

Meeting the Sexual and Reproductive Health Needs of Men Worldwide

An overview of international data illustrates that men have sexual and reproductive health-related information and service needs that are similar to those of women. Moreover, both men's and women's needs may best be met through adherence to shared principles: focusing on educational, counseling and skills-building services, rather than on purely medical ones; treating individuals as important, both in their own right and as partners; paying attention to the broader context of social and economic development; and promoting gender equity at the individual and societal levels.

By Adam Sonfield

When Congress passed the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, it made history in several ways. Most importantly, of course, the act for the first time articulates a comprehensive U.S. policy toward the worldwide HIV/AIDS pandemic and calls for a major increase in U.S. spending on global HIV/AIDS activities. Another first for U.S. policy is that it explicitly acknowledges the role of men in empowering women in developing countries: The act calls for programs to be funded “for the purpose of encouraging men to be responsible in their sexual behavior, child rearing, and to respect women.”

This provision reflects a growing awareness of the importance of men's attitudes and behaviors—not only in stemming the HIV/AIDS pandemic, but also in more broadly ensuring positive sexual and reproductive outcomes. Because of men's historic power dominance, much of the attention has been on their capacity to affect (and often harm) the health of women. The 1994 International Conference on Population and Development in Cairo, for example, emphasized the need for men to take greater responsibility for their sexual and reproductive behavior and for their roles as fathers and partners, largely as a means of empowering women. Yet, the HIV/AIDS pandemic has also forced the world to

acknowledge that some of the consequences of sexual behavior can be as severe for men as for women, and that men also have sexual and reproductive needs of their own.

Indicators of Men's Needs

Although men have many similarities in behavior, outcomes and need, statistics about them demonstrate real differences by country and by world region. Unfortunately, these data do not exist for many countries or regions and are limited for many others. The data in this article are drawn primarily from the United States, Sub-Saharan Africa, and Latin America and the Caribbean, where the relevant data are most comprehensive.

Sexual behavior. The age at which the typical man first has sexual intercourse varies substantially across countries, from younger than 16 in Nicaragua to the early 20s or later in Ethiopia and the Philippines. In the United States, the median age of first intercourse is around 17 (see chart, page 10). Whereas only 8% of young Nicaraguan men have not had sex by age 20, this is true of 68% of young Filipino men; in the United States, only 18% of young men have not had sex by that age.

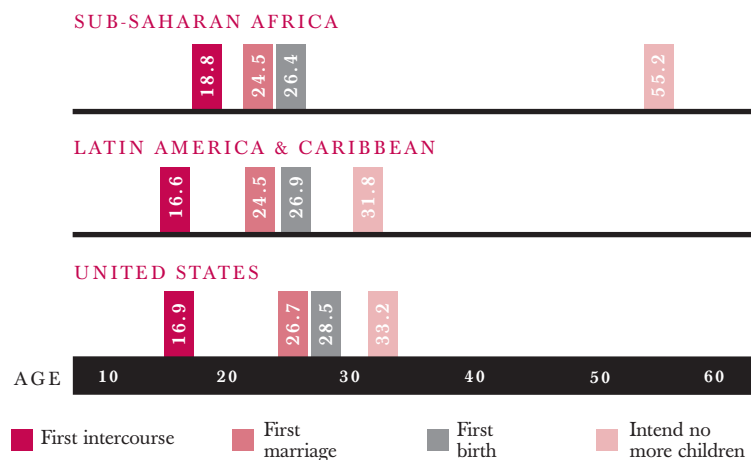
Not surprising, married men worldwide are much less likely than single men to report having multiple sexual partners in a given year—a behavior that puts them and their partners at increased risk of sexually transmitted infections (STIs). Even so, fidelity is far more common in some countries than in others. For example, of men in their late 20s and 30s, 15% of unmarried men in Ethiopia have two or more partners each year, and 7% of married men have at least one extramarital partner; in contrast, those rates are 65% for unmarried men and 36% for married men in the Dominican Republic. In the United States, one in 10 married men reports having an extramarital partner during a year compared with 4–5 in 10 single men who report having multiple partners.

Men worldwide tend to marry women younger than themselves, but this age gap varies from fewer than two years in China to nearly nine in Burkina Faso. In the United States, the typical age difference is 2.7 years. A large age difference between partners—particularly when the woman is an adolescent—can result in major problems at the personal and societal levels. It can affect the balance of power in a relationship and undermine cooperation and communication about decisions relating to contraceptive use and childbearing.

Sexual and reproductive outcomes. The most unambiguously negative outcomes of sex—HIV and other STIs—are particularly widespread in Sub-Saharan Africa and, to a lesser extent, Latin America. Nearly

DIFFERENT LIVES

The median ages at which men reach key stages in their sexual and reproductive lives depend in part on where men live.



Source: The Alan Guttmacher Institute (AGI), *In Their Own Right: Addressing the Sexual and Reproductive Health Needs of Men Worldwide*, New York: AGI, 2003, page 9.

three-quarters of the 42 million HIV-infected individuals worldwide are in Sub-Saharan Africa, where prevalence rates range as high as one in three adults in Zimbabwe. Rates are far lower (less than 1%) in most other countries, although exceptions exist, for instance, in certain Caribbean countries (including 6% in Haiti). Curable STIs also vary by region, although not to the same degree: The prevalence rate for the four major bacterial and parasitic STIs (trichomoniasis, chlamydia, gonorrhea and syphilis) is 119 per 1,000 individuals 15–49 in Sub-Saharan Africa, more than twice as high as in South and Southeast Asia and about six times as high as in North America.

Pregnancies and births, of course, can be regarded as positive or negative outcomes, depending on the preferences of the man and woman. Childbearing is a major motivation for men (and women) to marry, and the facts that men typically marry by their mid-20s and that the vast majority of reproductive-age men are married provide some evidence that men want to have children and to be involved more broadly in reproductive matters. Surveys that directly ask about men's fertility preferences provide more detail. They find that although younger men typically want smaller families than do men of prior generations, regional differences are stark. Men in Sub-Saharan Africa (especially those in rural areas) want many more children (5–8) than do men in Latin America (2–3) or in industrialized countries (1–2), and they continue to want them later in life. Among men in their 40s and early 50s, fewer than four in 10 in Sub-Saharan Africa want no more children, compared with eight in 10 in Latin America.

Partner disagreements over ideal family size are also considerable. In many countries in Sub-Saharan Africa, more than half of couples disagree by at least two children over their ideal family size (with the men typically wanting more children); such disagreement is considerably less common—though still substantial—among couples in Latin America (around one-quarter to one-third of couples). Even so, in most countries, men by their early 50s report having had more children than even they desired—twice as many children as desired in Bangladesh, Egypt and Kenya. While only 4% of married men in Guinea and Mali report that their last child was mistimed or unwanted, this figure is as high as 49% in Peru and is 38% among all U.S. men 25–49.

Use of and need for protection. Using condoms can protect against both STIs and unplanned pregnancy; however, condom use declines with men's increased age, largely because older men are more likely than younger men to be in an established relationship. In the United States, nearly seven in 10 men 15–17 used a condom during recent sex, compared with four in 10 men in their early 20s and two in 10 men in their early 30s. Again, these rates vary: Men in Sub-Saharan Africa are about half as likely as Latin American men in the same age-group to have used a condom the last time they had sex (for example, 15% vs. 35% for men 15–24.)

With some pointed exceptions, the contraceptive use rate for any method is generally lower in Sub-Saharan Africa than in Latin America, and lower in Latin America than in the United States and other industrialized countries. Much of the variation by region and by country can be explained by differences in the desired number and timing of children discussed above, which in turn are related to urbanization and education, particularly in the developing world.

By one rough measure—having had more than one sexual partner during the past year and not having used a condom at last sex—unmet need for STI prevention among men 15–54 is as low as 4% in Burkina Faso and as high as 28% in Mozambique (see chart). In the United States, 12% of men 18–54 have unmet need for STI prevention. Levels of unmet need for contraception (defined as being sexually active, fertile and wanting to delay or avoid having a child, but not relying on a male or female contraceptive method) are substantial in most developing countries, higher than 60% among men 25–54 in Mozambique, Niger and Pakistan.

Even men's knowledge of how to protect themselves varies tremendously. Fewer than one in 20 men in Bangladesh and Turkey are able to name condom use and either abstinence or fidelity as STI preventive strategies, compared with six in 10 men in Uganda and Zimbabwe (where HIV prevalence is extremely high).

Meeting Men's Needs

Other than the specific health care women need because of their unique childbearing capacity, men and women need basically the same things to achieve sexual and reproductive health. Both men and women need the skills, knowledge and mindset—along with the appropriate health care services and supplies—to prevent unintended pregnancies and achieve healthy, intended births. Both need access to STI prevention, screening and treatment services. And as a prerequisite, men and women need to understand their bodies and their sexuality, and those of their partners, and to be psychologically and socially equipped to form healthy, respectful and coercion-free relationships. To be sure, providing services to men poses some special challenges (see box, page 12). Yet, in essence, men and women are best served by the same principles.

A nonmedical focus. Women's reproductive health care has been perceived and organized largely as a medical service because of the medical care deemed necessary for modern contraceptive methods, as well as for pregnancy and childbirth or abortion. This focus has overshadowed the educational, counseling and skills-building services that may be equally important to women's sexual and reproductive health. In regard to men, it is

clear that such services form the bulk of what is really needed (at least until advanced male contraceptive methods are developed), a fact that poses a serious challenge in terms of how men's services might best be provided. Meeting this challenge should also be regarded as an opportunity for reassessing the scope and focus of women's services.

Respecting the individual. For most of history, women have been treated as instruments in achieving the fertility goals of fathers, husbands and governments. Only in relatively recent years have the countries of the world reached a consensus—articulated formally at the 1994 conference in Cairo—around an individual-centered perspective. This new paradigm, which eschews macrodemographic targets, expects government officials and health care providers to concentrate first and foremost on women's own goals and needs. The Cairo Program of Action recognizes that approaching women in this way is justified both on its own terms and as the most effective way to reach the broader societal goals of population stabilization and economic development.

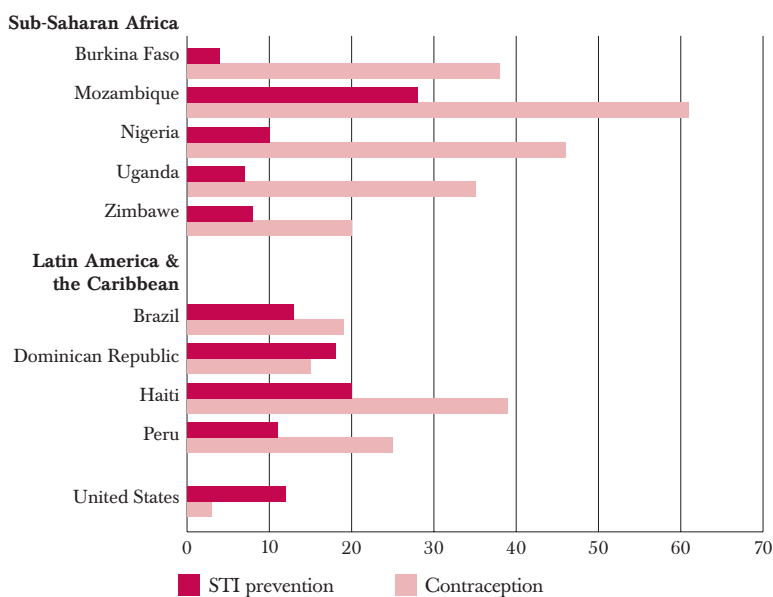
This perspective ought not be lost when seeking greater male involvement in sexual and reproductive health. If treated with respect and as important—not just as partners and fathers, but also in their own right—men will come to understand what they and their families will gain from changing their attitudes and behaviors, from communicating and negotiating with their partners and from being more aware of their own needs.

Promoting broader development. A third common principle for meeting men's and women's needs is paying attention to the broader context that frames their behavior and encouraging economic and social development. Part of this is practical: In many countries, significant infrastructure advancements must be made, so that supplies, personnel and information can get where they are needed. Beyond that, however, is an understanding that was articulated at the Cairo conference, which called for family planning to be integrated into a holistic, development-based approach to women's well-being.

This approach may be just as important for men. Beneath the raw data about changing patterns of sexual behavior and its consequences are broader trends. Poverty, lack of job opportunities and low expected life expectancy (especially in Sub-Saharan Africa) can undermine men's ability and desire to take responsibility for their future and the future of their partners and families. Increased urbanization and migration are tied to smaller families and increased access to services, but often also to weakened ties with men's families and communities and to increased opportunities and desire for extramarital sex. Increased education has been con-

TANGIBLE NEEDS

The proportion of men who have unmet needs for STI prevention or contraception varies considerably across countries.



Notes: Unmet need for STI prevention refers to the proportion of men 15–54 (18–54 for the United States) who had at least two partners in the past year and did not use a condom at last sex. Unmet need for contraception refers to the proportion of men 25–54 (20–39 for the United States) who are sexually active and fecund, and want to delay or avoid having children (who want no more children for the United States) but are not relying on a male or female contraceptive method. *Source:* AGI, *In Their Own Right*, page 67.

Practical Challenges to Providing Services to Men

The programmers and providers of sexual and reproductive health services for men have spent a decade since the Cairo conference learning from large- and small-scale experiments. The challenges they have encountered have been well explored in a number of conferences and reports.

Some of these challenges are logistical, such as when to provide services to men through separate facilities and by male personnel; how to make men feel comfortable at existing facilities that were designed for women; and when counseling services should be provided to individuals, to couples or in groups. Providers may also face ethical challenges, such as ensuring the privacy and autonomy of women when providing services to their male partners. Other challenges involve training—not only to understand men’s needs and the needs of specific groups, but also to counter some providers’ biases toward, misperceptions about and inexperience with men. A broad set of questions revolves around providing services and information outside of the traditional clinical setting, through men’s communities, workplaces and social gatherings and from sources, such as clergymen, community leaders and peers, who men may relate to best. As a rule, overcoming these challenges requires understanding and adapting to local customs and norms.

Other challenges stem directly from these customs and norms, and from formal societal structures. Secondary school attendance is uncommon in many developing countries, and as sex education is rarely taught in elementary school, few men (and women) ever receive sex education. Even in the United States, sex education is controversial and often limited in scope. In most developing countries, health care availability is severely limited. Even in those countries where it is not and where health insurance is common, access to and coverage of educational and skills-building services is far more rare. Men in many cultures resist using medical services, even if they are available and affordable.

Funding challenges underlie and intertwine with all of these other issues. Limited resources are a factor in prioritizing among services and among groups of men, when considering the settings and sources through which to provide services and information, and in evaluating and expanding the numerous pilot programs that have been at the center of efforts around men’s reproductive health. Raising additional money—both locally and abroad, from governments, companies, foundations and individuals—is vital. Moreover, this money must be raised without detracting from potentially competing interests, including the needs of women and children.

nected with older age at marriage, increased contraceptive use and greater knowledge of sexual and reproductive health, but also with increased and earlier nonmarital sex in many countries. Promoting the positive outcomes of continuing development while mitigating its potential negative fallout is a challenge that reaches through the entirety of sexual and reproductive health and rights, and far beyond.

Striving for gender equity. As the Cairo consensus and subsequent initiatives have stressed, a concern for gender equity is key to changes at the personal and societal levels. The male involvement provision of the 2003 HIV/AIDS law is an important expression of this concern.

There is no question that traditional norms about gender roles have led to persistent discrimination and violence against women and to customs, such as early marriage for adolescent girls and forced polygamy, that place women in subordinate roles and inhibit equitable partnerships. These norms have also led to—or, perhaps, resulted from—pressures, stereotypes and expectations about “masculine” behavior that are as destructive to men as they are to their families. Gender equity implies a world in which men and women are respectful of each other and seek true partnerships. At the individ-

ual level, this can be achieved through information, education and counseling to change behavior and beliefs, especially among the young, through messages targeted on culture, age, education and receptiveness. At the community and societal levels, advocacy and communication activities can help create a cultural and political environment that is more supportive of equal rights, individual change and open debate.

An important first step in all of this is raising awareness of and interest in men’s sexual and reproductive health among policymakers, opinion-shapers, donors, clinical and educational providers, and the general public. Policymakers and donors, especially, must be convinced to adopt a longer-term perspective, accepting that cultural change is a slow process. And they must be shown that investments in men’s sexual and reproductive health, just as in women’s, will spur broader social and economic development, improving the future capability of societies to achieve their goals. ☉

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