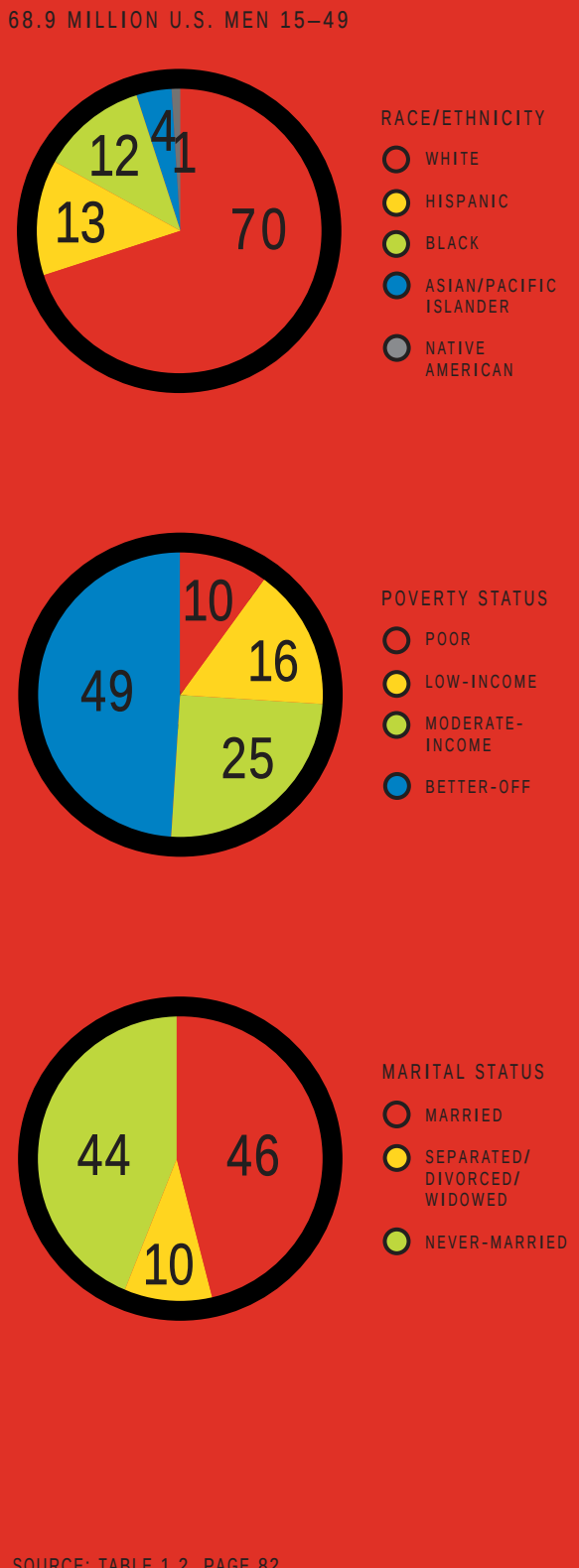
of all ages: STDs and condom use (chapter 5); and the sexual and reproductive health services men currently receive, as well as the services that many experts believe they still need (chapter 6). The report concludes with a summary of the findings and a discussion of their implications for policy and program efforts and for future research (chapter 7).

While this report presents a massive amount of data, it does not provide a complete or definitive set of findings; nor can it cover every implication for programs, public education and future research. In addition, the data have their limitations (see box, page 13). The report does not address the sexual and reproductive behavior and health needs of three important groups: men in prison and men who live on military bases (both excluded from national surveys, which typically cover the civilian, noninstitutionalized population), and men who have sex with men (who are included in surveys but not identified separately). However, because the behavior of incarcerated men and of men who have sex with men has important implications for sexual and reproductive health, some issues related to these groups are discussed briefly on pages 36 and 56, respectively.

This report is only a beginning. It provides an exploratory overview of some fundamental patterns in men's sexual and reproductive lives, and their implications for policy and programs. Large gaps remain in what is known, and much of the detailed and in-depth information needed to bring the outlines to life is still lacking. In the meantime, however, it is not too soon to consider and begin addressing the sexual and reproductive health needs of men in their own right.

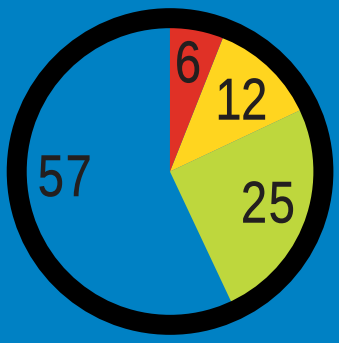
CHART 1.2

American men 15–49 have diverse social and economic characteristics.

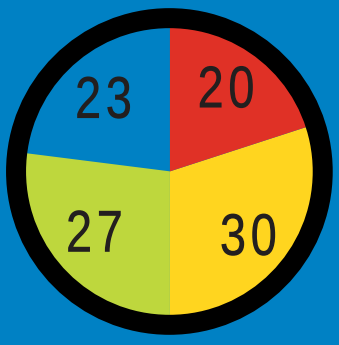


SOURCE: TABLE 1.2, PAGE 82.

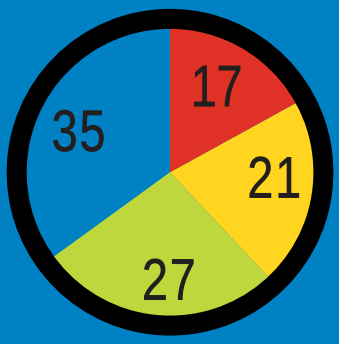
In the United States, race/ethnicity and poverty status are closely related.



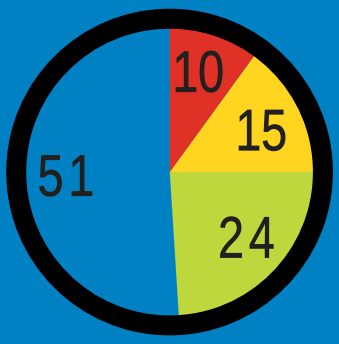
48.3 MILLION WHITE MEN



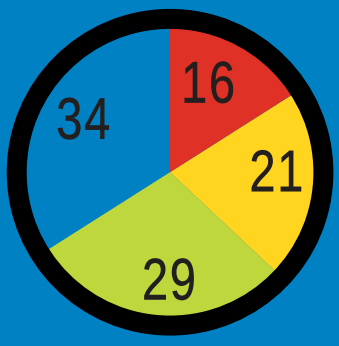
8.8 MILLION HISPANIC MEN



8.4 MILLION BLACK MEN



2.9 MILLION ASIAN/PACIFIC ISLAND MEN



500,000 NATIVE AMERICAN MEN

POVERTY STATUS, U.S. MEN 15–49

- POOR
- LOW-INCOME
- MODERATE-INCOME
- BETTER-OFF

SOURCE: TABLE 1.3, PAGE 82.

Principal Sources of Information

The information presented in this report and in the state-level measures shown in the appendix (page 80) is derived mainly from published reports of the following national surveys or unpublished tabulations by The Alan Guttmacher Institute of the data files:

- Current Population Survey (CPS): various years, 1970–2000
- National Survey of Families and Households (NSFH): 1987–1988 (Wave 1) and 1992–1994 (Wave 2)
- National Health and Social Life Survey (NHSLS): 1992
- National Survey of Adolescent Males (NSAM): 1995
- National Survey of Men (NSM): 1991
- National Ambulatory Medical Care Survey (NAMCS) and National Hospital Ambulatory Medical Care Survey of Emergency and Outpatient Departments (NHAMCS): 1996–1998
- National Survey of Family Growth (NSFG): 1995
- National Health and Nutrition Examination Survey (NHANES): 1988–1994
- General Social Survey (GSS): various years, 1980–1998
- Survey of Inmates in State and Federal Correction Facilities: 1997
- Survey of Inmates in Local Jails: 1996

Additional sources of information were published data from the Centers for Disease Control and Prevention (CDC), Bureau of the Census, Survey of Income and Program Participation, and National Center for Health Statistics.

Data Limitations

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

Men's reporting on some aspects of their sexual behavior (for example, how early they initiated intercourse and their number of sexual partners) may be overstated, but little evidence is available on the extent of overstatement. In addition, men may use different strategies from women in reporting their number of partners (for example, approximating and possibly rounding up). Furthermore, the sexual double standard may lead some men to exaggerate their number of partners, while having the opposite influence on women.[1]

Some evidence illustrates that men (particularly those not living with their children) underreport the number of children they have fathered. For example, one study shows that between one-third and one-half of men's nonmarital births and births within a previous marriage are not reported.[2] Another finds that underrepresentation of men in the national Panel Study of Income Dynamics accounted for a significant proportion of men's underreporting of their children, and that men's nonreporting of their children from previous marriages was relatively low (around 15%).[3] Because of these problems, this report draws on multiple sources for documenting the number of children men have fathered.

Patterns of contraceptive use reported by men and women in different surveys differ for some understandable reasons. Men (and women) probably report their own use more accurately than they report their partner's, and either partner may report use with an extramarital partner. In addition, differences in the wording of questions across surveys can affect reporting.

The need to rely on multiple surveys resulted in uneven coverage and in some inconsistencies in the data presented, in terms of both substance and the periods for which data are available. For example, data on contraceptive use were available for men 15–39 from two surveys (the 1995 NSAM for men 15–19 and the 1991 NSM for men 20–39), but equivalent data are not available for men 40–49; for men in their 40s, only a measure of current condom use was available, and only in the late 1990s, from the GSS.

Completeness of Coverage

In addition, the national surveys used here cover only the civilian, noninstitutionalized population. Substantial numbers of men are therefore omitted—in particular, men who live on military bases and men who are in prison (each of whom account for 2% of men 15–49). The proportion omitted because they live on military bases is larger among those aged 18–29 (3%) than among those 30–49 (1%), and is somewhat larger among black men (2.4%) than among all other racial and ethnic groups combined (1.5%). In the case of the prison population, omission is larger for men aged 20–34 (3%) than for older men (2%), and larger for minority groups (7% of black men 15–49 and 3% of Hispanic men) than for white men (1%).

Chapter 2

Men 15–19: Initiating Sexual Relationships

- *Fewer than one-quarter of American men are sexually experienced by age 15, but nine in 10 have intercourse before their 20th birthday.*
- *Poor and minority youth initiate intercourse somewhat earlier than more affluent and white teenagers.*
- *Slightly more than two in 10 sexually experienced men have had only one partner by their late teens, and about three in 10 have had six or more.*
- *Sexual activity in adolescence is often sporadic, and many relationships do not last very long.*
- *Most men use a condom the first time they have intercourse, but condom use subsequently declines and reliance on female methods increases.*
- *Very few adolescent men are married, and only 3% are fathers. Only 7% of births each year involve teenage men.*
- *Six in 10 pregnancies involving teenage fathers end in a birth; four in 10 end in an abortion. Thirteen percent of abortions each year involve teenage men.*

"The very heart of discovering who they are involves young men's exploration of romantic relationships, including the initiation of sexual relations."

Adolescence—the transition between childhood and adulthood—is a time of promise for most young men. This is the period when many complete high school, find jobs, leave home or begin college. It is also a stage at which most young men want to discover and establish an identity independent of their family. And often, the very heart of discovering who they are involves young men's exploration of romantic relationships, including the initiation of sexual relations.

The promise and excitement of adolescence are not equal for all young men. A young man's ability to pursue his dreams and shape his future depends on the social and economic resources available to him, his sense of himself, and whether society views him as a potential asset or burden to the community—all of which, in the United States, may be related to his racial or ethnic background. Most of these same factors also influence the degree to which he experiences the transition to sexual activity safely.

In Adolescence, Men's Lives Are Determined Largely by Their Family Background

Overall, two-thirds of 12–17-year-old men live with two parents, and slightly fewer than one-third live with one parent—overwhelmingly their mother. The remainder live with another relative (predominantly their grandmother) or with someone outside their family (Chart 2.1, page 16).[1] Black youth are far more likely than white and Hispanic youngsters to live with their mother only (not shown). Young people growing up in single-parent or unstable families are at increased risk of engaging in behaviors that may endanger their physical and emotional health, such as excessive alcohol or drug use, weapon carrying or fighting.[2]

Roughly one in seven men 18–24 have not completed high school. Although the high school completion rate has improved for both black and white youth since the 1970s, it has not increased for Hispanic youth; almost four in 10 Hispanic young men have not graduated, compared with two in 10 black and one in 10 white youth.[3] The employment and earnings prospects of young men without a high school diploma are not promising, given the decline in manufacturing jobs and the growing demand for skilled workers in the U.S. labor force.

One-third of teenage men are working and going to school, and most of the rest are doing one or the other (Chart 2.1). However, 5% are doing neither, and this proportion rises to 12% among those from poor families (not shown).[4]

One in three men aged 15–19 come from poor or low-income families, one-quarter from moderate-income families and the remainder from better-off families. Poverty disproportionately affects minority teenagers: Thirty percent of Hispanic, 27% of black and 9% of white men 15–19 are below the official poverty level (not shown).[5]

A sizable proportion of adolescent men (one in five) have no health insurance. Most men at this age are covered by their parents' plans, but since 18 is normally the cutoff age for inclusion in a parental policy, older teenagers are slightly less likely than those aged 15–17 to be covered (not shown).[6]

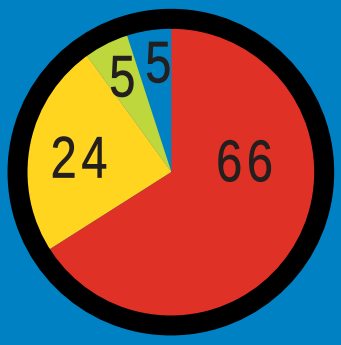
Most Teenage Men Experiment Sexually

For the average American male, puberty starts between the ages of 12 and 14, although some males are in their late teens before signs become evident.[7] During puberty, boys usually develop romantic and sexual interests in girls. Hanging out in groups of friends of both sexes, especially away from their parents, provides boys with a context in which to explore and express these feelings. By the time they are 17, 87% of young men say they have had at least one romantic relationship.[8]

Roughly half of men 13–18 report that they have ever masturbated.[9] In surveys of male college students, 85–88% report having masturbated,[10] but some researchers think that these pro-

Many adolescent men live with only one parent, are both going to school and working, come from poor or low-income families and have no health insurance.

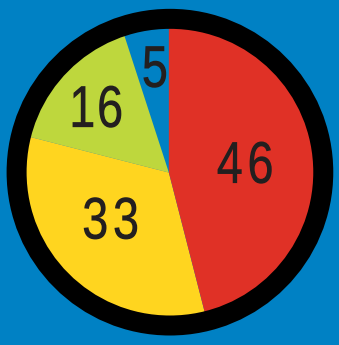
10.2 MILLION MEN 15–19



LIVING ARRANGEMENTS*

- TWO PARENTS
- MOTHER ONLY
- FATHER ONLY
- OTHER

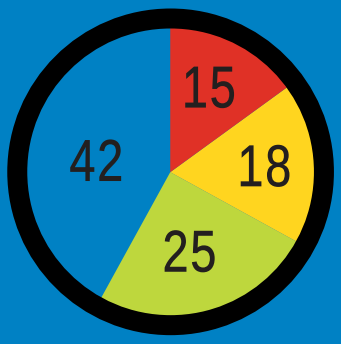
*BASED ON 12–17-YEAR-OLDS.



SCHOOL/WORK†

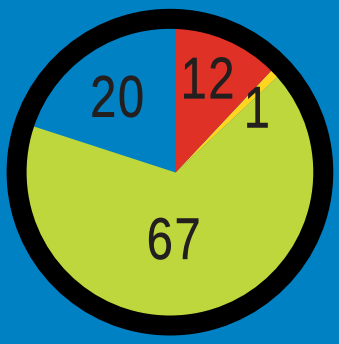
- SCHOOL ONLY
- SCHOOL AND WORK
- WORK ONLY
- NO SCHOOL OR WORK

†BASED ON 16–19-YEAR-OLDS.



POVERTY STATUS

- POOR
- LOW-INCOME
- MODERATE-INCOME
- BETTER-OFF



HEALTH INSURANCE COVERAGE

- MEDICAID
- OTHER GOVERNMENT
- PRIVATE
- NONE

SOURCE: TABLE 2.1, PAGE 82.

portions represent underestimates.[11]

In terms of noncoital activities between partners, slightly more than half of 15–19-year-old men in 1995 said they had been masturbated by a female or had received oral sex. The proportion does not differ by race or ethnicity, but is twice as high among men aged 17–19 as among those 15–16; it is also significantly higher than the level found in 1988.[12]

Among men aged 15–19 who have never had vaginal intercourse, 67% report that they have touched a woman's breasts, 22% have been stimulated to the point of orgasm, 18% have received oral sex and 14% have given oral sex.[13]

Noncoital sexual practices among adolescents might be on the rise in the United States, possibly because of the increasing emphasis some conservative groups place on abstaining from intercourse until marriage, and because of young people's growing fear of AIDS and other sexually transmitted diseases (STDs). According to anecdotal evidence, some adolescents perceive noncoital sex as "no big deal," whereas many consider vaginal sex "the real thing," connoting true intimacy, and to be reserved for a special relationship.[14]

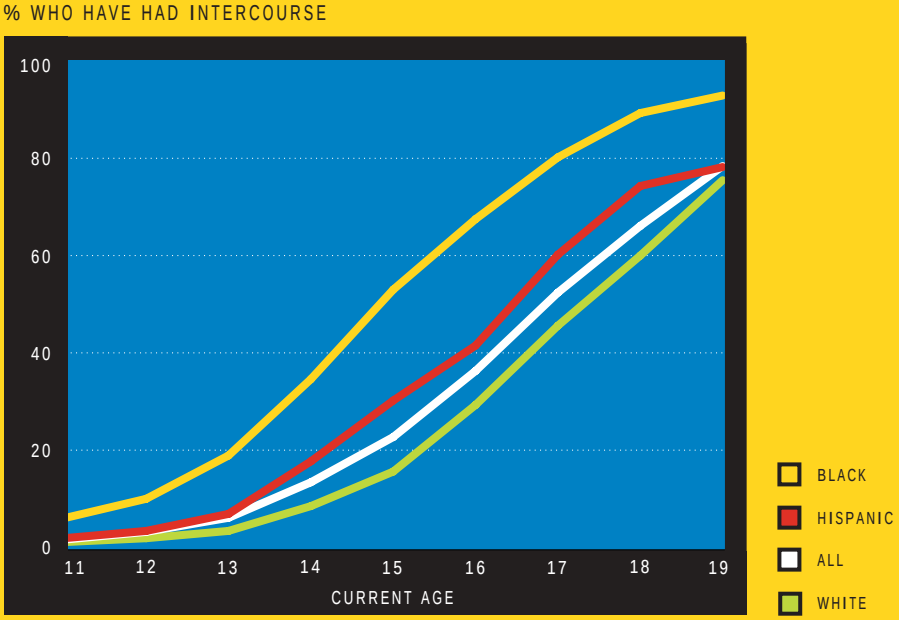
Young men are more likely than young women to equate some noncoital sexual experiences with intercourse,[15] which might help explain why young men usually report having had more sexual partners than young women do.[16]

The Timing of First Intercourse Varies for Different Groups

Many adults believe that a very high proportion of youth start having vaginal intercourse during their early teens. This is not actually the case. About one in five 15-year-olds have had intercourse with a woman. However, around eight out of 10 young men aged 19 have had intercourse at least once—a proportion very similar to that of young American women.[17] Considerably higher proportions of black than of white and Hispanic men

CHART 2.2

Most men begin sexual intercourse during their teenage years.



SOURCE: TABLE 2.2, PAGE 83.

have intercourse in the early teenage years, but the differential narrows by age 19 (Chart 2.2, page 17).[18] Interestingly, young men who have had intercourse express a greater sense of control over their lives than those who have not (the reverse is true of young women).[19]

Young men from poor families are more likely than those from better-off families to start their sexual lives at a very early age: At age 15, 42% and 23%, respectively, have had intercourse (not shown). However, after age 17, the differentials by poverty status are smaller than those by race and ethnicity.[20]

One in five young men 15–19 (one in three if they are poor, and one in eight if their mothers have a college degree) say they first had intercourse before they were 15.[21] Reports from young men that they first had intercourse when they were 14 or younger are perplexing and call for further research. Who are their sexual partners? Is intercourse at that age acceptable to both partners? Might peer pressure or coercion ever be involved?

Some youth do experience coercion. While fewer than 1% of men 18–49 report that their first experience of intercourse was "forced," 8% say it was "not wanted," though not forced.[22] Five percent of males in grades 5–12 report having been sexually abused, and half of these say they told no one.[23] In Massachusetts, 9% of male high school students report that they have ever had sexual contact against their will.[24]

Some young men probably exaggerate their sexual accomplishments by claiming that they first had intercourse earlier than they actually did, or by reporting intercourse when only noncoital activities took place. In fact, men of all ages tend to overstate, and women to understate, the number of partners they have had.[25] These patterns are not surprising, given the widespread sexual double standard still found in the United States and most other societies.

Sexual initiation in adolescence is not a new phenomenon among American men, although the pace accelerated in the 1980s. In the 1970s, about six in 10 men had had intercourse before age 18. By 1988, this proportion had risen to seven in 10.[26] Between 1988 and 1995, the proportion of teenage men with sexual experience declined somewhat—but only among those who were aged 15–17 (from 50% to 41%[27]) and among white 15–19-year-olds (from 73% to 64%[28]). The drop is thought to be related to a shift toward less-permissive attitudes about sex (which is associated with growing religiosity) and increased education about AIDS.[29] However, these influences do not appear to have affected the behavior of black and Hispanic youth.

Adolescent men's first partner typically is close

TABLE 2a

Many sexually experienced adolescent men have intercourse infrequently.

AGE	% WHO HAD INTERCOURSE, 1995			
	EVER	IN PAST YEAR*	IN PAST MONTH*	>10 TIMES IN PAST YEAR*
15–19	55	89	54	46
15–17	42	86	47	36
18–19	75	91	61	56

*BASED ON THOSE WHO HAVE EVER HAD INTERCOURSE.

SOURCE: REFERENCE 41.

to their own age. About two-thirds of men 15–19 indicate that their first female partner was their age or within one year of their age, and one in 10 report that she was two or more years younger. But one in five young men—an unexpectedly high proportion—say that their first sexual partner was two or more years older.[30]

The Pace of Sexual Initiation Is Influenced by Family and Community Characteristics

Many factors are related to the timing of young men's first intercourse. Sexually inexperienced men 14–16 who do not expect to have intercourse soon are characterized by different risk behaviors, peer norms, parenting factors, and school or religious involvement than their counterparts expecting to do so in the near future.[31]

Mothers' educational level and attitudes toward their children's sexual behavior seem to play an important role. Forty-four percent of 15–19-year-old men whose mothers have a college degree have ever had intercourse, compared with 60% of those whose mothers did not complete high school.[32] If an adolescent thinks that his mother disapproves strongly of young people's having sexual intercourse,[33] or if there is a high level of

MALE VIOLENCE AGAINST WOMEN

General violence and sexual violence against women are directly and indirectly related to men's sexual and reproductive lives. Moreover, the context for sexual violence is often domestic, and violence within the family affects many aspects of a couple's sexual and childbearing lives. While the focus here is on male violence directed against women, it should be emphasized that males may also be the victims of sexual abuse, especially in childhood and early youth *(see page 18).*

Male violence directed at women has complex roots, often involving social, cultural and event-related factors.[1] Sexual violence, in particular, is very difficult to measure accurately and is underreported in all parts of the world.[2]

■ *In a 1996 survey sponsored jointly by the Centers for Disease Control and Prevention and the Department of Justice, 15% of U.S. women 18 and older said they had been raped, and 3% said they had been the victims of attempted rape—for a total of 17.7 million women. Fifty-four percent of women who had been raped had been younger than 18 at the time, and 22% had been younger than 12.[3]*

■ *Fifty-two percent of women 18 and older said they had ever been physically assaulted by men in other ways—they had been slapped, hit, pushed, shoved, grabbed, hit with an object, beaten up, subjected to attempted chokings or drownings, kicked, bitten, or threatened with a knife or a gun, or had had something thrown at them.[4]*

■ *About three-quarters of the men involved in rape or assault against women were intimates—current or former husbands, cohabiting partners or boyfriends. The rest were friends or acquaintances, strangers and other relatives.[5]*

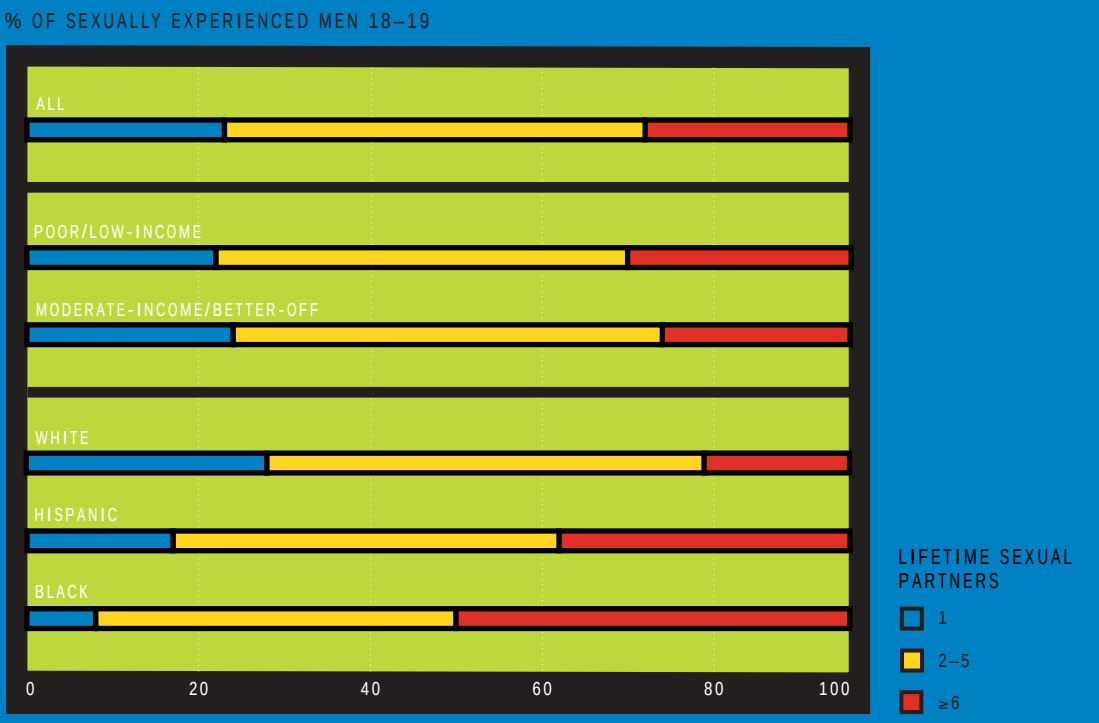
■ *White, black and Hispanic women have an equal chance of ever having been raped or assaulted.[6]*

■ *A survey in 14 states carried out in 1996–1997 found that 9% of women who had had a child in the previous 2–6 months had been physically abused around the time of their pregnancy. The probability was higher than average for women whose pregnancies were mistimed (13%) or unwanted (15%), and for teenagers (19%), black women (14%), unmarried women (18%), Medicaid recipients (21%) and women whose partners had not wanted the pregnancy (24%).[7]*

■ *Nine percent of women 15–24 whose first experience of intercourse was before marriage reported in 1995 that this experience was "forced." Another 25% said that although the experience was voluntary, they had not actually wanted it to happen.[8]*

CHART 2.3

By their late teenage years, just over two in 10 sexually experienced men have had only one partner, and almost three in 10 have had six or more.



SOURCE: TABLE 2.3, PAGE 83.

connectedness between mother and child,[34] first sexual intercourse tends to be delayed.

Fathers' attitudes can also be influential. Black adolescents who believe that their fathers disapprove of teenage sex, whether or not they live with their fathers, are more likely than others to delay first intercourse.[35] And young men from single-parent families are more likely than those living with two parents to begin their sexual careers at an early age.[36]

Religious belief appears to influence the age at which men first experience intercourse, but only among younger adolescents. Young men 15–17 who say religion is not important in their lives are slightly more likely than those for whom religion is important to have had intercourse.[37]

Differences in the pace of sexual initiation by racial and ethnic group have received a great deal of attention from social scientists, but explanations, particularly of the early sexual initiation of black males, remain elusive.[38] As we have seen, minority youth are much more likely than white youngsters to be disadvantaged in many areas of their lives, and growing up in difficult economic and family conditions affects not just young men's sexual behavior but other aspects of their lives as well. Levels of risky behaviors of all kinds (drug use, weapon carrying and fighting, as well as early sexual intercourse) are disproportionately high among minority adolescents, those living in single-parent families and those from poor and low-income families.[39]

There is insufficient knowledge to fully establish or understand the precise connections between disadvantage and adolescent risk-taking. However, much research shows that low income

and the low expectations that often come from growing up in poverty, difficulties in school, non-intact families and the absence of strong parental relationships all influence adolescents' chances of engaging in risky behavior.[40]

Sexual Relationships in Adolescence Are Often Sporadic

Teenagers who have had intercourse do not necessarily have sex frequently (Table 2a, page 18). Nine in 10 young men who have ever had intercourse did so at least once in the past year, but only half did so in the past month. Moreover, fewer than half of sexually experienced men 15–19 (and about a third of those 15–17) had intercourse more than 10 times in the past year. All sexually experienced adolescent men tend to have intercourse more frequently as they get older.[41]

Almost three in 10 sexually experienced men 15–17 have had only one lifetime partner, but two in 10 have already had six or more. By age 18–19, the proportion who have had only one lifetime partner declines to just over two in 10, and the proportion who have had six or more increases to almost three in 10 (Chart 2.3). Hispanic and black men aged 18–19 are less likely than their white peers to have had only one partner, and more likely to have had six or more.[42]

Partly reflecting personal and social factors that might contribute to risk-taking in adolescence, an association exists between alcohol use and having multiple sexual partners. Men aged 14–22 who in the past 30 days have engaged in binge drinking, ridden in a car with a drunken driver or driven immediately after drinking are more likely than others to have had six or more partners in the past year.[43]

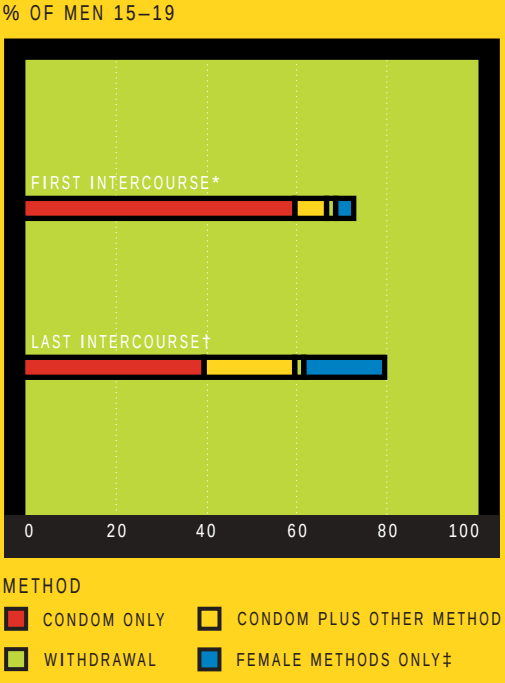
Most of young men's sexual relationships appear to be sequential, not concurrent. Only 20% of sexually experienced teenage men report having carried on more than one relationship at a time in the previous year.[44] Some of young men's sexual relationships probably last only a short time, and some might be one-night stands.

Teenage Men Who Are Having Intercourse Need Protection Against Unwanted Pregnancy and STDs

The pleasures of sexual relationships can be reduced by the fear of two unwelcome outcomes:

CHART 2.4

Most adolescent men and their partners use contraceptives, but their methods change over time.

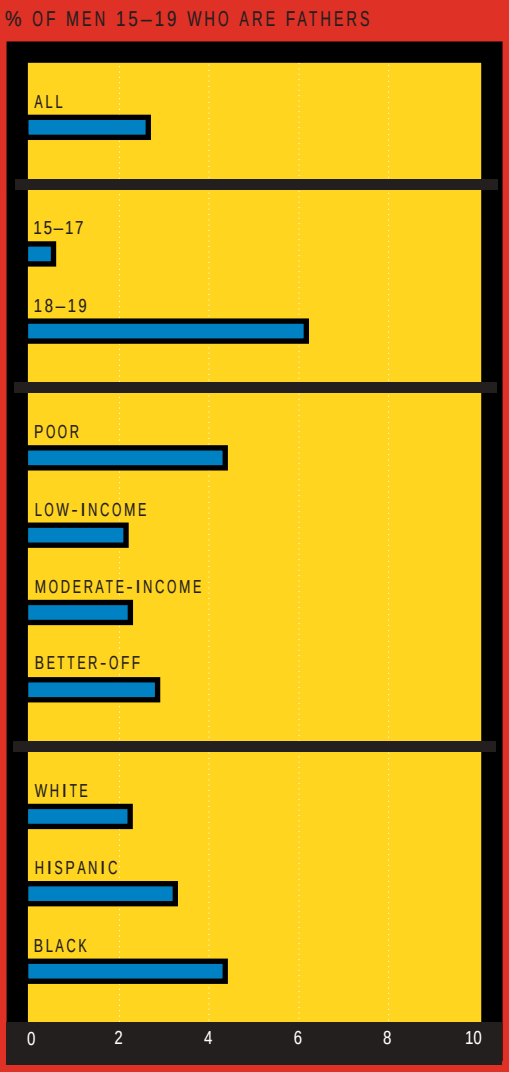


*Based on those who are sexually experienced.
†Based on those who have had intercourse in the past month.
‡Pill, implant, injectable, IUD, female sterilization, female condom, spermicide, douche, vaginal film or periodic abstinence.

SOURCE: TABLE 2.4, PAGE 83.

CHART 2.5

Very few teenage men become fathers.



SOURCE: TABLE 2.5, PAGE 83.

unwanted pregnancy and infection with an STD. For some adolescent men, the fear of pregnancy is greater than the fear of STDs.[45] The prevention of either is somewhat problematic for young men just starting to have intercourse. There are only two highly effective male contraceptive methods (the condom and vasectomy), and sterilization is largely irrelevant for adolescents. And there is only one method for men to use to avoid STD infection (the condom). Regular and consistent use of any method is complicated by the likelihood that many teenage men will have intercourse sporadically.

Nevertheless, at first intercourse, the condom is far and away young men's favored choice. The first time adolescent men have intercourse, 60% use a condom by itself, 7% use a condom in combination with a female method (dual methods), 2% practice withdrawal and 4% rely on their partner's method (Chart 2.4, page 21).[46] One-quarter (27%) have no protection of any kind. The very high level of condom use at first intercourse suggests that many young men (and perhaps some women) anticipate this event and have condoms on hand.

At adolescents' most recent intercourse, 40% used a condom by itself and 2% practiced withdrawal, while 20% used dual methods and 18% relied on female methods alone. The remaining 20% did not use any method. This means that most current protection among adolescent men involves male contraceptive practice. About two-thirds of dual-method use involves the pill, and the remainder, another female method (not shown).[47]

Poor and Hispanic Young Men Are the Least Well-Protected

While contraceptive use is generally similar among teenagers of varying characteristics, some differences are evident. At most recent intercourse, use of condoms (alone or in combination with other methods) was more common among men 15–17 (67%) than among older teenagers (55%), and it was lower for men whose family income was low (44%) than for those in families with higher incomes (64–65%).[48]

Overall protection is very similar for white and black youth, and somewhat higher among these groups than among Hispanic youth. Use of the condom alone is not much different among these three groups, but Hispanic youth are by far the

least likely to use condoms in combination with another method—7%, compared with 22% of both white and black men.[49]

The drop in condom use after first intercourse and the fact that this method is more commonly used by younger than by older teenagers reflect a commonly observed pattern of reduced condom use with increased maturity and over time. Once young couples settle into a relationship, condom use declines.[50] Presumably, in more stable relationships, the perceived need for STD protection diminishes and the perceived need for effective pregnancy protection rises.[51] A young person who asks a regular partner to use a condom might be interpreted as lacking trust.[52] In addition, couples might come to prefer female methods because they involve no interruption of lovemaking.

One in Five Sexually Active Adolescent Men Use No Method

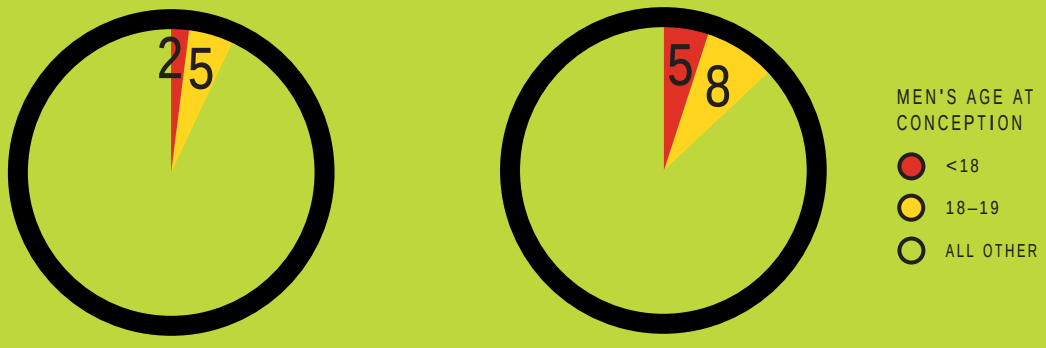
The last time they had intercourse, 20% of men 15–19 did not use any contraceptive method, but the proportion having unprotected intercourse is notably higher than average among young men with the lowest family incomes (37%) and Hispanic young men (30%).[53]

At least some sexually active young men not using a birth control method do not need contraceptive protection because they and their partner want to have a baby, or she is already pregnant. However, the rest, who know that they do not want a pregnancy, are at risk of just such an outcome. But sexually active men are also at risk of contracting and spreading an STD. The level of this risk may be hard for young men to assess because young people in sexual relationships do not always disclose to each other details about their sexual experiences, and many STDs have few obvious symptoms. Nevertheless, any young man who has had two or more sexual partners in a short period of time should consider himself a potential risk to his current partner. The fact that four in 10 sexually experienced men 15–19 are currently using no method or a method other than the condom suggests that this message is not well understood by all adolescents.

Regular and consistent use of any method is complicated by the likelihood that many teenage men will have sex sporadically.

CHART 2.6

Seven percent of births and 13% of abortions involve men in their teens.



3.9 MILLION
TOTAL U.S. BIRTHS, 1994

1.4 MILLION
TOTAL U.S. ABORTIONS, 1994

SOURCE: TABLE 2.6, PAGE 83.

TABLE 2b

Four in 10 pregnancies involving adolescent men are resolved by abortion.

AGE AT CONCEPTION	NO. OF PREGNANCIES, 1994*	% DISTRIBUTION, BY OUTCOME		
		BIRTHS	ABORTIONS	TOTAL
<20	466,000	59	41	100
<18	157,000	53	47	100
18–19	309,000	63	37	100

*DOES NOT INCLUDE PREGNANCIES ENDING IN MISCARRIAGES.

SOURCE: REFERENCE 66.

The Condom Is an Effective Method, but Teenage Men Often Do Not Know How to Use It Correctly

The condom is quite effective at preventing pregnancy if compared with periodic abstinence, spermicides or withdrawal; it is less effective, however, than hormonal methods, the IUD or sterilization. Fourteen percent of all U.S. women relying on condoms experience an accidental pregnancy in the first 12 months of use. However, the rate among women aged 18–19 (18%) is about half again the rate among 25–29-year-olds (12%),[54] which suggests that increased experience with the condom over time helps men use it more effectively and that consistency of use rises as men age.

Consistent and correct use of the condom enhances its ability to prevent pregnancy and disease, but some adolescent men are poorly informed about this method. Sexually experienced men aged 15–19 say they get most of their information about contraception from television (91%), school (89%), their parents (47%), and doctors or nurses (32%).[55] Six in 10 men 15–19 say they were taught in school sexuality education classes how to put on a condom.[56] But one in 10 do not know that it is risky to wait until just before ejaculation to put on the condom, and about one in four do not know that they must hold the condom as they withdraw after the sexual act is over. One-third do not know that oil-based lubricants can cause condoms to break.[57]

Most Teenage Men Do Not Want to Have a Child Right Now

Sixty-nine percent of men 15–19 say they would be very upset to learn that their girlfriend was pregnant. This reaction would be less common among young men living in poor, run-down neighborhoods (46%) than among those living in more favorable conditions (57–77%).[58] Only 4% of all adolescent men say that getting someone pregnant would make them feel a lot like a man, and 60% say it would have no such effect.[59]

Almost all teenage men think their parents would be upset if they made someone pregnant, and two-thirds believe that their friends would be upset. Younger teenagers and those from better-off families are the most likely to report that their parents would be upset. Black youth are the least likely to anticipate disapproval from their friends: Two-fifths would expect this response.[60]

Most teenage men want children in the future, however. On average, teenage men say that 2.3 children is the ideal family size, although young black and Hispanic men want slightly larger families than white men.[61] Among high school seniors interviewed in 1992, 39% of young men, compared with 49% of young women, said that having children was "very important."[62]

TABLE 2c

Nonmarital births are most common among adolescent men and men in their early 20s.

AGE AT CONCEPTION	% OF BIRTHS THAT ARE NONMARITAL, 1994
TOTAL	35
<20	87
<18	95
18–19	84
20–24	56
25–29	28
30–34	20
35–39	15
≥40	36

SOURCE: REFERENCE 67.

Few Adolescent Men Are Involved in a Pregnancy or Birth

Only 3% of men 15–19 have ever fathered a child. The likelihood of becoming a father during adolescence is not very different by poverty level or race (Chart 2.5, page 22). However, the rate among 18–19-year-olds (6%) is 10 times that among men 15–17 (0.6%).[63] Women younger than 18 are three times as likely as men younger than 18 to become involved in a pregnancy each year (86 versus 29 births per 1,000 in 1994).[64] Only 7% of annual U.S. births involve men younger than 20 (Chart 2.6, page 23).[65]

Four in 10 Pregnancies Involving Teenage Men End in Abortion

Each year, nearly 470,000 women become pregnant by teenage men, almost all of whom are unmarried. Four in 10 pregnancies involving teenage men are resolved by abortion, and six in 10 end in a birth (Table 2b);[66] the great majority of these births involve unmarried men (Table 2c). However, only 8% of the very few pregnancies involving married teenage men end in abortion, compared with 44% of those that involve unmarried men.[67] Of all women having abortions each year in the United States, 13% had sexual partners who were teenagers (Chart 2.6).[68]

Little is known about teenage men's participation in their partners' decision to end an unplanned pregnancy. However, among women younger than 18 attending abortion clinics in 1991, about one-third came with their boyfriend, three-quarters said their boyfriend had been involved in the abortion decision and one-fifth said that their boyfriend was the most helpful person in making the arrangements.[69]

Chapter 3

Men 20–29: Settling Down

- *Twenty-seven percent of men in their early 20s are married or cohabiting, but this proportion doubles by the late 20s.*
- *Black men are much less likely than white or Hispanic men to marry in their 20s, and poor black men are half as likely as better-off black men to do so.*
- *Most men in their 20s have only one sexual partner in the course of a year, but nearly one-third have two or more.*
- *Condom use is more common among men not in a union than among those who are cohabiting or married. It is therefore not surprising that men in their early 20s are more likely than those in their late 20s to use condoms.*
- *One-quarter of men have fathered a child by age 25, and one-half have done so by age 30. Minority men and those with the lowest incomes and least education are the most likely to become fathers in their 20s.*
- *Men in their 20s account for about half of births and half of abortions in the United States each year.*
- *Roughly six in 10 births involving men in their early 20s, and three in 10 of those involving men in their late 20s, are nonmarital.*

"Compared with their counterparts of a quarter of a century ago, men are now marrying later."

The 20s are the years in which many men first establish an independent place in society. During their 20s, many men complete their education and start working full-time. Most men this age are no longer primarily dependent on their parents, but many have not yet assumed responsibility for families of their own. More so than at other ages, men's economic situation during this decade influences, and is sometimes influenced by, their sexual, marital and reproductive behavior. Both incomes and some of these behaviors differ considerably among racial and ethnic groups.

The 20s Mark Men's Transition to Increased Self-Reliance

Men in their 20s increasingly move away from their parents' home and start living independently—with a wife or partner, with other people or by themselves. Roughly one in five men in their early 20s are married, and one in 10 are cohabiting.[1] By the late 20s, the proportion married more than doubles (Chart 3.1, page 28).[2] But many young men do not leave home, which suggests a measure of continuing dependency—probably because some young men are still attending college, but also partly because rents in many large cities are so high. Forty-eight percent of men in their early 20s and 19% of those 25–29 still live with their parents (not shown).[3]

During their 20s, men join the labor force in large numbers. In all, 80% of men 20–24 and 92% of those 25–29 are in the labor force—that is, currently employed (73% and 87%, respectively) or seeking work (7% and 5%, respectively). The proportion of men in the labor force who are seeking but have not found work is 7% for white and Hispanic men in their early 20s and 18% for comparable black men. In the late 20s, about 4% of white and Hispanic men and 8% of black men in the labor force are looking for work.[4]

In their early 20s, two in 10 men are not in the labor force at all, some because they are still full-time students; by the late 20s, the proportion not in the labor force drops to less than one in 10. Sixty percent of men 20–24 are working and not going to school, 19% are combining study and work, 14% are studying but not working and 6% are neither in the work force nor in school. Hispanic men this age are the most likely to be working only, while black men are the most likely both to be in school only and to be neither working nor in school (not shown).[5]

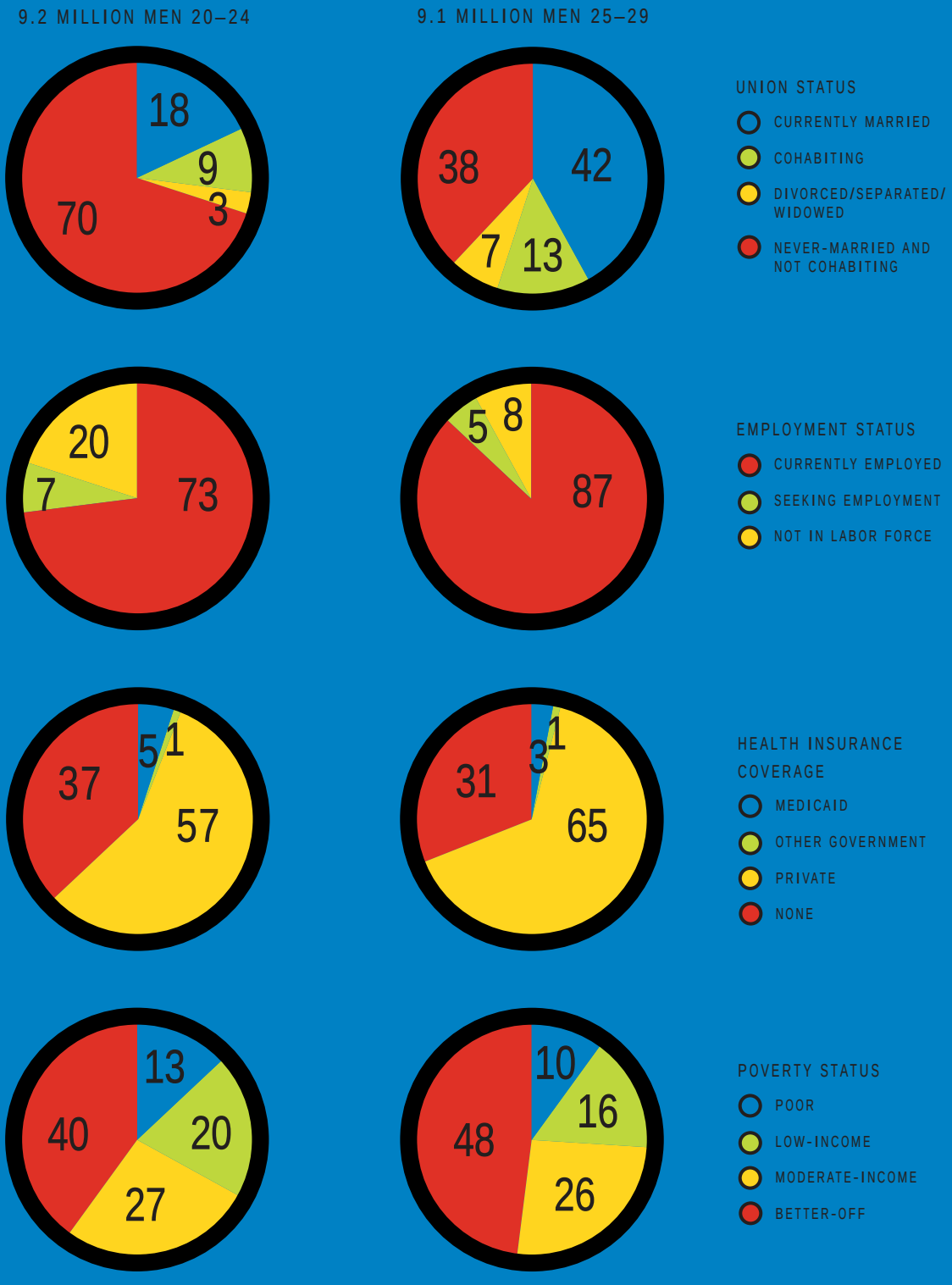
First jobs frequently pay low wages, and many do not offer health insurance coverage. Men's likelihood of having health insurance coverage is at its lowest point when they are in their 20s: Thirty-seven percent of those aged 20–24 and 31% of those 25–29 have no health insurance of any kind.[6]

Between the early and late 20s, some men obtain academic certificates and degrees, but educational attainment varies widely by racial and ethnic group. Hispanic men—many of whom are recent immigrants who have not attended school in the United States—start their adult lives with the largest educational deficit.[7]

Men's educational levels have a bearing on their subsequent economic status. In 1996, the median annual earnings of young men aged 25–34 who had not completed high school were 29% lower than those of their peers who had done so. Furthermore, many minority men earn less than white men with similar educational qualifications.[8]

One-third of men in their early 20s are poor or have low incomes, one in four have moderate incomes and four in 10 are better-off. By the late 20s, the proportion in the two lowest income categories has declined slightly, while the proportion who are better-off has risen. As is also true at other ages, during the 20s, white men are less likely to be in the two lowest income categories (22%) than are black and Hispanic men (38% and 52%, respectively).[9]

As men move through their 20s, they are increasingly likely to be married or cohabiting, employed, covered by health insurance and better-off economically.



SOURCE: TABLE 3.1, PAGE 84.

Men Are Marrying Later Now Than They Did in the Past

Compared with their counterparts of a quarter of a century ago, men are now marrying later. Fifty-one percent of men in their 20s in 1976, but only 32% in 1999, were legally married.[10] And among those who have wed, the median age at marriage rose from 22.8 in 1965 to 26.7 by 1998.[11] Much of the delay in marriage can probably be explained by men's and women's growing understanding of the importance of obtaining higher education or job training before they marry, to ensure being employable in today's changing economy. The postponement of marriage could also reflect more caution among recent generations of men and women, many of whom have seen their parents' marriages end in divorce.[12]

Yet there does not seem to be any large-scale rejection of the institution of marriage itself. Three-quarters of both men and women think marriage is important or somewhat important. Black men are less interested in marriage than white men, and Hispanic men are more interested than either.[13] One study finds that these disparities may stem partly from differences among racial and ethnic groups in the anticipated benefits of marriage (particularly, the expectation that it will improve one's sexual life), as well as the anticipated disadvantages (notably, that it will limit personal friendships outside marriage).[14]

Even as many men postpone formal marriage, some live with a woman in informal, or cohabiting, unions.[15] Four million American households include unmarried couples. In 1970, there was one such household for every 100 households with married couples; by 1996, the figure was seven for every 100.[16] About half of all men 25–44 have lived in a cohabiting relationship at some point.[17] Cohabitation is most common among people in their 20s and low-income groups, but approval of this type of union is highest among the most highly educated.[18]

The proportion of men who have ever cohabited is much higher than the proportion currently living with a woman, because cohabiting unions are often of short duration—an average of 1.3 years.[19] In one study of cohabiting couples, two in 10 were still unmarried and living together after 5–7 years; four in 10 had married, and four in 10 had broken up.[20]

The Age at Which Men Settle Down Differs Widely by Poverty Status

Men's union status changes dramatically between their early and late 20s. Seven in 10 men in their early 20s are not yet married,[21] but this proportion drops to about four in 10 men in their late 20s.[22] The pace of union formation varies considerably by race and ethnicity. Six in 10 white men 25–29, half of Hispanic men and one-third of black men are married or cohabiting (Chart 3.2, page 30).[23]

Not only are black men overall less likely than white and Hispanic men to marry in their 20s, but poor black men are half as likely as better-off black men to do so (one in 10 vs. two in 10—not shown). The association between income and marriage is in the opposite direction for Hispanic men: Two in five poor men are married, compared with one in four of those who are better-off. Among white men, income has no association with the likelihood of marrying.[24] The direction of the relationship between poverty and being married is complicated by the fact that marriage itself, because it often brings two earners together in one household, can help lift men out of poverty.

Among the many possible reasons suggested for black men's slower entry into marriage are their difficulties in finding a first job and in making the transition to subsequent better-paying jobs[25] (which reduce the number of "economically attractive" black men for black women to marry[26]) and the decline of America's heavy manufacturing industries, which employed many nonskilled black men in the 1950s and 1960s.[27] Another factor is the reality that there are fewer black men than black women in the ages when marriage is most likely to occur,[28] partly because of high levels of incarceration among black men in their 20s and 30s (see box on page 36). And since black women in their 20s tend to have completed more years of education than black men

and to have very similar employment levels to them,[29] such women stand to gain less by marrying. Hispanic men's earlier entry into marriage may reflect a cultural emphasis on strong familial bonds[30] and perhaps the Catholic upbringing of most Hispanic men.

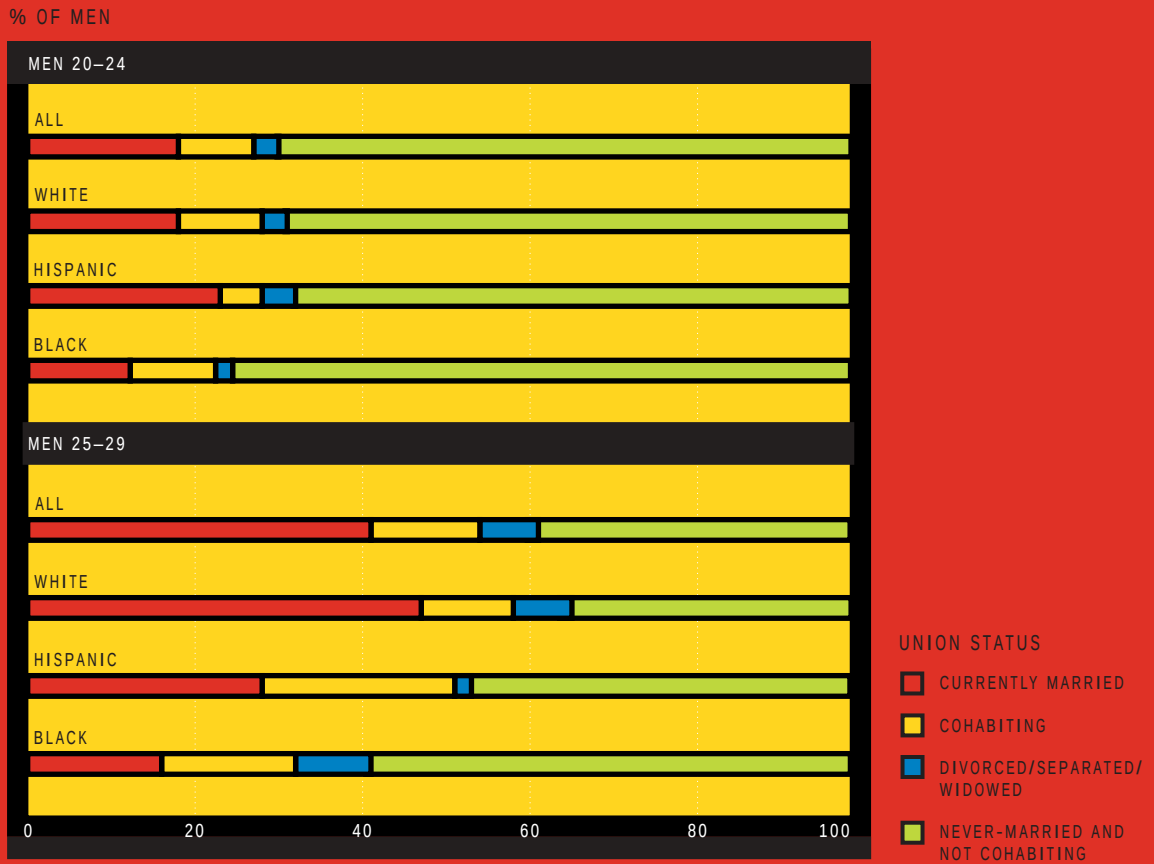
Most Men in Their 20s Are in a Sexual Relationship

All but 7% of men in their 20s have had sexual intercourse, and all but 12% have been in a sexual relationship in the past year (marital or otherwise). Almost three in 10 young adult men knew their current partner for more than a year before having intercourse with her, and more than four in 10 knew her for more than a month; the remaining three in 10 knew her for less than a month.[31] The age of young men's sexual partners is not known, but about one-quarter of sexually active men 22–26 have had intercourse with a woman younger than 20 during the past year.[32]

Married and cohabiting men in their 20s are more likely than sexually experienced single men to have intercourse at least once a month (100% vs. 76%). Their frequency of intercourse is greater as well: Eighty-seven percent of these men, compared with 49% of those who are not married or cohabiting, have sex once a week or more.[33] Most men in their 20s find their current sexual rela-

CHART 3.2

Union status varies by race and ethnicity, especially in men's late 20s.



SOURCE: TABLE 3.2, PAGE 84.

tionship physically satisfying (84%) and emotionally satisfying (75%).

An individual's satisfaction with a sexual relationship is influenced by factors other than the frequency of sexual activity or the pleasure it gives—emotional investment in the relationship and its duration, for example. On these measures, men in long-term sexual partnerships and men living with their partner seem to have the advantage over men involved in short-lived relationships and men not living with their sexual partner. In addition, men's satisfaction with their sexual lives appears to be a function of such considerations as their age, their general state of happiness, their attitudes toward extramarital sex or sex without love, and whether they have sex predominantly to express affection or to relieve tension.[34]

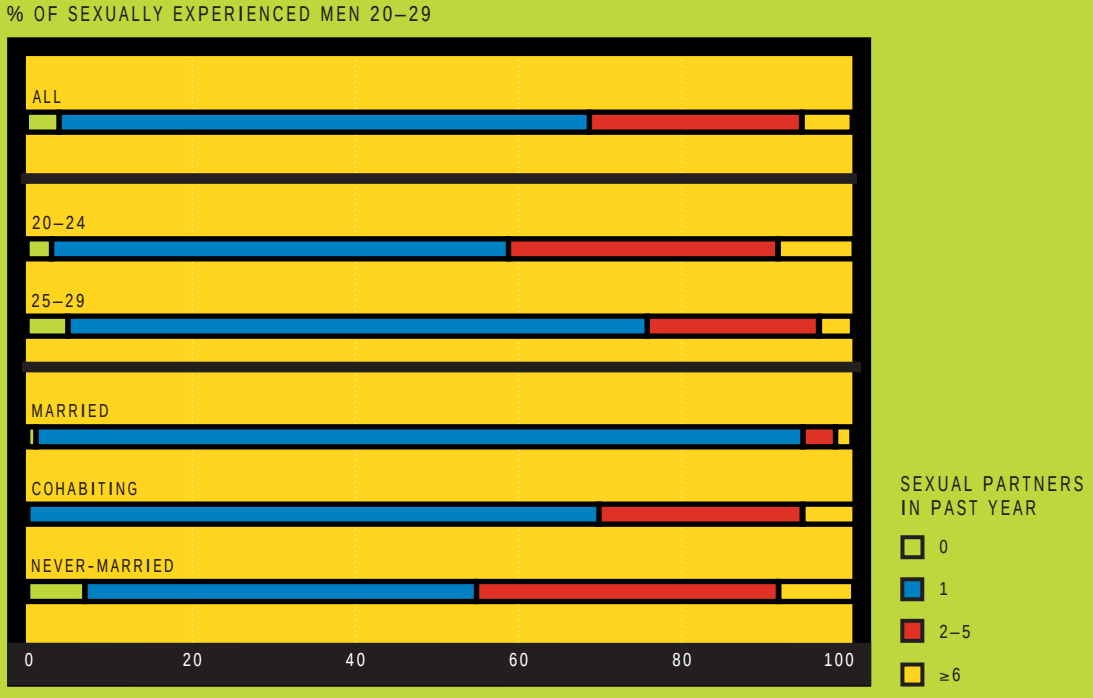
The Majority of Men in Their 20s Have Had Only One Sexual Partner in the Past Year

Given that an average of 10 years separates the first time men have intercourse from the first time they marry, it is not surprising that many men have multiple sexual partners before they settle down. Only one in eight sexually experienced men 20–29 have had only one partner ever, and more than half have had at least six.[35]

But the picture changes with regard to the number of sexual partners in the past year (Chart 3.3). Some 65% of sexually experienced men in their 20s have had a single partner in the past year, 26% have had 2–5 partners, 5% have had six or more, and 4% have had none. These patterns are very different for currently married and

CHART 3.3

Two-thirds of all sexually experienced men in their 20s had one partner in the past year, but this proportion varies among subgroups.



Note: The survey included too few divorced, separated or widowed men to permit separate measures for this group.

SOURCE: TABLE 3.3, PAGE 84.

never-married men. Only 5% of married men have had two or more partners in the past year, compared with 45% of never-married men. Cohabiting men are closer to never-married men in this respect.[36] (So few men in their 20s are divorced or separated that the measurement of patterns among this group is not possible.)

Men's number of sexual partners in the past year varies very little by poverty status, but differences emerge by race and ethnicity. Two percent of Hispanic men, 4% of white men and 18% of black men have had six or more partners in the past year. Much of this differential can be attributed to the fact that black men in their 20s are much less likely than whites and Hispanics to be married.[37]

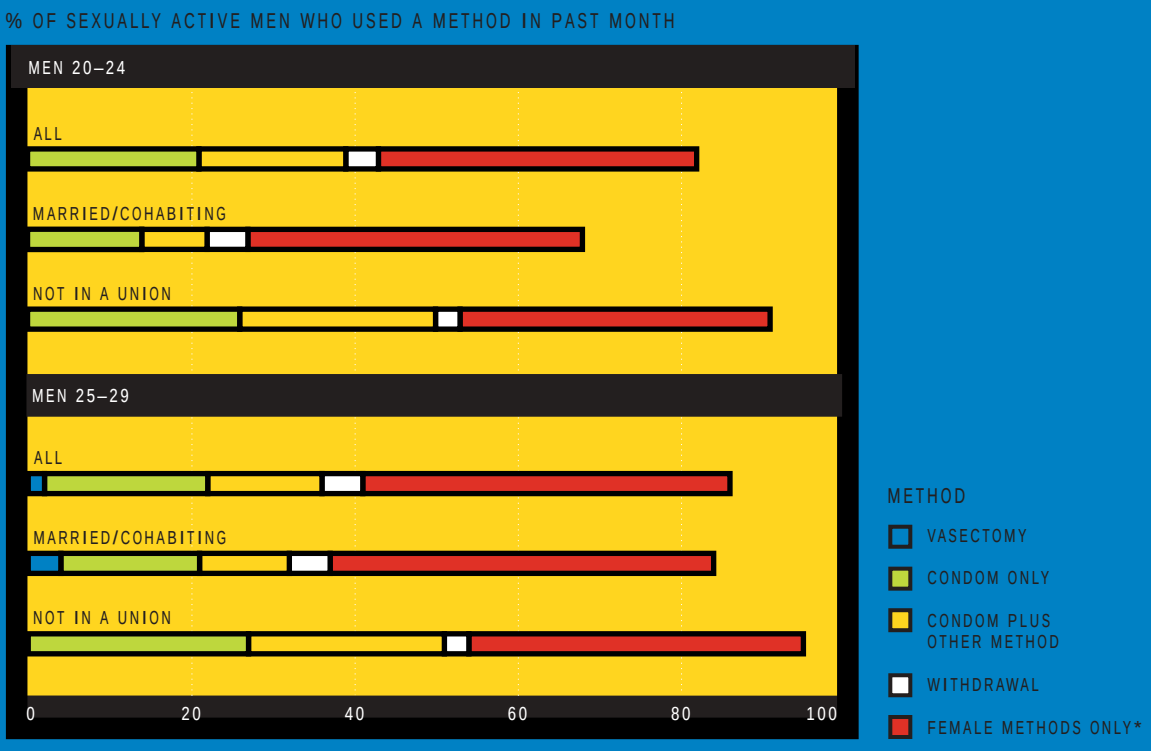
Most Sexually Active Men in Their 20s Practice Contraception

The decisions that individuals make about whether to protect themselves against pregnancy and sexually transmitted diseases (STDs) and which method of protection to use depend largely on their life situation. A man's number of sexual partners over a given period, his union status and whether he and his partner want a pregnancy are key considerations.

In both the early and the late 20s, more than eight in 10 men who have had intercourse in the past month are protected through either their own or their partners' contraceptive use (Chart 3.4). About one-half of use among the younger group involves male methods: Twenty-one percent of

CHART 3.4

Most sexually active men in their 20s or their partners use contraceptives.

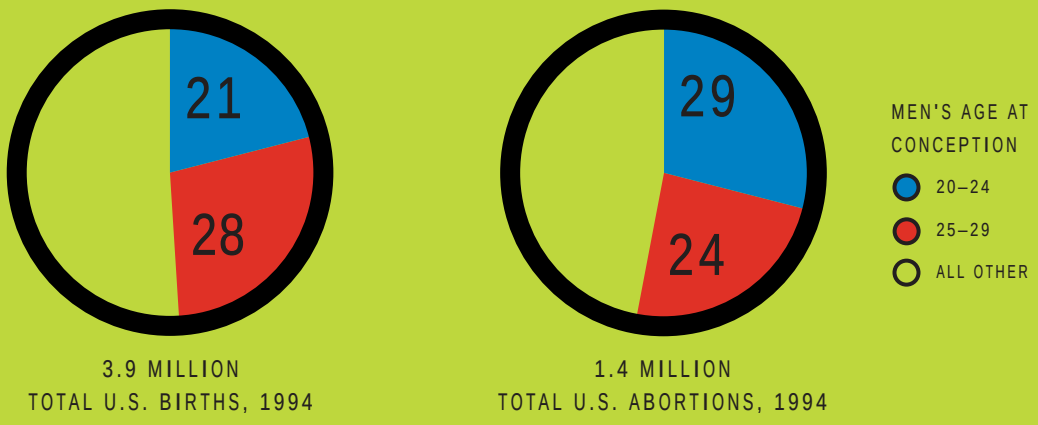


*Pill, implant, injectable, IUD, female sterilization, female condom, spermicide, douche, vaginal film or periodic abstinence.

SOURCE: TABLE 3.4, PAGE 84.

CHART 3.5

Forty-nine percent of births and 53% of abortions involve men in their 20s.



3.9 MILLION
TOTAL U.S. BIRTHS, 1994

1.4 MILLION
TOTAL U.S. ABORTIONS, 1994

SOURCE: TABLE 3.5, PAGE 85.

these men use the condom alone, 18% the condom plus another method and 4% withdrawal.[38]

As men move through their 20s, the first sign of reliance on vasectomy begins to emerge, although use of this method remains at a low level. About seven in 10 men in both their early and their late 20s rely on female methods, alone or along with the condom.[39]

In their early 20s, sexually active men who are not in a union are much more likely to use condoms—alone or with another method—than are their married and cohabiting counterparts (50% vs. 22%). They also are more likely to use female methods, alone or with condoms (62% vs. 49%).[40] The relatively high level of condom use among men not in a union may reflect that they are less likely than married and cohabiting men to be involved in an exclusive sexual relationship, or that they have been in a relationship for less time.

On the other hand, the low level of condom use among married and cohabiting men may suggest that a large majority consider themselves—many with good reason—to be at low risk of acquiring STDs. At the same time, the substantial proportion of men not in a union who do not use condoms suggests that they also may believe themselves to be at low risk of contracting an infection.

At ages 20–24, condom use alone is more common among low-income than among higher-income men (21% vs. 15%) and among black than among white men (29% vs. 20%). By ages 25–29, no race-based differences remain, but poor men continue to be the most likely to use only the condom.[41]

By their late 20s, 2% of sexually experienced men have had a vasectomy, and 7% are in a sexual relationship with a woman who has had a tubal ligation. The proportion whose partner has been sterilized is highest—23%—among poor men (not shown).[42]

Men View Contraceptive Methods a Little Differently Than Women

Men and women in their 20s do not always have the same opinions about the main purpose of contraceptive practice, about methods' ease of use or about their effectiveness. In general, women give priority to a method's effectiveness in preventing pregnancy, whereas men think that STD protection is equally important. Considerably higher proportions of men than of women believe that the condom is effective in preventing pregnancy, and women are somewhat more likely than men to believe this of the pill. Both men and women consider ease of use and the need to plan ahead more important features of a method than whether it interferes with sexual pleasure. Four in 10 men aged 20–27 believe—erroneously—that

condom use involves health risks. At the same time, only one-third of both men and women consider the method easy to use, and only one in 10 say that it does not interfere with sexual pleasure.[43]

While men considering the use of condoms or withdrawal have to weigh such aspects of these methods as their effect on spontaneity in love-making, they do not have to measure relative health benefits and disadvantages in the same way that women do before choosing many of their methods. If male hormonal methods are developed, these too may have some benefits outside of their ability to prevent pregnancies and some side effects, and men will have to weigh these factors in choosing the method that is best for them.

TABLE 3a

The ages at which men and women have children are slightly different.

AGE AT BIRTH	BIRTHS PER 1,000, 1998	
	MEN	WOMEN
10–14	0	1
15–19	22	51
20–24	85	111
25–29	113	116
30–34	99	87
35–39	54	37
40–44	21	7
45–49	7	<1
50–54	3	0
≥55	<1	0

SOURCE: REFERENCE 50.

During the Young Adult Years, Men Begin to Anticipate and Initiate Fatherhood

More than nine in 10 men aged 25–49 say they want to have children, and their average ideal family size is 2.5 children.[44] Men at all ages seem to believe that having children is one of life's greatest joys.[45] However, in some studies, men have identified more negative, and fewer positive, consequences of having children than have women.[46]

Men volunteer pretty much the same reasons for wanting children as women do: The benefits—personal, emotional and social—outweigh the economic and personal costs; and having children strengthens a marriage, ensures against loneliness in old age and marks an important developmental stage.[47]

However, as men are delaying marriage longer, so are they delaying becoming fathers: Only 19% of men who were 25–29 in 1993 had had their first child in their early 20s, compared with 36% of men who were aged 25–29 in the early 1970s.[48] In addition to later marriage, such factors as the ability to support a child, the stress and worry of raising children, being able to buy a home and having time for a career undoubtedly influence when men start having children.

Roughly half of all births each year in the United States involve fathers who are in their 20s (Chart 3.5, page 33).[49] The rates of births among men and among women are at their closest in the late 20s (Table 3a),[50] indicating that this is a time when men and women are likely to be having and caring for small children.

Before they are 25 years old, 26% of men have had a child, and before they are 30, 50% have become fathers (Chart 3.6). However, fatherhood happens much earlier for certain groups of men, particularly those who did not complete high school. Among men without a high school diploma, half had at least one child before age 25, and three-quarters before age 30. Poor and low-income men, as well as those with moderate incomes, begin fatherhood much sooner than better-off men. And black and Hispanic men start having children sooner than white men do.[51]

The links between poverty and fatherhood and between education and fatherhood can work in both directions. Having a child at a very young age may prevent a man from completing his high

school education, especially if he works full-time to help support the child. And starting work at a young age without any qualifications tends to keep a man in low-paying jobs. On the other hand, young men who are already poor or whose prospects are unfavorable may feel that they have little to lose by having a child. Strikingly, only 26% of men with a graduate degree have fathered a child before the age of 30.[52] Not having the responsibility of fatherhood may have enabled them to earn the degree, but it is also possible that the desire to study and earn a degree deterred them from becoming fathers at a younger age.

The low earning power of the least-educated American men has potentially adverse implications for their children. In 1997, 68% of men 25 and older with less than a high school education were earning less than $25,000 a year, compared with 37% of all men 25 and older.[53]

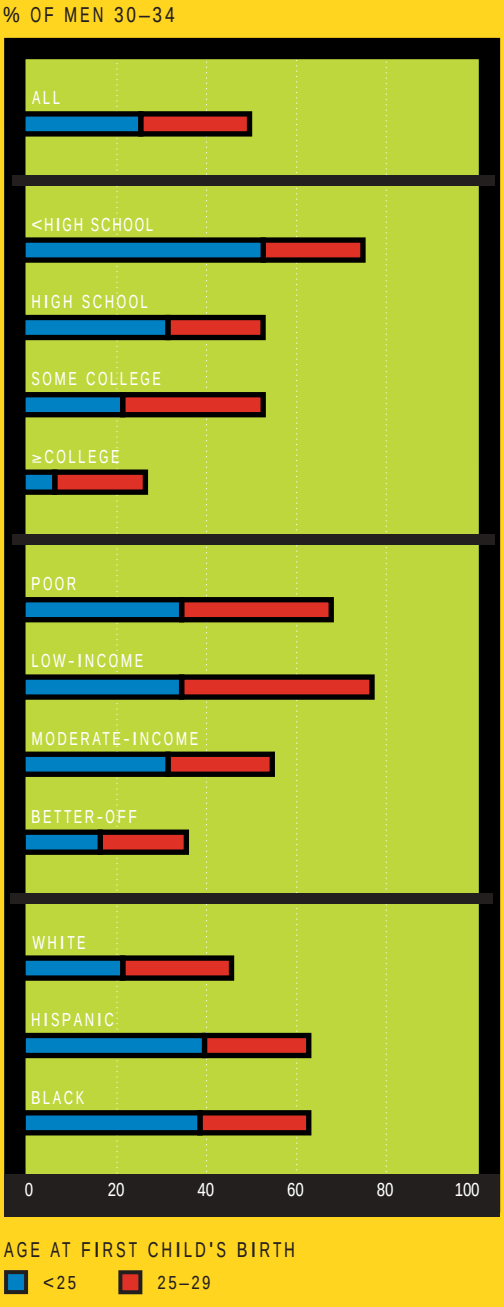
Apart from the adolescent years, the early 20s see higher levels of nonmarital childbearing than any other age (Table 2c, page 25). In 1994, 56% of births involving men 20–24 were nonmarital; by ages 25–29 the proportion drops to 28%.[54]

Many Births Involving Men in Their 20s Are Unintended

Although many men start having children in their 20s, some young adult men say those births were not intended. Among men 25–29 whose partners gave birth between 1988 and 1994, 34% said the child was born earlier than intended, and 15% reported that no time would have been good. Twenty percent of all

CHART 3.6

Men who are poor or low-income or have little education are the most likely to have a child by their late 20s.



SOURCE: TABLE 3.6, PAGE 85.

An estimated 1.4 million men 15–49 were in America's prisons and jails—federal, state and local—in 1996. Some 33% of male prisoners 15–49 were white; 18%, Hispanic; 45%, black; and 3%, of other racial and ethnic backgrounds. Thus, even though black and Hispanic men make up only 25% of noninstitutionalized men aged 15–49, they account for 63% of the incarcerated population in this age-group.[1]

Seven percent of all black men 15–49 were incarcerated in 1996, compared with 3% of Hispanic and 1% of white men in this age-group. Among black men, this proportion was even higher (one in 10) at ages 20–39, a time when many men are becoming fathers or having a second or third child.[2] If current rates of first incarceration are translated into lifetime prospects, black men's chances of going to state or federal prison sometime in their lives (28%) are considerably higher than Hispanic men's (16%) and many times white men's (4%).[3]

Criminal justice experts emphasize that profound inequities in arrest rates and sentencing practices are one of the primary reasons for the grossly disproportionate incarceration rates of black men. Even though black men account for 15% of drug users in the United States, they represent 35% of those arrested for drug offenses, 55% of those convicted of drug possession and 74% of those incarcerated for possession.[4]

Fifty percent of Hispanic, 46% of black and 39% of white inmates 15–49 are younger than 30. Many incarcerated men have only a low level of education. Almost six in 10 have not completed high school,[5] compared with one in eight in the general male population.[6] And 36% had not been employed the month before their arrest.[7]

Sexually Transmitted Diseases (STDs) Are More Prevalent in Prisons Than Among the General Population

Sexual health conditions in America's jails are extremely poor. Rape is common, and conditions conducive to the spread of HIV and other STDs are widespread. About 0.4–0.5% of men in federal and state prisons in 1993 were infected with HIV[8]— about six times the estimated AIDS rate in the general male population that year (0.07%).[9] And among young men entering state juvenile correction facilities in 1999, 4% nationwide (10% in New Jersey and Maryland) had positive blood tests for chlamydia.[10] By comparison, the reported chlamydia rate among all U.S. men 15–19 was 0.3%.[11]

Many Incarcerated Men Have Children

On average, incarcerated men 18–49 have 1.5 children, and married prisoners have 2.6. Those aged 45–49 have 2.5 children,[12] whereas in the general population of men that age, the average is 2.1.[13] Thirty-six percent of incarcerated men have no children, 23% have one, 18% have two and 23% have three or more.[14]

About 2.1 million American children have fathers in prison or jail at any given time. About one million children with imprisoned fathers are black, 421,000 are Hispanic and 600,000 are white.[15] An estimated 600,000 poor U.S. men not in compliance with child support payments are currently incarcerated.[16] Imprisonment has been characterized as "the most significant factor contributing to the . . . breakdown of African American families" during the 1990s.[17]

TABLE 3b

One in three pregnancies involving men in their early 20s are resolved by abortion.

AGE AT CONCEPTION	NO. OF PREGNANCIES, 1994*	% DISTRIBUTION, BY OUTCOME		
		BIRTHS	ABORTIONS	TOTAL
20–24	1,214,000	67	33	100
25–29	1,449,000	77	23	100

*DOES NOT INCLUDE PREGNANCIES ENDING IN MISCARRIAGES.

SOURCE: REFERENCE 57.

men in their late 20s do not want any more children.[55]

Men in their 20s are responsible for 53% of the pregnancies that terminate in abortion each year in the United States (Chart 3.5).[56] About one-third of pregnancies involving men aged 20–24 and one-quarter of those involving men in their late 20s end in abortion (Table 3b).[57]

Women cite many reasons for having an abortion, the most common of which are the need to stop or postpone childbearing, economic difficulties and problems in the relationship with the father.[58] Information about the life circumstances of young adult men involved in a pregnancy termination, however, is lacking. Do the couple love one another? Is the marriage or relationship stable? Does the man have a job, or health insurance? Does he think that he makes enough money to support a family? These are all questions to which answers directly from men are needed.

Chapter 4

Men 30–49: Forming Families

- *The great majority of adult men are married or living with a woman: seven in 10 of those in their 30s and eight in 10 of those in their 40s.*
- *In their 30s and 40s, poor men are the least likely to be married and the most likely to be separated or divorced.*
- *Four in 10 never-married men and five in 10 previously married men have two or more partners in a given 12-month period, compared with one in 20 married men.*
- *During their 30s and 40s, men's use of condoms for contraception declines, and their reliance on male and female sterilization grows.*
- *By age 49, the average man has had about two children. In addition, many men are fathers to stepchildren, adopted children or foster children.*
- *Men in their 30s and 40s account for 44% of births and 34% of abortions each year. The number of men who father children after age 49 is very small.*
- *Eleven percent of men in their 30s have biological children but do not live with them, compared with only 4% of women.*

"High levels of divorce and remarriage among men in their 30s and 40s [contribute to] an increase in blended families and stepfamilies."

Most men in the 30s and 40s, like most women, are engaged in three major areas of their lives: work, marriage and parenting. Very few men in this age-group have not married or become fathers. However, because of separation, divorce, nonmarital childbearing and children's starting to leave home, some men who have had children are not living with them.

Reflecting high employment levels among men in their 30s and 40s, poverty levels are lower for this than for any other age-group covered in this report. Health insurance coverage is also at its highest. However, wide racial and ethnic differentials persist in income and health coverage.

Most Men in Their 30s and 40s Are Married and Have Moved Out of Poverty

Between 72% and 82% of men in their 30s and 40s are married or cohabiting, and 9–13% are divorced or separated. In their 30s, 19% have never married and are not cohabiting, but this proportion drops to 5% among men in their 40s (Chart 4.1, page 40).[1]

Some 7–8% of men in their 30s and 40s live in poverty, lower proportions than among men in their 20s. However, race-based differentials remain: Seventeen percent of Hispanic men in their 30s and 40s, 13% of black men, but only 5% of white men are poor (not shown). The proportion of men who are better-off increases with age, from 49% among men in their 30s to 58% among those in their 40s.[2]

Almost nine in 10 men in their 30s and 40s are employed, and 3% are looking for work. The remainder are out of the labor force, mostly because they are disabled. While 9% of all men in their 40s and 4% of better-off men are disabled, the proportion reaches 33% among poor men this age (not shown).[3]

Most men in their 30s and 40s have health insurance coverage—78% and 84%, respectively.[4] These levels of coverage are consistent with men's high employment levels in their 30s and 40s and, presumably, the fact that these men are likely to be in jobs that provide health insurance or to be able to afford private coverage. Nevertheless, as will be shown in chapter 6, poor men in their 30s and 40s continue to be disproportionately without health insurance.

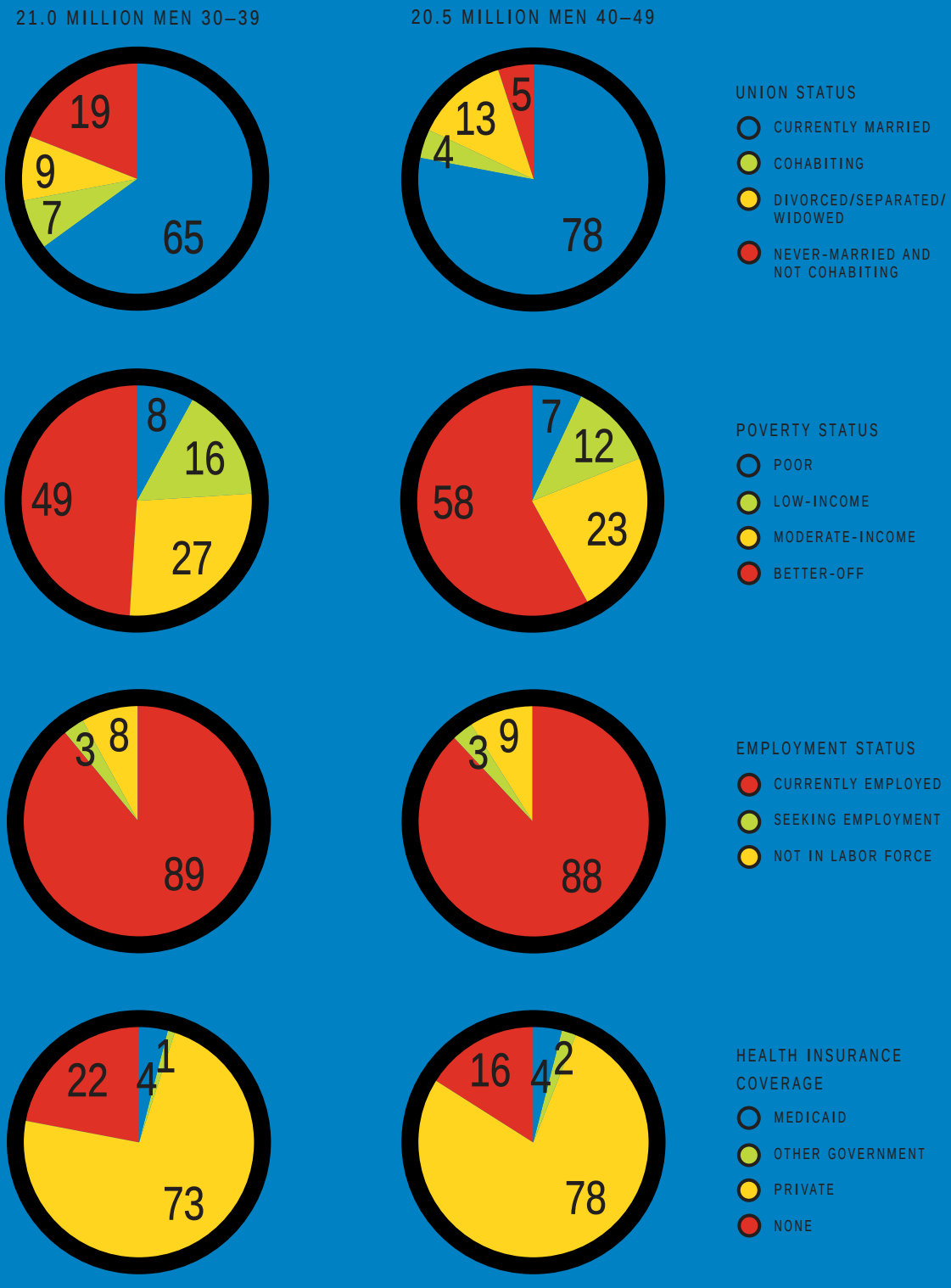
Earnings differentials by race and ethnicity similar to those of men in their 20s persist among men in their 30s and 40s (not shown), partly because of differentials in the types of jobs that men hold. Employed white men are more likely to be in managerial and professional positions (30%) than are working black and Hispanic men (16% and 11%, respectively). They also are half as likely to work in low-paying service or agricultural jobs and much less likely to work in unskilled manual jobs: More than half of employed Hispanic and black men are in such jobs, compared with three out of 10 white men.[5] Higher educational levels among white men explain some, but not all, of these differences.

Union Status Varies with Men's Income and Background

In all, 71% of men aged 30–49 are married and 6% are cohabiting (bringing the total in a union to 77%), 11% were formerly married and 12% have never married (Chart 4.2, page 41).[6] Most of the rapid increase in marriage occurs in men's 30s. Between men's 20s and 30s, the proportion legally married increases by 33 percentage points, compared with only seven percentage points between men's 30s and 40s (not shown).[7] In part, this apparent slowing reflects that after the 20s, increasing proportions of men are marrying, but increasing proportions are also separating or divorcing.

Poor men are the least likely to be married (60%), the most likely to be cohabiting (13%) and the most likely to be divorced or separated (18%). Marriage patterns among the three other

In their 30s and 40s, men are increasingly likely to be married and have at least a moderate income; the vast majority have a job and health insurance.



SOURCE: TABLE 4.1, PAGE 85.

income groups are quite similar to the average.[8]

The racial and ethnic differentials in union status seen among men in their 20s are also found among more mature men. Six in 10 black men in their 30s and 40s are married or cohabiting, compared with about eight in 10 white and Hispanic men. And the proportion of black men who are divorced, separated or widowed is twice that of white and Hispanic men.[9]

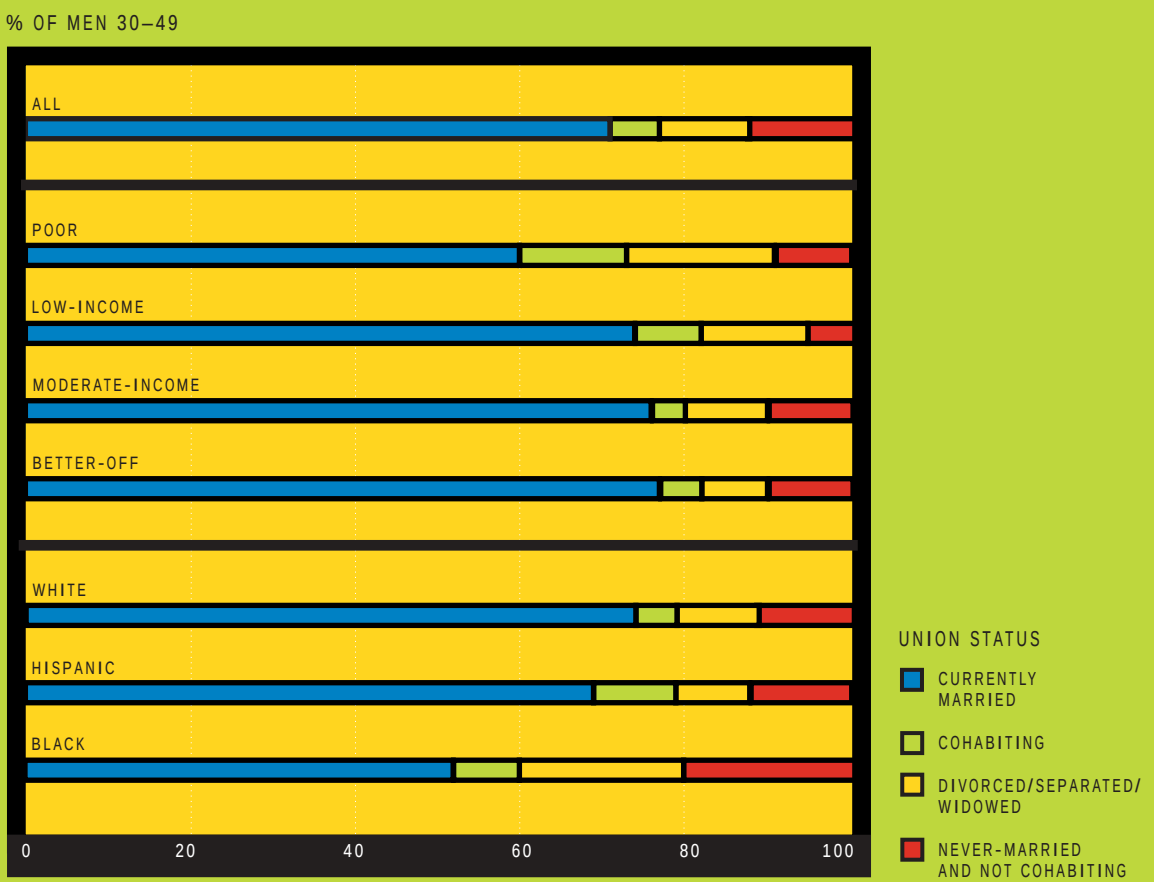
Only 23% of poor black men aged 30–39 are married, compared with 51% of those with moderate or higher family incomes. And in their 40s, only 32% of poor black men, but 63% of those who are better-off, are married.[10] The very high proportion of poor black men who are not married and the fact that so many black men are poor are major factors driving lower overall marriage rates among black men.

For all men in their 30s and 40s, not being poor seems to be linked to a higher likelihood of being married.[11] Better-off men are about half as likely as poor men to be divorced or separated—8% vs. 18%.[12] Poverty apparently helps to foster or exacerbate marital disharmony.

Divorce rates in the United States rose steeply from the 1960s to the mid-1980s and then leveled off.[13] Still, anywhere from half to two-thirds of future first marriages are expected to end in divorce.[14] The typical duration of the first marriage for men who divorce is 8.1 years.[15] Men

CHART 4.2

In their 30s and 40s, poor men and black men are the least likely to be married.



SOURCE: TABLE 4.2, PAGE 85.

who end their first marriage typically do so in their mid-30s. However, the majority of divorced men and women—between two-thirds and three-quarters—remarry.[16] In almost one in four marriages that took place in 1988, both the groom and the bride had been married before; in an equal proportion, one of the pair had been.[17] Some remarriages end in divorce followed by reentry into marriage. For men, second marriages that also end in divorce typically last about six years, while third or higher-order marriages last less than five years.[18]

By the time they reach their 30s, only 2% of men have never had vaginal intercourse; by their 40s, this proportion drops below 1%.

High levels of divorce and remarriage among men in their 30s and 40s have important consequences. One is an increase in the proportion of blended families and stepfamilies. Another is that 18–28% of men in this age-group are not living with a wife or partner, a situation that has important implications for their patterns of sexual behavior.

Most Men 30–49 Currently Have Only One Sexual Partner

By the time they reach their 30s, only 2% of men have never had vaginal intercourse; by their 40s, this proportion drops below 1%. About one in eight men 30–49 have had only one sexual partner, but two in five have had 10 or more in their lifetime.[19]

In terms of potential health risk, more germane than a man's lifetime number of sexual partners is the number he has concurrently or over a brief period of time. Among sexually experienced men aged 30–49, an overwhelming majority (85%) have had only one or no sexual partner in the past year. However, differences by union status are substantial: Ninety-four percent of married men in their 30s and 40s, 86% of cohabiting men, 52% of formerly married men and 57% of never-married men have had only one or no sexual partner in the past year (Chart 4.3). Poverty status has little bearing on the number of sexual partners men in this age-group have in a given year (not shown).[20]

Because almost eight in 10 men in their 30s and 40s are in a union, frequent sexual activity is common. Roughly nine in 10 men in their 30s had intercourse at least once in the past month. Half (including six in 10 married and cohabiting men, and four in 10 men not in a union) did so 1–3 times a week.[21]

Some sexual problems exist, however. About one-third of men 18–59 report some kind of sexual dysfunction. Increasing age is particularly associated with erection problems and a diminished desire for sex: Men in their 50s are three times as likely as men 18–29 to experience these two problems. By contrast, younger women are more likely than older women to report having sexual problems.[22]

The vast majority of men and women 30–49 say they have sex with their partner to express love or affection (91%), and both men and women appear to take the same high degree of pleasure from their current sexual relationship. However, men are somewhat less likely than women to say that affairs outside of marriage are always wrong (70% vs. 79%). And 32% of single men, compared with 69% of single women 30–49 agree they would not have intercourse unless they were in love. Men are also more likely to find the idea of sex with a stranger or group sex appealing (31% vs. 11%).[23]

As Men Mature, Their Contraceptive Patterns Change

There are no national data available on contraceptive use among men 40 and older, but information is available for men in their 30s. Many men aged 30–39 need nonpermanent contraceptive methods, which make it possible for couples to space and time pregnancies. But for those in their early 30s who first became fathers at an early age and

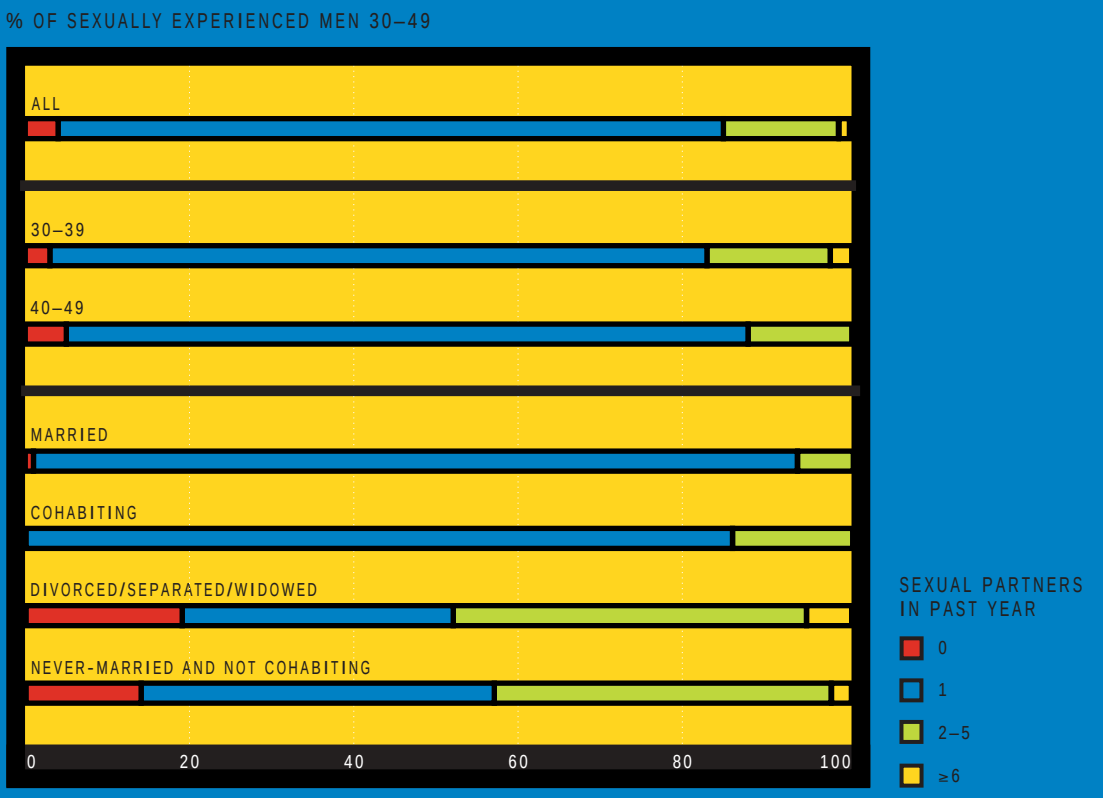
for most men in their late 30s (two-thirds of whom have had all the children they want[24]), very effective methods to prevent further pregnancies become necessary. Many couples in this situation decide that sterilization is a more reliable and convenient, and probably less-expensive, method of fertility control than the pill or the condom.

Among men aged 30–34 who have had intercourse in the past month, 33% rely on nonpermanent female methods of contraception, 22% use condoms (alone or with another method) and 17% are protected by their partner's sterilization; only 5% have had a vasectomy and 4% practice withdrawal. The remaining 19% use no method. Among men in their late 30s, reliance on vasectomy rises sharply (to 20%), and male and female sterilization together are the leading contraceptive method (44%), followed by other female methods (21%) and the condom, alone or as part of dual use (16%). (Levels of sterilization may even be somewhat higher than shown, because a small proportion of couples relying on this method also use condoms. These have been counted primarily as condom users.) Three percent of sexually active men 35–39 practice withdrawal, and the remaining 16% use no method to protect against pregnancy (Chart 4.4, page 44).[25]

From the mid-1960s to the mid-1990s, sterilization rates increased rapidly in the United States, particularly among women. The proportion of married women 15–44 who have had a tubal ligation went from 4% in 1965 to 24% in 1995; the proportion of their male partners who have had a vasectomy rose from 4% to 15% in the

CHART 4.3

The great majority of men in their 30s and 40s, except for those not in union, have only one sexual partner in a given year.



SOURCE: TABLE 4.3, PAGE 86.

same period.[26] Among the conditions that might contribute to women's greater likelihood of being sterilized are that women have more at stake than men in wanting to avoid unwanted pregnancy; some men lack interest in, and perhaps fear, vasectomy; communication between partners about sharing the responsibility for contraception is sometimes inadequate; and women are increasingly likely to decide on their own to seek sterilization.[27]

Whereas the poorest men are the least likely to have had a vasectomy (5%, compared with 15% of the better-off), the poorest women are the most likely to have had a tubal ligation (41%, compared with 19% of those in the highest-income category). Among black and Hispanic couples—who are more likely than their white counterparts to be poor—it is overwhelmingly the woman who becomes sterilized.[28]

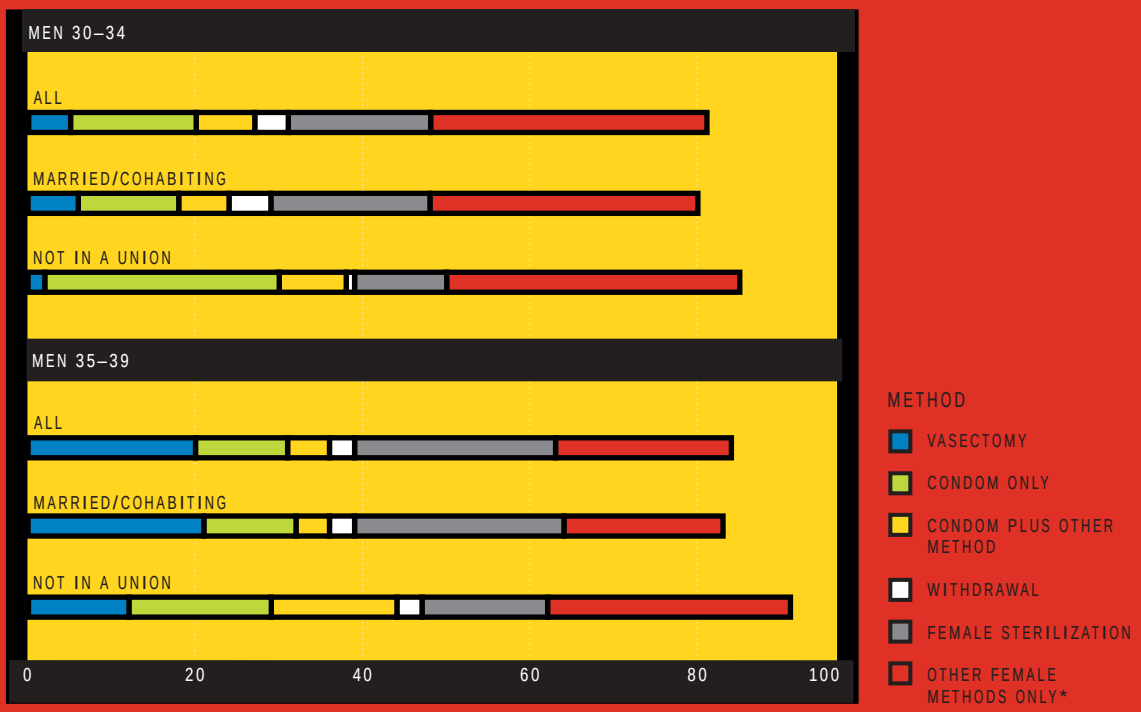
Men's Contraceptive Decisions Differ Widely by Union Status

In their early 30s, men who are not married or cohabiting are about twice as likely to use condoms, alone or in combination with a female method, as are men in a union (36% vs. 18%); the same is true in their late 30s (32% vs. 15%). And at ages 35–39, men not in a union are more likely than married and cohabiting men to use any method (91% vs. 83%), suggesting that they are

CHART 4.4

Reliance on vasectomy increases rapidly in men's late 30s, but female methods provide the greater part of overall protection.

% OF SEXUALLY ACTIVE MEN WHO USED A METHOD IN PAST MONTH



*Pill, implant, injectable, IUD, female condom, spermicide, douche, vaginal film or periodic abstinence.
NOTE: The survey included too few divorced, separated or widowed men to permit separate measures for this group.

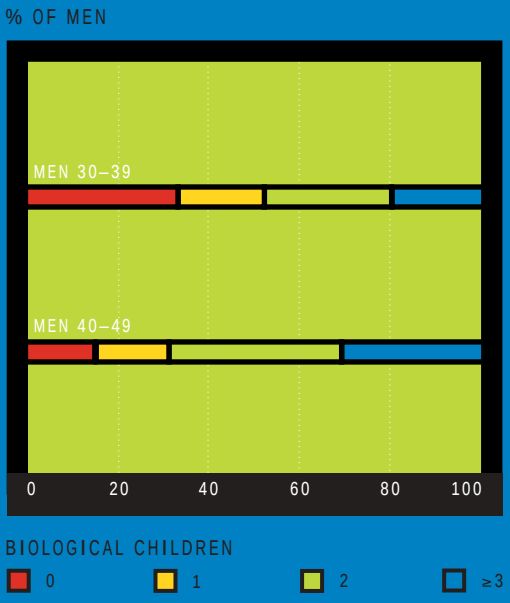
SOURCE: TABLE 4.4, PAGE 86.

more concerned about avoiding pregnancy (Chart 4.4).[29]

The relatively high proportion of married and cohabiting men in their late 30s not using any method (17%) probably reflects that some of these men or their partners are infertile, and that some are having intercourse with women who are pregnant or trying to get pregnant. Among sexually active women in their early 30s—the group most likely to be the partners of men in their late 30s—about 20% are not using a contraceptive method, and these same reasons account for two-thirds to three-quarters of their nonuse.[30] That still leaves some nonusers (men and women) at risk of an unintended pregnancy—that is, fertile, not pregnant or wanting a pregnancy, and using no method. Nearly half of unintended pregnancies in the United States (47%) occur among couples who do not want a pregnancy but are not using a contraceptive method.[31]

CHART 4.5

From men's 30s to their 40s, the proportion with no children drops steeply and the proportion with three or more rises.



SOURCE: TABLE 4.5, PAGE 86.

Most Men in Their 30s and 40s Are Building Families

In their 30s, one-third of men have no children, but this proportion drops to 15% in men's 40s. At the same time, the proportion of men with three or more children rises from 20% to 31% (Chart 4.5).[32]

By age 45–49, when future fathering is very unlikely, men have had an average of 2.1 children. The number is slightly higher than average among poor and minority men, and slightly lower among higher-income men. It is also somewhat smaller than the average number of children men report as their ideal—2.5.[33]

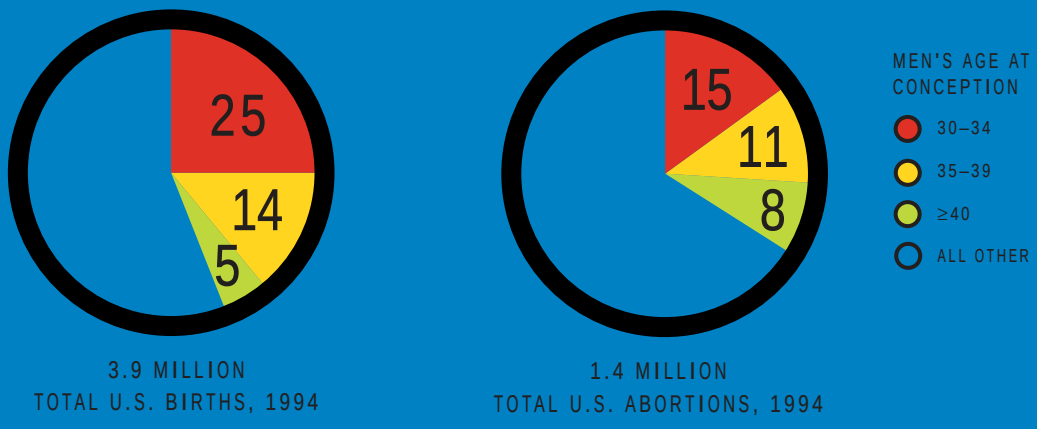
Men often say they have had fewer children than the data for women suggest is the case. Some men—particularly young and unmarried men—tend to underreport, or fail to report, the number of children they have had, especially if they are not living with them.[34] It is also possible that some unmarried women who become pregnant and keep the child do not tell the father, or that some men do not wish to acknowledge children they have fathered outside of marriage or in an earlier relationship.

Men in their 30s are responsible for an estimated 1.5 million births each year; men in their 40s, for an estimated 213,000 births—almost as many in total as men in their 20s. Forty-four percent of infants born each year in the United States were fathered by men 30 and older (Chart 4.6, page 46).[35] Whereas women finish childbearing by the end of their 40s, a very small number of men father children well after this age (Table 3a, page 34).[36]

Some 15–20% of men in their 30s who father children are not married to the child's mother (Table 2c, page 25).[37] However, some of these men are in a cohabiting relationship with her. Overall, 8% of the 19.6 million American children with unmarried parents are living with both

CHART 4.6

Forty-four percent of births and 34% of abortions involve men in their 30s and 40s.



3.9 MILLION
TOTAL U.S. BIRTHS, 1994

1.4 MILLION
TOTAL U.S. ABORTIONS, 1994

SOURCE: TABLE 4.6, PAGE 86.

of their biological parents.[38]

Because of divorce, separation, remarriage, recombined families, infertility and adoption, many men at some point in their lives act as fathers to children who are not biologically their own. On average, men in their early 30s are fathers to 1.2 biological children plus 0.2 stepchildren, foster children or adopted children; both numbers rise as men age (Chart 4.7). The likelihood of becoming a father to more than just one's biological children is pretty much the same for men of all racial and ethnic backgrounds (not shown).[39]

Some Men Never Have Children

As men and their partners age, they face an increased risk of not being able to have a child. Women between the ages of 35 and 44 are four times more likely than those 25–34 to report that they or their partners have some kind of fertility impairment.[40]

But men can be childless for reasons other than their own or their partner's infertility. They may not want to become a parent, may have never been in a relationship with somebody with whom they wanted to have a child or may have a partner who does not want a child. True childlessness among men can be measured only once the biological possibility of fathering children has ended; as a result, it is extremely difficult to obtain reliable estimates of the proportion of American men who are infertile, as compared with the proportion who have not had children by choice.

Not All Births Involving Adult Men Are Intended

Around two-thirds of men in their 30s and early 40s say they wanted their most recent child. The rest felt either that the birth occurred at a time they did not want a child or that they did not want to have a child (or another child). Among men in their 30s and early 40s, about one-third of births are unintended (Table 4a, page 48).[41]

A substantial proportion of men's partners resolve unintended pregnancies by abortion. Roughly one in five pregnancies involving men in their 30s end in abortion, as do one in three of those involving men in their 40s (Table 4b, page 48).[42]

Men in their 30s are responsible for an estimated 373,000 pregnancies ending in abortions; men in their 40s, for 110,000. Overall, men 30 and older account for one-third of abortions performed each year in the United States (Chart 4.6).[43] Given that more than half of men in their 30s and more than eight in 10 in their 40s want no more children, this is not surprising.

Some Men in Their 30s Live Apart from Their Children

Although 66% of men in their 30s have fathered children, only 55% live with a biological child (53% also with the child's mother and 2% without her). At age 40–49, 87% of men are biological fathers, but only 62% live with a biological child (59% also with the mother and 3% without her).[44]

When fathers in their 30s are not living with their biological children, the main reasons are probably that the children were born outside marriage or the parents were married but have separated or divorced. However, in men's 40s, some of the gap between fatherhood and coresidence with children is also attributable to the fact that children are beginning to leave home.

The events that break up families—nonmarital childbearing, separation, divorce and remarriage—do not always affect men and women in the same way. For example, 11% of men in their 30s, compared with only 4% of women, have children but are not living with them. And only 2% of men in their 30s, compared with 17% of women, live in households with children but no spouse or partner.[45] Overall, 1.8 million children—4% of all American children younger than 18—live with their father alone.[46]

Black men in their 30s are the least likely to be living with a spouse or partner and children. They also are more likely than white or Hispanic men to have children but not be living with them (23%, 9% and 6%, respectively).[47] Black men's higher levels of poverty, unemployment and incarceration, and lower levels of marriage, are all likely to contribute to their reduced likelihood of living with their biological children.

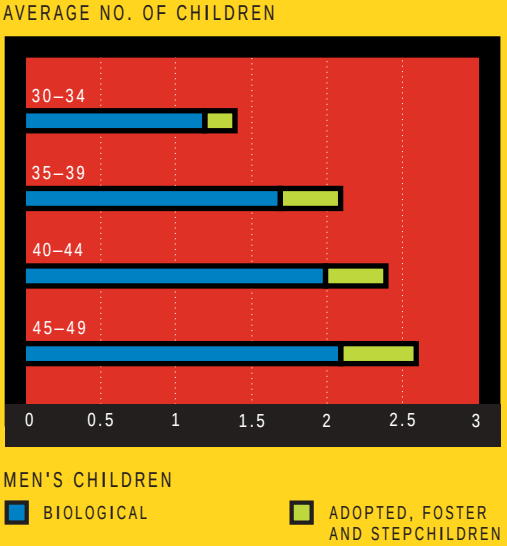
An author who has compared the living arrangements of men and women in the 1990s comments that "ties between parents and children are increasingly convoluted, especially for men. Increasingly, men…face complex decisions about allocating resources to children from different unions who live in different households."[48]

Two-thirds of the 11 million fathers who do not live with their children do not pay formal child support. Of these approximately seven million fathers, an estimated 4.5 million have no obvious financial reason not to do so, but the remaining 2.5 million are poor themselves and without any of the supports that society offers poor mothers.[49]

Fifteen percent of custodial parents in the United States are men. Seventy-six percent of men with custody of their children are white, 10% black and 14% Hispanic. Forty-five percent are divorced (as are 31% of custodial mothers), 25% are still married to the child's mother, 18% were never married to her and 12% are separated or widowed.[50] Thirty-two percent of custodial mothers with written agreements say the nonresi-

CHART 4.7

Fatherhood may encompass more than a man's biological children.



SOURCE: TABLE 4.7, PAGE 86.

TABLE 4a

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

AGE	% OF BIRTHS THAT ARE UNPLANNED		
	TOTAL	MISTIMED	UNWANTED
25–49	38	21	17
25–29	49	34	15
30–34	35	20	15
35–39	32	15	17
40–44	38	9	29
45–49	21	4	17

NOTE: PERCENTAGES ARE BASED ON MEN WHOSE PARTNERS HAD A CHILD BETWEEN THE 1987–1988 AND THE 1992–1994 WAVES OF THE NATIONAL SURVEY OF FAMILIES AND HOUSEHOLDS.

SOURCE: REFERENCE 41.

dent fathers have not spent any time with their children in the past year, but 24% report that the fathers see their children at least once a week.[51]

Men of All Ages Play an Increasing Role in Helping Raise Children

Because of the rapid rise in the labor-force participation of women with young children, the high cost of private child care and the general unavailability of high-quality, affordable child care in the United States, men now spend more time than their fathers did in helping care for young children.

Time diary estimates collected in 1995 indicate that married men with children younger than 18 spend an average of one hour more a day with them than comparable men did 30 years earlier. In 1965, these fathers spent half the time mothers did; in 1998, they spent two-thirds the time. Nevertheless, mothers still spend twice as much time as fathers doing nothing but taking care of

TABLE 4b

Most pregnancies involving men in their 30s and 40s end in a birth.

AGE AT CONCEPTION	NO. OF PREGNANCIES, 1994 *	% DISTRIBUTION, BY OUTCOME		
		BIRTHS	ABORTIONS	TOTAL
30–34	1,195,000	82	18	100
35–39	686,000	77	23	100
40–49	323,000	66	34	100

*DOES NOT INCLUDE PREGNANCIES ENDING IN MISCARRIAGES.

SOURCE: REFERENCE 42.

children.[52] Because the information on which estimates like these are based comes from married couples, the findings do not take into consideration the situation of unmarried fathers, now a substantial proportion of fathers. Unmarried fathers probably spend less time, on average, with or taking care of their children simply because many are not living with them.

One in four married fathers were helping care for the 10 million preschool children whose mothers were working in 1993. Men younger than 25, those living in the Northeast, poor men, those not employed and those working in service industries are the most likely to contribute to the care of small children with working mothers. Fathers accounted for 16% of this type of care, grandmothers and other family members for 26%, organized day care facilities for 31%, informal baby-sitters for 21% and mothers themselves (mostly those working at home) for 6%.[53]

Most working women also expect men to assume a larger share of housework. In 1995, women spent less time doing housework than their counterparts did in 1965, a decline from 30 hours per week, on average, to 18. Much of this drop is because more women now are working full-time, but some of it may stem from the availability of labor-saving devices and take-out foods, women's greater ability to employ outside help and less-meticulous housekeeping standards. Over the same period, on the other hand, men have doubled the number of hours they spend on housework (from five to 10 hours each week, on average). As a result, the total hours spent by both partners has declined only from 35 to 28 in the past 30 years.[54]

Chapter 5

Sexually Transmitted Diseases and Condom Use

- *Eight in 10 adults living with AIDS in the United States are men. More than one in 10 men who had AIDS diagnosed in 1999 were exposed to HIV through heterosexual activity.*
- *Reported rates of chlamydia and gonorrhea reach 500–600 per 100,000 men in their early 20s, levels that are much higher than those of men in their 30s or older.*
- *Compared with white and Hispanic men, black men have twice as high a level of infection with herpes, and probably have several times the rates of bacterial STDs.*
- *Nine in 10 men have heard of HIV, AIDS, gonorrhea and syphilis, but far fewer know about genital warts and are aware that chlamydia can infect men. Men's knowledge of effective measures for preventing STDs is sketchy.*
- *Condom use has almost doubled since the early 1980s, but men's reliance on this method drops as they mature. Half of men who use condoms do so for birth control, not STD protection.*

"Considering the high levels of STD incidence, [condom] use is probably inadequate in level and in consistency at all ages."

The personal, societal and economic costs of sexually transmitted diseases (STDs) are enormous and growing. Some common and treatable STDs are often little more than a nuisance if treated without delay, even though the infected person probably finds them an indignity or source of embarrassment. Some infections are of short duration and can be self-resolving, while others have serious long-term consequences if untreated. The newest infection, HIV, has no cure, even though new drug therapies can delay the onset of AIDS.

The spread of an STD is determined largely by how infectious the bacterium or virus involved is, the number of individuals in a community who are infected, the ability of infected individuals to obtain treatment, and prevailing patterns of sexual behavior within and beyond population subgroups—particularly, the rate at which individuals acquire new partners, the level of concurrent partnerships and the type of sexual activity people engage in. Some of the factors associated with modernity and technological progress—people's increased mobility, worldwide travel, the breakdown of barriers between social classes and changing sexual mores—also help expand and accelerate transmission.

Although sexual activity is the major route for the transmission of STDs, a small proportion of people acquire these diseases through infected blood products, injection-drug use or mother-to-fetus transmission.

Viral STDs Are Long-Term Infections and Can Have Severe Consequences

Three infections—HIV, genital herpes simplex virus (HSV) and human papillomavirus (HPV)—account for the bulk of viral STDs in the United States. As with viral infections in general, these three diseases, once contracted, cannot be eradicated from the body.

HIV and AIDS

As of June 2000, according to the Centers for Disease Control and Prevention (CDC), an estimated 308,000 adult Americans of both sexes were living with AIDS, and 118,000 were living with HIV infection. Virtually all Americans living with AIDS or HIV (99%) are adults, and eight in 10 are men.[1] These figures are known to be serious underestimates, and experts believe that about 300,000 more Americans have been infected with HIV but are unaware of it.[2]

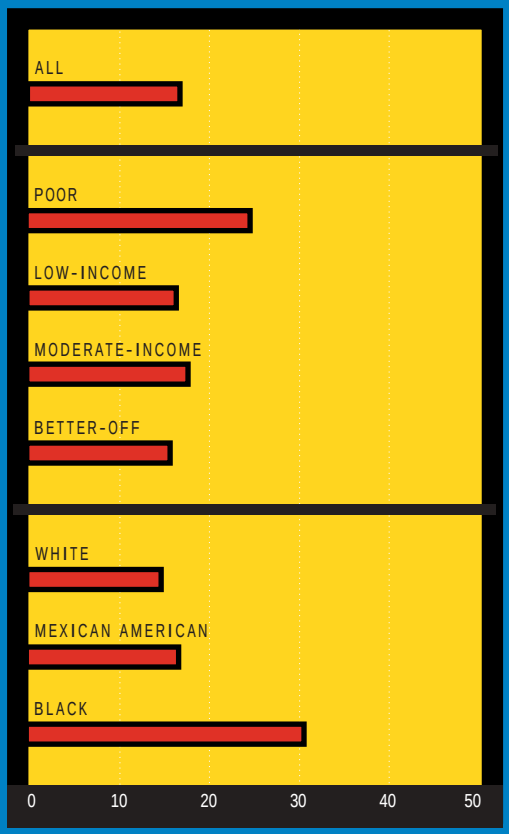
Of men who received AIDS diagnoses in 1999, 53% had been exposed to HIV infection by having sex with other men, 27% through injection-drug use and 6% through both means. Thirteen percent had been exposed through heterosexual activity—three times the proportion in the early 1990s and six times that of the mid-1980s.[3]

There is no way of knowing when the men with AIDS who contracted HIV through heterosexual activity became infected. However, 16% of all men who have had AIDS were in their 20s when they received the diagnosis, 45% were in their 30s, 27% were in their 40s and 11% were 50 or older.[4] Before the introduction of antiretroviral therapies to slow and perhaps halt the progression of HIV into AIDS, a latency period of about 10 years separated infection with HIV from the development of AIDS. Using 10 years' latency as a yardstick, an estimated six out of 10 men with AIDS today would have been in their teens and 20s when they were infected.

The AIDS epidemic disproportionately affects minorities. Thirty-nine percent of people living with AIDS are white, 40% are black, 20% are Hispanic and 1% are members of other racial or ethnic groups.[5] Furthermore, while 13% of men with new AIDS diagnoses in 1999 contracted the disease heterosexually, this is true for 5% of white men, 14–16% of Hispanic men and of Asian/Pacific Islanders, and 18% of black men.[6]

CHART 5.1

Genital herpes is most common among men who are poor or black.



SOURCE: TABLE 5.1, PAGE 87.

HIV is now the third leading cause of death among black males 25–34 (after homicide and accidents) and the second leading cause among black men 35–44 (after heart disease).[7]

Genital Herpes

An estimated one million new cases of genital herpes occur each year among men and women in the United States.[8] The disease, like other genital diseases that produce sores, is believed to facilitate the transmission of the AIDS virus.[9] Genital herpes also causes problems for pregnant women, since babies can be infected during their passage through the birth canal if HSV is present.

The prevalence of genital herpes rose by 30% between 1976–1978 and 1988–1994; it increased fivefold among white teenagers.[10] Because genital herpes cannot be cured (although the duration of the outbreak can be shortened with antiviral therapies[11]), many millions of Americans of both sexes are infected with this virus, even though the disease is dormant in most of them. Prevention of genital herpes is complicated by the fact that many people do not know that after a primary outbreak, the infection is communicable even if it is latent.

One in six U.S. men 15–49 have genital herpes—which translates into about 11 million infected men (Chart 5.1). The prevalence of this disease is highest among poor men and black men. Prevalence rises with age and with the number of lifetime sexual partners a person has had, and is higher among people who did not complete high school than among those with some college education (not shown).[12]

HPV

An estimated five million new cases of HPV—the medical label for what is commonly known as genital warts—occur among men and women each year. It is estimated that at least 20 million Americans are infected with the disease,[13] but data specifically on the prevalence of HPV among men are lacking. Studies carried out in other countries show that prevalence can be as high as 17–30% among young men.[14]

Ulcerative genital warts, like genital herpes, can facilitate the transmission of HIV; certain types of HPV are strongly associated with cancer of the cervix among women and with anal cancer among people who have anal sex. Genital warts also threaten infants born to infected mothers.

Bacterial STDs Can Be Cured, but Many Men Are Unaware That They Have Been Infected

Sexually active Americans are also at risk of three major bacterial STDs—chlamydia, gonorrhea and

syphilis. These infections can be successfully treated with antibiotics.

Chlamydia has been recognized as an STD only since the 1970s. Sexually active men are often unaware that they have been infected, so there are men in the general community with undiagnosed, and therefore untreated, disease. If the infection goes untreated, it can cause sterility in men and can have serious health consequences for women (pelvic inflammatory disease, which may lead to ectopic pregnancies, infertility and chronic pelvic pain).[15]

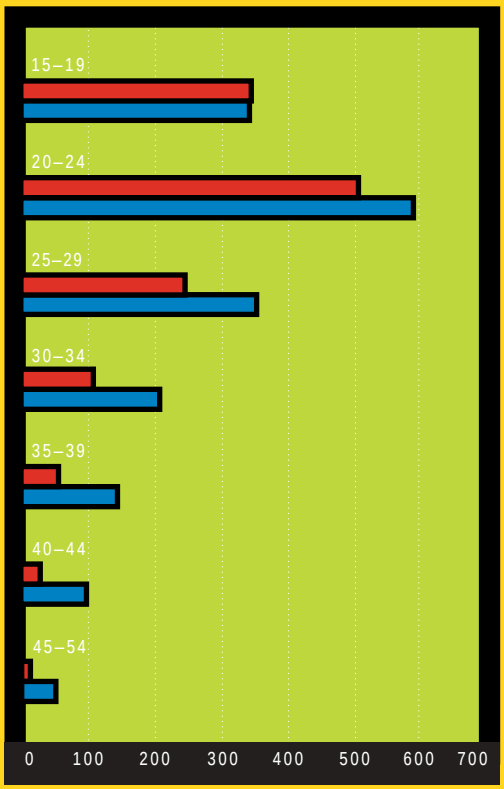
Gonorrhea—which used to be referred to as "the clap"—has been known since ancient times. It is highly infective and is easier to detect among men than among women. Gonorrhea usually affects the urogenital tract, but can also spread to other areas of the body. Infected pregnant women are at risk of having a spontaneous abortion, premature rupture of membranes and premature delivery, and their newborns may have eye infections. Treatment of gonorrhea with antibiotics is highly effective in most cases, although some strains of the bacterium are now drug-resistant. When gonorrhea is suspected, most authorities recommend the immediate treatment of an infected person's partners from the prior 2–4 weeks even before a definitive diagnosis is made.[16]

Syphilis was endemic in Europe in the late 15th century, and the natural history of the disease has been known since the 19th century. Because of the successful use of penicillin and other antibiotics, incidence levels of this once widely feared disease have reached all-time lows in Europe and the United States, even though the disease remains a problem in some southern states. The long-term effects of untreated syphilis involve the insidious deterioration of the central nervous system.[17]

CHART 5.2

Men in their teens and 20s are the most likely to contract chlamydia and gonorrhea.

RATE OF NEW INFECTIONS PER 100,000 MEN, 1999



SOURCE: TABLE 5.2, PAGE 87.

Young Men and Black Men Are at Greatest Risk of Contracting Bacterial STDs

National estimates of bacterial STD cases are based on reports collected by the CDC from state public health authorities. However, the reports do not represent the complete count of new cases, because some states do not report chlamydia, and one state does not report syphilis. And even in states that report to the CDC, public clinics probably provide more complete reports than do private doctors.[18] As a result, more affluent men,

TABLE 5a

Sexually experienced adolescents are more likely than adult men to have had two or more partners in the past year.

AGE	% DISTRIBUTION, BY NUMBER OF PARTNERS, 1992					
	0	1	2	3–5	≥6	TOTAL
15–19	11	44	26	15	4	100
20–29	4	64	11	16	5	100
30–39	3	80	8	7	2	100
40–49	5	83	8	4	0	100

SOURCE: REFERENCE 21.

who probably seek treatment privately, are undercounted to a greater extent than those who are less well-to-do. The counts are also incomplete because many infected men with no obvious symptoms have no reason to seek a diagnosis, which means that their infections are not counted. This is truer of chlamydia than of gonorrhea and syphilis. An estimated 50% of chlamydia cases and 30% of gonorrhea cases (male and female) are not reported, although the reporting of syphilis is generally considered more complete.[19]

Reported rates of gonorrhea and chlamydia are higher among men in their early 20s (roughly 500–600 new cases a year per 100,000) than among other age-groups. Rates of both diseases are high also among teenagers (about 340 per 100,000), and gonorrhea is at a similar level among men in their late 20s (Chart 5.2, page 53).[20] Younger men's high rates of these diseases are attributable to their elevated likelihood of having multiple sexual partners during those years in which few are married (Table 5a).[21]

The reported incidence of both gonorrhea and chlamydia is many times higher among black men (451 and 944 cases per 100,000, respectively) than among Hispanic men (148 and 74 per 100,000) and white men (34 and 22 per 100,000). These wide differentials are hard to explain. The fact that most minority men receive STD care from publicly funded clinics with very complete reporting levels[22] undoubtedly contributes to the disparity. Other factors include black men's higher poverty and more limited access to general health care, their involvement in sexual networks with high infection levels, their relatively low likelihood of being married and their high likelihood of having multiple sexual partners.

Men's Knowledge of STDs Is Rather Uneven

More than nine in 10 men aged 20–39 in 1991 had heard of HIV and AIDS, gonorrhea and syphilis. However, only two in three knew about genital warts, and only one in three understood that a man can become infected with chlamydia. Eight in 10 knew that the pill and vasectomy do not provide any protection against STD transmission, that the condom offers good or very good protection and that monogamy is a highly effective way of reducing the chance of contracting HIV.[23] Only half of adolescents in 1995 knew that it is possible to be infected with genital herpes, gonorrhea or chlamydia, yet have no symptoms.[24]

These findings suggest that although American men's knowledge of STDs is incomplete, their knowledge of how to protect themselves from possible infection by using condoms is somewhat better.

Condom Use Has Been on the Rise

The proportion of couples using the condom by itself rose from 12% in 1982 to 15% in 1988 and then to 20% in 1995.[25] Increases were steepest among couples who were not married or cohabiting—from 16% in 1988 to 30% in 1995.[26] These trends underestimate overall condom use, because many couples use condoms in combination with another method. Taking dual use into account, the proportion using the condom is very high among sexually active teenagers (nearly seven in 10 at ages 15–17) and still quite high among men in their early 20s (four in 10), but is no more than two in 10 among men in their 30s (Chart 5.3).[27] Considering the high levels of STD incidence, use is probably inadequate in level and in consistency at all ages.

The increased use of condoms in the United States has probably been spurred in large part by growing concerns about HIV and other STDs. Consistent condom use has been estimated to be effective 99% of the time in preventing heterosexual HIV transmission.[28] The failure to prevent transmission is due largely to inconsistent use, or to slippage and other problems, rather than to the method itself.[29]

Men's Attitudes Toward the Condom Are Mixed

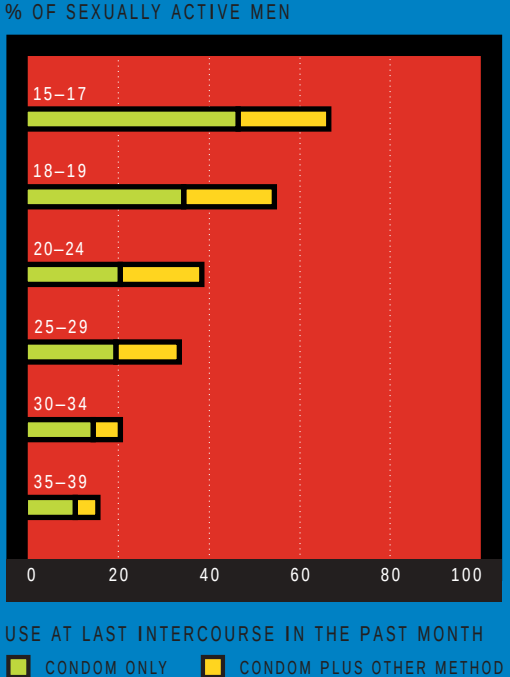
Although men know that the condom is effective against STD transmission, many say the main reason they use this method is for birth control. Among men 20–39 using the condom, 49% use it for birth control only, 43% to prevent both pregnancy and STDs, and 8% for STD prevention only.[30] Most adolescent men who use the condom—83%—do so only to prevent pregnancy; 12% use it to prevent infection, 2% for both reasons and 3% because their partner requested it.[31] Of course, whatever the user's intent, condoms provide protection against both pregnancy and most STDs.

Despite its dual efficacy, men's opinions about the condom are not all positive. Many complain that it reduces their sexual pleasure. Some men find it embarrassing to buy condoms or put one on in front of their partner. Others dislike having to discuss condom use before sex. And some men are fearful of losing an erection when they interrupt lovemaking to put on a condom.[32]

A national study of 17–22-year-old men who used condoms found that 23% had had at least one condom break in the previous 12 months, and 2–3% of all condoms used had broken. Young men who had recently taken a sexuality education course were less likely than average to experience condom breakage, whereas men who had ever had an STD (or whose partners had) and men from households with incomes below

CHART 5.3

Use of the condom is quite high at younger ages but declines as men get older.



SOURCE: TABLE 5.3, PAGE 87.

Although the focus of this report is the sexual behavior of men who have sex with women, any future, more comprehensive, overview of male sexual behavior should include men who have sex with men. Unsafe sexual practices have grave health implications for many of these men.

Homosexuality is variously defined on the basis of three components—identity, desire and behavior.[1] Same-sex behavior does not always correspond with same-sex identity. For example, in 1995, 61% of young men 15–19 who said that they had ever engaged in same-sex behavior identified themselves as "100% heterosexual or straight," and 4% as "mostly" or "100%" homosexual. Five percent were unsure of their sexual orientation, and 30% identified themselves as mostly heterosexual or bisexual.[2]

Given the fluidity of these definitions, it is extremely difficult to obtain accurate information on the proportion of men who have sex with men. From men's own reports, the proportion appears to be low, but it is probably understated because of the widespread social stigma attached to homosexuality. The following are among the best estimates available:

- In the 1991 National Survey of Men, 2% of 20–39-year-olds reported that they had engaged in any same-sex activity in the previous 10 years, and 1% reported having engaged exclusively in same-sex relations during this time.[3]

- In 1992, the National Health and Social Life Survey found that 9% of men 18–59 had had sex with a man at least once since puberty, but only 3% identified themselves as homosexual or bisexual.[4]

- In the 1995 National Survey of Adolescent Males, 5% of 15–19-year-olds said they had ever engaged in any sexual activity with a man, ranging from masturbation to anal intercourse.[5]

Relationships and family situations vary among men who have sex with men. Most have had vaginal intercourse at least once.[6] About three in 10 are currently living with a male partner, and two-thirds have ever lived with a male partner. Almost one in three men currently in a same-sex relationship were previously married. Five percent of gay couples have children living with them.[7]

In the 1990 National AIDS Behavioral Study, 24% of 18–49-year-old men who have sex with men said they had had no partners in the previous year, 41% had had one and 35% had had two or more.[8]

After a Decade of Decline, the Incidence of AIDS Could Increase Again Among Certain Groups

After peaking at more than 40,000 new cases in 1992, AIDS incidence among men who have sex with men declined to about 20,000 in 2000.[9] There is no way of knowing how much of this decline can be attributed to the efficacy of new antiretroviral drugs in slowing the progression of HIV to AIDS, and how much to increases in safer sexual practices among men who have sex with men starting in the early 1990s. Some observers believe that impressive increases in condom use and declines in the number of partners among men who have sex with men,[10] along with a dramatic increase in public and private HIV prevention and education programs in the hardest-hit communities,[11] should take credit for part of the reduction in AIDS levels.

However, some research suggests that the success of antiretroviral therapies in prolonging life and improving the health of HIV-infected people might have had the effect of making some men who have sex with men less vigilant about safer sex[12] and more complacent about AIDS,[13] which could lead to a resurgence of the epidemic among certain groups. In a large study of gay men in San Francisco, the proportion who had engaged in anal sex increased between 1994 and 1997 (from 58% to 61%), whereas the proportion reporting that they always used condoms declined (from 70% to 61%).[14]

Similarly, even though the incidence of rectal gonorrhea among men who have sex with men declined in the early 1990s, it rose from 21 to 38 new cases per 100,000 men between 1994 and 1997.[15] Gonorrhea is believed to facilitate the transmission of HIV. Statistics collected from STD clinics in 29 U.S. cities and counties between 1992 and 1999 show that the proportion of gonorrhea cases attributable to sexual activity between men increased from 5% to 13%—a pattern that also suggests increasing rates of unsafe sexual behavior among men who have sex with men.[16]

$60,000 were more likely.[33]

But some reasons for men's reluctance or inability to use the condom are not related to characteristics of the method:

■ Couples in relationships going on for less than six months are more likely to use the condom than those in much longer relationships.[34] In one survey, two in 10 adult men in an ongoing sexual relationship, compared with six in 10 of those in a casual relationship, used condoms. Seventy-two percent of men in ongoing relationships said they did not use condoms because they were having sex with only one person. In contrast, the most common reason given by men in casual relationships was that a condom was not handy or available at the time of intercourse (37%).[35]

■ Condom use among adolescent men is likely to decline as a relationship continues. If a new sexual relationship begins, use often picks up again.[36]

■ Couples in which the man expects his partner to assume the primary responsibility for contraception are less likely to use a condom than are those in which the man believes that he has greater responsibility for contraception.[37]

■ Adolescent men with traditional attitudes toward masculinity have more sexual partners, less-intimate sexual relationships and a stronger belief that relationships between men and women are basically adversarial. This constellation of attitudes is often associated with lower and less-consistent use of condoms, with a weaker belief that it is the man's role to prevent pregnancy and with a stronger belief that pregnancy validates a man's masculinity.[38]

Chapter 6

Sexual and Reproductive Health Information and Services for Men

- *There is no commonly agreed upon definition of sexual and reproductive health care for men, and many barriers to the provision of such care exist at the individual, economic and structural levels. The consequences of not effecting change on all these fronts are too serious to be dismissed.*

- *Obstacles to care include the tendency of many men not to seek regular, routine check-ups; the fact that health insurance, in both the private and the public sectors, often does not cover the types of services men need, especially information and counseling; and the high proportions of men—particularly poor men—who do not have health insurance.*

- *Few health professionals are specifically trained to provide men with sexual and reproductive health education and services.*

- *Men's service needs change as they move through the reproductive life stages. The older men get, the more likely they are to need medical sexual and reproductive health services rather than information.*

- *At all ages, sexually active men, particularly those who do not use a condom and have multiple partners, need regular screening for sexually transmitted diseases.*

"The availability of [information for men] in any widely accepted institutional or professional context is striking mainly for its absence."

Because men do not get pregnant or bear children and because condom use is possible with no medical monitoring, men's sexual and reproductive health needs are not as obvious, as directly related to reproductive events or as clearly medical as women's. Nevertheless, from adolescence on, most men need information and counseling about sexual and reproductive health matters, and they need somewhere reliable to go for related education and health care.

At a minimum, all men need information and education about contraceptive use, pregnancy and childbearing, sexually transmitted diseases (STDs) and how to avoid them, where to obtain and how to use the condom correctly, and how to talk about these issues with partners. In terms of their medical needs, all men should have access to routine screening and treatment for STDs, the frequency of which would depend on their level of exposure to these infections. Some older men will also require surgical services for vasectomy, screening and treatment for reproductive cancers, and infertility treatment.

Information and Education Are Essential, Particularly for Younger Men

Early in their teenage years, and probably even sooner, young men need accurate, unbiased, straightforward information and advice about sexual and reproductive health matters from people or institutions they trust. Adolescents, particularly, need information about puberty, male and female sexual development, gender and sexual identity. They also need skills in resisting peer pressure, avoiding sexual violence (whether as victims or as perpetrators), building relationships and communicating with young women about personal and sexual matters.

One might assume that young men learn what they need to know about sex and sexuality from their friends and parents, or at school. But friends are often an unreliable source of information, and a great many parents do not feel up to the task of teaching their children all they need to know.[1] Most school curricula include sexuality education, although vocal opponents in some communities believe that this subject should be left to parents and religious counselors. If schools provide sexuality education, these critics believe that the curriculum should stress refraining from intercourse altogether as the only effective way of avoiding pregnancy and STDs; in their view, it should also teach that contraceptives and condoms are ineffective at preventing pregnancy and STDs.

Almost six in 10 adolescent men 15–18 say they have discussed AIDS with their parents, and four in 10 say they have talked about STDs or birth control.[2] However, boys are significantly less likely than girls to have discussions about sexuality with a parent.[3] This might be because parents are most likely to talk about sex with their offspring of the same sex, and mothers are much more likely than fathers to have conversations of this kind.[4]

The reluctance of many parents and children to talk to each other about sexual matters and the ever-widening range of up-to-date information that young people need clearly leaves an important role for schools. Virtually all young men 15–19 have taken reproductive health education courses at school.[5] Most sexuality education teachers in grades 7–12 teach their students about HIV and other STDs, abstinence from sexual intercourse and the skills needed to resist peer pressure to have intercourse. These topics are more likely to be included in the sexuality education curriculum than they were 10 years ago. But fewer teachers now cover birth control methods, abortion, ethical issues relating to abortion, and where students can go for birth control and STD services.[6]

The decline in teaching about birth control and abortion does not reflect most parents' wishes. More than 90% of parents of secondary school students want schools to cover the basics of preg-

nancy and childbirth, birth control, information about HIV and other STDs, and how to obtain testing for these. Three-quarters or more want their children to be taught about how to use condoms, where to get contraceptive methods other than the condom, and abortion and sexual orientation.[7]

Increasing proportions of sexuality education teachers in the United States use an abstinence-only approach—23% in 1999, compared with 2% in 1988. One in 10 teachers do not cover contraception at all, and about three in 10 emphasize that contraceptives and condoms are ineffective against pregnancy and STDs.[8]

In addition, much of the instruction given in schools probably comes too late: Three in 10 young men 15–19 begin having intercourse before they have received any school instruction about AIDS, STDs, how to say no to intercourse, birth control or the correct use of the condom.[9] Many public school teachers believe that students should receive information on a wider range of topics and at earlier grades than is now the case.[10]

Beyond the adolescent years, men continue to need sexual and reproductive health information, but the availability of such information in any widely accepted institutional or professional context is striking mainly for its absence. The Internet has begun to provide young men with a vast array of resources designed to answer their questions and fill in the gaps in their knowledge. Still, not all men have access to the Internet, and both accurate and biased information are equally available from this medium.

A wide range of voluntary organizations, including churches, youth groups and men's clubs, are also increasingly becoming involved in counseling and information services for men.[11] Their programs may offer sessions on sexuality, relationships and family life for adolescent men, and marriage and family counseling and discussion groups for men of all ages. Community-based groups' familiarity with local conditions and with the day-to-day context of men's lives makes these volunteer groups particularly well placed to provide these programs.

Men Also Need Medical Services, Particularly at Older Ages

Although the purely medical aspects of sexual and reproductive health care for men are much narrower than those for women, men need a basic core of services. These include contraceptive services; screening, testing and treatment for STDs; and diagnosis and treatment of infertility, sexual dysfunction and reproductive cancers (particularly prostate and testicular cancer).

Male Contraceptive Services

Only three contraceptive methods are currently available to men: the condom, vasectomy and withdrawal (coitus interruptus). The condom, by far the most widely used of these methods, does not require a medical visit, and most men purchase condoms over the counter. The male condom is one of the most inexpensive contraceptives available, and few men complain that it costs too much: A year's supply, given average coital frequency, could cost as little as $40.[12] In addition, some young and poor men obtain free or low-cost condoms from publicly funded STD or family planning clinics.

Fees for a vasectomy range between $240 and $1,000 for an interview, counseling, examination, operation and follow-up sperm count. (Sterilization for women costs up to four times as much.)[13] Some clinics and doctors use a sliding scale according to patients' income. Most private health insurance policies pay some or most of the cost.[14] In about three dozen states, Medicaid will cover the operation, but some restrictions apply to patient eligibility.[15]

Most vasectomies are performed by urologists (72%); the rest, by family physicians (15%) and general surgeons (13%). These operations are carried out in doctors' offices (77%); hospital outpatient settings (19%); and freestanding surgical centers, family planning clinics and health maintenance organizations (4%).[16]

Dissatisfaction with the limited contraceptive choices available to men has encouraged scientific research and development in this area. A male hormonal method may become available in 5–10

years.[17] When this happens, men's service needs will probably expand to include clinical screening, prescriptions, monitoring and the kind of follow-up that women taking the pill have been used to receiving for more than 40 years.

Screening, Testing and Treatment for STDs

For STD screening to be cost-effective, clinicians must know the general pattern of risk to which each of their male patients is exposed. This involves knowing, among other important background characteristics, the types of sexual behavior a man engages in, the number of sexual partners he has had in a recent time period and whether he injects drugs. These, as it turns out, are precisely the sensitive areas that many general practitioners are reluctant to broach with patients. The professionals working in specialized public health clinics to diagnose and treat STDs may have less of a problem with such questions, but many have little time to take a full history and provide counseling.

Contact and follow-up with the sexual partners of infected men are important aspects of the process required to reduce or contain the spread of STDs. Busy general practitioners and specialists are unlikely to have the time or interest to carry out this next step, and most public health clinics lack the resources.

Infertility

Little information is available about whether men want but are unable to father a child. Of the estimated 13% of men in their late 40s who have never had children, some could have but did not want to, while others may have wanted to but could not.

An estimated 10% of women aged 15–44 are unable to have a child (or another child) because their fertility or their partner's is impaired.[18] Of the approximately 6.7 million women 15–44 with fertility problems in 1995, 42% had ever received some form of infertility services. Of those who had ever sought treatment, 22% reported that the problem was their husband's or partner's (about 600,000 men).[19]

Reproductive Cancers

Prostate cancer is the most common nonskin cancer in U.S. men. It is very rare among younger men—in 1996, three per 1,000 men younger than 45 (or 241,000) had prostate disease diagnosed. However, the rate rises sharply thereafter, to 30 per 1,000 men aged 45–64 (or 780,000) and 134 per 1,000 men aged 65 and over (or 1.8 million). An estimated 180,400 new cases and 31,900 deaths were expected in 2000. Although the number of men with this disease is large, the majority do not die of it. At all ages, the incidence of prostate cancer among black men exceeds that of white men.[20]

While both digital rectal examination and a specific clinical test are reasonably effective for the early detection of prostate cancer, a lack of evidence that screening and treatment reduces deaths from this cause has led many health providers to stop screening men.

Nearly 70% of men who have been treated for prostate cancer experience long-term sexual dysfunction (erectile dysfunction or loss of sexual desire).[21] One study raises the possibility that prostate cancer may be linked to the number of sexual partners a man has in his lifetime.[22]

Testicular cancer is the most common form of cancer in young men between the ages of 15 and 35. An estimated 7,400 men in the United States were expected to receive a diagnosis of testicular cancer in 1999.[23] This disease is four times more common in white men than in black men.[24] Most cancers of this type are discovered by men themselves, or by their partners, either unintentionally or during self-examination.[25]

Sexual Dysfunction

What men mean by sexual dysfunction (impotence, premature ejaculation, loss of sexual desire and feeling a loss of manhood, for example) does not always correspond with a clinical definition of sexual dysfunction. In a 1992 survey, 32% of men 18–59 reported ever having had at least one symptom of sexual dysfunction, and the proportion increased steadily with age.[26] Sexual dysfunction is also associated with poor health in

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

Most attention to delivering sexual and reproductive health services to U.S. men has focused on adolescents, young adults and gay men. There is no generally accepted standard set of sexual and reproductive health information and services for all men, but several organizations have begun to develop prototype sets of services for different target groups. The set presented below draws heavily from existing ones 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. At the same time, any prototype service set 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 sexuality 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 diseases (STDs), 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 STD 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 properly, recognizing STD 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 partner's role in pregnancy, abortion, adoption, delivery and the postpartum period, contraceptive method choice, decision-making regarding sterilization (male or female) and hysterectomy

- 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 last six months; history of exchanging sex for money or drugs, injecting drugs, engaging in sex with other males, having a partner at risk of STD infection, having an STD, 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 STDs, including HIV (determined by the individual's risk factors and performed in conjunction with pretest and posttest counseling); diagnosis; treatment; counseling; partner referral
- Diagnosis 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

general, urinary tract symptoms, depression, deterioration of a man's economic position and other kinds of stress. In addition, men who were sexually abused as children are three times as likely to experience erectile dysfunction and twice as likely to experience premature ejaculation as men who had no such experience.[27]

The range of factors associated with men's sexual dysfunction suggests a wide array of treatment options. However, the range also makes correct diagnosis and appropriate treatment for the condition, or conditions, complex issues. The new drug Viagra (approved by the Food and Drug Administration in 1998) is targeted at one condition, erectile dysfunction. As of 2000, more than six million prescriptions for Viagra had been written in the United States.[28]

Men Need Skills and Counseling, as Well as Information and Medical Services

More comprehensive definitions of men's reproductive health needs have been suggested by various agencies working in the field.[29] Taken together, these contributions help create a framework for moving toward a consensus on what constitutes a model of appropriate sexual and reproductive health care for men (see box).

Although the framework is not organized in terms of men's changing sexual and reproductive needs as they age, most of the needs listed in the first two categories—information and skills—will emerge in men's teenage and early adult years. These needs are already being addressed in schools and youth programs, although not nearly at the level necessary. Many counseling and information services for young people are the responsibility of nonmedical people—teachers, youth workers, social workers and community volunteers—whose number and skills clearly need to be upgraded.

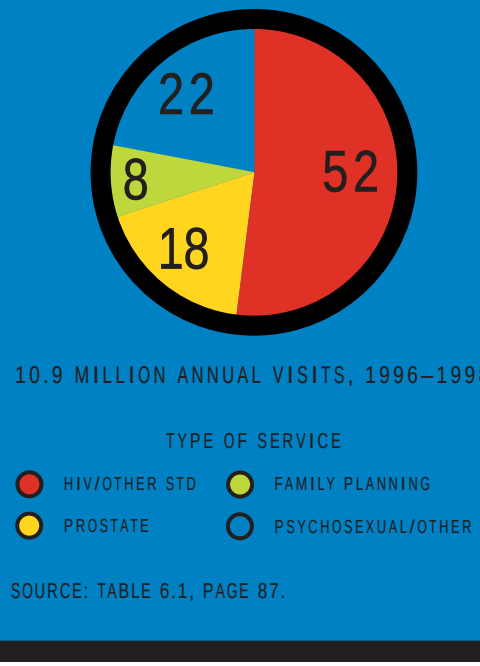
The third and fourth categories in the

framework—counseling and screening (particularly screening for STDs)—are applicable to men of all ages. All men should get a regular physical checkup, including an assessment of their sexual and reproductive health status and needs. Health maintenance organizations typically cover routine checkups, but these examinations may not include an assessment of sexual and reproductive health and its implied health care needs.

Most health insurance plans—health maintenance organizations and other private plans—are likely to cover male services that involve clinical diagnosis and treatment. With appropriate indications and referrals, men with health insurance can probably obtain most of the screening protocols listed under their plan's coverage. But any type of counseling service is likely to be covered only under the most generous health insurance plan, and men with no coverage are unlikely to obtain counseling, checkups or referrals.

CHART 6.1

Testing and treatment for STDs, including HIV, are the primary reasons men seek sexual and reproductive health care.



SOURCE: TABLE 6.1, PAGE 87.

Men Currently Receive a Wide Range of Reproductive Health Services, but Are They Sufficient?

Many doctors seeing men for routine health care do not bring up issues related to sexual and reproductive health. In a 1992 survey of private primary care physicians, 49% reported that they always or usually ask their patients (both male and female) about STDs, 31% about condom use, 27% about sexual orientation and 22% about the number of sex partners they have had. Twenty-five percent believe their patients would be offended by questions of this type.[30]

Despite the apparent reticence of some doctors, American men are receiving sexual and reproductive health services. In the late 1990s, men 15–49 made 8.4 million visits a year to office-based physicians in which they received care related to sexual and reproductive health. They made another 1.7 million visits to hospital outpatient departments and emergency rooms for the same reasons. And 2% of the 4.5 million visits made to publicly funded family planning clinics in 1995—or 94,000 visits—involved men obtaining counseling, education or supplies of contraceptive methods.[31] Finally, publicly funded local health department clinics provide STD services to an estimated 800,000 men annually.[32] Altogether, men 15–49 make about 10.9 million visits annually to private physicians' offices, hospital outpatient departments, emergency rooms and publicly funded STD and family planning clinics for sexual and reproductive health care.[33]

The most common reason for men to seek reproductive health care is to obtain testing or treatment services for HIV or other STDs: Fifty-two percent of the 10.9 million visits that men make each year are for these services. Prostate problems account for the next largest share of visits (18%). Only 8% of visits are for family planning—mostly for vasectomy counseling or services. About one-fifth of visits are for psychosexual care and for other reasons—such as problems involving the

urinary tract, scrotum, penis or testicles (Chart 6.1).[34] It is impossible to know whether this distribution reflects the actual pattern of men's needs. The preponderance of visits for HIV and other STDs partly reflects the frequent doctor visits that men with AIDS must make to maintain their health. However, other kinds of care related to STDs undoubtedly represent a large part of the medical services that many men need.

Each year, men 15–49 (excluding the 800,000 men receiving STD care in public clinics) make an average of 14 sexual and reproductive health care visits per 100. This rate increases substantially with men's age, from six visits per 100 men aged 15–19 to 23 visits per 100 men aged 45–49. Black men aged 15–49 make an average of 22 visits per 100 per year, about twice the number made by men of other races (Chart 6.2).[35] Again, it is impossible to evaluate how closely these patterns reflect men's actual needs. Nevertheless, the rates seem particularly low for adolescent men (all of whom should at least be receiving a medical assessment of their sexual and reproductive health once a year) and for men in their late 40s (all of whom should probably be screened for prostate cancer with some regularity).

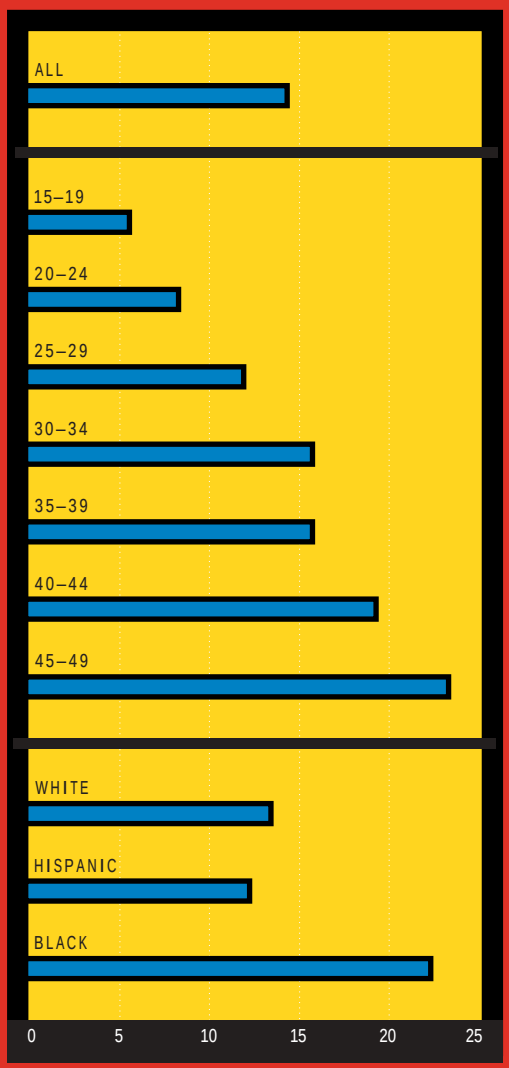
A Lack of Health Insurance Prevents Some Men from Obtaining Care

Of almost 69 million American men between the ages of 15 and 49, 23% have no health coverage of any kind. Men are more likely than women to be without health insurance, and the gap has widened a little in recent years. The proportion of men without health insurance peaks in men's early 20s (37%) and drops to 14% among men in their late 40s. Men aged 20–29 living in poor families are the most likely to have no health insurance (59%), but even at older ages, about half of poor men have no coverage (Chart 6.3, page 66).[36]

Hispanic men are more likely to be uninsured (45%) than are members of other racial and ethnic groups (31% of blacks, 21–26% of other minority groups and 17% of whites).[37] For men

CHART 6.2

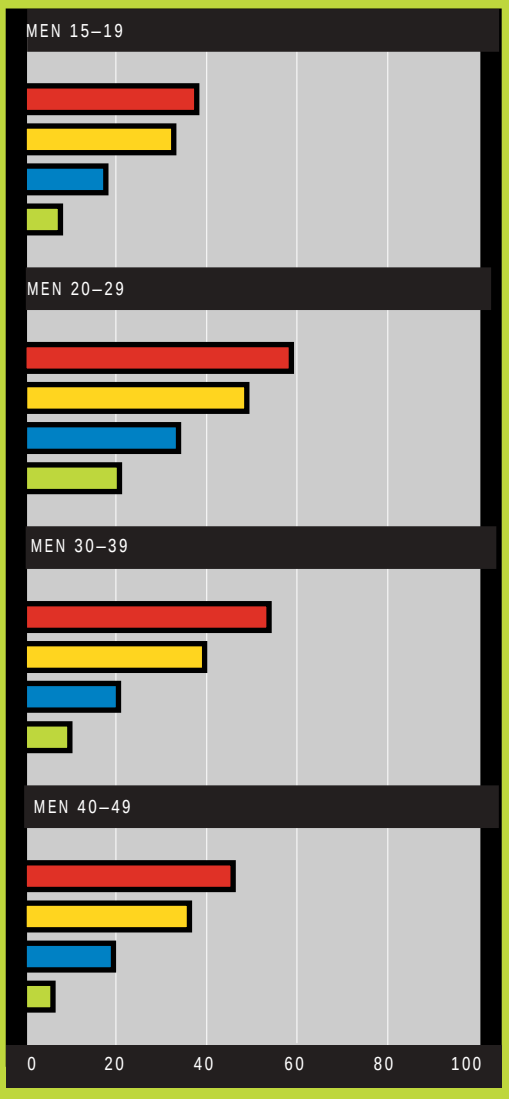
Older men and black men are the most likely to make sexual and reproductive health visits.



SOURCE: TABLE 6.2, PAGE 87.

CHART 6.3

At every age, poor and low-income men are the most likely to be uninsured.



SOURCE: TABLE 6.3, PAGE 88.

overall, the other main factors associated with a lack of health insurance are being out of the labor force, being unemployed, working part-time, working in a small company (especially one with fewer than 25 employees) and being foreign-born.[38]

In the teenage years, 78% of white men have private insurance coverage (mostly through their parents), compared with only 50% of black adolescents and 41% of Hispanic youth. However, 23% of black teenagers and 18% of their Hispanic peers have Medicaid coverage, reducing the gap in coverage. As they leave adolescence behind, many men lose either the Medicaid coverage they were entitled to through their mothers or the automatic inclusion in their parents' private family health insurance policies; in all racial groups, the proportion of men with health coverage is lower in the early 20s than in adolescence.[39]

Structural Barriers Are an Impediment

The health care infrastructure itself, in both the public and the private sectors, creates obstacles to meeting men's needs. Public funding for men's sexual and reproductive health programs is insufficient. Many federally supported programs are designed to serve women but not men, and do not offer male services, like vasectomies. State funding may be earmarked only for female procedures.[40]

In the private health sector, insurance coverage and training for service providers present challenges. For example, it is not clear that health insurance covers the full range of medical and psychosexual counseling services men might need at various stages of their lives. And little is known about support within the medical training community for the inclusion of specialized instruction in male sexual and reproductive health care.

Without such training, many doctors do not have the knowledge or experience that would make them comfortable in the role of sexual and reproductive health care providers for men. Fewer than half of pediatricians, nurses, psychologists and social workers working with adolescents consider themselves highly knowledgeable about sex-

uality education, contraceptive counseling or adolescent pregnancy.[41]

In addition to these problems, many men are out of touch with a regular source of preventive health care of any kind. More than one in three men 18–44 do not have a regular doctor, and one-third have not seen a doctor in the past year. Among men 50–64, six out of 10 have not been screened for prostate cancer in the past year, and one-third have not been screened for colon cancer. Fifty-one percent of men 18–44 have received no preventive services at all in the past year (compared with 16–18% of women of this age). Poor men, uninsured men and Hispanic men have by far the hardest time gaining access to preventive health care services.[42]

Most women begin seeing a doctor for routine and regular reproductive health care services after they become sexually active, and women who have children become linked to the health system when they are pregnant and giving birth. But men do not have a similar routine channel for obtaining sexual and reproductive health care services, and have traditionally not been encouraged to seek such services. Because of the predominance of female clients in family planning clinics, many men believe that these clinics provide care only to women, so are reluctant to go.[43] In addition, of course, most men do not require any medical services to become fathers.

Young Men Face Additional Barriers

Young men's physical, emotional and psychological development changes very rapidly in the adolescent years. In addition, young men who have a regular doctor often switch from a pediatrician to an internist at some point during adolescence. Both of these types of general practice physicians tend to serve a wide age range of clients, and may have difficulty providing comprehensive counseling and services specifically geared to adolescents.

Adolescents coming to adulthood in a world of AIDS and growing social conservatism must reconcile the impetus of their emerging sexuality with the social realities around them. It is often difficult to promote sexual abstinence as an acceptable option for teenage men, some of whom already hold casual attitudes toward sex. In some communities, deep-seated societal assumptions hold that fatherhood at an early age is inevitable. Young men in these communities often lack adequate exposure to role models of men who are financially and emotionally responsible for the children they father. Young men in poor communities may also be apathetic and feel that their life situation cannot be improved.[44]

What Is to Be Done?

The sexual and reproductive health service needs of young men have received somewhat greater recognition than have the needs of adult men. In fact, most of the small number of pilot projects designed to serve men focus on adolescents. However, these programs reach only a fraction of adolescent men. And in a society where many influential policymakers frown on sexuality education, how should young men be taught not just about reproductive biology, safer sex and healthy relationships, but where to go if they need counseling and advice in these areas?

How can the groups in society involved in men's sexual and reproductive health—medical and other health professionals; community-based organizations, especially those targeting young men; parents; schools; and insurance companies—reach a consensus on the types and range of education and services that men need? Which medical specialists should be tapped to provide services? What is the best way to overcome the scarcity of resources and staff available to provide for men's sexual and reproductive health care needs? And what health policies are being considered to address the needs of the millions of men who lack any form of health insurance?

Moreover, given the reluctance of many men to use the condom, what strategies can the public health community recommend and implement on a broad scale to involve men in reducing their own and their partners' STD levels? In particular, how can they reach unmarried men?

As this report makes clear, the need to address all these questions is critical.

Chapter 7

Summing Up

"Helping men take greater control of their sexual and reproductive lives should be an important national goal."

It is clearly essential to recognize the sexual and reproductive health care needs of American men and to increase their access to services addressing those needs. This report has touched upon many of the reasons for the sense of urgency: Because in addition to being partners and fathers, men are individuals in their own right and deserve to be treated accordingly. Because men who perceive that taking care of their sexual and reproductive health is to their own advantage are more likely than those who lack this understanding to obtain the kinds of care they need and to assume responsibility for their sexual activity. Because emphasizing the importance of information and counseling services in sexual and reproductive health care—the component that men now most lack—also promises to enhance the comprehensiveness and quality of services for women. Because in the end, meeting the needs of *both* men and women should result in lower levels of sexually transmitted diseases (STDs), fewer unwanted pregnancies, healthier pregnancies and births, and better parenting.

Two basic facts about male sexual and reproductive health and behavior in the United States emerge from this overview. First, a significant number of men, particularly young men, are taking action to avoid the undesirable consequences of sex—unintended pregnancy and sexually transmitted disease. Eight in 10 teenage men practice contraception the first time they have sex, mostly using the condom, and high proportions continue to use birth control from then onward. At the same time, however, many men still expose themselves and their partners to a high risk of STDs and unwanted pregnancy. Nearly one in five men of all ages use no protection when they have intercourse.

There are many explanations for why some men fail to be more careful in their sexual relationships. Some are rooted in men's insufficient appreciation of the risks they face, others in their failure to acknowledge their own vulnerability. Others undoubtedly stem from a lack of concern about the consequences of irresponsible sexual behavior. But as this report shows, additional reasons well might be the inadequacy of existing information and services for men, and men's limited access to the services that are available, often because so many lack health insurance.

Men's Needs Can Be Measured Only Indirectly

It is extremely difficult to quantify men's unmet need for sexual and reproductive information and health care. Nonetheless, the data in this report offer some strong indirect indicators. The proportion of men with AIDS who were infected through heterosexual contact is continuing to rise, and rates of STDs, particularly among adolescents and men in their 20s, are alarmingly high. The proportion of men in each age-group who are experiencing key events can also provide measures of need.

Of the almost 69 million American men who are between the ages of 15 and 49, some 62 million have ever had intercourse, including half of adolescent men, nine in 10 of those in their 20s and virtually all of those in their 30s and 40s. Substantial proportions have had intercourse very recently (three in 10 teenagers, almost eight in 10 men in their 20s and nearly nine in 10 men in their 30s and 40s). The proportions who have had two or more partners in the past year, behavior that increases the risk of contracting an STD, are especially high among adolescents and men in their 20s—25% and 29%, respectively (Chart 7.1, page 70).[1]

Use of the condom is substantial at all ages and is especially high among men in their 20s,[2] but the high rate of STDs suggests that condom use needs to be even higher and even more consistent than it now is. Certainly, all sexually active men should have the knowledge and skills necessary to use condoms effectively. But equally important, they should also be knowledgeable

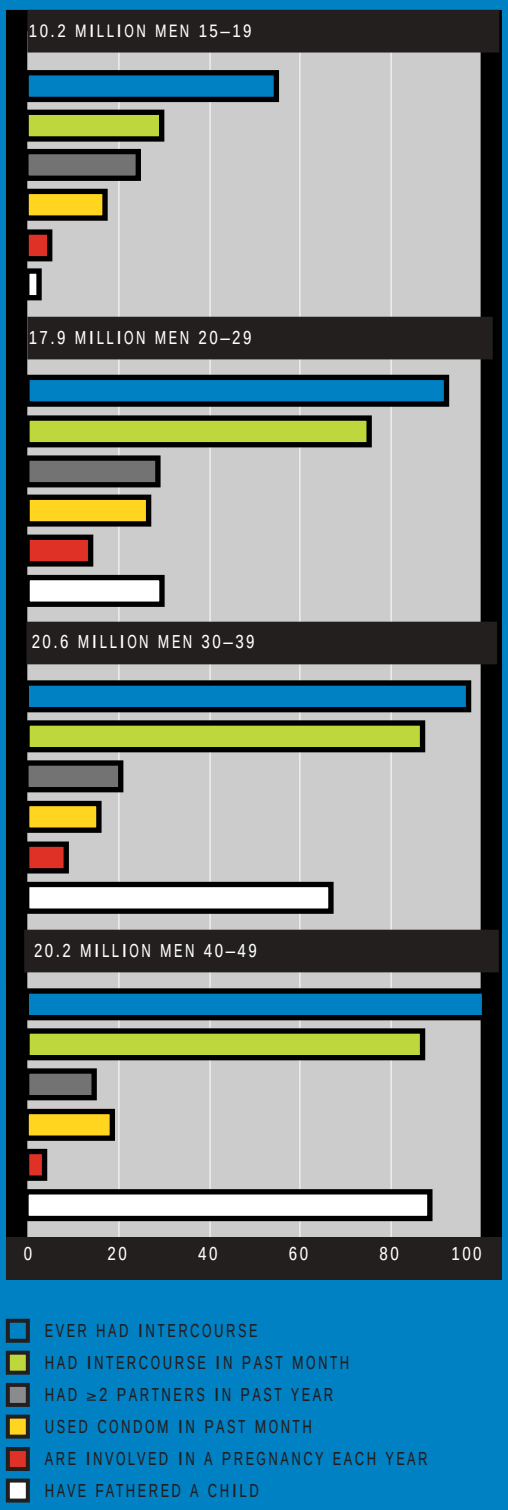
about the range of female methods of pregnancy and disease prevention and have the interpersonal skills required to support their partner's effective use of a method. The challenge here is to craft messages, programs and policies that do not try to fight human nature—for example, by urging all unmarried men to abstain from sex—but that focus on helping men recognize risky behavior, make responsible decisions and lessen the risks.

Each year, 3–14% of men, depending on the age-group, are involved in a pregnancy.[3] These men need an understanding of the importance of prenatal care, and how to give their partners emotional support during this period. There are some indications that domestic violence increases when women are pregnant, especially when the circumstances surrounding the pregnancy are less than ideal.[4] Men at high risk of violent behavior may require especially intensive counseling and social services. Finally, men involved in a pregnancy need accurate information about the options available to women who may wish to consider ending a pregnancy.

Male sexual and reproductive health is also about fatherhood. By their 40s, almost nine in 10 men have fathered a child.[5] At some point in their lives, therefore, most men need information about good parenting practices, child health and development, paternal responsibilities and rights, and the importance of maintaining close and supportive ties with children with whom they might not live. Men who are fathers also need to be able to talk comfortably with their children about the pleasures,

CHART 7.1

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



SOURCE: TABLE 7.1, PAGE 88.

consequences and responsibilities of sexual expression and of having children of their own one day.

At the same time, men whose marriages have broken up and who find themselves single again need information that will help them navigate a world that may be very different from the one in which they were first single—particularly if their marriage predated AIDS and the current epidemic of STDs.

The Powerful External Conditions Shaping Some Men's Behavior Must Be Acknowledged

The broad links highlighted in this report among men's race and ethnicity, socioeconomic circumstances, and sexual and reproductive behaviors are striking. However, these connections are far more complex than is suggested by the data presented here, and they merit more in-depth investigation and clarification than was possible in this report.

Nevertheless, the report reveals some sobering statistics about the conditions of some men's lives: More than one-third of all boys, and an even higher proportion of black youth, grow up with only one parent in the home. One-third of men live in poor or low-income families during their teens and 20s, an important measure, in light of consistent findings linking economic and social disadvantage and reduced hopes of moving out of poverty to higher rates of sexual risk-taking. Minority men have higher rates of STDs than white men, and AIDS is increasingly becoming a problem of poor and minority men.

However, poverty is not destiny, and race and ethnicity do not determine one's life course. Some men with all the advantages of high income, "intact" families, good education and successful careers contract STDs, experience unintended pregnancies, see their families break up and become separated from their children. And many low-income and minority men avoid these problems entirely. Clearly, more attention must be paid to the sexual and reproductive health needs of men of all income levels and racial and ethnic backgrounds.

Still, the complex relationships between poverty, high-risk behaviors, poor health outcomes, and further economic and social disadvantage are undeniable for both men and women. It will be difficult to fully address a range of problematic sexual and reproductive behaviors without also addressing the broader social issues of poverty, racial and ethnic discrimination, and the social dislocation that flows from both.

It is surprising that so little sense of public urgency surrounds men's sexual and reproductive behavior and its consequences.

Punitive Social Policies Are Not the Answer

Men, and women, of all ages and from all cultural backgrounds are having to adapt their sexual and reproductive lives to new societal expectations about male and female roles, new definitions of marriage and family, and the dramatically altered context of all sexual relationships because of the advent of HIV and AIDS and the prevalence of other STDs. Such trends as the rising labor-force participation of women with children, later marriage, increasing rates of cohabitation and nonmarital childbearing, and high, though apparently stable, divorce rates probably will not be reversed any time soon.[6] Many of the demands these new and often difficult circumstances place on men are not going to go away, either.

It is surprising, therefore, that so little sense of public urgency surrounds men's sexual and reproductive behavior and its consequences for families and society. Issues like impotence and prostate cancer among well-known public figures often receive a high level of media attention, but men's more routine sexual and reproductive health needs capture far less attention.

There also seems to be no lack of concern about escalating rates of nonmarital births. Historically, most policies designed to address

out-of-wedlock childbearing have focused on unmarried mothers. More recent steps, however, have targeted men. These have been largely punitive measures designed to increase men's financial support for children they father but do not live with. The 1992 Child Support Recovery Act, for example, makes it a federal crime to willfully fail to pay child support. Under the 1994 Full Faith and Credit for Child Support Orders Act, states are required to enforce child support orders established in other states. The 1998 Deadbeat Parents Act makes it a felony to cross state lines to evade a child support obligation. And Title III of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (the welfare reform legislation) requires states to establish legal paternity if children born out of wedlock are to be eligible for aid under the federal Child Assistance Program.

Reversing the neglect of men's needs will require confronting some difficult ideological and political realities.

Whatever the intent of these laws, about one in four nonresident fathers who are not in compliance with child support laws are so poor—and receive so little help in surmounting poverty—that there is little hope of their being able to assist their children, however much they might want to.[7] The same is true of fathers who are in prison.[8]

Addressing the entrenched national problem of poverty among children, and especially children living with one parent, requires a broader policy approach: Focusing primarily on the unwillingness or inability of some unmarried fathers to stay in their children's lives and contribute to their support is not sufficient.

Reversing the neglect of men's needs will also require confronting some difficult ideological and political realities, given that many influential policymakers believe either that sexuality and its implications do not require program interventions at all or that such programs should preach sexual abstinence.

Serving Men Will Require New Approaches

Helping men lead healthier sexual and reproductive lives is a goal that is garnering increased attention and legitimacy. Still, some health professionals and many feminist activists fear that an emphasis on men will inevitably drain much-needed focus and health care resources away from women. To be sure, more must be done to meet the needs of women. However, anticipated inroads into funding for women's reproductive health services may be somewhat overestimated, since men need fewer high-cost, purely medical services than women. Nonetheless, it will be important to monitor the allocation of scarce resources to ensure that the pressing unmet and ongoing needs of women are fully attended to.

But even if it were free of any concern about scarce resources, the planning and delivery of sexual and reproductive health services for men would not be a simple matter. A consensus of what appropriately should constitute the basic sexual and reproductive health "service set" for men is still in the making, but it seems clear that the bulk of men's needs are for counseling and education—services that both private health insurance and Medicaid traditionally have been unwilling to pay for. And because most reproductive health practitioners have been trained to serve women's medical needs, few professionals exist to address men's counseling needs in these areas. In addition, what might constitute the best settings for the delivery of men's sexual and reproductive health services within today's system of narrow medical specialization is the subject of much active discussion but little agreement.

Despite the obstacles standing in the way of improved sexual and reproductive health services for men, helping men take greater control of their sexual and reproductive lives should be an important national goal. Men with enhanced reproductive education and competency are an essential part of a "virtuous circle" linking their own improved health with that of their partners, wives

and children. Helping more men obtain the sexual and reproductive health information and services they need could help reduce unintended pregnancies and births, just as the introduction of maternal health and family planning programs made it possible for women to better plan their families. The impact on rates of HIV and other STDs could be equally impressive.

But a strong case also can be made for bringing men into the sexual and reproductive health picture in their own right. Men, like women, have a basic right to act on their own behalf, not just for the "the greater good." And, as is the case for women, in the United States and around the world, men are more likely to be responsive to health messages about sex if they believe that these messages reflect their own best interests. They are also more likely to behave responsibly as partners and as parents if they feel that their involvement counts, and that their participation is respected.

Finally, where men—especially adolescent men—have been the focus of pilot programs, their need for education, information, counseling and improved skills in communications and relationship-building has quickly become apparent. So has the realization that effectively serving men often requires frank discussion about sexuality, sexual behaviors and gender roles, communication and negotiation within relationships and the role of the community and peer groups in establishing or undermining positive models of male sexual and reproductive behavior.[9] These insights, though highly challenging for program professionals to respond to, should help them address men's sexual and reproductive health needs more effectively and in a more comprehensive, less purely medical, way.

Most advocates of women's sexual and reproductive health and rights would contend that these are the very perspectives that have been lacking in the highly medicalized approach often taken in addressing women's needs. Some health professionals have made an encouraging first step in the right direction by beginning to acknowledge that men's—and women's—sexual and reproductive behaviors are expressions, and reflections, of many other aspects of their lives, including the legitimate desire for sexual pleasure. This report is intended to support the continued movement of the health care field toward a more holistic and broad-based approach to sexual and reproductive health care. Such an approach should help to improve not just the volume of services available to men, but also the scope and quality of services for women. What increasingly is seen as good for men in their own right should turn out to be just as good for women—to the ultimate benefit of men and women as individuals, couples everywhere, their families and society as a whole.

What increasingly is seen as good for men in their own right should turn out to be just as good for women.

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

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CHAPTER 7: SUMMING UP

1. Number of men: The Alan Guttmacher Institute (AGI), unpublished tabulations of the 1999 Current Population Survey. **Sexual behavior, 15–19:** AGI, unpublished tabulations of the 1995 National Survey of Adolescent Males (NSAM). **Sexual behavior, 20–49:** AGI, unpublished tabulations of the 1992 National Health and Social Life Survey.

2. Condom use, 15–19: AGI, unpublished tabulations of the 1995 NSAM. **Condom use, 20–39:** AGI, unpublished tabulations of the 1991 National Survey of Men. **Condom use, 40–49:** AGI, unpublished tabulations of the 1996 and 1998 General Social Surveys.

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APPENDIX: SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF U.S. MEN, AND RATES OF SEXUALLY TRANSMITTED DISEASES,

	MEN 15–49	*EDUCATION*			*POVERTY STATUS*			*MARITAL STATUS*		*RACE/ETHNICITY*		
State	No. (in 000s), 1999	% of men 25–49 with <high school education, 1999	% of men 25–49 with ≥some college, 1980	% of men 25–49 with ≥some college, 1999	% of men 20–49 at <200% of poverty, 1980	% of men 20–49 at <200% of poverty, 1999	% of women 20–49 at <200% of poverty, 1999	% of men 20–49 currently married, 1980	% of men 20–49 currently married, 1999	% of men 15–49 non-Hispanic white, 1999	% of men 15–49 non-Hispanic black, 1999	% of men 15–49 Hispanic, 1999
U.S. total	68,952	12.6	47.8	54.3	22.7	24.0	29.8	63.7	54.0	75.0	12.1	12.9
Alabama	1,058	13.4	36.0	49.3	32.6	26.1	33.7	67.1	57.5	70.8	27.6	1.6
Alaska	165	7.3	59.7	58.4	21.1	21.6	25.5	58.5	51.7	93.7	4.2	2.0
Arizona	1,181	16.8	59.6	56.3	26.2	32.6	39.7	65.6	50.2	66.0	3.2	30.9
Arkansas	633	12.8	34.3	44.5	33.9	34.7	40.8	71.1	54.4	79.3	18.0	2.7
California	8,825	18.9	60.8	56.8	23.1	29.7	35.1	57.3	51.3	60.6	6.4	33.0
Colorado	1,128	8.5	62.9	64.4	20.0	19.2	22.8	64.5	52.2	80.1	3.6	16.3
Connecticut	767	9.7	53.4	58.6	14.1	17.6	18.9	60.2	54.3	79.0	11.4	9.6
Delaware	189	10.1	45.7	48.5	21.2	17.6	25.0	62.2	51.9	70.1	25.2	4.8
D.C.	139	11.1	52.4	61.1	25.9	25.1	36.0	31.4	23.8	34.2	58.1	7.7
Florida	3,590	13.4	43.2	53.0	29.2	26.8	32.8	60.4	50.3	65.6	14.7	19.7
Georgia	1,983	14.0	43.8	49.1	25.3	21.8	31.0	69.6	53.8	62.2	34.6	3.2
Hawaii	290	9.3	55.3	56.2	19.4	23.9	29.9	57.1	48.5	93.6	2.4	4.0
Idaho	319	13.7	54.7	53.8	30.0	30.4	34.1	75.2	61.7	87.9	0.3	11.8
Illinois	3,123	11.1	51.0	58.1	17.5	18.4	24.5	61.6	53.9	73.5	14.1	12.4
Indiana	1,508	13.5	36.2	45.9	22.3	20.8	23.1	68.6	58.0	91.1	5.9	3.1
Iowa	714	7.7	45.3	53.3	20.1	23.8	29.1	70.3	57.9	95.2	1.9	2.9
Kansas	643	7.9	53.3	63.5	20.4	21.9	31.5	67.3	53.6	87.8	6.3	5.9
Kentucky	990	17.2	38.5	46.0	27.1	24.6	32.3	72.7	61.1	89.9	8.7	1.4
Louisiana	1,043	13.8	40.0	45.9	28.9	28.2	38.2	68.5	54.3	68.3	30.0	1.7
Maine	301	7.0	42.0	47.2	31.8	20.2	28.5	64.6	56.7	99.4	0.2	0.3
Maryland	1,286	12.4	51.8	52.7	15.6	17.3	19.7	60.7	52.2	65.1	30.7	4.2
Massachusetts	1,588	10.5	51.7	57.0	19.3	18.8	23.9	57.6	46.2	88.6	4.5	6.9
Michigan	2,589	8.8	45.8	54.0	17.0	17.9	25.5	63.4	53.8	85.4	11.5	3.1
Minnesota	1,249	4.8	52.6	68.9	20.0	17.5	18.8	62.7	59.4	93.5	3.7	2.8
Mississippi	677	15.8	40.9	48.0	35.2	32.8	38.7	69.6	57.1	62.0	36.7	1.3
Missouri	1,400	10.4	43.9	57.3	25.2	20.2	27.1	65.7	54.0	89.1	9.2	1.7
Montana	232	6.4	51.1	54.9	26.2	34.9	40.9	68.1	54.5	97.7	0.4	1.9
Nebraska	421	7.1	51.7	57.5	21.9	23.6	29.0	69.1	58.0	90.3	4.1	5.6
Nevada	453	13.3	52.1	49.4	20.0	24.1	27.2	60.6	54.3	73.0	5.5	21.5
New Hampshire	318	10.5	53.1	54.5	18.7	16.8	20.3	68.5	57.9	97.3	1.5	1.3
New Jersey	2,042	8.1	47.4	59.4	16.6	16.9	20.4	62.2	53.2	72.2	14.5	13.3
New Mexico	432	15.1	46.8	53.4	36.2	35.6	44.2	69.9	55.7	56.9	1.8	41.3
New York	4,571	13.2	48.0	54.5	22.0	24.9	32.1	58.7	50.6	69.3	14.4	16.3
North Carolina	1,840	14.5	41.2	49.2	28.1	22.3	30.0	66.5	56.3	74.4	21.5	4.1
North Dakota	151	7.1	51.4	62.0	23.5	26.6	34.7	64.1	57.9	99.3	0.2	0.4
Ohio	2,755	7.9	41.2	52.9	18.4	20.9	26.9	66.0	56.9	88.0	10.2	1.8
Oklahoma	790	10.0	50.6	54.0	25.2	28.0	32.5	68.8	60.0	87.3	9.2	3.5
Oregon	868	12.8	56.4	59.5	21.5	27.7	32.7	63.4	56.5	88.0	1.8	10.2
Pennsylvania	2,864	8.4	38.3	48.3	20.2	20.8	26.5	63.5	55.1	88.7	8.8	2.4
Rhode Island	232	12.4	50.9	57.7	17.5	18.1	22.3	63.2	50.2	89.1	4.3	6.6
South Carolina	953	13.5	34.7	49.4	32.4	21.8	33.0	63.9	56.3	72.5	26.0	1.5
South Dakota	188	7.0	41.9	55.7	29.5	28.0	31.6	66.2	52.5	96.8	1.8	1.4
Tennessee	1,349	16.4	36.7	46.6	30.8	27.7	33.5	70.2	58.2	78.9	19.4	1.7
Texas	5,268	17.5	48.1	52.5	25.2	30.6	34.6	67.4	57.2	55.0	12.0	33.1
Utah	552	10.0	66.2	65.0	29.3	22.9	27.9	74.7	63.6	91.1	0.7	8.2
Vermont	155	8.7	42.5	50.3	31.1	22.9	29.2	65.6	54.0	98.9	0.2	0.9
Virginia	1,729	9.2	49.9	58.5	19.1	16.7	23.2	62.3	52.7	76.0	20.7	3.3
Washington	1,469	7.8	59.0	60.0	19.8	20.5	25.4	64.3	55.1	92.2	2.9	4.9
West Virginia	426	16.6	30.5	36.0	31.0	36.0	39.9	69.3	57.0	96.6	3.1	0.4
Wisconsin	1,390	8.0	44.2	56.1	17.1	18.6	23.3	67.7	53.2	91.3	6.0	2.7
Wyoming	123	4.9	55.2	57.7	17.2	26.2	32.5	66.6	57.5	94.1	1.1	4.9

*The Current Population Survey (CPS) measures respondents' health insurance coverage in the previous year. If an individual male had been covered by both Medicaid and private health insurance, he was counted as being covered only by Medicaid.
†Data are based on New York City; no cases were reported elsewhere in the state.

Note: To obtain reasonably large samples for analysis of CPS data, we combined information for three years, 1998–2000, and calculated annual averages, centered on 1999. Similarly, data for 1980 are based on combining surveys conducted in 1979–1981.
Sources: Number of men; education; poverty, marital, immigrant, employment and

VARIOUS YEARS, BY STATE

State	IMMIGRANT STATUS	EMPLOYMENT STATUS		HEALTH INSURANCE STATUS*			HOUSEHOLD HEADSHIP	CHILD SUPPORT	SEXUALLY TRANSMITTED DISEASES		
	% of men 15–49 foreign-born, 1999	% of men 20–49 in labor force, 1999	% of men 20–49 in labor force who are unemployed, 1999	% of men 15–49 with Medicaid, 1999	% of men 15–49 with private/ other insurance, 1999	% of men 15–49 uninsured, 1999	% of house-holds with children younger than 18 headed by father, 1996	% of child support enforcement cases resulting in collection of support, 1996	Chlamydia rate per 100,000 males 10 and older, 1999	Gonorrhea rate per 100,000 males 10 and older, 1999	Syphilis rate per 100,000 males 10 and older, 1999
U.S. total	13.3	90.2	3.4	5.2	71.9	22.8	3.9	20.5	94.7	136.0	2.9
Alabama	3.4	87.8	2.2	5.0	73.5	21.5	4.1	21.3	38.1	258.6	4.8
Alaska	5.1	87.6	5.8	5.3	67.9	26.9	6.4	17.8	133.4	46.2	0.3
Arizona	18.9	91.7	3.9	4.5	63.2	32.3	4.3	13.9	113.2	109.7	6.4
Arkansas	3.9	88.2	5.1	5.1	67.5	27.4	3.3	27.8	101.7	134.6	3.5
California	33.2	89.1	4.5	6.9	63.9	29.3	4.2	17.2	111.7	58.9	1.3
Colorado	10.8	92.7	1.7	3.1	75.3	21.6	5.1	16.7	135.5	63.8	0.1
Connecticut	11.5	88.5	3.5	4.4	78.1	17.6	4.6	17.6	86.2	96.0	0.6
Delaware	5.5	90.3	2.9	5.5	74.8	19.8	5.2	28.3	136.3	207.4	2.5
D.C.	15.3	84.0	7.8	10.8	65.1	24.2	4.0	9.9	129.0	821.9	8.6
Florida	20.7	89.1	2.7	4.0	66.6	29.4	4.2	15.7	74.4	163.7	3.0
Georgia	4.7	91.0	3.0	4.7	71.4	23.9	3.5	20.1	146.9	296.9	7.2
Hawaii	17.5	88.0	5.6	6.6	76.6	16.9	4.3	23.6	97.5	35.3	0.2
Idaho	8.2	93.6	2.7	3.3	72.7	23.9	3.4	24.9	72.7	7.5	0.2
Illinois	14.0	91.6	3.1	3.4	76.7	19.8	3.5	11.8	123.7	196.6	4.1
Indiana	2.6	91.6	2.3	2.7	81.3	16.0	4.3	12.6	80.6	98.8	7.8
Iowa	4.1	94.7	1.9	4.0	82.2	13.9	5.1	20.2	93.4	43.5	0.2
Kansas	6.8	92.3	1.7	4.2	78.4	17.4	5.8	34.1	81.9	84.5	0.5
Kentucky	2.6	89.9	3.4	5.2	72.6	22.2	4.7	16.3	69.5	87.4	2.9
Louisiana	3.1	84.9	4.1	5.7	68.7	25.7	4.5	16.1	161.3	309.0	7.3
Maine	2.0	90.4	3.9	4.5	75.9	19.6	5.8	37.1	37.8	7.1	0.0
Maryland	10.8	90.4	2.4	3.6	76.5	19.9	3.2	22.7	88.0	227.2	7.2
Massachusetts	14.4	88.7	2.9	7.7	74.5	17.7	2.6	30.4	61.3	42.0	0.7
Michigan	6.1	90.4	2.9	6.0	76.8	17.2	4.2	16.1	88.7	170.3	3.2
Minnesota	6.9	93.3	1.8	5.4	81.5	13.1	3.8	41.2	85.1	57.3	0.2
Mississippi	1.4	86.3	4.9	6.6	67.0	26.3	3.0	14.5	109.9	317.2	7.7
Missouri	2.7	91.0	2.9	3.9	80.0	16.1	2.4	21.1	69.9	141.6	1.8
Montana	1.4	89.5	4.7	5.0	68.8	26.2	5.7	24.7	89.6	4.1	0.2
Nebraska	6.6	93.3	2.2	3.4	80.1	16.5	3.3	21.0	87.5	80.8	0.4
Nevada	20.3	94.0	3.6	2.7	68.3	29.0	5.5	22.9	65.9	92.5	0.2
New Hampshire	4.3	91.9	2.1	3.4	78.8	17.8	5.6	36.8	35.5	9.3	0.0
New Jersey	19.1	90.6	4.8	3.2	74.8	22.1	2.7	26.4	32.6	102.2	0.9
New Mexico	7.6	87.9	4.9	7.8	61.1	31.1	4.4	21.9	98.2	52.1	1.1
New York	24.6	87.1	4.6	8.2	65.1	26.7	3.6	16.3	81.6†	105.0†	1.3†
North Carolina	6.1	91.8	2.4	4.0	74.4	21.6	4.6	22.6	92.8	282.5	7.2
North Dakota	1.1	92.6	2.6	3.1	77.7	19.2	4.8	23.8	84.1	11.6	0.0
Ohio	3.4	90.5	3.3	4.1	79.9	16.1	3.8	28.5	103.4	152.2	0.9
Oklahoma	4.0	90.2	3.6	3.1	72.5	24.3	4.0	19.5	89.2	109.0	6.7
Oregon	12.9	92.9	3.2	6.9	71.0	22.1	4.2	19.6	102.7	29.0	0.2
Pennsylvania	4.2	90.4	3.3	6.4	79.0	14.7	3.5	32.7	78.8	102.9	1.0
Rhode Island	12.3	91.5	3.4	6.6	78.9	14.5	3.3	14.8	121.2	48.4	0.4
South Carolina	1.7	91.9	3.1	3.2	77.1	19.7	4.9	26.8	90.8	489.7	8.2
South Dakota	1.1	90.2	1.9	3.4	79.1	17.6	5.8	33.0	95.8	20.7	0.0
Tennessee	2.3	89.6	3.4	13.2	67.4	19.3	3.5	14.2	119.5	244.3	13.7
Texas	16.9	91.2	3.4	3.9	64.7	31.5	3.4	20.1	108.7	163.9	3.0
Utah	8.5	95.1	3.0	2.3	78.2	19.5	2.6	21.0	57.6	14.8	0.2
Vermont	3.4	91.5	1.4	10.7	72.7	16.5	4.7	41.7	24.4	10.3	0.3
Virginia	9.0	91.6	2.1	2.6	77.7	19.7	3.7	23.0	65.6	145.7	2.5
Washington	9.6	91.9	3.1	5.8	74.6	19.6	5.2	33.7	109.0	39.7	2.6
West Virginia	1.2	84.3	5.5	9.5	64.1	26.3	3.7	22.8	26.7	26.0	0.2
Wisconsin	3.4	91.6	2.2	4.6	81.4	14.0	2.8	27.0	125.1	110.1	0.9
Wyoming	1.6	93.5	4.2	4.1	75.1	20.8	5.3	14.1	57.1	7.0	0.0

health insurance status; and race/ethnicity: The Alan Guttmacher Institute, unpublished tabulations of the 1998–2000 CPS. **Household headship and child support:** Bernard SN and Knitzer J, *Map and Track: State Initiatives to Encourage Responsible Fatherhood, 1999 Edition*, New York: National Center for Children in Poverty, 1999, Appendix C, Table 1, p. 197, and Table 6, p. 203. **Sexually transmitted diseases:** Centers for Disease Control and Prevention (CDC), *Sexually Transmitted Disease Surveillance, 1999*, Atlanta: CDC, 2000, Tables 7, 11, 16, 18, 27 and 29.

TABLES

Table 1.1: Men and women experience important sexual and reproductive events at similar ages.

Event	Median age*	
	Men	Women
Spermarche/menarche	14.0	12.6
First intercourse	16.9	17.4
First marriage	26.7	25.1
First birth	28.5	26.0
Intend no more children	33.2	30.9

*Age by which half of men or women have experienced the event. *Sources:* Men: Spermarche: Kulin HE et al., The onset of sperm production in pubertal boys: relationship to gonadotropin excretion, *American Journal of Diseases of Children,* 1989, 143(2):190–193. 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. First birth: Estimated as equivalent to the median for women plus 2.5 years, which is the difference between women's and men's median age at birth in the five years before the interview date, based on women's reports in the 1995 National Survey of Family Growth (NSFG). Intend no more children: AGI, unpublished tabulations of the 1992–1994 National Survey of Families and Households. Women, all events: AGI, unpublished tabulations of the 1995 NSFG.

Table 1.2: American men 15–49 have diverse social and economic characteristics.

Characteristic	% distribution of men 15–49, 1999 (N=68.9 million)
Race/ethnicity	
White	70
Hispanic	13
Black	12
Asian/Pacific Islander	4
Native American	1
Poverty status	
Poor	10
Low-income	16
Moderate-income	25
Better-off	49
Marital status	
Married	46
Separated/divorced/widowed	10
Never-married	44
Total	100

Note: Poverty level is based on the individual's family income and the number of people in the family. Men are classified as poor if their family income is less than 100% of the poverty level ($16,450 for a family of four in 1998), low-income if it is 100–199% of poverty, moderate-income if it is 200–349% of poverty and better-off if it is more than 350% of poverty. *Source:* AGI, unpublished tabulations of the 1999 Current Population Survey.

Table 1.3: In the United States, race/ethnicity and poverty status are closely related.

Poverty	% distribution of men 15–49, by poverty status, 1999				
	White (N=48.3 million)	Hispanic (N=8.8 million)	Black (N=8.4 million)	Asian/ Pacific Islander (N=2.9 million)	Native American (N= 500,000)
Poor	6	20	17	10	16
Low-income	12	30	21	15	21
Moderate-income	25	27	27	24	29
Better-off	57	23	35	51	34
Total	100	100	100	100	100

Source: AGI, unpublished tabulations of the 1999 Current Population Survey.

Table 2.1: Many adolescent men live with only one parent, are both going to school and working, come from poor or low-income families and have no health insurance.

Characteristic	% distribution of men, 1999 (N=10.2 million)
Living arrangements*	
Two parents	66
Mother only	24
Father only	5
Other	5
School/work†	
School only	46
School and work	33
Work only	16
No school or work	5
Poverty status‡	
Poor	15
Low-income	18
Moderate-income	25
Better-off	42
Health insurance coverage‡	
Medicaid	12
Other government	1
Private	67
None	20
Total	100

*Based on 12–17-year-olds; data are for 1998. †Based on 16–19-year-olds. ‡Based on 15–19-year-olds. *Sources:* Living arrangements: Lugaila TA, Marital status and living arrangements: March 1998 (update), *Current Population Reports,* 1998, Series P-20, No. 514, Table 4, pp. 26–30. All other measures: AGI, unpublished tabulations of the 1999 Current Population Survey.

Table 2.2: Most men begin sexual intercourse during their teenage years.

Age	% of men who have had intercourse, 1995			
	All	White	Hispanic	Black
11	1.6	1.1	1.9	6.0
12	3.2	1.9	3.4	10.0
13	6.1	3.4	6.9	18.9
14	13.4	8.5	17.7	34.6
15	22.7	15.6	30.2	53.0
16	36.3	29.3	41.5	67.5
17	52.4	45.6	60.2	80.2
18	66.1	60.0	74.3	89.3
19	78.4	75.5	78.2	92.9

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

Table 2.3: By their late teenage years, just over two in 10 sexually experienced men have had only one partner, and almost three in 10 have had six or more.

Characteristic	% distribution of sexually experienced men 18–19, by number of partners, 1995		
	1	2–5	≥6
All	23	49	28
Poverty status			
Poor/low-income	22	48	30
Moderate-income/ better-off	24	50	26
Race/ethnicity			
White	28	51	21
Hispanic	17	45	38
Black	8	42	50

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

Table 2.4: Most adolescent men and their partners use contraceptives, but their methods change over time.

Timing of intercourse	% of men 15–19, by method used, 1995			
	Condom only	Condom plus other method	Withdrawal	Female methods only*
First†	60	7	2	4
Most recent‡	40	20	2	18

*Pill, implant, injectable, IUD, female sterilization, female condom, spermicide, douche, vaginal film or periodic abstinence. †Based on those who are sexually experienced. ‡Based on those who have had intercourse in the past month. *Note*: When respondents reported using more than one method, they were assigned to only one category, according to the effectiveness of any male method used: vasectomy, condom only, condom plus another method, withdrawal, all female methods. *Source:* AGI, unpublished tabulations of the 1995 National Survey of Adolescent Males.

Table 2.5: Very few teenage men become fathers.

Characteristic	% of men 15–19 who are fathers, 1995
All	2.7
Age	
15–17	0.6
18–19	6.2
Poverty status	
Poor	4.4
Low-income	2.2
Moderate-income	2.3
Better-off	2.9
Race/ethnicity	
White	2.3
Hispanic	3.3
Black	4.4

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

Table 2.6: Seven percent of births and 13% of abortions involve men in their teens.

Age	% distribution of men, by age at conception, 1994	
	Births (N=3.9 million)	Abortions (N=1.4 million)
<18	2	5
18–19	5	8
All other	93	87
Total	100	100

Sources: Numbers and percentage distributions calculated by applying age-specific birthrates and abortion rates for 1994 to the 1994 population of men 15–44. Birthrates and abortion rates: Darroch JE, Landry DJ and Oslak S, Pregnancy rates among U.S. women and their partners in 1994, *Family Planning Perspectives,* 1999, 31(3):122–126 & 136, Table 1. Number of men: Deardorff KE, Hollmann FW and Montgomery P, *U.S. Population Estimates, by Age, Sex, Race, and Hispanic Origin: 1990 to 1994,* Washington, DC: U.S. Bureau of the Census, 1995.

Table 3.1: As men move through their 20s, they are increasingly likely to be married or cohabiting, employed, covered by health insurance and better-off economically.

Characteristic	% distribution of men, 1990s	
	20–24 (N=9.2 million)	25–29 (N=9.1 million)
Union status		
Currently married	18	42
Cohabiting	9	13
Divorced/separated/widowed	3	7
Never-married and not cohabiting	70	38
Employment status		
Currently employed	73	87
Seeking employment	7	5
Not in labor force	20	8
Health insurance coverage		
Private	57	65
Medicaid	5	3
Other government	1	1
None	37	31
Poverty status		
Poor	13	10
Low-income	20	16
Moderate-income	27	26
Better-off	40	48
Total	100	100

Sources: Union status, 20–24: AGI, unpublished tabulations of the 1991 National Survey of Men. Union status, 25–29: AGI, unpublished tabulations of the 1992–1994 National Survey of Families and Households. All other measures: AGI, unpublished tabulations of the 1999 Current Population Survey.

Table 3.2: Union status varies by race and ethnicity, especially in men's late 20s.

Characteristic	% distribution of men, by union status, early 1990s				
	Currently married	Cohabiting	Divorced/ separated/ widowed	Never-married and not cohabiting	Total
All men 20–24	18	9	3	70	100
White	18	10	3	69	100
Hispanic	23	5	4	68	100
Black	12	10	2	76	100
All men 25–29	41	13	7	39	100
White	47	11	7	34	100
Hispanic	28	23	2	47	100
Black	16	16	9	59	100

Sources: Men 20–24: AGI, unpublished tabulations of the 1991 National Survey of Men. Men 25–29: AGI, unpublished tabulations of the 1992–1994 National Survey of Families and Households.

Table 3.3: Two-thirds of all sexually experienced men in their 20s had one partner in the past year, but this proportion varies among subgroups.

Characteristic	% distribution of sexually experienced men 20–29, by number of partners in the past year, 1992				
	0	1	2–5	≥6	Total
All men 20–29	4	65	26	5	100
Age					
20–24	3	56	33	8	100
25–29	5	71	21	3	100
Union status					
Married	1	94	4	1	100
Cohabiting	0	70	25	5	100
Never-married	7	48	37	8	100

Note: The survey included too few divorced, separated or widowed men to permit separate measures for this group. However, they are included in the distributions according to age. *Source:* AGI, unpublished tabulations of the 1992 National Health and Social Life Survey.

Table 3.4: Most sexually active men in their 20s or their partners use contraceptives.

Men's age and method	Among men who had intercourse in the past month, % using various methods, 1991		
	All	Married/ cohabiting	Not in a union
20–24	82	68	91
Vasectomy	0	0	0
Condom only	21	14	26
Condom plus other method	18	8	24
Withdrawal	4	5	3
Female methods only*	39	41	38
25–29	87	84	95
Vasectomy	3	4	0
Condom only	20	17	27
Condom plus other method	14	11	24
Withdrawal	5	5	3
Female methods only*	45	47	41

*Pill, implant, injectable, IUD, female sterilization, female condom, spermicide, douche, vaginal film or periodic abstinence. *Source:* AGI, unpublished tabulations of the 1991 National Survey of Men.

Table 3.5: Forty-nine percent of births and 53% of abortions involve men in their 20s.

Age	% distribution of men, by age at conception, 1994	
	Births (N=3.9 million)	Abortions (N=1.4 million)
20–24	21	29
25–29	28	24
All other	51	47
Total	100	100

Sources: Numbers and percentage distributions calculated by applying age-specific birthrates and abortion rates for 1994 to the 1994 population of men 15–44. Birthrates and abortion rates: Darroch JE, Landry DJ and Oslak S, Pregnancy rates among U.S. women and their partners in 1994, *Family Planning Perspectives*, 1999, 31(3):122–126 & 136, Table 1. Number of men: Deardorff KE, Hollmann FW and Montgomery P, *U.S. Population Estimates, by Age, Sex, Race, and Hispanic Origin: 1990 to 1994*, Washington, DC: U.S. Bureau of the Census, 1995.

Table 3.6: Men who are poor or low-income or have little education are the most likely to have had a child by their late 20s.

Characteristic	% of men 30–34, by age at first child's birth, early 1990s	
	<25	25–29
All men 30–34	26	24
Education		
<high school	53	22
Complete high school	32	21
Some college	22	31
≥college	7	20
Poverty status		
Poor	35	33
Low-income	35	42
Moderate-income	32	23
Better-off	17	19
Race/ethnicity		
White	22	24
Hispanic	40	23
Black	39	24

Note: These data are based on men's actual reporting, which may be understated (see box, page 13). *Source:* AGI, unpublished tabulations of the 1992–1994 National Survey of Families and Households.

Table 4.1: In their 30s and 40s, men are increasingly likely to be married and have at least a moderate income; the vast majority have a job and health insurance.

Characteristic	% distribution of men, 1990s	
	30–39 (N=21.0 million)	40–49 (N=20.5 million)
Union status		
Currently married	65	78
Cohabiting	7	4
Divorced/separated/widowed	9	13
Never-married and not cohabiting	19	5
Poverty status		
Poor	8	7
Low-income	16	12
Moderate-income	27	23
Better-off	49	58
Employment status		
Currently employed	89	88
Seeking employment	3	3
Not in labor force	8	9
Health insurance coverage		
Medicaid	4	4
Other government	1	2
Private	73	78
None	22	16
Total	100	100

Sources: Union status: AGI, unpublished tabulations of the 1992–1994 National Survey of Families and Households. All other measures: AGI, unpublished tabulations of the 1999 Current Population Survey.

Table 4.2: In their 30s and 40s, poor men and black men are the least likely to be married.

Characteristic	% distribution of men, by union status, early 1990s				
	Currently married	Cohabiting	Divorced/ separated/ widowed	Never-married and not cohabiting	Total
All men 30–49	71	6	11	12	100
Race/ethnicity					
Black	52	8	20	20	100
Hispanic	69	10	9	12	100
White	74	5	10	11	100
Poverty status					
Poor	60	13	18	9	100
Low-income	74	8	13	5	100
Moderate-income	76	4	10	10	100
Better-off	77	5	8	10	100

Source: AGI, unpublished tabulations of the 1992–1994 National Survey of Families and Households.

Table 4.3: The great majority of men in their 30s and 40s, except for those not in union, have only one sexual partner in a given year.

Characteristic	% distribution of sexually experienced men, by number of partners in the past year, 1992				
	0	1	2–5	≥6	Total
All men 30–49	4	81	14	1	100
Age					
30–39	3	80	15	2	100
40–49	5	83	12	0	100
Union status					
Married	1	93	6	0	100
Cohabiting	0	86	14	0	100
Divorced/separated/ widowed	19	33	43	5	100
Never-married and not cohabiting	14	43	41	2	100

Source: AGI, unpublished tabulations of the 1992 National Health and Social Life Survey.

Table 4.4: Reliance on vasectomy increases rapidly in men's late 30s, but female methods provide the greater part of overall protection.

Men's age and method	Among men who had intercourse in the past month, % using various methods, 1991		
	All	Married/ cohabiting	Not in a union
30–34	81	80	85
Vasectomy	5	6	2
Condom only	15	12	28
Condom plus other method	7	6	8
Withdrawal	4	5	1
Female sterilization	17	19	11
Other female methods only*	33	32	35
35–39	84	83	91
Vasectomy	20	21	12
Condom only	11	11	17
Condom plus other method	5	4	15
Withdrawal	3	3	3
Female sterilization	24	25	15
Other female methods only*	21	19	29

*Pill, implant, injectable, IUD, female condom, spermicide, douche, vaginal film or periodic abstinence. *Notes:* No national statistics are available on the contraceptive use of men 40 and older. When respondents reported using more than one method, they were assigned to only one category, according to the effectiveness of any male method used: vasectomy, condom only, condom plus another method, withdrawal, all female methods. *Source:* AGI, unpublished tabulations of the 1991 National Survey of Men.

Table 4.5: From men's 30s to their 40s, the proportion with no children drops steeply and the proportion with three or more rises.

Age	% distribution of men, by number of children, early 1990s				
	0	1	2	≥3	Total
30–39	33	19	28	20	100
40–49	15	16	38	31	100

Source: AGI, unpublished tabulations of the 1992–1994 National Survey of Families and Households.

Table 4.6: Forty-four percent of births and 34% of abortions involve men in their 30s and 40s.

Age	% distribution of men, by age at conception, 1994	
	Births (N=3.9 million)	Abortions (N=1.4 million)
30–34	25	15
35–39	14	11
≥40	5	8
All other	56	66
Total	100	100

Sources: Numbers and percentage distributions calculated by applying age-specific birthrates and abortion rates for 1994 to the 1994 population of men 15–44. Birthrates and abortion rates: Darroch JE, Landry DJ and Oslak S, Pregnancy rates among U.S. women and their partners in 1994, *Family Planning Perspectives,* 1999, 31(3):122–126 & 136, Table 1. Number of men: Deardorff KE, Hollmann FW and Montgomery P, *U.S. Population Estimates, by Age, Sex, Race, and Hispanic Origin: 1990 to 1994*, Washington, DC: U.S. Bureau of the Census, 1995.

Table 4.7: Fatherhood may encompass more than a man's biological children.

Age	Mean number of children per man, early 1990s		
	Biological	Adopted, foster and stepchildren	Total
30–34	1.2	0.2	1.4
35–39	1.7	0.4	2.1
40–44	2.0	0.4	2.4
45–49	2.1	0.5	2.6

Source: AGI, unpublished tabulations of the 1992–1994 National Survey of Families and Households.

Table 5.1: Genital herpes is most common among men who are poor or black.

Characteristic	% of men 15–49 with herpes simplex virus type 2, 1988–1994
All	17
Poverty status	
Poor	25
Low-income	17
Moderate-income	18
Better-off	16
Race/ethnicity	
White	15
Mexican American	17
Black	31

Note: The survey oversampled Mexican Americans; therefore, estimates can be made for this subgroup of Hispanic men. Other Hispanic men were included in a residual race/ethnicity category ("other"); therefore, all Hispanics could not be analyzed as a group. *Source:* AGI, unpublished tabulations of the 1988–1994 National Health and Nutrition Examination Surveys.

Table 5.2: Men in their teens and 20s are the most likely to contract chlamydia and gonorrhea.

Age	Rate of new infections per 100,000 men, 1999	
	Chlamydia	Gonorrhea
15–19	344	341
20–24	504	586
25–29	245	352
30–34	108	207
35–39	56	144
40–44	29	98
45–54	13	51

Note: Rates are based on numbers reported to state health departments and suffer from substantial levels of underreporting; however, relative differences by age likely indicate real patterns of variation. *Source:* Division of STD Prevention, Centers for Disease Control and Prevention (CDC), *Sexually Transmitted Disease Surveillance,* 1999, Atlanta: CDC, 2000, pp. 79 and 89.

Table 5.3: Use of the condom is quite high at younger ages but declines as men get older.

Age	% of men who used condoms in the past month, 1990s	
	Condom only	Condom plus other method
15–17	47	20
18–19	35	20
20–24	21	18
25–29	20	14
30–34	15	6
35–39	11	5

Note: For men 15–19, figures are for use at most recent intercourse in the past month. For those 20 and older, figures are for use any time in the past month. *Source:* AGI, unpublished tabulations of the 1995 National Survey of Adolescent Males and 1991 National Survey of Men.

Table 6.1: Testing and treatment for STDs, including HIV, are the primary reasons men seek sexual and reproductive health care.

Type of service	% distribution of annual sexual and reproductive health visits made by men 15–49, 1990s
HIV/other STD services	52
Prostate	18
Family planning	8
Psychosexual/other	22
Total	100

Note: Each year, men 15–49 made an estimated 10.9 million visits to private physicians' offices, hospital outpatient departments, hospital emergency rooms, family planning clinics and STD clinics for sexual and reproductive health services. To give appropriate weight to all services obtained, the denominator of the percentage distribution is all reported sexual health services received. A visit was counted more than once if it involved more than one of these sevices. *Sources:* AGI, unpublished tabulations of the 1996–1998 National Ambulatory Medical Care Surveys and the National Hospital Ambulatory Medical Care Surveys of Emergency and Outpatient Departments; Manzella K and Frost J, Family planning annual report: 1995 summary, part 2: detailed tables and data forms, report submitted to the Office of Population Affairs, Department of Health and Human Services, New York: AGI, 1996; and Landry DJ and Forrest JD, Public health departments providing sexually transmitted disease services, *Family Planning Perspectives,* 1996, 28(6):261–266.

Table 6.2: Older men and black men are the most likely to make sexual and reproductive health visits.

Characteristic	Mean annual number of visits per 100 men, late 1990s
All men 15–49	14.4
Age	
15–19	5.7
20–24	8.4
25–29	12.0
30–34	15.8
35–39	15.8
40–44	19.3
45–49	23.3
Race/ethnicity	
White	13.5
Hispanic	12.3
Black	22.3

Note: Includes visits to private physicians' offices, hospital outpatient departments and hospital emergency rooms. *Sources:* Number of visits: AGI, unpublished tabulations of the 1996–1998 National Ambulatory Medical Care Surveys and the National Hospital Ambulatory Medical Care Surveys of Emergency and Outpatient Departments. Base populations: Hollmann FW et al., *U.S. Population Estimates by Age, Sex, Race and Hispanic Origin: 1990 to 1997,* Washington, DC: U.S. Bureau of the Census, 1998.

Table 6.3: At every age, poor and low-income men are the most likely to be uninsured.

Characteristic	% uninsured, 1999
Age 15–19	
Poor	38
Low-income	33
Moderate-income	18
Better-off	8
Age 20–29	
Poor	59
Low-income	49
Moderate-income	34
Better-off	21
Age 30–39	
Poor	54
Low-income	40
Moderate-income	21
Better-off	10
Age 40–49	
Poor	46
Low-income	36
Moderate-income	20
Better-off	6

Source: AGI, unpublished tabulations of the 1999 Current Population Survey.

Table 7.1: Men's sexual and reproductive health behaviors, and hence their needs, change over the course of their lives.

Age	15–19	20–29	30–39	40–49
No. of men (in millions)	10.2	17.9	20.6	20.2
% of all men who:				
Ever had intercourse	55.2	92.8	97.5	99.8
Had intercourse in past month	29.9	75.1	87.3	87.8
Had ≥2 partners in past year	24.8	28.8	16.6	12.0
Used condom in past month	17.4	27.1	16.3	15.4
Are involved in a pregnancy each year	5.2	14.1	8.6	3.3
Have fathered a child	2.7	30.0	67.0	87.0

Sources: Number of men: AGI, unpublished tabulations of the 1999 Current Population Survey. Sexual behavior, 15–19: AGI, unpublished tabulations of the 1995 National Survey of Adolescent Men (NSAM). Sexual behavior, 20–49: AGI, unpublished tabulations of the 1992 National Health and Social Life Survey. Condom use, 15–19: AGI, unpublished tabulations of the 1995 NSAM. Condom use, 20–39: AGI, unpublished tabulations of the1991 National Survey of Men. Condom use, 40–49: AGI, unpublished tabulations of the 1996 and 1998 General Social Surveys. Pregnancy involvement: Numbers and percentage distributions calculated by applying age-specific birthrates and abortion rates for 1994 to the 1994 population of men 15–44. Birthrates and abortion rates: Darroch JE, Landry DJ and Oslak S, Pregnancy rates among U.S. women and their partners in 1994, *Family Planning Perspectives,* 1999, 31(3):122–126 & 136, Table 1. Number of men: Deardorff KE, Hollmann FW and Montgomery P, U.S. *Population Estimates, by Age, Sex, Race, and Hispanic Origin:* 1990 to 1994, Washington, DC: U.S. Bureau of the Census, 1995. Fathered a child, 15–19: AGI, unpublished tabulations of the 1995 NSAM. Fathered a child, 20–29: weighted average of the proportions for 20–24 and 25–29 from the 1992 Survey of Income and Program Participation. See: Bachu A, *Fertility of American Men,* Working Paper, Washington, DC: Population Division, U.S. Bureau of the Census, 1996, No. 14. Fathered a child, 30–39 and 40–49: AGI, unpublished tabulations of the 1992–1994 National Survey of Families and Households.

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