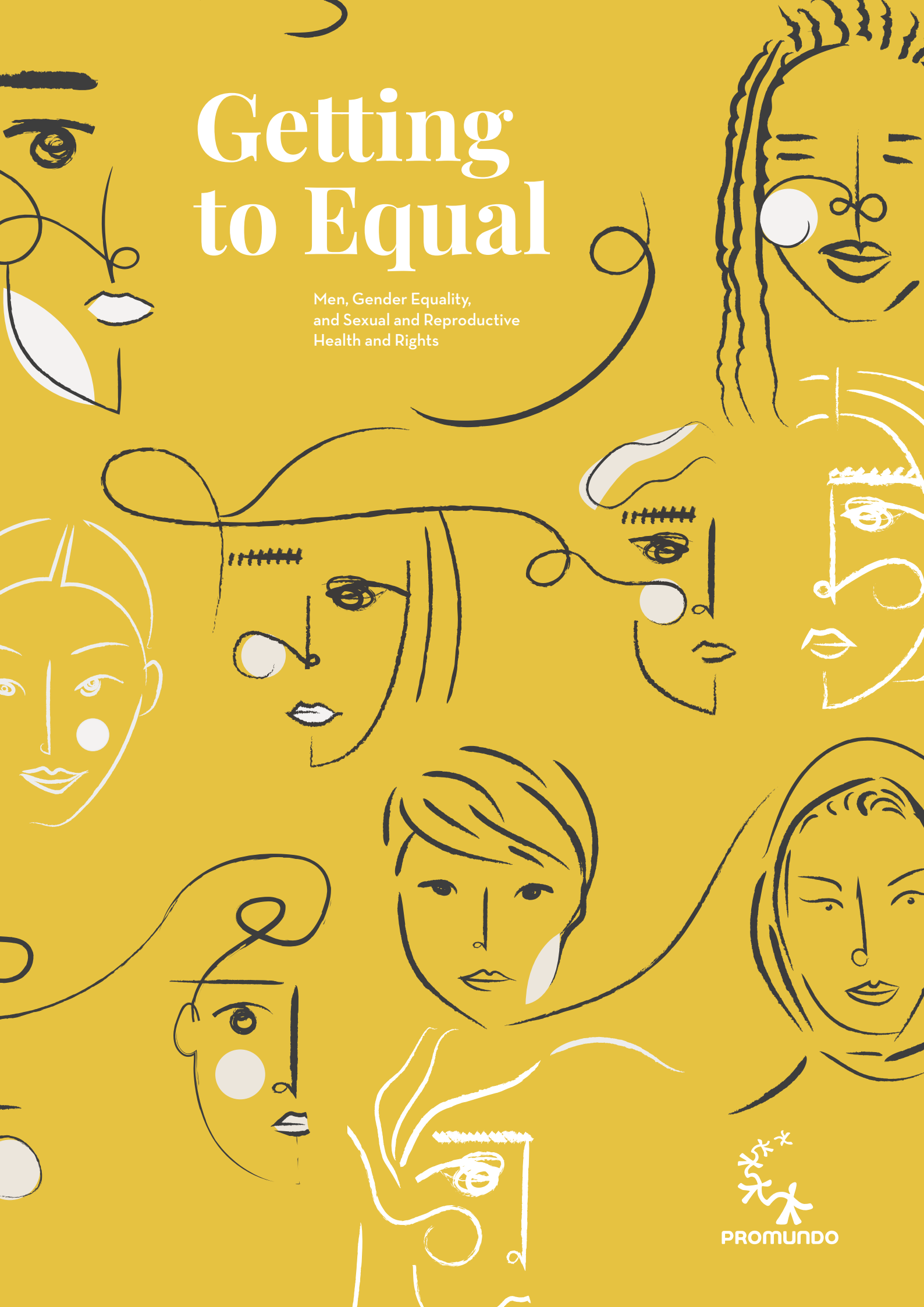


Getting to Equal

Men, Gender Equality,
and Sexual and Reproductive
Health and Rights



PROMUNDO

**Getting to Equal:
Men, Gender Equality,
and Sexual and
Reproductive Health
and Rights**

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The *Getting to Equal* Global Initiative

Promundo's *Getting to Equal* initiative aims to shift the global discourse on men and sexual and reproductive health and rights (SRHR) among practitioners, funders, academics, policymakers, and providers toward a more holistic, gendered, and relational understanding of SRHR, as well as toward ways to achieve global goals of health and gender equality, including universal access to family planning, by 2030. Components of the initiative include:

1. ***Global Evidence and Action on Men, Gender Equality, and Sexual and Reproductive Health and Rights.*** A comprehensive review of the global data that takes a deep dive on the challenges, reframes the problem, and proposes concrete actions that build on the existing evidence base (this report).
2. ***Strengthening National Responses: A Review of Family Planning Costed Implementation Plans.*** A detailed analysis of the extent to which national plans of organizations in FP2020 incorporate a focus on engaging men and transforming gender norms; provides recommendations for strengthening country responses (forthcoming, with FP2020).
3. ***Engaging Men and Boys in SRHR and Gender Equality: A Call to Action.*** A call to action document that diagnoses the problem, provides guiding principles, and highlights the key areas that require attention to strengthen the global and national focus on men, gender equality, and SRHR; produced with input from an expert consultation meeting in Washington, DC, and in partnership with Family Planning 2020. (Available online at: promundoglobal.org/getting-to-equal-call-to-action).

Foreword

Gary Barker - President and CEO, Promundo-US

Margaret Greene - Senior Advisor for Gender and Health, Promundo-US

Men's limited participation in sexual and reproductive health and rights doesn't fall out of the sky. It is the result of gender inequalities, of historical divisions related to who does what in the home, of patriarchal control over women's bodies, and of our deep discomfort in talking to our sons and daughters about sexuality. This report is part of Promundo's effort to change this: bringing men in as full partners in sexual and reproductive health and rights, and starting early with daughters and sons using comprehensive, gender-transformative sexuality education. This cause requires us to walk the talk. You would have to ask our son and daughter if we have succeeded, but we affirm that open discussions of sexuality, gender, and intimacy have been key aspects of how we have raised them.

Gary: My daughter had the support from my partner and me to know and believe she could talk about and ask about sexuality from an early age. We had age-appropriate material for her (*It's Perfectly Normal* was the early favorite) that was sitting on the coffee table along with art books, newspapers, and the novels we would read. In her many visits to the Promundo office, she also saw our many open materials on safe sex, condom use, and HIV prevention. When she started middle school in the United States (after having spent her early years in a very progressive school in Rio de Janeiro, Brazil), she immediately perceived the squeamishness in talking about sexuality. Without planning it, our dining room became a safe space for her friends – boys and girls – to feel open in talking about their lives and crushes and all that comes with that. Our daughter was always keenly aware of how different that was compared to school and compared to other families.

Meg: We have always responded to our son's questions about gender and sexuality very directly. Confident that more questions would always be coming soon, my partner and I never felt the need to deliver "the talk" and have had dozens of discussions about physical changes, sexual orientation, girls and boys, gender justice, relationships, health, and contraception. In our house, the books on offer started with *It's Not the Stork!* and eventually shifted to *It's Perfectly Normal* and *Changing Bodies, Changing Lives*. When asked if he had anything to say about sexuality education for this report, our son laughed and said, "There is nothing I wish I'd known because you've provided me with so much information!" We feel real satisfaction at having established this norm of openness in our household. We know that sometimes our answers to questions are being shared with friends whose parents are less comfortable talking about these things.

Both: This report highlights the need to work with young people – especially boys and young men – on sexual and reproductive health and rights. Boys' and men's sexuality and reproduction are absolutely central to their entire lives, but you'd never know it from looking at the information provided to them, the services that are offered, and the data that are collected on their experiences. Social norms and expectations and institutional priorities highlight the importance of sexual and reproductive health and rights to girls and women, and including boys and men can only enhance health and well-being for all. Boys are interested, eager, and open – we need to work with that openness to craft a world where their caring and commitment are cultivated and improve *everyone's* well-being.

Table of Contents

| | |
|--|-----|
| Acronyms | 9 |
| Glossary | 10 |
| Introduction: Why Should Men Care About Sexual and Reproductive Health and Rights? | 12 |
| Men's Bodies: Knowledge, Health, and Identity | 20 |
| Men's Relationships: Intimate Partnerships, Health, and Rights | 42 |
| Men's Reproduction: Motivations and Intentions | 76 |
| Men's Lives: Reframing SRHR and What it Means to Men | 94 |
| Men and SRHR: Services and Policies | 100 |
| Conclusion | 108 |
| Priority Action Areas to Advance Men's Engagement in SRHR | 112 |

Acronyms

| | |
|-----------------|--|
| aOR | Adjusted odds ratio |
| CI | Confidence interval |
| CSE | Comprehensive sexuality education |
| DALYs | Disability-adjusted life years |
| DHS | Demographic and Health Survey |
| FP | Family planning |
| FP2020 | Family Planning 2020 |
| IMAGES | International Men and Gender Equality Survey |
| IUD | Intrauterine device |
| LGBTQIA+ | Lesbian, gay, bisexual, transgender, queer/ questioning, intersex, agender/asexual+ |
| MSM | Men who have sex with men |
| S.D. | Standard Deviation |
| SDGs | Sustainable Development Goals |
| SRHR | Sexual and reproductive health and rights |
| STI | Sexually transmitted infection |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organization |

Glossary

CISGENDER: Individuals who agree and feel aligned with the sex they were assigned at birth, or whose gender identity match the sex they were assigned at birth.

GENDER: Entitlements associated with being male, female, or nonbinary in a given setting, along with the power relations between and among women and men, boys and girls, and all individuals. These vary across cultures and over time and often intersect with other factors such as race, class, age, and sexual orientation.

GENDER-BASED VIOLENCE: Violence perpetrated against someone because of their gender.

GENDER EQUALITY: The concept that all human beings, regardless of their sex or gender identity have equal rights and access to opportunities and resources, and are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or discrimination.

GENDER EQUITY: The process of being fair to individuals of all gender identities. To ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent individuals from operating on a level playing field.

GENDER IDENTITY: A person's internal psychological sense of being male or female, neither, or both. One's gender identity can be the same as or different from one's sex assigned at birth.

GENDER MINORITY: A group whose gender identity and/or expression differ from the majority of the surrounding society. Can also refer to transgender, genderqueer (including third gender), or nonbinary identities.

GENDER NORMS: The often-unspoken social rules that govern the attributes and behaviors that are valued and considered acceptable for individuals of a particular gender within a given culture or social group. Norms are learned and reinforced from childhood to adulthood through observation, instruction, positive and negative sanctioning, the media, religion, and other social institutions.

GENDER-RELATIONAL: An approach that acknowledges that gender roles, norms, and characteristics for a particular gender identity are defined in relation to those for other gender identities.

GENDER ROLES: Attitudes and behaviors considered acceptable and expected from people according to their actual or perceived gender identity.

GENDER-TRANSFORMATIVE: Activities or interventions that seek to transform harmful gender norms and promote equitable relationships.

HARMFUL MASCULINE NORMS: Expectations of how masculinity should be embodied or expressed that have widespread negative impacts; linked to concept of *toxic masculinity*.

HEGEMONIC MASCULINITY: The “highest” or most socially valued form of masculinity or “real” manhood that perpetuates and legitimizes the dominance of men, and the subordination of women and other gender identities (as well as men who practice other types of masculinity); also called *dominant masculinity*.

HOMOPHOBIA: Dislike, fear of, or prejudice against persons attracted to the same sex and/or gender.

MASCULINITIES: The idea that there is no single, fixed definition of what it means to be a man or what it means to be masculine.

NONBINARY: A term describing a person who does not identify exclusively as a man or a woman, identifying rather as being both a man and a woman, somewhere in between, or as falling completely outside these categories.

PATRIARCHY: A system in which men and boys and/or the masculine dominate and are valued more than women and girls and/or the feminine (i.e., male-led/male-dominant).

POWER DYNAMICS: The ways in which power is distributed, usually unequally, giving some groups more power than others.

SEXUAL AGENCY: The ability to define, choose, pursue, and act (or not act) on sexual desires.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: Human rights related to sexuality and reproduction.

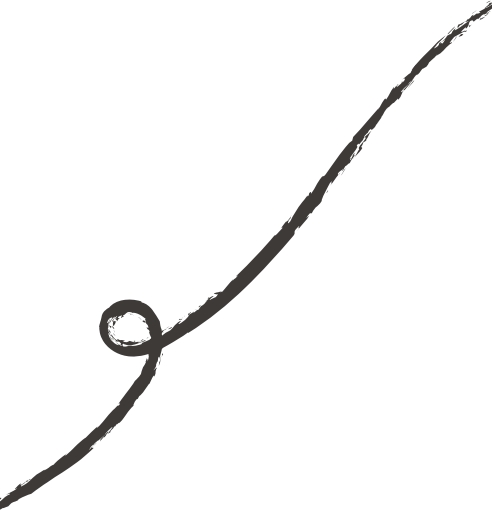
SEXUALITY: One’s expression of or ability to have sexual feelings, which may include sexual orientation as well as sexual fantasies, attitudes, and values related to sex.

These definitions are drawn and adapted from a dictionary of terms gathered by Promundo-US and from the Lancet series on gender inequality, social norms, and health available [here](#).



Introduction:

Why Should Men Care About Sexual and Reproductive Health and Rights?



What would people's sexual and reproductive lives look like if people in all their gender and other diversities equally enjoyed knowledge, skills, self-esteem, and access to services; conducted their relationships with respect for their partners and their rights; avoided or embraced parenthood with intention and planning; and made decisions that took into account the impact of their choices throughout their lives and the lives of their partners and children? What would it look like if national laws everywhere prohibited discrimination, proactively advanced human rights, and ensured that everyone enjoyed their full right to health, as enshrined in international laws and global and regional declarations?

This is the positive vision that motivates Promundo's *Getting to Equal* initiative.

The world is far from achieving this vision. In many parts of the world, discriminatory laws and policies restrict access to vital services and reinforce stigma toward marginalized and socially excluded communities, including migrants and people on the move, LGBTQIA+ communities, communities of color in the Global North, sex workers, intravenous drug users, inmates, and people held in detention facilities. In still other parts of the world, health policies take a narrow view of gender, fail to recognize the relational nature of many women's and men's lives, and pay insufficient attention to men's health or to the impact men's poor health has on those who care for them at home and in the public sector.

In most of the world, gender inequality intersects with widespread reticence about sexuality in ways that reverberate throughout people's lives. The harms to women's health and well-being are well documented. However, comparatively little is known about how this works for men, and even less has been done to engage men positively as full and equal partners. The strong emphasis on women's sexual and reproductive roles is mirrored by an emphasis on men's productive roles and a lack of attention by the health sector to men's sexual and reproductive lives. The large gaps in collective knowledge reflect a worldview that does not treat men's sexual and reproductive health and rights (SRHR) as central to their lives or to the lives and well-being of others.

This report attempts to shift global discourse on men and SRHR among practitioners, funders, academics, and policymakers toward a more holistic, gendered, and relational understanding of SRHR and how to achieve global goals of health and gender equality. Building on men's important roles in SRHR could contribute to the broader achievement of these rights and the health and development outcomes related to them. Men's SRHR is important for men, certainly, and the benefits to their partners and children are enormous.

The arguments and focus of this report are global, even though data in specific areas emerge from low- and middle-income countries in some instances and industrialized countries in others. The report attempts to fill some of the gaps in knowledge and understanding of men and their roles in SRHR. It interprets the findings in light of gender inequality and restrictive gender norms, and it makes recommendations for how the SRHR field could contribute more fully to achieving gender equality.

The report showcases cutting-edge evidence and new analyses of relevant data to address the following research questions:

1. What are global trends and patterns related to men and SRHR, and where are there gaps in knowledge on men's and boys' SRHR attitudes and behaviors?
2. How are attitudes and norms related to gender, femininity, and masculinity associated with people's SRH behavior, communication with sexual partners, and decision-making?
3. What are the barriers and challenges to advancing work on men and SRHR at the individual, community, national, and regional levels?
4. What are the global obligations for United Nations member states to take action to engage men in SRHR, including to advance gender equality, and what progress has been achieved in this regard?

One basic premise of this comprehensive report – that men matter to sexual and reproductive health and rights – is not new. We know men can make important contributions to SRHR for all and there is much to do to realize that potential. What is new in this report is a second premise, one that may get the field further: that SRHR profoundly impacts men. Mobilizing the indisputable global evidence on SRHR's fundamental impact on men's well-being, relationships, schooling, work, economic success, mental health, and living arrangements offers the field the opportunity to reframe the issues fundamentally. It is time for a big change.

New also is the global context into which this report is being launched: the backdrop of the Sustainable Development Goals (SDGs), including universal health coverage. To achieve national health goals, universal health coverage (SDG 3, Target 3.8, to which all United Nations member states committed in 2015), and gender equality and empowerment (under SDG 5), the world must understand and address the ways gender inequalities and restrictive gender norms impact health and well-being. Global attention to the routine sexual harassment and abuse of women, as well as on the violence and stigma associated with identity as a sexual or gender minority, has sharpened the focus on gender inequalities and restrictive gender norms.

Three principles of the SDGs are reflected in this report: first, **universality**, recognizing that people face related challenges in virtually every setting in the world, poor and rich countries, even if those challenges differ in degree of intensity; second, **synergy**, recognizing that every investment in health and well-being should be prioritized with regard to its contributions to improving outcomes in a variety of areas; and third, the emphasis on **leaving no one behind**, recognizing that while the national averages of the Millennium Development Goals concealed many areas of deep social injustice, the SDGs move decisively toward a focus on the intersectional realities and intersecting disadvantages of people's lives.

Gender equality is recognized as a global priority in its own right as an SDG (SDG 5). The SDG website observes, "In 51 countries with data on the subject, only 57

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percent of women aged 15 to 49, married or in union, make their own decisions about sexual relations and the use of contraceptives and health services,”¹ yet the contributions that men could make to gender equality and SRHR do not feature in most statements and strategies for fulfilling these goals. What does the UN Political Declaration on Universal Health Coverage say on men and health? Almost nothing, as it turns out.²

Conceptual Framework for This Research

The report is framed around analyses of men’s experiences of their own bodies, their sexual relationships, and whether and how they reproduce, including how these three areas shape their lives (Figure 1). As they grow into and experience their bodies and their sexuality, decide whether and what kind of sexual relationships to enter, and whether and when to have children, and how many, they are influenced by positive factors, such as an enabling environment that might include gender equality education, quality services, parental leave, and research that describes their lives and supports best practices. Their experience is also shaped by negative factors, including shame and stigma regarding talking about sexuality, pornography, and gender inequality and restrictive gender norms.

Figure 1. Framework for conceptualizing the impact of SRHR on men’s lives



Norms related to sexuality and to gender, including masculinity, influence boys' and men's attitudes, knowledge, skills, SRH behavior, and ultimately, SRH outcomes for themselves and for their partners. Men's experiences of their bodies, relationships, and lives shape other outcomes, including their mental health, schooling, economic roles, caregiving opportunities, and living arrangements.

Current Debates Around Men and SRHR

Wait! Why Are We Even Talking About This?

Sexual and reproductive health needs continue to be an urgent global public health issue, a threat to the health of women, men, and individuals of all gender identities and expressions, and sexual orientations, worldwide. Men's limited HIV testing in many settings, men's use of violence against women, unintended pregnancies (which are as much about men's lack of contraceptive use as women's), male policymakers controlling women's access to abortion – all involve men.

- SRH issues, including sexually transmitted infections (STIs), HIV and AIDS, family planning, menstrual hygiene, and maternity-related morbidity, represent 14 percent of the global burden of disease, a proportion that has remained largely unchanged since 1990.³
- Globally, the lifetime prevalence of intimate partner violence among women who have ever been in partnerships is 30 percent.⁴ A systematic review of sexual violence against LGBTQIA+ individuals in the United States found prevalence estimates ranging from 16 to 85 percent for lesbian and bisexual women and 12 to 54 percent for gay and bisexual men.⁵
- The consequences of early, mistimed, and unwanted pregnancies ripple through women's and men's lives with lasting effects. Globally, 85 million (or 40 percent) of all pregnancies were estimated to be unintended in 2012.⁶ Of these, 13 percent ended in miscarriage, 50 percent in induced abortion, and 38 percent in unplanned births.
- The estimated annual incidence of non-HIV STIs increased by nearly 50 percent between 1995 and 2008,⁷ and global prevalence and incidence of chlamydia, gonorrhea, trichomoniasis, and syphilis remain high among adult men and women, with nearly 1 million new cases acquired each day.⁸

These challenges reflect the failure of the SRH field to devote resources, policies, and attention to men. The world is missing out on chances to improve health and promote gender equality as long as men's central roles in SRHR are not recognized.

Sexual and reproductive health needs continue to be an urgent global public health issue, a threat to the health of women, men, and individuals of all gender identities and expressions, and sexual orientations, worldwide.



Box 1

Gender Justice and SRHR

Gender norms reflect a social hierarchy wherein that which is male or masculine is viewed as superior to that which is female or feminine, with power distributed accordingly. People who are perceived as ambiguously located with regard to gender identity categories or gender-related norms also find themselves discriminated against or stigmatized.⁹ Other hierarchies are also at work in how gender is experienced across the life course: a person's status varies by age, race, socioeconomic status, sexual identity or expression, and other features. These important structural inequalities shape individual health, and require a response from health systems and the development field.

This report builds on existing definitions of sexual and reproductive health and rights emerging from the World Health Organization,¹⁰ with its emphasis on well-being, positive approach to sexuality, pleasure, freedom from violence; and the 2018 [Guttmacher-Lancet Commission on Sexual and Reproductive Rights](#) report, which provides an integrated definition of SRHR:

“Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to:

- Have their bodily integrity, privacy, and personal autonomy respected
- Freely define their own sexuality, including sexual orientation and gender identity and expression
- Decide whether and when to be sexually active
- Choose their sexual partners
- Have safe and pleasurable sexual experiences
- Decide whether, when, and whom to marry
- Decide whether, when, and by what means to have a child or children, and how many children to have
- Have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.”¹¹

Among the top recommendations the Commission lays out for achieving SRHR is to “engage men to support women's health, rights and autonomy and address the SRHR needs of men.” This report takes the challenge forward.

Addressing inequitable gender power dynamics is increasingly recognized as core to achieving progress in SRHR.¹² Global frameworks have typically failed to address the roles played by inequitable gender dynamics and masculinities in perpetuating poor SRH outcomes. Promoting gender-equitable norms in men and adolescent boys' SRH gives them the tools to take responsibility; care for themselves and protect their health; respect, encourage, and support their partners and others in their lives; care for children and family members; and support the SRHR and choices of all.

Research has demonstrated the pathways through which gender inequality and restrictive gender norms influence health outcomes.¹³ These pathways include differences in exposure to ill health as a consequence of work or other roles (e.g., coal miners' (usually men) exposure to injury and silicosis, or homemakers' (usually women) exposure to indoor air pollution from cooking fires); differences in gendered health behaviors, such as sexual risk-taking by men or a reluctance to discuss sex-related topics among women; gendered differences in access to care; gender-biased health systems that serve some people in specific areas while neglecting other groups in other areas (e.g., the neglect of men's reproductive health and women's occupational health); and gender-biased health research, institutions, and data collection.



A key tension in this work is to maintain a focus on women while expanding the work to reflect a fuller perspective on men in SRHR. The modest portion of the world's vast financial resources set aside for sexual and reproductive health in domestic budgets and international development aid rightly prioritizes the needs of women and girls. However, the inherently relational aspects and power dynamics of SRHR (mostly men's power over women in sexual decision-making) are often neglected. The SRHR and gender equality agendas are both advanced by gender-transformative programs and policies that reinforce the gains in girls' and women's – and boys' and men's – access by respecting, protecting, and fulfilling their rights; empowering and supporting women; and ensuring that men and boys are informed, respectful, mutualistic, and use services themselves. Taking up men's SRHR is fundamental to the gender equality agenda. Deep change is needed in how the world thinks about men and SRHR.

Another key tension is the continued focus on user uptake numbers while the field misses out on addressing gender norms and transformation. An approach to SRHR built on statistics alone is inadequate; rather, deep social transformation is required, and the gains from that transformation will go far beyond improved uptake of reproductive health services.

This *Getting to Equal* report provides a comprehensive review of the global data, takes a deep dive on the challenges, reframes the problem, and proposes concrete ways forward, building on the existing evidence. It is guided by three principles:

- **Engaging men needs to be accompanied by a sustained focus on women's rights and choice.** All work must unequivocally take a human rights-based approach, incorporating sexual and reproductive rights and upholding women's rights and autonomy – including women's right to choose if and how their partners are included in their SRH decisions and services. This framing affirms and complements efforts to improve SRHR for women around the world.
- **Changing ideas about manhood and gender relations calls for gender-transformative programs and policies.** Rigid masculine norms around self-sufficiency and dominance impede men from positive health-seeking behaviors, with consequences for them and their partners. Interventions should routinely provide opportunities to reflect on and challenge gender inequality and restrictive gender norms, as well as to practice healthy, caring behaviors, including their more equitable participation in unpaid care work. These norms also shape women's behaviors and interactions, such that gender-transformative and gender-synchronized (that is, coordinated across different gendered groups) intervention approaches need to target everyone.
- **Work with men should reflect that men are diverse and that men and ideas about manhood evolve over time.** The diverse contexts and masculinities of men around the world and across the life course shape their experiences of sexuality, relationships, marriage, childbearing, parenting, caregiving, and use of SRH services. Approaches must be adapted to the local realities and needs of men, their partners, and families, and they must involve men meaningfully in their design and evaluation. The framing of these interventions should address differential access and stigma to include individuals of diverse sexual orientations and gender identities and expressions, as well as men of diverse racial and ethnic backgrounds.¹⁴

This report emphasizes the central role of SRHR in the lives of men and demonstrates that they – and those around them – miss out when they fail to, or are unable to, manage their SRHR with information, skills, and compassion. The rewards to be reaped from men’s more supportive and active role as “SRHR citizens” are very substantial and could improve the health and lives of everyone.¹⁵

Organization of This Report

This report is organized around a bodies–relationships–reproduction–lives framing: **bodies** for talking about what men know and how they think and feel about their own sexuality and their bodies; **relationships** for talking about how men’s sexual relationships are formed and play out in their engagement with peers, partners, and others; **reproduction** for discussing whether and when men have children, and how involved in raising and caring for these children they are; and **lives** for documenting the lasting impact of men’s experience of SRHR, their ability to protect their health and that of their partners, and their ability to plan their childbearing and how these impact their living arrangements, educational and employment prospects, and prospects for life satisfaction.

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Men's Bodies: Knowledge, Health, and Identity

It is a problem: Men and boys don't see SRHR as "their" issue and as central to their lives. Often, this is framed as a problem of individual "derelict" men when the fact is that patriarchal values in most places in the world contribute to shaping men's sexuality and relationships. Women's bodies and reproductive functions remain subject to spousal control, public comment, and policy regulation even as men retain control over these areas. The burden of responsibility for addressing SRHR challenges tends to sit with women, but the locus of power and control often does not. This requires conducting advocacy with men, from family members to community leaders to service providers to policymakers, and holding them accountable while also working to shift power dynamics. All must, therefore, be part of the solution and the change.

Men's limited engagement with SRHR reflects traditional premises and practices within SRHR. Parents, schools, health systems, and society all reinforce the idea that SRHR is primarily of concern to women. Men and boys also often lack the knowledge and resources required to assume personal agency and take responsibility in the SRHR arena. Women carry out over three times the amount of daily care work that men do,¹⁶ and the emphasis on their SRHR further reinforces the idea that men need not be involved in contraceptive use, nor in caring for the children who result from their sexual relationships. A greater insistence that men appreciate the impact of their choices and act upon a commitment to mutuality and consent is essential for reconciling the tension between having men see SRHR as important to them and respecting the sexual and reproductive autonomy of women; this is a key link in the chain of actions required to nudge men toward being equitable caregivers.

What Do Boys and Men Know About SRHR, And Where Do They Learn It?

Parents and other adults tend to avoid talking about SRH with children and adolescents. So, then, where do boys and men get their information? What do they know about the workings of their own and others' bodies, their own sexuality, how to understand and manage their feelings, the mechanics of sex, masturbation, how to prevent disease and avoid pregnancy, the connections between sexuality and gender, the skills to interpret peer talk about sex and sexuality, and their sense of their own rights and those of others? This chapter brings together the sparse data and highlights the need to do a better job of preparing boys and men, as well as girls and women, and all individuals, for their sexual and reproductive lives.

Comprehensive Sexuality Education

The headline on parents and peers is that the information they provide can often be inaccurate, incomplete, or charged with judgment. This is part of the reason that so many countries have elected to provide “sex education” in the context of school classrooms. Comprehensive sexuality education (CSE) is a rights-based and gender equality-focused approach to sexuality education for youth both in and out of school that addresses the cognitive, emotional, physical, and social aspects of sexuality.¹⁷ It equips children and young people with developmentally appropriate and accurate information, skills, attitudes, and values that enable them to care for their bodies and protect their health and well-being throughout their lives. CSE seeks to promote healthy, pleasurable, and respectful relationships and to build young people’s capacity to make responsible and autonomous decisions about their sexuality and SRH while respecting the rights and dignity of others.

Evidence also shows that sexuality education is not, as many people fear, associated with increases in sexual activity, sexual risk-taking behavior, or STI and/or HIV infection rates.¹⁸ To the contrary: In addition to making people more informed and tolerant, curriculum-based sexuality education programs have been shown to delay the initiation of sexual intercourse, reduce the frequency of sexual intercourse, reduce the number of sexual partners, decrease risk-taking, and increase the use of contraception among boys and girls.¹⁹

Growing numbers of young people, adults, and organizations are calling for governments to provide access to CSE in formal and non-formal settings.²⁰ Though schools are often officially responsible for educating children about sexuality, their capacity to provide high-quality CSE is limited and young people often receive no instruction. As a consequence, in sub-Saharan Africa, for example, very young adolescents (ages 10 to 14) have heard of HIV but understand little about it and grasp even less about how to prevent pregnancy.²¹

Research shows that CSE programs emphasizing gender, power, and rights are more likely to reduce rates of STIs and/or unintended pregnancy than “gender-blind” curricula.²² A review of the evidence on CSE programs with these components disaggregated by sex showed an increase in boys’ understanding of sexuality and pregnancy prevention, and increased gender-equitable attitudes.²³ By talking about power and values, CSE can open up critical reflections on topics such as pornography and societal messages that elevate harmful masculinities.²⁴

Who is Reached by Comprehensive Sexuality Education?

Since Western European countries first introduced school-based sexuality education programs about 50 years ago, many governments have demonstrated increased political will to develop and implement CSE. National and local CSE policies are also emerging or being revised across a range of settings. A 2015 UNESCO review of CSE implementation analyzed data from 48 countries, including CSE’s position within the national curriculum, whether it is mandatory or optional, the age groups covered, the provision of teacher training, and the existence of a national policy mandating CSE in schools.²⁵ Though most countries now support some form of sexuality education, however, gaps persist between the stated policy and the quality of the content and actual coverage, and many policies do not provide students with the knowledge and skills necessary to challenge harmful gender norms. Almost 80 percent of the countries assessed had policies or strategies supporting CSE (see **Box 2** for a summary of the status of CSE at the regional level).

Evidence also shows that sexuality education is not, as many people fear, associated with increases in sexual activity, sexual risk-taking behavior, or STI and/or HIV infection rates.

Box 2

Overview of Policies on Comprehensive Sexuality Education by Region*

Asia-Pacific: Twenty-one of 25 countries' national HIV strategies/plans referenced the role of education; most targeted young people in school, mentioned the capacity development of teachers, and promoted HIV and life skills education. Cambodia and Papua New Guinea had established HIV policies for the education sector, and most countries had integrated sexuality education at the secondary level into their national HIV strategies.

Eastern Europe and Central Asia: All countries covered in the assessment had national policies supporting CSE (with the exception of Uzbekistan, Kazakhstan, and Russia), providing a cornerstone for the delivery of life skills-based health education, with HIV and SRH education being central.

West and Central Africa: Most countries in the assessment had an education sector policy on HIV and AIDS, complemented by a strategy creating an enabling environment for the delivery of life skills-based HIV and sexuality education.

The Sexuality Education and Review Assessment Tool (SERAT) studies show that 12 of 13 countries have plans that support the implementation of a sexuality education program.

Latin America and the Caribbean: In 2008, health and education ministers signed a declaration affirming a mandate for national school-based sexuality and HIV education, as well as endorsing the increased availability of adolescent-friendly reproductive health services.

Eastern and Southern Africa: Ministers of health and education from 20 countries affirmed and endorsed the ministerial commitment on CSE and SRH services for adolescents and young people in December 2013, setting specific targets to ensure access to high-quality, comprehensive, life skills-based HIV and sexuality education and appropriate youth-friendly health services for all young people.

Source: UNESCO. (2015). *Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education: A Global Review*. Paris: UNESCO. Retrieved from https://www.unfpa.org/sites/default/files/pub-pdf/CSE_Global_Review_2015.pdf: 33.

*This analysis, unfortunately, did not reference North America or the Middle East and North Africa.

Despite the progress, CSE initiatives face persistent challenges in realizing the gains envisioned by policymakers. The recent WHO global technical guidance on CSE and the Standards for Sexuality Education in Europe, developed by the WHO Regional Office for Europe, provide useful frameworks to assist in the implementation of quality standards for sexuality education.²⁶

Life skills, sexuality, SRH, and HIV prevention are among the essential areas of knowledge that enable men and boys to manage their lives and make informed decisions. Since these are sensitive subjects in many cultures, people avoid discussions about them, especially with children and adolescents. For these same reasons, the data available on how girls and boys feel about their bodies and sexuality are extremely limited.

How Boys and Men Learn: Pornography as the New Sexuality Education

In the absence of informed, direct discussions between young people and adults about sex, pornography has become an important source of explicit information for boys and men, but its impact on young people has not been well understood. A ten-country study in Southern Africa on multiple and concurrent partnerships identified pornography as an impetus for men to find additional relationships with women who would be willing to do the things in “blue movies.”²⁷ What does it mean when the first glimpse so many young men have of sex depicts women as submissive, sexually adventurous, saying “no” when they mean “yes,” devoid of body hair, and otherwise stereotyped—while also depicting men as dominant, forceful or violent, endowed with giant penises, and able to maintain erections for extended periods?

Box 3

Pornography, Body Satisfaction, and Expectations for Sexual Relations

The expansion of sexually explicit materials into online formats and increased Internet access globally have resulted in changes in who consumes this material and how (where, when, and in what form) it is accessed. Research on the sexual health impacts of the use of these materials continues to emerge and raise important questions. Does using this material lead to increased sexual violence? Is it harmful or helpful to romantic relationships? Does it lead to increased sexual risk-taking? Is it an important and helpful source of sex education, or does it cause harmful norms about condom use and sexual power dynamics to proliferate? Interesting questions have emerged about whether and how the use of sexually explicit materials may differentially affect different groups—men versus women, heterosexual versus LGBTQIA+.

Some porn may well support healthy learning and exploration, in particular for LGBTQIA+ young people exploring their sexuality. Some qualitative evidence suggests that for some people, the use of pornography has educational and social value

and may diminish sexual anxiety and increase satisfaction.²⁸ However, an estimated 37 to 88 percent of mainstream porn scenes depict physical aggression, usually toward female actors who appear willing,²⁹ and women are frequently depicted as sexually submissive.³⁰

The proliferation of sexually explicit materials depicting sexually risky, misogynistic, and violent behavior raises serious concerns about how consuming such material may translate into behavior that mirrors its content. A strong association has been shown between pornography use, a higher number of sexual partners and greater incidence of unprotected sex,³¹ especially unprotected receptive anal intercourse among men who have sex with men (MSM) porn consumers.³² The unique properties of Internet pornography (limitless, easy access, private, and available extreme material) could combine to condition users such that sexual arousal no longer translates to real-life partners.³³ In addition, a meta-analysis showed a significant association between pornography use and attitudes supporting violence against women.³⁴

Measuring pornography's impact on relationships and well-being is difficult in the absence of objective measures. In addition, the literature has not placed sufficient focus on pornography's links to mental health challenges like addiction and social isolation.

Respect for One's Body and the Bodies of Others

Much attention has been paid to the harmful impact of patriarchy and its emphasis on female attractiveness as it relates to many women's dissatisfaction with their own bodies. However, globalization and the Internet have contributed to driving an emphasis on *men's* appearance and food consumption as well.³⁵ Research on men's feelings about their bodies and attractiveness in Mexico, the United Kingdom, and the United States found that men who were inside the "Man Box" (i.e., held more traditional views of what it meant to "be a man") were more satisfied with their own appearance.³⁶ Young men's sense of physical attractiveness was primarily associated with muscle bulk and body shape rather than a more inwardly focused sense of self. These men also spent more time bathing, grooming, and clothing themselves before going out, demonstrating the work required to maintain a traditional masculinity.

The International Men and Gender Equality Survey (IMAGES), created by Promundo and the International Center for Research on Women, is a comprehensive household survey that has been conducted in more than 40 countries to evaluate men's and women's attitudes and practices related to gender equality. Data from IMAGES studies in several regions provide further information on men's attitudes related to their bodies and physical confidence. In Egypt, Lebanon, and Palestine, men were more likely than women to be satisfied with their bodies: 80 to 90 percent of men versus 60 to 75 percent of women.³⁷ In those three countries and Morocco, about half of men stated that they would like to have more muscular bodies. In Eastern Europe and Central Asia, IMAGES found large proportions of men generally agreed with

the statement, “I am happy with my body.”³⁸ Data from Latin America and India showed that men had high rates of satisfaction with both their bodies and their sex lives.

Film heroes, men in ads, and action figures all show that the ideal male body has become increasingly muscular, and the use of social media has enhanced the “drive for muscularity” among men around the world.³⁹ Nationally representative cohort data from the United States found that 22 percent of the young men and 5 percent of the young women had muscularity-oriented eating disorders.⁴⁰ Other research has found that nearly one-third of teenage boys in the United States skip meals, fast, smoke cigarettes, vomit, or take laxatives in order to control their weight.⁴¹ In another study, boys who were worried about their muscularity were more likely to use unhealthy supplements, including growth hormones and steroids, and were nearly twice as likely as their peers to binge drink and use drugs.⁴² Anxiety about masculinity seems to be linked to a performance-oriented idea of sexuality.

The Place of Sexual Pleasure in SRHR

Pleasure is rarely covered as part of sexuality education or in discussions of SRHR, and yet it is core to human experience and highly gendered. The WHO unequivocally relates pleasure to sexuality, recognizing the personal and communal aspects of sexuality, as well as its importance to being human, describing it as “a central aspect of being human throughout life [that] encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.”⁴³

Box 4

The Pleasure Gap: Overlooking a Key Driver of Sexual Behavior

SRHR discussions often sidestep a core issue: the importance of pleasure in driving sexual activity, especially as part of a traditional framing of masculinity. Most discussion of sexual motivation instead emphasizes other frames for sexuality, such as reproduction, fertility, relationship stability, and social validation.

In general, the tendency is to downplay how men’s pursuit of specific kinds of sexual pleasure affects their partners and society. Historically, sexologists drew on research and assumptions from the West to promote “scientific” notions they claimed were rooted in nature.⁴⁴ However, gender, sexuality, and pleasure are culturally grounded, and views about sexuality and pleasure vary over time and from location to location. Using concepts such as

“pleasure” or “rights” is challenging, as they are understood so differently in different contexts.

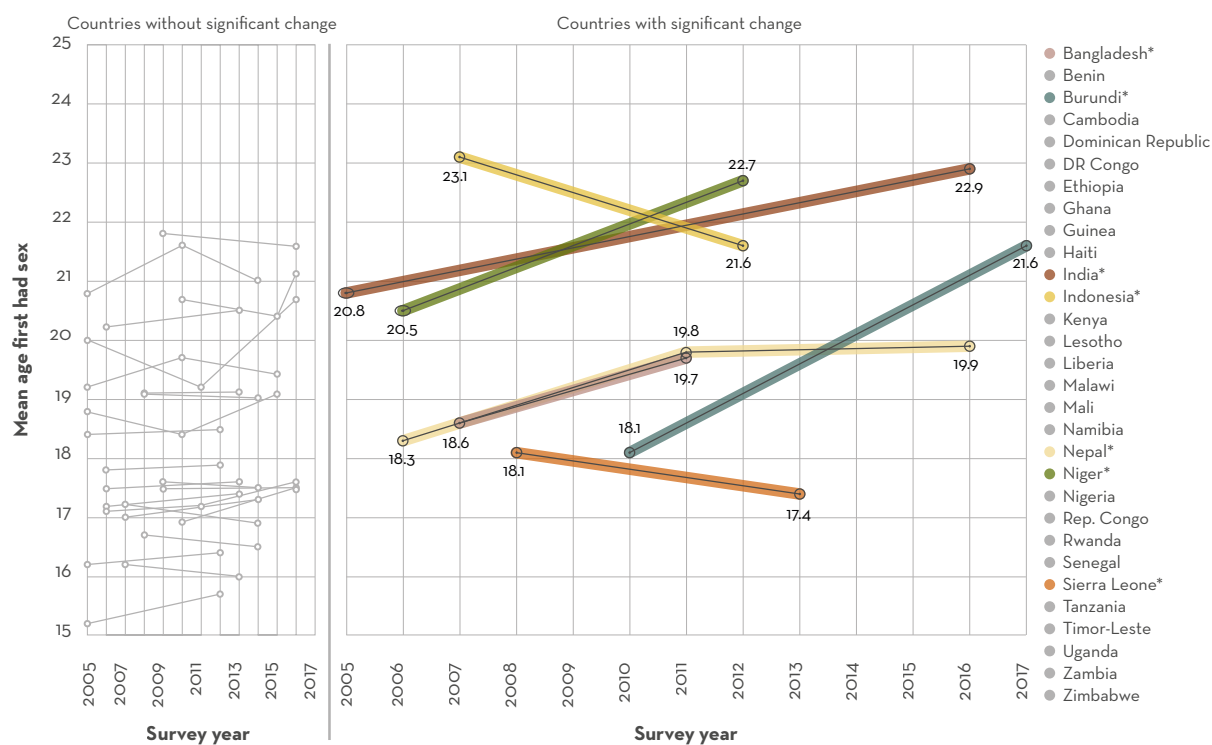
A comparative study of the Netherlands and the United States describes how sharp the contrast in framing of adolescent sexuality can be in two settings.⁴⁵ The positive Dutch approach emphasizes public health, pleasure, personal responsibility, and mutuality, and it promotes greater openness between children and their parents about sex and relationships than in the US. Greater openness in the Netherlands about sexuality and pleasure as a key motive is associated with *later* age of sexual debut and *lower* rates of STIs, adolescent pregnancy, and abortion. The US, by contrast, experiences the highest rates of these burdens of any country in the developed world. Its restrictive (and abstract, clinical, and statist) approach to adolescent sexuality is evident in framings that emphasize health, schooling, productivity, and prevention of the intergenerational transmission of poverty.⁴⁶ SRHR discourse in the US has not attempted to unpack “prudishness” or “pleasure” as cultural products.

Trends in Age at Sexual Debut

Initiation of sexual intercourse is a biological and psychological milestone across cultural contexts, yet little is known about the social and emotional consequences of early sexual debut. Instead, research has focused on the health impact: One review of 65 studies on these associations found that people who initiate sex early are more likely to have more sexual partners over time and experience a greater likelihood of adolescent pregnancy and STIs, though this literature has significant methodological inconsistencies and limitations.⁴⁷

Our analysis of the most recent Demographic and Health Survey (DHS) trend data for each country (Figure 2) shows that most countries included have not seen significant changes in men's mean age at first sex in recent years. In the seven of 30 countries where change did occur, age at first sex among young men rose in all but two. Men's age at sexual debut rose 3.5 years in Burundi, while falling 1.5 years in Indonesia and 6 months in Sierra Leone.

Figure 2. Trends in men's mean age at first sex (2005–2017)



Source: Demographic and Health Surveys, analysis by authors

Notes: Analyses were only conducted for respondents who 1) reported ever having intercourse, and 2) recorded a numeric age at first sex (i.e., excluded "don't know" responses). All estimates are based on weighted design-based analyses to account for complex survey design. Inclusion criteria are provided in Annex 1.

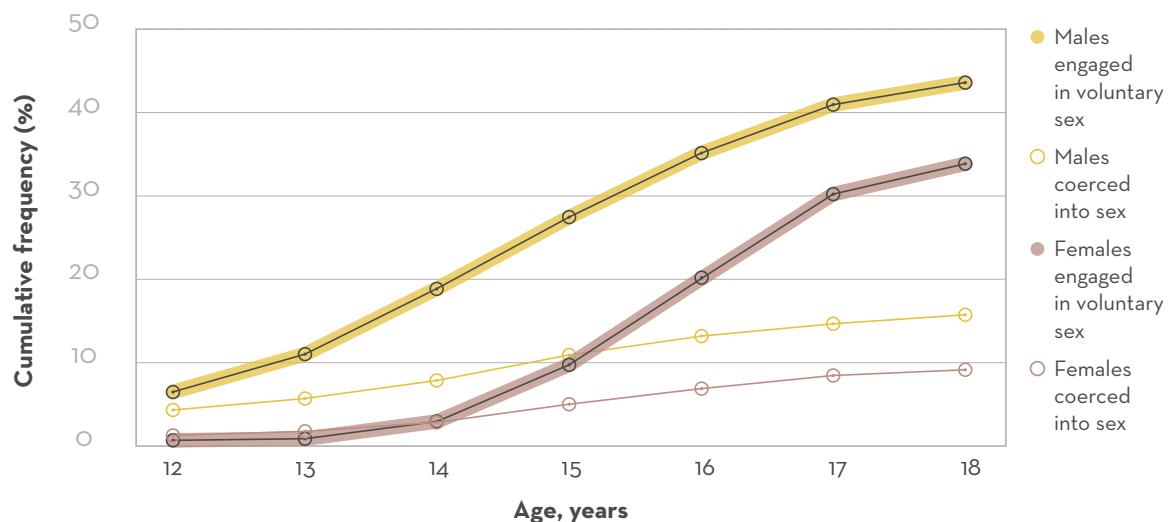
*Countries with significant change over time at $p < 0.05$; p-value based on Rao-Scott second-order corrected Pearson statistics

A 2012 analysis of data from 24 countries in sub-Saharan Africa found large differences in the proportions of 15- to 19-year-olds who reported having sex before age 15.⁴⁸ West African girls were significantly more likely than boys to report sex before age 15, and the findings were mixed in Central, East, and Southern Africa: Benin, Kenya, Mozambique, Rwanda, Tanzania, Zambia, Lesotho, and Namibia reported more boys than girls having sex before 15, while in Mali, Nigeria, Ethiopia, and Madagascar, girls were significantly more likely than boys to have had sex before 15. A study among 10- to 15-year-olds

around the world found that the proportions of young adolescents who had experienced sexual debut were highest in Brazil, South Africa, and countries in the Caribbean, ranging from 19 to 35 percent.⁴⁹ An analysis of sexual debut among adolescent boys and young men in the United States found great geographic variability, with 5 percent in San Francisco reporting sex before age 13, compared to 25 percent in Memphis, Tennessee.⁵⁰

Sexual coercion is a common feature of sexual debut. The limited data show that more boys than girls tend to have sex at very young ages; qualitative studies indicate that early sex is often a positive experience for boys and is often coerced or otherwise negative for girls.⁵¹ The longitudinal Birth to Twenty data on South African boys and girls found that sexual debut occurs through sex with peers and young adults rather than older adults.⁵² Importantly, the earlier sexual debut occurred, the more likely it was to have been coerced; approximately 50 percent of boys who had first sex before age 13 were coerced, while about 36 percent of boys who had first sex before age 18 had been coerced (see **Figure 3**).

Figure 3. Sexual debut by age from the first retrospective report of sexual intercourse starting before age 12



Source: Richter, L., Mabaso, M., Ramjith, J., & Norris, S. A. (2015). Early sexual debut: Voluntary or coerced? Evidence from longitudinal data in South Africa—the Birth to Twenty Plus study. *South African Medical Journal*, 105(4), 304-307.

Childhood experiences of coerced first sex influence men’s own future sexual experiences and contribute to their own perpetration of sexual violence.⁵³ In recent years, the impact of the broad sexual abuse scandal in the Catholic Church (and other trusted institutions) on the lives of many boys and girls has received considerable public attention.⁵⁴

Nationally representative data on unwanted sex among boys aged 12 to 19 in Burkina Faso, Ghana, Malawi, and Uganda found that 4 to 12 percent said they were “not willing at all” at sexual debut.⁵⁵ Recent research has documented sexual abuse among refugee boys in Libya, Bangladesh, and Syria.⁵⁶ A large survey of high school students in China found that 41 percent of the female students and 30 percent of the male students who had had sexual intercourse had experienced sexual coercion.⁵⁷

The lack of data on sexual violence against girls and boys prevents an appropriate response to this experience despite its lasting consequences: only 40 countries have comparable data on sexual violence against girls, and only seven have data on sexual violence against boys.⁵⁸ Open discussions of sexuality and gender equality are essential and can play an important role upstream in preventing violence, cultivating tolerance and mutuality, and promoting gender equality.

Attitudes Toward Sexual Orientation and Sexuality

The “Man Box” study in Mexico, the United Kingdom, and the United States identified heterosexuality and homophobia as one of the seven key pillars of traditional masculinity.⁵⁹ The 2016 International Lesbian, Gay, Bisexual and Trans and Intersex Association (ILGA)–RIWI Global Attitudes Survey inquired about *personal* attitudes toward sexual and gender diversity – and their relation to ideological and political attitudes.⁶⁰ Administered to 96,331 individuals from 65 countries, the survey also obtained information about respondents’ direct experience with and views of sexual minorities and gender diversities. For example, 43 percent of African respondents and 50 percent of Asian respondents would feel “no concern” with having a lesbian, gay, or bisexual neighbor compared to 71 percent of respondents in the Americas, 74 percent in Europe, and 83 percent in Oceania.

Worldwide, 68 percent of respondents reported they would be somewhat or very upset if one of their children expressed being in love with someone of the same sex. Only a quarter of respondents felt that people who feel attracted to others of the same sex are born that way. Overall, around the world, nearly a third of respondents said they believe that diversity in sexual orientation is a Western phenomenon. Unlike sexual orientation, gender identity was *not* viewed as something that was chosen or adopted by an individual. Only 13 percent of respondents worldwide believed that people who do not identify with the sex they were assigned at birth “become so” or develop away from the assigned identity, and 22 percent felt that they chose to identify as they do.

The ILGA–RIWI Global Attitudes Survey of 2017 collected data from 116,000 individuals in 75 countries to determine *public* attitudes on gender and sexuality.⁶¹ The study found that equitable attitudes were influenced by personally knowing someone who belonged to a sexual and gender minority group. The survey results showed that many respondents felt they could accept sexual and gender diversity while remaining respectful of their religion or culture. Results also showed that the criminalization of same-sex activities influenced respondents’ attitudes toward sexual and gender diversity.⁶² The criminalization of same-sex activities influenced attitudes toward work protection for gender and sexual minorities. Attitudes regarding marriage equality are in flux around the world: While 45 percent of respondents believed that marriage for same-sex couples should be illegal, 32 percent reacted positively to the idea that marriage for same-sex couples should be legal. In Africa and Asia, 60 percent and 50 percent of respondents, respectively, rejected marriage equality altogether.

IMAGES surveys have linked attitudes toward masculinity (measured via the Gender Equitable Men, or GEM, scale) to multiple indicators of sexual diversity, including perceptions of, attitudes toward, and comfort with various manifestations of sexual diversity.⁶³ Not all IMAGES adaptations assessed opinions on sexual diversity, and among those that did, not all indicators were evaluated. The surveys document quite negative views of sexual diversity, though attitudes vary in response to specific questions (e.g., how one would

react to having a gay son or react to public demonstrations of same-sex affection). In most countries where IMAGES assessed attitudes towards sexual diversity, women were more accepting of sexual diversity and LGBTQIA+ rights compared to men.

Opinions varied within and between countries, suggesting the cultural and historical contexts for attitudes toward sexual diversity. Men surveyed in Southeastern Europe – Kosovo, Moldova, Serbia, Croatia, and Bosnia and Herzegovina – were less accepting than men in Latin America. Men in Mexico and Chile in Latin America were more accepting of legal marriage rights of same-sex couples than men in countries in Southeastern Europe (e.g., Serbia, Kosovo, and Moldova), which had the lowest acceptance rates.⁶⁴ Generally, men in all countries surveyed had unfavorable attitudes towards same-sex couples' rights to adoption, with greatest disapproval in Moldova and Bosnia and Herzegovina and lowest in Brazil.⁶⁵

In Brazil, Chile, Mexico, Croatia, Moldova, and Armenia, IMAGES inquired about men's justification for using violence against gay and lesbian people in a variety of hypothetical scenarios. Except in Moldova, fewer than 20 percent of men justified violence when a man is kissing another man in public. Men were much more likely to justify violence when a man is perceived to be flirting with or trying to seduce an unreceptive man: for example, 53 percent in Chile and 38 percent in Croatia.⁶⁶ Forty-one percent of men in Armenia rationalized violence when a man is staring at them compared to 7 percent of men in Brazil.⁶⁷

In Morocco, respondents in qualitative interviews described same-gender attraction as un-Islamic, immoral, unnatural, and a Western import.⁶⁸ Respondents from Lebanon expressed slightly more favorable attitudes, yet the majority of men and women held non-accepting attitudes of homosexuality.⁶⁹ These cultural norms and beliefs impact the sexual and reproductive lives of LGBTQIA+, harm their mental health, cause them to fear being "outed," and impede their access to services.

Girls' and Boys' Experiences of Gender- and Sexuality-Related Bullying at School

Around the world, schools are places where girls – and gender and sexual minorities in particular – often face a variety of forms of gender-based harassment, sexual violence, and discrimination.⁷⁰ Membership in a marginalized group may incur more severe discipline from teachers and administrators and overt violence from peers.⁷¹ The 2016 *Out in the Open* report on school violence and harassment of sexual and gender minority children affirms that many students are affected by homophobic and transphobic violence at school.⁷²

Though many governments and institutions around the world have begun to address bullying on the basis of race, religion, or disability,⁷³ fewer are taking steps to address bullying based on sexual orientation or gender identity.⁷⁴ LGBTQIA+ youth remain vulnerable to violence, and those around them are often slow to respond appropriately. Indeed, schools themselves can promote gender intolerance, as in the case of 2014 legislation in Algeria and Nigeria that forbade discussing sexual orientation or gender identity/expression in a positive or neutral way – making it impossible for teachers to address discrimination and violence.⁷⁵

Staying Healthy: Sexually transmitted infections, HIV, and SRH

**The challenges of STIs and HIV face people everywhere. However, the data in this section highlight sub-Saharan African countries, where rich comparative information on STIs and HIV among men has been collected. The data from sub-Saharan Africa also often reflect trends that stand out in the diagrams of DHS data from low- and middle-income countries. This should not be taken to imply that the challenges described here are not manifested in all regions of the world.*

The global prevalence and incidence of chlamydia, gonorrhea, trichomoniasis, and syphilis (the four curable STIs) remain high in adult men and women, with nearly 1 million new cases acquired each day.⁷⁶ STIs other than HIV are often neglected within SRH, and the estimated annual incidence of non-HIV STIs increased by nearly 50 percent between 1995 and 2008.⁷⁷

The urgency to reduce STIs has reinforced the case for paying more attention to men's roles in SRHR and for integrating them into other services. It is essential to leverage existing – often standalone – HIV programs to incorporate other STIs in order to improve the health of large numbers of people around the world.⁷⁸ Integrating STI and/or HIV services with other SRH programs, such as family planning and maternal health, would better meet clients' needs and more efficiently use health system resources.⁷⁹ Finally, there is much to be done to integrate STI services into programs in primary healthcare settings.

Upholding a dominant masculine sexuality can lead men to view their sexual relationships and, indeed, their experience contracting an STI quite differently than women do (see **Box 5**). Masculinity-related factors drive men to have extramarital affairs in Tanzania, for example, and drive multiple partnerships among young men in Ghana, who affirm their masculinity through sexual promiscuity while expecting young women to be monogamous.⁸⁰ In the United States, gang membership – an intensely masculine identity – is associated with sexual risk-taking across multiple partners, group sex, unprotected sex, coerced sex, and sex under the influence of drugs and alcohol.⁸¹ These studies and others suggest that having an STI could at times be experienced as a “badge of honor.”



Box 5

Hypersexuality as a Pillar of Dominant Masculinity

In 2017, building on the work of Paul Kivel,⁸² Promundo conducted a multi-country study on the prevalent social constructions of masculinity seen in many parts of the world. The seven “pillars” of normative masculinity found by this study comprise the “Man Box,” a set of beliefs that pressure boys and men to think and behave in specific ways.⁸³ Though they vary by individual and cultural context,

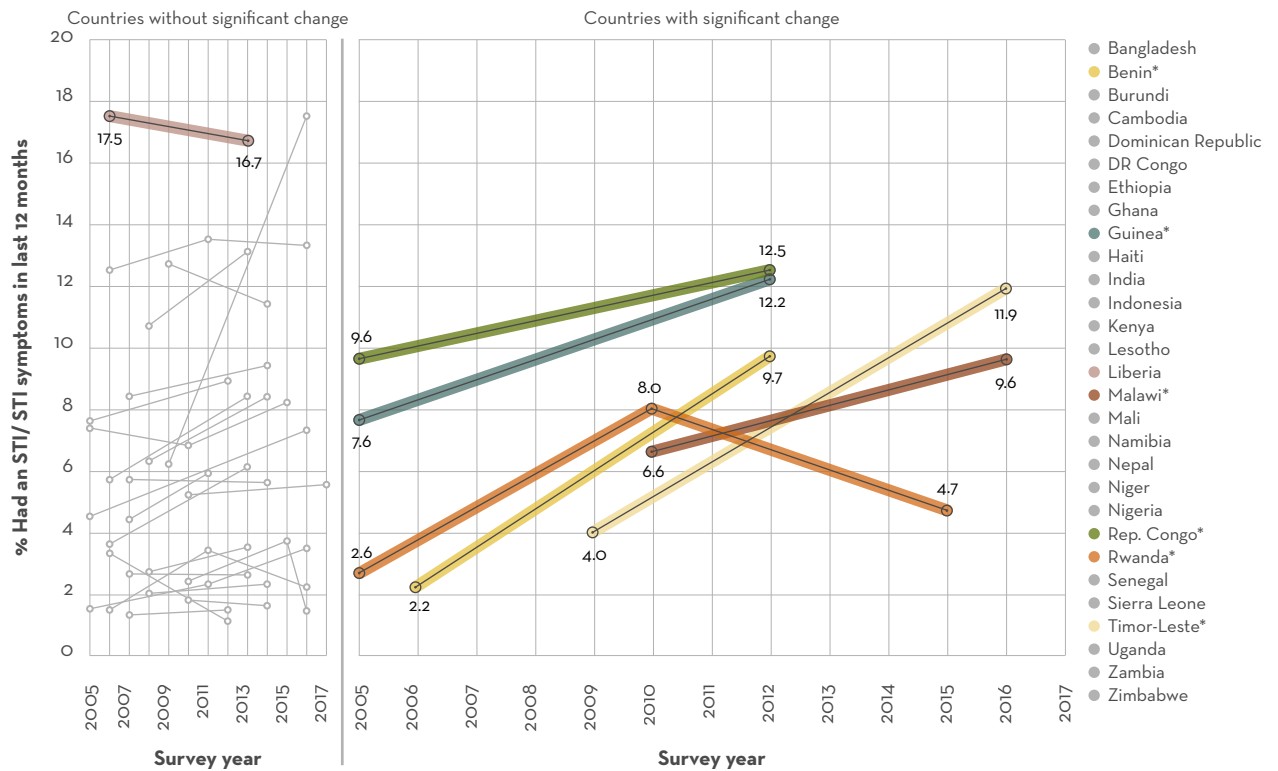
these components represent salient and widely reinforced norms about manhood.

The principle of hypersexuality emphasizes not only that a man should be unambiguously heterosexual but also that he should always be ready for sex and eager to acquire another “sexual conquest.” This undermines men’s sexual agency and sexual health – as well as women’s – and contributes to sexual coercion and emphasizes sexual performance rather than connection, communication, and sexual health. A 2019 analysis of the connections between masculinities and men’s health affirmed that body image, muscularity, size, and a man’s lack of confidence about his body and physical endowments are closely related to sexual risk-taking.⁸⁴

The expression of dominant masculinity, including the need to demonstrate strength and virility, can impede men’s self-care and health-seeking behavior: In Botswana, for example, it leads many to resume sexual relations too soon after having circumcisions and before their wounds have completely healed, exposing themselves to the risk of contracting HIV.⁸⁵ Across sub-Saharan Africa and around the world, masculine norms appear to keep men from getting tested for HIV,⁸⁶ with men in Uganda, for example, reluctant to seek health care, disclose their HIV status, or participate in peer support groups, which are viewed as “feminine.”⁸⁷

Figure 4 shows trends in the percentage of men who had an STI or STI symptom in the previous 12 months. There was no significant change in the proportion of men reporting STIs or STI symptoms in most of the countries, with just six of 29 showing significant upward trends. Rwanda is anomalous: following a threefold increase, its prevalence declined to 4.7 percent in 2015. The drop could be a result of the strong focus on HIV prevention and outreach during the time preceding the latest DHS, a period during which strong emphasis was placed on educating men about male circumcision, distributing and marketing condoms, and increasing testing facilities. Prevalence in Liberia (on left) was highest among all countries, trending down only slightly from 17.5 percent to 16.7 percent between 2006 and 2013, while Benin saw a rapid increase, rising from 2.2 percent in 2006 to 9.7 percent in 2012.

Figure 4. Trends in the percentage of men who had an STI or STI symptom in the previous 12 months (2005–2017)



Source: Demographic and Health Surveys, analysis by authors

Notes: Analysis was conducted for 29 countries. “STI or STI symptoms” include a “yes” response to any of the following: any STD, genital sore or ulcer, or genital discharge. This was only assessed among men who had ever had sexual intercourse. All estimates are based on weighted design-based analyses to account for complex survey design. (STD=sexually transmitted disease)

*Countries with significant change over time at $p < 0.05$; p -value based on Rao-Scott second-order corrected Pearson statistics

Men’s Testing and Treatment for HIV

The total number of people living with HIV globally has risen in recent years, from 33.3 million in 2010 to 37.9 million in 2018.⁸⁸ According to the UNAIDS Gap Report, 75 percent of all people living with HIV hail from 15 countries.⁸⁹ Six countries in sub-Saharan Africa (Botswana, Lesotho, Namibia, Swaziland, South Africa, and Zimbabwe) have HIV prevalence rates of more than 10 percent of the entire population, and another nine have prevalence rates of more than 2.5 percent of the population.⁹⁰

The ratio of female-to-male prevalence in sub-Saharan Africa tends to be lower where overall HIV infection rates are low, ranging from 0.88 to 2.0.⁹¹ HIV prevalence is at least 50 percent higher among women than men in sub-Saharan Africa and higher among men everywhere else.⁹² In other regions, more men than women live with HIV, and HIV is prevalent among at-risk populations, such as sex workers, MSM, people who inject drugs, and transgender people.

The cycle perpetuated by harmful masculine norms – i.e., risky sexual behavior, avoidance of HIV testing, more risky behavior when HIV status is not known, and avoidance of treatment – is a driver of HIV transmission for men and their partners. Men are less likely to get tested for HIV,⁹³ and men who don’t know

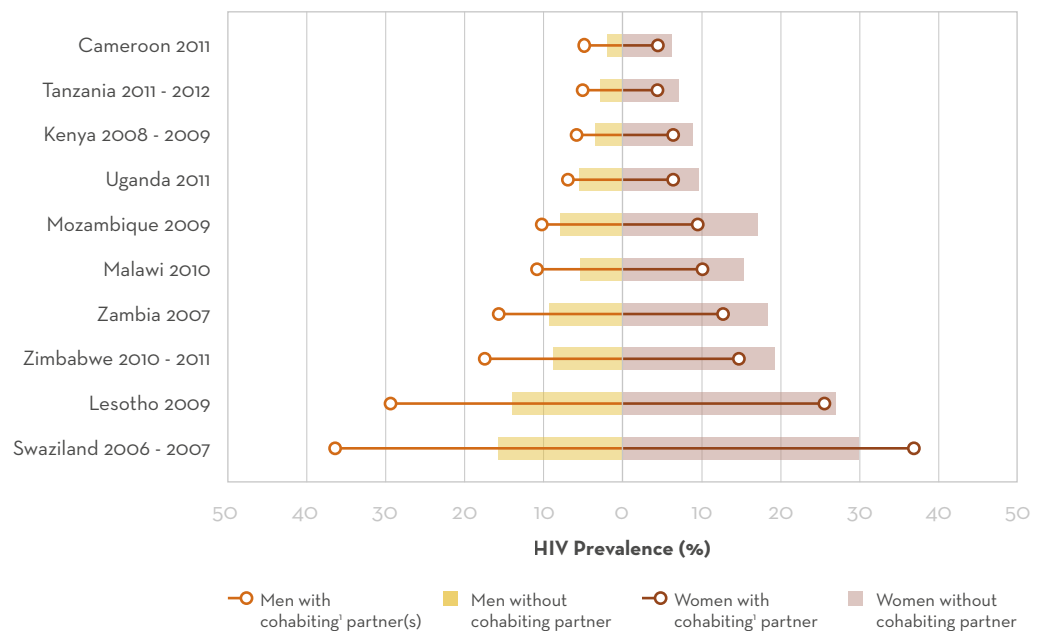
their HIV status are more likely to engage in risky sex,⁹⁴ while men and women who know their HIV status are more likely to use condoms.⁹⁵ Male reluctance to access testing and treatment services early leads to poor treatment outcomes for HIV-positive men: They are less likely to obtain antiretroviral therapy and more likely to start treatment late, break off treatment, and be lost to treatment follow-up than women, and they are more likely to die of AIDS and AIDS-related illnesses than women.⁹⁶

Trend data from 47 countries show that HIV testing among women and men in sub-Saharan Africa has increased in the past decade.⁹⁷ Among women, the *increase* ranged from 8 percentage points in Nigeria to 59 percentage points in Uganda and Malawi; among men, it ranged from 0.4 percentage points in Nigeria to 49 percentage points in Rwanda. Women are more likely than men to have ever been tested for HIV; indeed, they were at least 50 percent more likely than men to have been tested in Lesotho, Madagascar, Mozambique, Senegal, and Zimbabwe.

Marital Status and HIV Prevalence

DHS and AIDS Indicator Surveys from sub-Saharan Africa find that men are *more* likely to be HIV-positive if they have a cohabiting partner, while women are overall *less* likely to be HIV-positive if they have a cohabiting partner (see **Figure 5**).⁹⁸ Patterns of widowhood, divorce, and remarriage and norms affecting whether a person has extramarital partners influence these correlations alongside the protective effects of marriage.

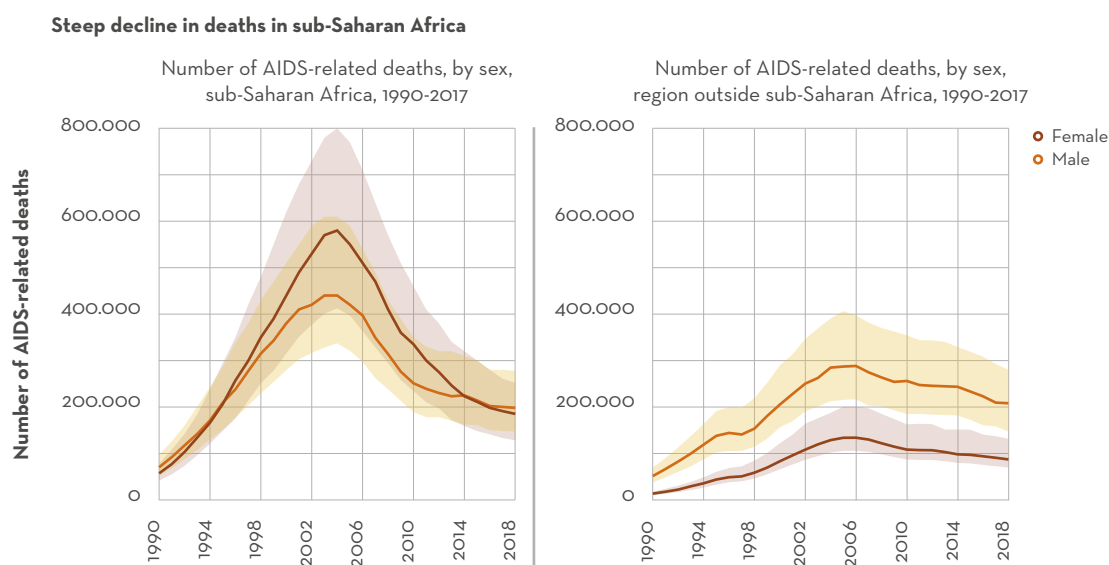
Figure 5. HIV prevalence by sex and cohabiting partner status (with or without cohabiting partner), from ten DHS surveys in sub-Saharan Africa, 2006-2012



¹ Respondent identifies someone in the household as a husband/wife/partner, and the partner was also interviewed separately and identified respondent as husband/wife/partner, and both partners consented to an HIV test and had valid results, *= $p < .05$
Source: Pullum, T., & Staveteig, S. (2013). *HIV status and cohabitation in sub-Saharan Africa* (DHS Analytical Studies No. 35). Rockville, MD: ICF International.

Young women have faced greater risk of HIV infection than young men in sub-Saharan Africa (2.2 percent versus 1.1 percent) and the Caribbean (0.5 percent versus 0.4 percent), according to the UNAIDS Gap Report.⁹⁹ In Latin America, Western and Central Europe, and North America, young men have a slightly higher prevalence of HIV than young women. Young men and women have similar rates of HIV prevalence in Asia and the Pacific and the Middle East and North Africa (<0.1 percent for both genders in both regions) and in Eastern Europe and Central Asia (0.2 percent for both). Though overall death rates have declined sharply since 2005, women experience proportionately more AIDS-related deaths in sub-Saharan Africa. AIDS-related deaths have been much higher among men everywhere else in the world, possibly because of women's access to treatment through prenatal services. The age pattern of HIV-related mortality peaks at younger ages for women than men, with a crossover occurring at age 34.¹⁰⁰ Figure 6 shows AIDS-related deaths by sex by year.

Figure 6. AIDS-related deaths in sub-Saharan Africa and regions outside sub-Saharan Africa, 1990-2017



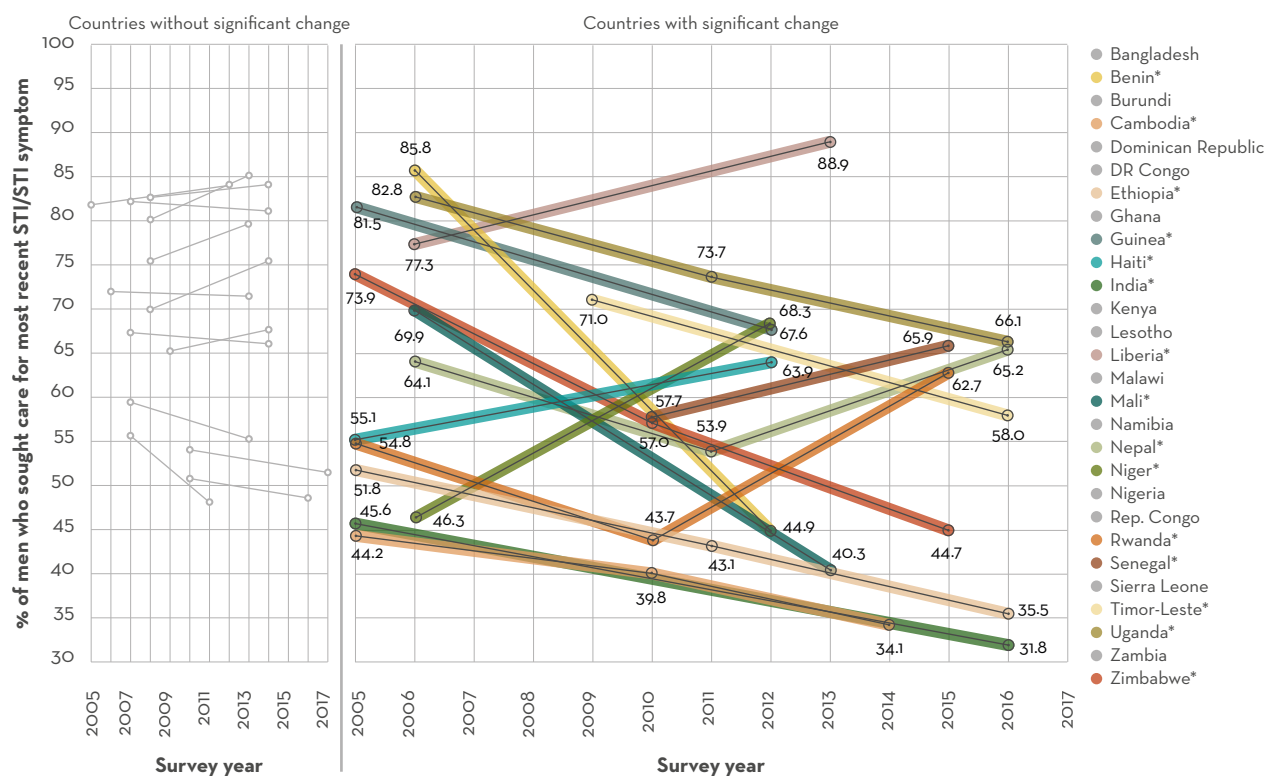
Source: World Health Organization. (2019). *UNAIDS data 2018*. Geneva, Switzerland: World Health Organization. Retrieved from <http://aidsinfo.unaids.org/>

Knowledge of SRHR is Necessary but not Sufficient

Our understanding of women's and men's motivations for specific behaviors has been enriched in recent years by the study of social and gender norms. Gender norms – the often-unstated “rules” that govern the attributes and behaviors that are accepted and valued for men, women, and gender-diverse individuals – hold the gender system in place.¹⁰¹ These internalized rules about what others do and what others believe one *should* do are a secret ingredient in decisions to behave in ways contrary to people's knowledge of what is best for their health. The unacceptability of condom use in established relationships illustrates this challenge: Although couples may know that it would be best for their health to use condoms, men are less likely to use them in primary relationships because condoms are associated with infidelity.¹⁰² Men who adhere to masculine norms associated with sexual dominance tend to have negative attitudes toward condom use.¹⁰³

Figure 7 shows trends between 2005 and 2017 across 30 countries in terms of the percentage of men who sought testing for their most recent STI. The overall picture is quite shocking, with over a third of the included countries and all three global regions seeing significant *declines* over time in the proportion of men seeking care for their most recent STIs. In 2006, just over three in four men in Liberia sought care for STIs; in 2014, that proportion jumped to 89 percent, the highest of any country assessed. Despite high levels of awareness of HIV and greater exposure to HIV testing and treatment, it may be that men remain unaware of other STIs and their symptoms and treatments and, therefore, do not seek care. The lack of integrated testing means men may have been tested for HIV but not for syphilis, for example. Additionally, many men experience shame when they seek STI screenings, viewing it as a judgment of not having “done” sex right or having picked a “clean” partner.¹⁰⁴

Figure 7. Trends in percentage of men who sought care for their most recent STI (2005–2017)



Source: Demographic and Health Surveys; analysis conducted by the authors for 28 countries

Notes: Based on survey question for “sought advice for last disease (STD).” Only assessed among men who responded “yes” to having an infection in the last 12 months. All estimates are based on weighted design-based analyses to account for complex survey design. Inclusion criteria are included in Annex 1. (STD=sexually transmitted disease)

* Countries with significant change over time at $p < 0.05$; p-value based on Rao-Scott second-order corrected Pearson statistics

Voluntary medical male circumcision is a proven biomedical approach for protecting both men and women from HIV infection. Well-designed voluntary medical male circumcision programs that take a gender-transformative approach can provide an important access point for engaging men in SRHR while slowing the transmission of HIV (see **Box 6**). Circumcision can significantly reduce HIV incidence in men, though its impact on women is less marked.¹⁰⁵ Gender-transformative content in voluntary medical male circumcision programs is key, as evidence from Botswana suggests that pressures to demonstrate virility lead men to resume sexual relations too soon after circumcision, exposing them to increased risk of contracting HIV.¹⁰⁶

Box 6

Men's Circumcision and its Connections with Gender, Masculinity, and Culture

For many years, research priorities around circumcision have been shaped primarily around its impact on the transmission of STIs and HIV. While the global prevalence of circumcision among men and boys over the age of 15 is about 30 percent, regional prevalence varies profoundly. The highest prevalence is in Muslim-majority countries, Africa, North America, Australia, South Korea, and Indonesia.¹⁰⁷ The potential for achieving significantly improved SRH and other health outcomes through voluntary medical male circumcision – though hotly debated – makes it an appealing intervention for practitioners in a number of settings.¹⁰⁸

This health-focused framing contrasts culturally, socially, and institutionally with the meaning of circumcision in many settings. Male circumcision is a rite of passage for adolescents among ethnic groups in the Nairobi area (e.g., Kikuyu, Luhya, and Luo communities),¹⁰⁹ for example, and rituals in those settings provide a framework for educating boys about adult responsibilities and sexuality.

A number of contentious and paradoxical issues surround male circumcision:

- **Does circumcision sufficiently prioritize gender equality?** This single-sex approach to a primarily heterosexually transmitted epidemic (in sub-Saharan Africa) may raise ethical issues about fairness in treatment unless countervailing measures offer similar protections and reductions in prevalence for women.¹¹⁰

- **What is the impact of circumcision on women's health outcomes?** Substantial evidence associates male circumcision with decreased risk of numerous diseases in men and women.¹¹¹ By reducing the spread of HIV among heterosexual men, male circumcision directly addresses two of the top 20 regional causes of female mortality (HIV and tuberculosis).¹¹²
- **Is circumcision a violation of human rights?** Some argue that medically, ethically, and legally, there is no justification for circumcision, which is effectively a violation of human rights.¹¹³

Women's Social and Physical Vulnerability to HIV: Male circumcision does not address the social factors that make women more vulnerable generally in sexual relationships with men.¹¹⁴ An emphasis on the biological dimensions of transmission neglects the vastly unequal power relationships, significant age differences, unequal access to resources, and so on that often exist between men and women, as well as how those disparities shape sexual relationships. Exploring, describing, and transforming these disparities is at least as important in reducing the prevalence of STIs as promoting more clinical strategies. Activities to address gender inequality, reduce intimate partner violence, and reduce concurrent sexual partners should accompany programs to increase circumcision.¹¹⁵

Integrating Medical Circumcision and HIV and STI Prevention with SRH Education: Rates of medical complications and negative health outcomes from circumcision are low in institutional medical settings, but tend to be much higher outside of these.¹¹⁶ In medical settings, however, CSE is rarely provided, and future expansion of circumcision services must take the opportunity to educate men about a variety of topics related to SRHR.¹¹⁷

Men's Specific Concerns About SRH

Men and adolescent boys have a variety of SRH needs, including support for male cancers and infertility. Few health systems offer a full array of services for men, service environments are not gender-sensitive, and men do not always access existing services. Providing male-friendly SRH care also means addressing issues such as sexual dysfunction, which can lead to feelings of failure and low self-esteem.¹¹⁸ Poor sexual performance and difficulty having children run counter to the prevailing notions of what a “real man” should be and may cause men distress. Self-reports and interview data from 27,500 men and women in 29 countries found that 28 percent of men aged 40 to 80 reported having at least one sexual dysfunction;¹¹⁹ a study among men aged 15 to 24 in France found only slightly lower rates (23 percent).¹²⁰

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Men's Relationships: Intimate Partnerships, Health, and Rights

Sexual relationships are a key context for people's health and well-being. Men's sexual relationships – their number of sexual partners and how they communicate, take responsibility for themselves and others in preventing STIs, decide about having children, use or experience violence with partners, and so on – reflect ideas about the “proper” expression of sexuality and what it means to be a man.¹²¹ A dominant or risk-taking male sexuality that disregards the care for or input of partners disempowers partners – usually women – and constrains men, limits their personal fulfillment, and contributes to poor mental health, violence, and unwanted sex and pregnancy.¹²²

Forming Relationships and Families: Data Limitations

The analysis of age at sexual debut offers a glimpse of men's entry into sexual relationships with others. Though very important relationships can be formed with or without cohabitation, and with or without formal recognition as marriage, this research is obliged to rely on limited measures of household or family formation such as trend data on age at first (heterosexual) marriage. Increases in age at marriage are important because they relate to school completion, employment, and greater decision-making power within relationships.

Relationships and families come in many forms all over the world. While the authors wanted to include LGBTQIA+ relationships in this discussion, significant comparative data are lacking. In the context of this research, therefore, a “married man” is a man married to a woman, and a “married woman” is a woman married to a man. Similarly, the data assume that “men” are cisgender men, and “women” are cisgender women. Finally, when discussing “unions” or other terms related to two people cohabiting, the data reflect the experiences of heterosexual couples, unless otherwise noted.

Trends in Age at First Marriage

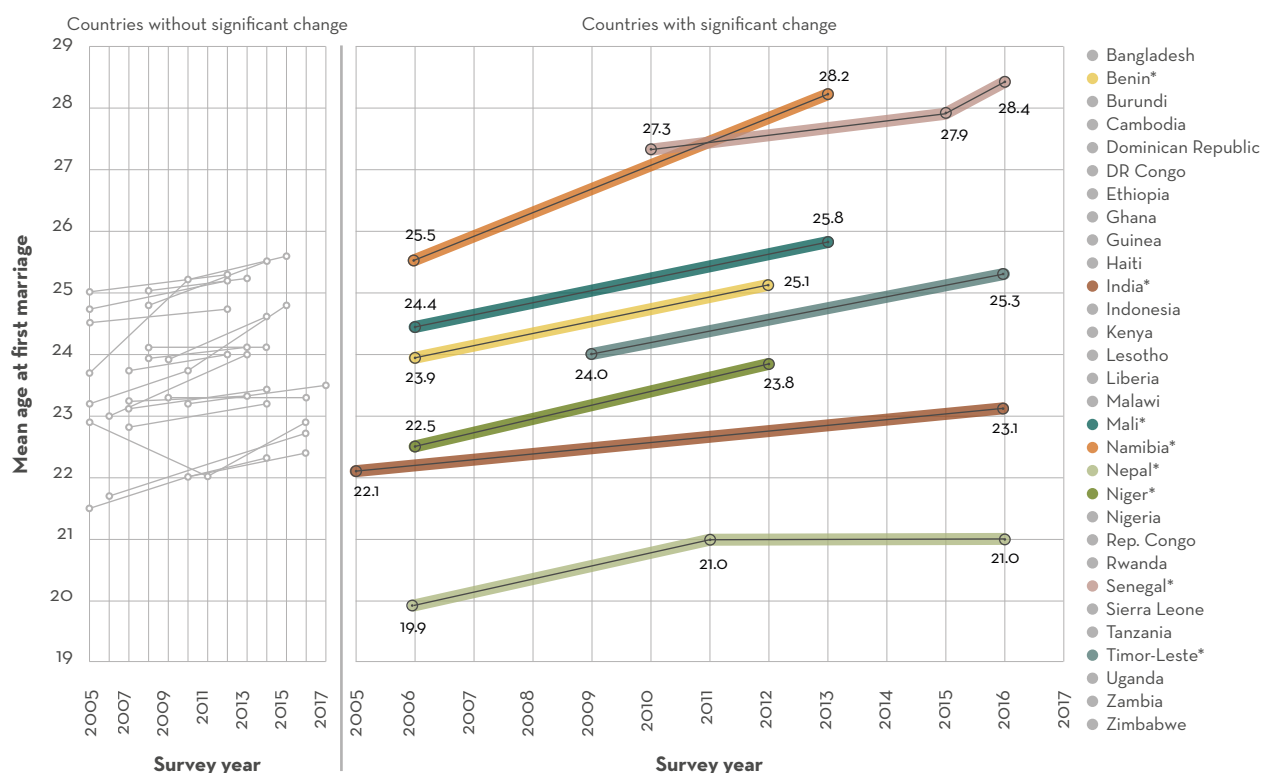
Age at first marriage has been increasing for women but has not changed much for men. Women have historically been more likely to marry in adolescence than men; however, age at first marriage is rising for girls, except in Latin America and the Caribbean, where informal unions have remained steady among girls.¹²³ Median age at marriage increased between 1950 and 2005 by 3.3 years in urban areas and 1.1 years in rural areas in a range of low- and middle-income countries.¹²⁴ Age at first marriage in sub-Saharan Africa continues to increase among women, accompanied by a decline in the proportion of women

who are married and an increase in the proportion of women who are living with male partners but not married to them.¹²⁵

Cohabitation and informal unions are on the rise. A massive increase in consensual unions as a fraction of all unions occurred throughout the Americas between 2000 and 2010.¹²⁶ Women in Latin America are increasingly likely to self-report as heads of household,¹²⁷ likely reflecting high rates of migration in the region that leave women on their own with children.¹²⁸

Men’s mean age at first marriage has remained fairly constant. The authors’ analysis of DHS data from 30 countries found that in only eight did men’s mean age at first marriage rise between 2005 and 2017 (Figure 8); these countries, all in sub-Saharan Africa and Asia, saw increases of at least one year. Nepal, one of the few countries where significant numbers of boys marry as children, continues to have the youngest mean age at marriage among men of all countries assessed (21 in 2016).

Figure 8. Trends in men’s mean age at first marriage (2005–2017)



Source: Demographic and Health Surveys, analysis by authors

Notes: Analysis was conducted for 30 countries. All estimates are based on weighted design-based analyses to account for complex survey design. Inclusion criteria appear in Annex 1.

*Countries with significant change over time at $p < 0.05$; p-value based on Rao-Scott second order corrected Pearson statistics

In all regions, between 2005 and 2017, men experienced declines in ever marrying. An original analysis of DHS data shown in Table 1 found that nearly 88 percent of men ages 25 to 59 had ever been married or in a union, and there was little decline over this period. The proportion of young men aged 20 to 24 ever married or in a union dropped from 28.4 percent in 2005–2010 to 24.6 percent in 2011–2017, with the largest regional decline seen among young men in West and Central Africa. South Asia was the only region to have an increase in the proportion of young men ever married or in a union, though the change was minimal.

Table 1. Proportion of men ever married or in a union by age, time period, type of union, and region (2005-2017)

| Region ^a | Ages 20-24 | | | | | | Ages 25-59 | | | | | |
|---|-------------|------------|-------------|------------|-----------------------|--------------|-------------|-------------|-------------|------------|-------------|--------------|
| | 2005-2010 | | 2011-2017 | | % change ^b | | 2005-2010 | | 2011-2017 | | % change | |
| | M* | P* | M | P | M | P | M | P | M | P | M | P |
| Africa | | | | | | | | | | | | |
| Western/Central Africa N=118,124 | 23.2 | 5.9 | 17.8 | 2.8 | -23.3 | -52.5 | 86.5 | 19.7 | 84.1 | 18.7 | -2.8 | 1.6 |
| Eastern/Southern Africa N=171,895 | 28.1 | 2.9 | 25.5 | 1.8 | -9.3 | -37.9 | 87.7 | 9.9 | 87.0 | 7.8 | -0.8 | -21.2 |
| Asia | | | | | | | | | | | | |
| South Asia N=199,072 | 25.3 | 0.2 | 26.3 | 0.2 | 4.0 | 0.0 | 96.8 | 2.5 | 88.9 | 0.53 | -8.2 | -78.8 |
| Southeast Asia N=28,858 | 33.1 | -- | 29.6 | -- | -10.6 | -- | 91.1 | 1.0 | 87.4 | 0.51 | -4.1 | -49.0 |
| Latin America and the Caribbean | | | | | | | | | | | | |
| Latin America and the Caribbean N=52,732 | 32.2 | 6.5 | 28.3 | 4.0 | -12.1 | -38.5 | 87.4 | 9.0 | 83.8 | 6.9 | -4.1 | -23.3 |
| TOTAL | 28.4 | 3.7 | 24.6 | 1.3 | -13.4 | -64.9 | 87.9 | 13.3 | 87.0 | 6.5 | -1.0 | -51.1 |

(M=all marriages, P polygamous unions)

Source: Demographic and Health Surveys from 28 countries, analysis by authors, updated and adapted from Mensch, B. S., Singh, S., & Casterline, J. B. (2005). Trends in the timing of first marriage among men and women in the developing world. In C. B. Lloyd, J. R. Behrman, N. P. Stromquist, & B. Cohen (Eds.), *The changing transitions to adulthood in developing countries: Selected studies* (pp. 118-171). Washington, DC: The National Academies Press.

Notes: All estimates are based on weighted design-based analyses to account for complex survey design, pooled between 2005-2010 and 2011-2017. "Ever married or in a union" includes men who are either currently or formerly married or living/cohabiting with a partner. Weighted estimates are based on data from the following number of countries and year ranges in each region: Western/Central Africa: ten countries between 2005 and 2016; Eastern/Southern Africa: 12 countries between 2005 and 2017; South Asia: two countries between 2005 and 2016; Southeast Asia: two countries between 2005 and 2016; and Latin America/Caribbean: two countries between 2006 and 2013.

^a Geographic groupings based on: United Nations. (2017). World population prospects: The 2017 revision. New York, NY: United Nations Population Division. Retrieved from https://population.un.org/wpp/Publications/Files/WPP2017_DataBooklet.pdf

^b Based on weighted proportions

The Way Marriage Is Taking Place Is Changing

Arranged marriage still predominates in some regions but is giving way to greater input from the future spouses. The shift seems to represent marriages "jointly arranged" by women in cooperation with their parents rather than "love marriages." Between 1970 and 2012, for example, women in India were increasingly active in choosing their own husbands.¹²⁹ Combined with related trends, such as a decrease in the prevalence of spouses meeting for the first time on their wedding day, increased intercaste marriage, and decreased consanguineous marriage, this suggests that traditional arranged marriage practices are evolving. In South Asia, non-family experiences – including contact with fellow students at school, community engagement, and greater mobility – seem to increase the chances that a person will contribute to choosing their own spouse.¹³⁰ In India, as elsewhere, computers and the explosion of private personal communications have expanded the pool of potential partners to which young people and their families refer, irrevocably changing the marriage market.¹³¹ In Japan, arranged marriage has diminished greatly over the past 50 years, and the delay and refusal of marriage and childrearing among young women can be seen as a rejection of the patriarchal institution of marriage.¹³²

Box 7

“Masculine” Sexuality and the Sexual Double Standard

The patriarchal sexual double standard permits sexual freedom for men and demands sexual restraint from women.¹³³ The control of women’s sexuality and reproduction calls for women to be pure and passive, to come to sex unprepared, and to defer to their male partners with regard to sex.¹³⁴

The sexual double standard is characterized by three key requirements: purity and chastity for women (forgetting pleasure); heteronormative performance for men; and invisibility and stigma for people who are LGBTQIA+.¹³⁵ The pressures to perform as an unassailably heterosexual man are reflected in multiple partnerships, pressures from

other men, relationship inequality, coercion, and a sense of male sexual entitlement.¹³⁶

The “incel rebellion” has encapsulated the anger and violence toward women of involuntarily celibate men in the United States and Canada and toward those “lucky” men who *do* have sexual partners. It has emerged out of the ideology of a sexual double standard, reflecting a sense of men’s *right* to pleasure.¹³⁷ The anger toward women has given rise to a new form of hate crime in industrialized countries.

The importance of sexuality to defining what it means to be a “good woman” or a “good man” means that the sexual double standard influences people’s health across their lives, exposing men to a broad range of health risks and reaching far beyond women’s SRH to limit their mobility, ability to socialize with friends, and work opportunities, as well as driving early marriage.¹³⁸ The sexual double standard rationalizes violence against women and makes rape within marriage invisible.

The tendency for men to marry “down” with regard to education is on the decline. The gap between men and women in schooling has reversed and now favors girls and young women in virtually all high- and middle-income countries.¹³⁹ Global data from 1960 to 2011 show women are increasingly more educated than their partners, with implications for marital dynamics.

Commercially mediated marriage across national borders has risen sharply in recent years. Adult men from wealthier countries, including the United States and European nations, are marrying girls and young women from poorer countries, often resulting in a large age gap between native-born husbands and immigrant wives.¹⁴⁰ In places like South Korea, Taiwan, and China, where son preference has led to skewed sex ratios, wealthier husbands are paying for young brides from poorer communities in their own countries or from poorer nations in Southeast Asia: One-third of all marriages in Taiwan are estimated to involve women from Southeast Asian countries, for example.¹⁴¹

Divorce is on the rise. Globalization, with its principles of individualism, human rights, and gender equality, has reshaped understandings of marriage and family relations.¹⁴² Data from 84 countries between 1970 and 2008 show strong associations between divorce and these globalized principles. In Asia, divorce trends reflect great diversity, with three major sub-regional patterns: increasing divorce rates in East Asia, declining divorce rates until recently in Muslim-majority countries and regions of Southeast Asia, and stable, low divorce rates in South Asia.¹⁴³

Men are more likely to approve of polygamy than women. IMAGES data on respondents’ attitudes towards polygamy found that men in the Middle East and North Africa were three to four times more likely than women to approve of their sons marrying multiple wives and their daughters marrying a man who already has wives.¹⁴⁴ In Nigeria, 29 percent of men and 25 percent of women agreed that a “real man” is one with many wives, and in Mali, 84 percent of men and 73 percent of women believed that the practice of polygamy should continue.¹⁴⁵ In Pakistan, 30 percent of men and 18 percent of women

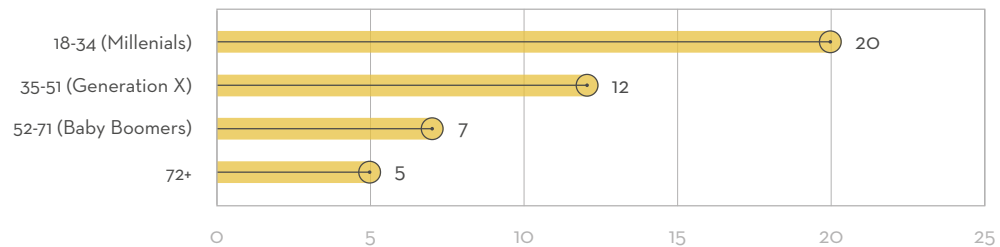
believed a man has a right to remarry if his wife gave birth to daughters only, demonstrating deeply rooted son preference.¹⁴⁶

Though approval persists, polygamous marriages in all regions declined between 2005 and 2017. Among men aged 20 to 24, polygamous unions declined by 38 percent or more across the regions, for a global decline of 65 percent, according to an analysis of DHS data conducted for this report. Among older men aged 25 to 59, polygamy declined by 79 percent in South Asia, while *increasing* less than 2 percent in Western and Central Africa, for a 51 percent decline globally.

Multiple sexual partnerships are also more common among men. In Armenia, men were almost twice as likely as women to express positive attitudes toward men having multiple partnerships (45 percent versus 26 percent).¹⁴⁷ In sub-Saharan Africa, men are significantly more likely than women to have had multiple partnerships in the previous 12 months, regardless of marital status. An analysis of data from 20 sub-Saharan African countries showed that unmarried women were more likely than married women to have multiple partners, while the association between marital status and multiple sexual partnerships was weak among men.¹⁴⁸

Increasing numbers of people are identifying as LGBTQ and are entering same-gender and other non-heterosexual relationships, though the data are limited. In the United States, GLAAD's most recent *Accelerating Acceptance* survey found a sharp increase across cohorts, with millennials five times more likely to identify as LGBTQ than people aged 72 and over (see **Figure 9**).¹⁴⁹

Figure 9. Percentage of people in the United States who identify as LGBTQ, by age cohort



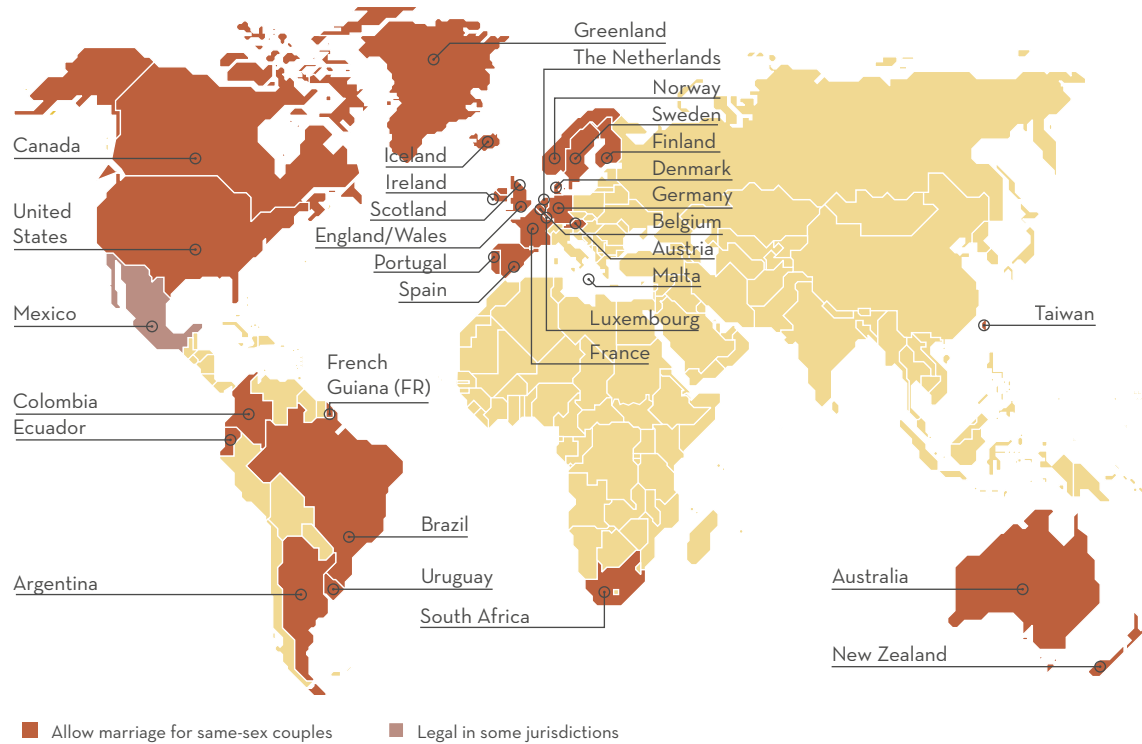
Source: GLAAD. *GLAAD accelerating acceptance 2017 survey*. Retrieved from <https://www.glaad.org/publications/accelerating-acceptance-2017>

As Organisation for Economic Co-operation and Development data show, however, many more people report same-gender sexual behavior or attraction than self-identify as lesbian, gay, or bisexual.¹⁵⁰ Greater social acceptance can also be seen in many settings, with 26 countries around the world now allowing same-sex couples to marry (see **Figure 10**).¹⁵¹

Figure 10. Marriage for same-sex couples around the world

MARRIAGE FOR SAME-SEX COUPLES AROUND THE WORLD

Countries that allow marriage for same-sex couples or where it is legal in some jurisdictions



Source: Pew Research Center. (2019, June 20). *A global snapshot of same-sex marriage: Same-sex marriage around the world*. Retrieved from <https://www.pewresearch.org/fact-tank/2019/06/21/global-snapshot-same-sex-marriage/ft-19-06-20-globalsamesexmarriage-gay-marriage-around-world/>; and Pew Research Center. (2019, May 17). *Same-sex marriage around the world*. Retrieved from <https://www.pewforum.org/fact-sheet/gay-marriage-around-the-world/>

Many more people report same-gender sexual behavior or attraction than self-identify as lesbian, gay, or bisexual. Greater social acceptance can also be seen in many settings, with 26 countries around the world now allowing same-sex couples to marry.

The Sexual Double Standard and Relationship Inequality

The sexual double standard can contribute to relationship inequality. Vast majorities of people in the Muslim-majority countries surveyed by IMAGES in the Middle East value premarital virginity for men and women:¹⁵² more than three-quarters of men and women surveyed in Morocco, and around two-thirds of men and women surveyed in Lebanon reported believing that women should be virgins when they marry, yet these figures were 47 percent and 30 percent, respectively, regarding men's virginity at marriage.

Significant proportions of men in the IMAGES surveys in Eastern Europe and in sub-Saharan Africa shared the view that men need sex more than women do or

that men are always ready to have sex.¹⁵³ (Fewer than 50 percent of men in Mexico, Brazil, and Chile believed that men needed sex more than women did, although they were still significant proportions of respondents.¹⁵⁴) For example, three-fourths of respondents in Moldova and two-thirds of respondents in Kosovo said that men need sex more than women do.¹⁵⁵ This perspective is accompanied by the view that men should be embarrassed if they cannot perform sexually, with over 90 percent of men believing this in Mali and in India.¹⁵⁶

All of these attitudes support men's participation in transactional sex and their purchasing of sexual services. Many men around the world are involved in transactions for sex, whether they are the sellers or the buyers. As a recent global review states, "Hegemonic masculinity around the world calls for men to be sexually dominant, skilled and experienced,"¹⁵⁷ and when men pay for sex, their masculinity, sexual skill, and sexual desirability are affirmed.¹⁵⁸ The power gradient is evident among Western men seeking out unprotected sex in Thailand: these men noted that their older age, modest attractiveness, and limited financial means – all of which might have subordinated them back in their home countries – were not an obstacle for them in Thailand.¹⁵⁹ Unprotected sex was viewed as a strong affirmation of masculinity, and condom use was viewed as less masculine than unprotected sex. The pressures of modern life and the need for respite were described by men in the United Kingdom as motivations for purchasing sex.¹⁶⁰

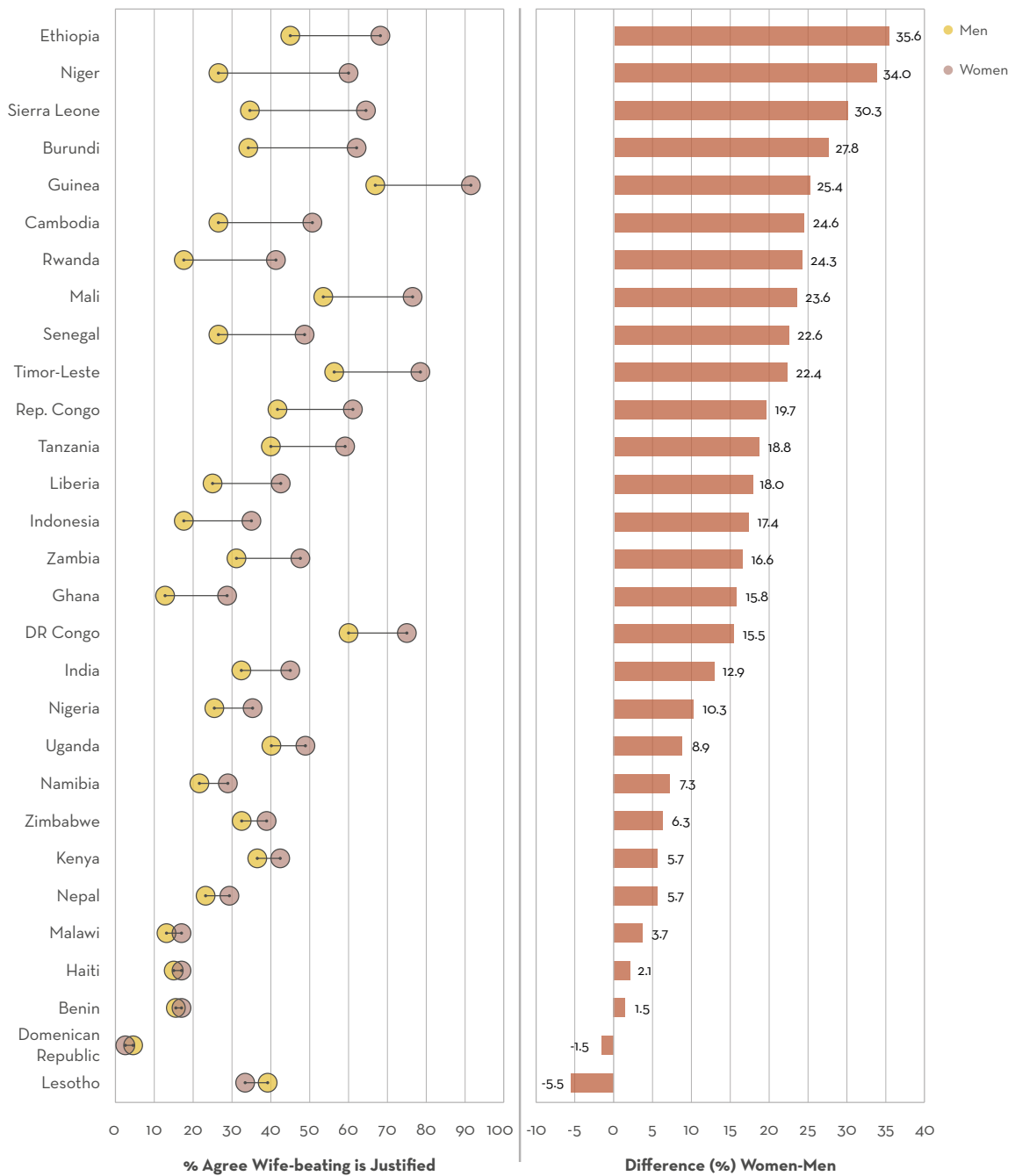
Some men also sell their own services as sex workers. An analysis of data from the largest online male sex worker website in the United States found that escorts who advertise "more masculine behavior" charge more than escorts who advertise "less masculine behavior," for a difference of approximately 17 percent.¹⁶¹ A systematic review and meta-analysis of the relative risk of men who engage in transactional sex (as service providers) versus those who do not found disproportionately high rates of HIV in this population, with HIV prevalence rates more than 32 times higher in Europe, 35 times higher in Latin America, 15 times higher in Southeast Asia, nine times higher in sub-Saharan Africa, and 25 times higher in North America than the general male population.¹⁶²

Relationship Violence and SRHR

Relationship violence contributes to risk-taking, unhealthful practices, poor communication, and poor SRH outcomes.¹⁶³ **Figure 11** compares husbands' and wives' views that wife-beating is justified under some circumstances, and in almost every setting in the analysis, *women are more likely to believe that wife-beating is justified than men*. What is more, the gap between women is substantial, with over 35 percentage points *more women than men* in Sierra Leone, Ethiopia, and Niger believing that wife-beating is justified. However, just how conflict and violence play out in SRHR is not easy to predict: women facing violence may be more or less likely to use contraception, more or less likely to have abortions, and more or less likely to have children.

Hegemonic masculinity around the world calls for men to be sexually dominant, skilled, and experienced.

Figure 11. Proportion of men and women who agree that wife-beating is justified in at least one scenario



Source: Demographic and Health Surveys; analysis conducted by the authors for 30 countries
 Notes: All estimates are based on weighted design-based analyses to account for complex survey design.

Sexual Violence and Attitudes Toward Coerced Sex and Rape

A dominant masculine sexuality is linked to sexual violence, including rape, marital rape, and reproductive coercion and can be influenced by childhood experiences of sexual abuse. The IMAGES data offer a global picture of sexuality and coercion that varies across countries and regions, yet repeats certain patterns: that men's financial support often comes with expectations about their right to sex; the idea that rape should often be "solved" through marriage; the idea that women, through their dress and behavior, are deserving of rape; and that husbands tend to underestimate the extent to which sex is perceived as forced by their wives.

Women and men offered divergent reports of sexual violence in the IMAGES data collected in the Middle East and North Africa: for example, one in six women in Egypt reported having been forced to have sex with her husband compared to less than one percent of men who said they had forced their wives.¹⁶⁴ Forty percent of men in Morocco and Palestine said that it is a woman's obligation to have sex in exchange for financial support. In Egypt, however, more than four-fifths of men disagreed with this statement. The majority of respondents in all three countries agreed that if a woman is raped, she should marry her rapist.

In IMAGES data from Eastern Europe and Central Asia, men's reports of perpetrating sexual violence were under 5 percent, except in Croatia, where 33 percent of men reported ever perpetrating and 38 percent of women reported ever experiencing forced spousal sex.¹⁶⁵ IMAGES data from sub-Saharan Africa found that men from Rwanda (39 percent) were far more likely than men from Nigeria (6 percent) to report ever perpetrating sexual violence against their wives.¹⁶⁶ A large discrepancy between men's (12 percent) and women's (49 percent) reports was observed in the Democratic Republic of the Congo. Men's reports of forcing their wives to have sex in the Latin American countries included in the IMAGES study were 30 percent in Chile, 24 percent in Brazil, and 17 percent in Mexico, with wives reporting higher percentages than husbands in all three settings.¹⁶⁷ Rates of both perpetration and experience of forced spousal sex in the previous 12 months and in the lifetime were higher in India (37 percent) compared to Nepal (26 percent) and Vietnam (11 percent). Men's belief that a woman could not refuse sex with her husband ranged from 37 percent in Vietnam to 66 percent in the Papua region of Indonesia.¹⁶⁸

Male IMAGES respondents in Eastern Europe, Central Asia, South Asia, Latin America, and sub-Saharan Africa offered a creative range of rationalizations for rape, including women's alcohol consumption, dress, reputation, and behavior.¹⁶⁹ More than 50 percent of respondents across the countries surveyed in Asia, with the exceptions of Papua New Guinea and Sri Lanka, believed that if a woman does not physically fight back, the incident is not rape.

What “Reasons” Do Men Give for Raping Women?

A Partners for Prevention survey in Asia collected important data on the motivations for sexual violence (see [Table 2](#)).¹⁷⁰ Sexual entitlement, boredom, punishment, and alcohol consumption were the main reasons men who had raped gave, with men reporting rape most likely to identify entitlement to sex as their primary motivation. Twenty-three percent of men in China, Papua New Guinea, and the Papua region of Indonesia reported drinking alcohol as the “reason” for rape.

Table 2. Motivations for rape among men aged 18 to 49 in Asia and the Pacific, 2010-2013

| | | Bangladesh (rural site - Dhaka) | Bangladesh (urban site - Matlab) | Cambodia (national) | China (urban/ rural) | Indonesia (rural) | Indonesia (urban) | Indonesia (Papua) | Papua New Guinea (Bougainville) | Sri Lanka (national) |
|--|----------------------------------|---------------------------------------|--|------------------------|----------------------------|----------------------|----------------------|----------------------|---------------------------------------|-------------------------|
| Survey characteristics | Sample size for men (N) | 161 | 119 | 369 | 222 | 156 | 224 | 428 | 530 | 209 |
| | Nationally representative (Y/N)? | N | N | Y | N | N | N | N | N | Y |
| Motivation, men reporting ever raping a woman or girl | Sexual entitlement | 82% | 79% | 45% | 86% | 58% | 75% | 75% | 71% | 66% |
| | Fun/bored | 66% | 58% | 27% | 57% | 29% | 23% | 43% | 63% | 20% |
| | Anger/punishment | 36% | 30% | 42% | 43% | 23% | 36% | 24% | 50% | 13% |
| | Drinking | 9% | 9% | 14% | 23% | 9% | 10% | 23% | 23% | 10% |

Source: Fulu, E., Warner, X., Miedema, S., Jewkes, R., Roselli, T., & Lang, J. (2013). *Why do some men use violence against women and how can we prevent it? Quantitative findings from the United Nations Multi-Country Study on Men and Violence in Asia and the Pacific*. Bangkok, Thailand: United Nations Development Programme, United Nations Population Fund, UN Women, & United Nations Volunteers.

Alcohol and Rape

The Partners for Prevention study provides data on men who had raped, while IMAGES surveys document alcohol use and rape prevalence among all men surveyed in four countries in Eastern Europe and Central Asia, Mozambique in sub-Saharan Africa, and Chile in Latin America. In Moldova, 15 percent of men reported having sexual intercourse once with a woman or girl who was too drunk to say whether she wanted it;¹⁷¹ this figure was 12 percent in Mozambique.¹⁷² In Armenia, 1.8 percent and in Moldova, 4.2 percent reported having raped, *more than once*, a woman or girl who was too drunk to say whether she wanted it.

Spousal Control

In diverse settings, IMAGES respondents conveyed their control of women’s movement and freedom. About 90 percent of men in Egypt, Palestine, and Morocco agreed that men could control their wives’ clothing and whereabouts, and nearly two-thirds agreed that men could control their wives’ mobility and have sex with their wives on demand. In Palestine, almost half of the men (45 percent) controlled their wives by threatening that the husbands could have more partners if they wanted.¹⁷³ In Armenia, 85 percent of men wanted to know where their wives were at all times, and 57 percent did not allow their wives to wear certain clothes.¹⁷⁴ In Nicaragua, 66 percent of men reported wanting to know where their wives are at all times, but they were less likely to control their wives’ mobility or threaten them with other partners.¹⁷⁵

Attitudes regarding public sexual harassment reflect the same values that support sexual violence. A nationally representative survey conducted in the United States found that 65 percent of American women have experienced street harassment.¹⁷⁶ The majority of men in the Middle East and in Pakistan who had ever sexually harassed a woman or girl said they believe that women who dressed “provocatively,” did not wear headscarves, or were in public places at night deserved to be harassed;¹⁷⁷ 86 percent of men and 71 percent of women in Pakistan believe that dressing in modern attire is inviting harassment.¹⁷⁸ Significant proportions of men in diverse settings assert that women *like* the attention when men harass them (71 percent in Morocco, for example, and 29 percent in Nicaragua).¹⁷⁹ Men who had experienced violence at home or witnessed violence against their mothers were more likely to harass women compared to men who did not.

Attitudes Toward Female Genital Mutilation and Honor Killings

Female genital mutilation and honor killings reflect the sexual double standard and the regulation of women’s sexuality. More than half of women and two-thirds of men in the Egypt IMAGES survey reported believing that female circumcision makes women less sexually demanding.¹⁸⁰ Ninety-two percent of women in that survey reported being cut, yet only 56 percent of women and only 70 percent of men were supportive of the practice. A third of men reported being willing to marry an uncut woman; a third of men and half of women were willing to have their sons marry an uncut woman. In Nigeria, only nine percent of men and five percent of women believe that the practice of female genital mutilation is important and should continue.¹⁸¹

The proper management of women’s sexuality is a key aspect of family honor in many parts of the world. Most men in the Middle East consider it their duty to protect the honor of women and girls in their families. Most men and women, with the exception of women in Lebanon, reported seeing honor as contingent on their female relatives’ dress and behavior (see **Table 3**).¹⁸² The only country where IMAGES asked about honor killings was in Pakistan, where 46 percent of men and women reported that people in their communities approved of honor killings.¹⁸³

Table 3. Attitudes toward honor killings

| | | Middle East and North Africa | | | | Asia and the Pacific | |
|---|---|------------------------------|---------|---------|-----------|----------------------|-----------------------------|
| | | Male/female | Morocco | Lebanon | Palestine | Egypt | Pakistan |
| Agreement with statement (Indicated by strongly agree or partially agree) | How female relatives act and dress directly affects a man’s honor | M | 83% | 68% | 82% | 95% | |
| | | F | 76% | 32% | 66% | 83% | |
| | The girl or woman usually deserves such punishment from her family | M | 34% | 26% | 47% | 62% | |
| | | F | 12% | 8% | 38% | 49% | |
| | Men who kill their female relatives for (so-called) honor should not be punished by law | M | 14% | 12% | 35% | 31% | |
| | | F | 9% | 8% | 22% | 33% | |
| | Most times these cases are just ways to hide family issues and problems | M | | 54% | | | |
| | | F | | 44% | | | |
| | People in their community approve of honor killing | M | | | | | 46% (N=1,195 men and women) |
| | | F | | | | | |

Source: El Feki, S., Heilman, B., & Barker, G. (2017). Understanding masculinities: Results from the International Men and Gender Equality Study in the Middle East and North Africa. Cairo, Egypt, & Washington, DC: UN Women & Promundo-US.; Fulu, E., Jewkes, R., Roselli, T., & Garcia-Moreno, C. (2013). Prevalence of and factors associated with male perpetration of intimate partner violence: Findings from the UN Multi-Country Cross-Sectional Study on Men and Violence in Asia and the Pacific. *The Lancet Global Health*, 1(4), e187-e207.

Contraceptive Knowledge

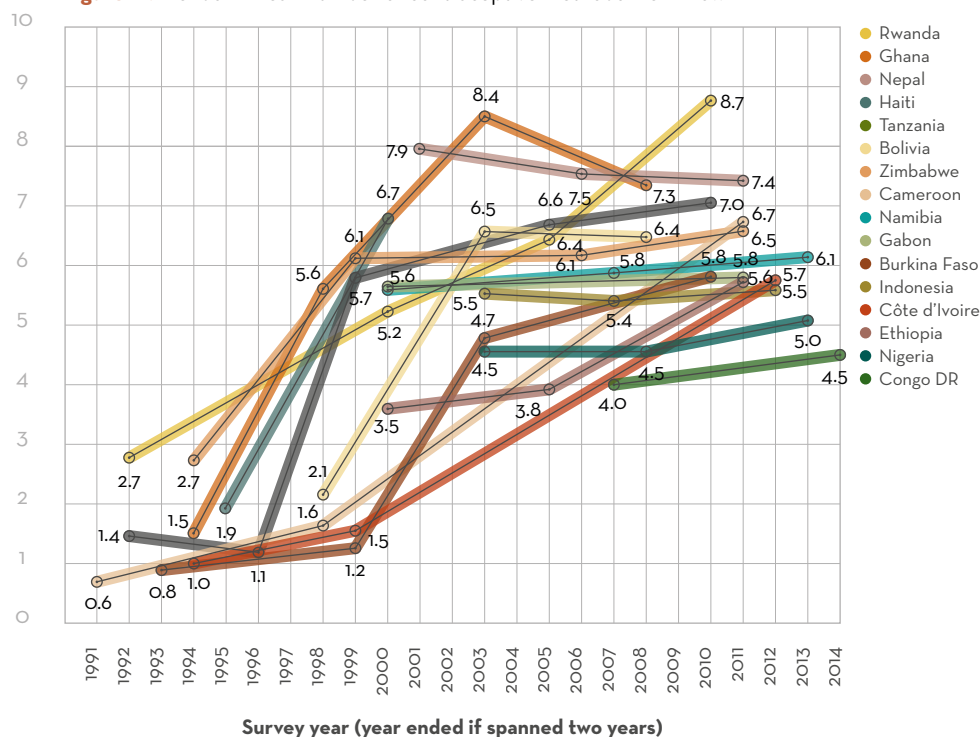
Contraceptive knowledge is a key determinant of contraceptive use and prevalence and the methods people use. It is important to evaluate both men's and women's overall knowledge of contraceptive methods, as well as the types of methods.

Minimal differences in knowledge of modern contraception (male and female sterilization, the intrauterine device (IUD), the pill, the injectable, and the condom) exist between adolescents and older women in countries with overall high knowledge of modern contraception.¹⁸⁴ However, in a study of low- and middle-income countries with lower overall knowledge of modern contraception, fewer adolescents knew about modern contraception methods compared to older women. Knowledge of a modern method of contraception among currently or "ever-married" women aged 15 to 19 varied widely across the countries in the study, ranging from 31 percent to 99 percent.

DHS data from surveys of men in 16 countries across Africa, Asia, Latin America, and the Caribbean assessed contraceptive knowledge by inquiring about all relevant contraceptive methods – modern, traditional, and "folkloric" or local.¹⁸⁵ Of the 12 listed contraceptive methods, the average number of contraceptive methods men knew ranged from 4.5 in Democratic Republic of the Congo to 8.8 in Rwanda. Clear regional patterns did not emerge, as countries within each region had both high and low levels of contraceptive knowledge.

The same comparative study analyzed country-specific trends and found a general increase in contraceptive knowledge over time. The largest proportional increase in knowledge was in Haiti, where the mean number of contraceptive methods known increased from 1.9 in 1994–95 to 6.8 in 2000. In some countries, including Nepal and Ghana, contraceptive knowledge stagnated or took a downturn in the later period (see **Figure 12**).

Figure 12. Trends in mean number of contraceptive methods men know



Source: MacQuarrie, K. L. D., Edmeades, J., Steinhaus, M., & Head, S. K. (2015). *Men and contraception: Trends in attitudes and use* (DHS Analytical Studies No. 49). Rockville, MD: ICF International.

Unsurprisingly, contraceptive knowledge varies with stage of life and socioeconomic factors. Never-married men and men with no children had the lowest contraceptive knowledge in most countries (with the exception of Indonesia and Bolivia), and level of education was also an important correlate with contraceptive knowledge (Rwanda, Democratic Republic of the Congo, and Ghana were exceptions). An analysis in the United States found disparities in contraceptive knowledge by age and ethnicity, with adolescents less knowledgeable than young adults, and Latinos less knowledgeable than Whites, highlighting the need to address disparities in contraceptive knowledge among specific groups.¹⁸⁶

Does What Men Know about Sexual and Reproductive Health Matter?

Gender norms cause women and men to behave in ways that do not always reflect what they know. But how *does* contraceptive knowledge relate to contraceptive use, especially among men?

An analysis of DHS data from 52 low- and middle-income countries with DHS surveys since 2001 documented current levels and trends since 1990 in the unmet need for modern family planning methods.¹⁸⁷ Married women who did not use contraception but either wanted to postpone the next child or did not want any children were asked about their reasons for non-use. Lack of knowledge about contraception as a reason for non-use among women with an unmet need was common predominantly in West and Central Africa, exceeding 20 percent in Burkina Faso, Cameroon, Chad, and Niger.

Gender norms cause women and men to behave in ways that do not always reflect what they know.

The 2009 National Survey of Reproductive and Contraception Knowledge, a nationally representative survey of unmarried adults aged 18 to 29 in the United States, found that *contraceptive behaviors were strongly associated with young adults' objective knowledge about contraceptive methods*; this association was especially strong among women.¹⁸⁸ The more knowledgeable women were, the less likely they were to expect to have unprotected sex in the coming three months, and the more likely they were to use a hormonal or long-acting contraceptive method. Similarly, an association was found among men between contraceptive knowledge and their partner's use of hormonal or long-acting methods.

Who Should Be Responsible for Using Contraception?

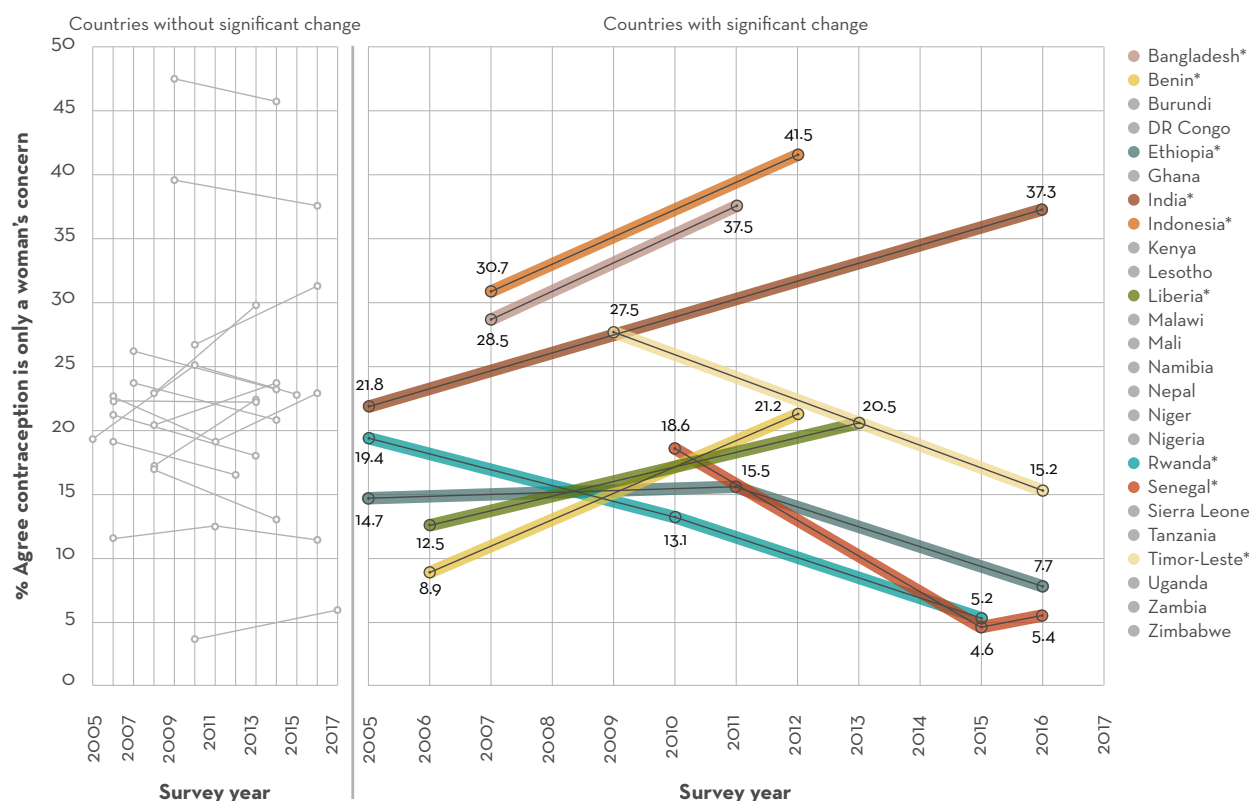
While there is strong support for joint contraceptive decision-making in heterosexual relationships, the belief that avoiding pregnancy is a woman's responsibility also persists in many parts of the world. More than 70 percent of respondents in Lebanon and Palestine reported that men and women together decide whether contraception is used, yet both men and women believed that men were more likely to have the final say.¹⁸⁹ The majority of survey respondents in Eastern Europe, Central Asia, and sub-Saharan Africa believed that a man and woman should decide together what type of contraceptive to use.¹⁹⁰ In Nicaragua and Chile, almost two-thirds of men and around 90 percent of women believed that men and women should decide together, and in Pakistan, almost all respondents (95 percent of men and 98 percent of women) believed that men and women should jointly make contraceptive decisions.¹⁹¹

The belief that it is women's responsibility to avoid getting pregnant varied from 29 percent among men in Mozambique to 68 percent among women in Nigeria.¹⁹² Around 60 percent of men and women in Moldova believed that it was a woman's responsibility to avoid getting pregnant,¹⁹³ and even 22 percent

of women in China shared this view.¹⁹⁴ Cross-sectional data from the most recent survey year available found that men were most likely to agree that contraception is a woman's concern in Lesotho, Indonesia, and Bangladesh and least likely in Burundi, Rwanda, and Senegal; the differences between these two groups were roughly tenfold.

Figure 13 shows trends in the percent of men who agree with the statement that contraception is a woman's concern. In most of the countries, the proportion of men who agree has remained steady. However, in India, the proportion of men who agreed that contraception is a woman's concern rose from about 22 percent in 2005 to 37 percent in 2016; in Senegal, it fell from nearly 19 percent in 2010 to roughly 5 percent in 2016.

Figure 13. Trends in the proportion of men who agree that contraception is a woman's concern (2005–2017)



Source: Most recent Demographic and Health Survey, analysis by authors

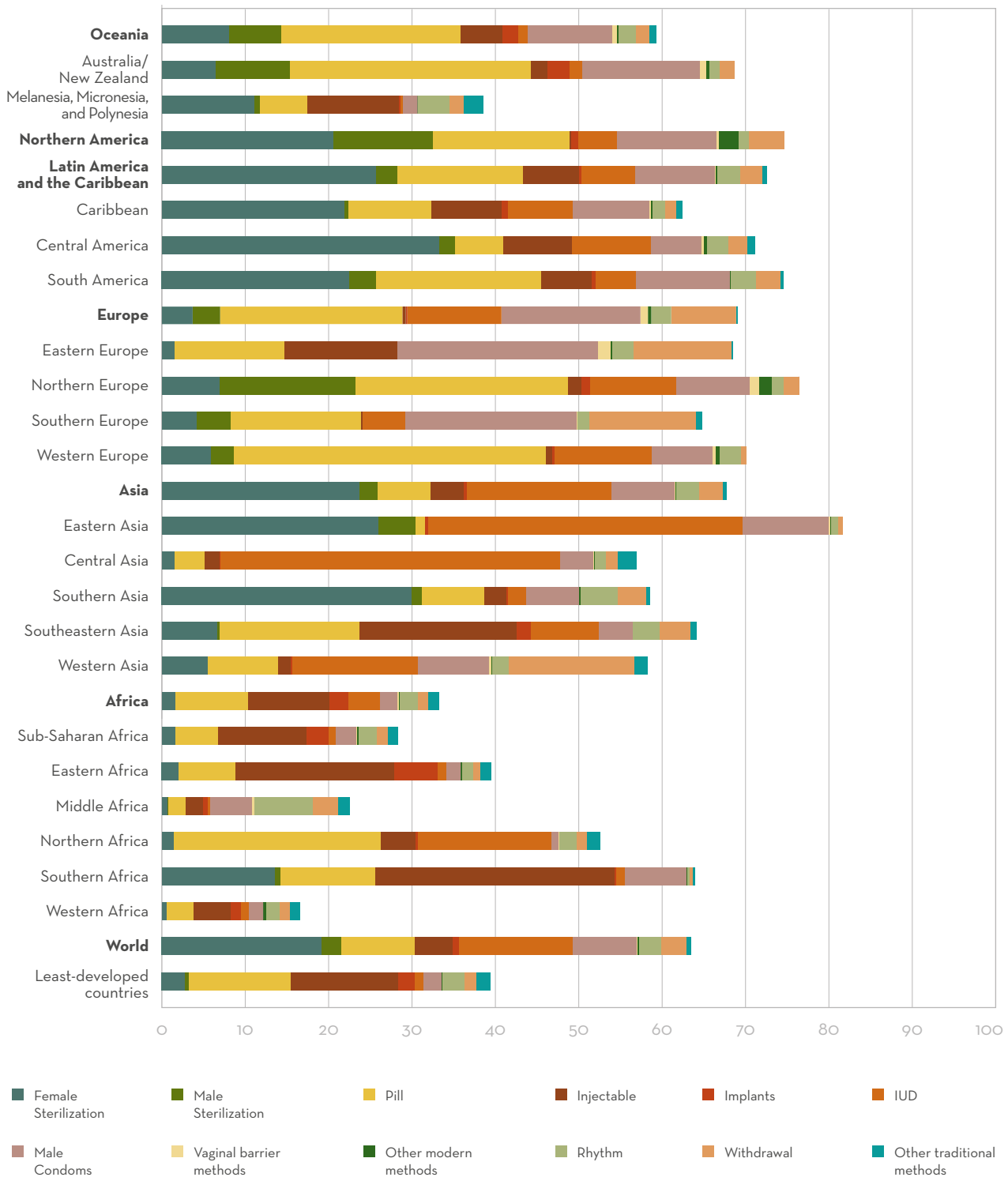
Notes: Analysis was conducted for 25 countries; this figure is based on a "yes" response to the survey question: "Contraception is a woman's business and a man should not worry." All estimates are based on weighted design-based analyses to account for complex survey design.

The common aspiration in many settings for joint decision-making appears to be in "cognitive dissonance" with the persistence of norms that downplay men's contraceptive responsibility and women's right to bodily integrity and reproductive choice.

Figure 14 shows that female methods of contraception predominate in most regions, with female sterilization higher in the Americas and in Asia, and the pill more common in Europe, North America, and South America, and injectables especially widespread in southern and eastern Africa and Southeast Asia.

The IUD is most used in Eastern and Central Asia. Vasectomy is most common in Northern Europe, North America, and Australia/New Zealand, while condom use is most common in Southern and Eastern Europe.

Figure 14. Contraceptive prevalence by type of method, by region



Source: United Nations Department for Economic and Social Affairs. (2015). *Annex table III*. Retrieved from <https://www.un.org/en/development/desa/population/publications/pdf/family/trendsContraceptiveUse2015Report.pdf>

Box 8

The Need to Expand the Contraceptive Technology Mix for Men and Their Partners

In addition to further research to understand why men are not using existing contraceptive methods at high rates, expanding new methods for men is critical. The absence of a reversible method for men that falls somewhere between condoms and vasectomy limits efforts to equalize the gendered burden of contraception, and demand exists for a novel and reversible male method.¹⁹⁵ Across four cities around the world, 44 percent to 63 percent of men reported they would use a contraceptive pill, and over 70 percent of women in a study in Scotland, South Africa, and Shanghai reported willingness to rely on their partner's use of a hormonal male contraceptive, with only 2 percent saying they would not trust it.¹⁹⁶ If even 10 percent of men interested in using a new male-controlled method did so, the introduction of a male pill or temporary vas-occlusion could substantially increase pregnancy prevention, between approximately 3 to 5 percent in the United States and South Africa, and as much as 30 to 38 percent in Nigeria.¹⁹⁷

Two promising reversible male non-hormonal contraceptive methods are currently in late-stage development: Vasalgel is a non-hormonal gel that is inserted into the vas deferens and blocks sperm passage, and a pill form of an Indonesian herb called Gendarussa temporarily interferes with the sperm's ability to penetrate the surface of an egg. While no

significant clinical human trial of Vasalgel has been conducted outside of India, the Gendarussa pill has demonstrated high effectiveness in preventing pregnancy in several human trials and may go to market as early as 2020. Other promising approaches include hormones that block sperm production; a fast-acting muscle relaxant in the vas deferens; and a device that binds to the sperm's surface and prevents motility.¹⁹⁸

Although a novel male contraceptive could open up a market of an estimated 44 million new users,¹⁹⁹ large pharmaceutical companies have so far been reluctant to move forward, owing to concerns over side effects and liability, as well as skepticism that men would use the methods correctly.²⁰⁰ The development of a testosterone and androgen male contraceptive pill was put on hold in 2015 after clinical human trials revealed significant mood-altering side effects. Some suggested the halting of the trial reflected a double-standard, since the side effects of this novel male pill were similar to those reported in some female hormonal methods.

Evidence is needed on the unique barriers to acceptance of these new methods among both men and women. How will female partners perceive sharing contraceptive responsibility with men? How can misperceptions about hormonal contraception and male infertility or sexual performance be confronted? It will be essential to create a market for new methods and services by piloting service delivery and outreach strategies that appeal to users. Creating a market for novel male contraceptive methods may also bring men into a larger "culture of health," in which clinic visits for contraceptive counseling are paired with other essential services.

How Many Children Do People Want to Have?

DHS data from men's surveys in 18 countries across Africa, Asia, and Latin America and the Caribbean assessed various dimensions of men's fertility preferences:²⁰¹

- Mean ideal number of children;
- Among men who wanted at least one child, the proportion who express a preference for the sex of all their desired children; and
- Among men with complete preference for their desired children, the sex breakdown of that preference.

Men's mean ideal number of children was above replacement in all 18 countries surveyed, ranging from 2.3 to 8 children. The highest mean ideal number of children was found in West and Central Africa, ranging from 4.7 in Ghana to 8.0 in Nigeria. East and Southern Africa also had high rates of mean ideal number of children, ranging from 2.9 in Rwanda to 5.1 in Ethiopia. In Asia, the mean ideal number of children ranged from 2.3 in Nepal to 3.1 in Cambodia; in Latin America and the Caribbean, it was 2.8 in Bolivia and Haiti.

More educated, richer, urban, (heterosexual) monogamous men wanted fewer children, while older, polygamous, rural men with more children wanted more. The most significant association was found in Cameroon, where men with no schooling desired an average of 12.1 children while men with higher education desired an average of 4.5 children. Among countries where the negative association between wealth and the mean ideal number of children was strongest, Nigeria had the largest difference in mean ideal number of children between the poorest and richest quintile, at 12.6 and 5.0 children, respectively. Among men who wanted to have at least one child, a high proportion desired a specific sex for all children, ranging from 74 percent in Tanzania to 96 percent in Cambodia. The highest percentage of men who preferred equal numbers of male and female children were predominantly in Asia (Indonesia, Cambodia, and Nepal) and Haiti. The lowest percentage of men who preferred equal numbers of male and female children were predominantly from West and Central Africa (Democratic Republic of the Congo, Cameroon, Burkina Faso, and Nigeria). (Sex preference for children is explored further later in this report.)

Trends in Contraceptive Use, Including Prevalence, Method Mix, and Unmet Need

The focus of this report is on men, yet trends in contraceptive use are measured largely using data on married women, whose experience nonetheless describes the context for contraceptive use. The United Nations estimated levels and trends in contraceptive use among married or in-union women aged 15 to 49 from 1970 to 2030 based on data from 195 countries or geographic areas.²⁰² Contraceptive use overall has increased steadily since 1970, with overall prevalence rising from 36 percent in 1970 to 64 percent in 2015, though this trend conceals wide diversity among and within regions.

Method Mix Among Married Women, by Region

An analysis of data from 58 men's surveys in 18 countries in Africa, Asia, and Latin America and the Caribbean assessed men's contraceptive knowledge, fertility and fertility preferences, desired sex composition of children, attitudes toward contraception, gender attitudes, and use of contraception at last sex.²⁰³ The use of modern contraception methods has increased over time in all countries. In seven of the eight countries in Asia, the Middle East and North Africa, and Latin America, more than 50 percent of women use modern contraceptives based on the most recent DHS findings. However, in sub-Saharan Africa, only three of the eight countries (Kenya, Malawi, and Zimbabwe) had 50 percent or higher use of modern contraceptives among women. Trends in the use of traditional methods vary significantly by method and are quite inconsistent. For instance, periodic abstinence declined in Ghana, Kenya, Malawi, and Colombia but increased in Tanzania. Similarly, the use of withdrawal increased in the Philippines, Jordan, and Peru but decreased in Bangladesh and Colombia.²⁰⁴

Unmet Need

An analysis of the 2006–2010 National Survey of Family Growth in the United States found that about 60 percent of men aged 15 to 44 were in need of family planning.²⁰⁵ This need decreased with increasing age among all sexually active men, and married and cohabiting men said they needed family planning less than those who were not in co-residential unions. Remarkably, only 7 percent of men had visited a family planning clinic, 26 percent reported consistently using condoms, and 41 percent had partners consistently using contraception.

Men's Contraceptive Use at Last Sex

Men were asked whether they used a condom and whether they or their partner used something to prevent pregnancy at the time of their last sexual intercourse. Men who used contraception at last sex were more likely to have used a modern method than a traditional method.²⁰⁶ Countries in Central Africa and Latin America and the Caribbean had lower ratios of modern-to-traditional method use than countries in East, West, and Southern Africa. Use of modern methods ranged from a low of 11 percent in the Democratic Republic of the Congo to a high of 60 percent in Indonesia.

The authors' analysis of DHS data found that men's use of modern methods of contraception at last sex increased in four countries over the periods for which trend data were available: in Côte d'Ivoire from 20 percent in 1994 to 30 percent in 1998–99; in Tanzania, from 8 percent in 1991–92 to 18 percent in 1996 to 26 percent in 1999; in Ethiopia, from 10 percent in 2005 to 21 percent in 2011; and in Haiti from 15 percent in 1994–95 to 22 percent in 2000.

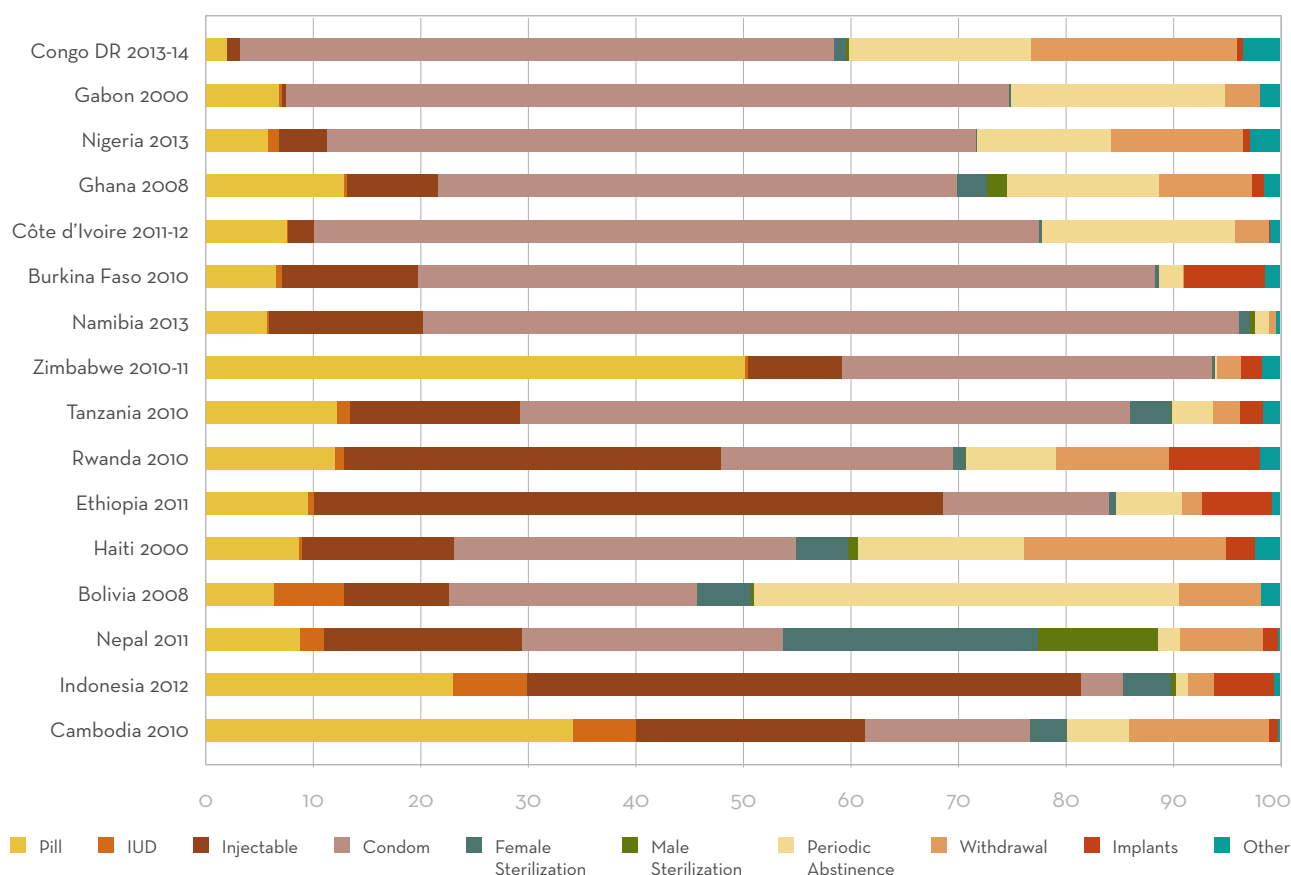
Methods of Contraception Used by Men

Just a few contraceptive methods – the pill, condoms, and injectables – account for most contraceptive use at last sex. A few headlines emerge from **Figure 16**, which shows the method mix across the 16 countries analyzed: In ten of the countries, the male condom accounts for *more than 50 percent of all contraceptive use at last sex*. In Tanzania, condoms accounted for 31 percent of all contraceptive use in 1991–92 and increased to 57 percent of all contraceptive use in 2010. The pill accounts for 50 percent of all contraceptive use in Zimbabwe, while injectables are the most commonly used method in Rwanda, Ethiopia, and Indonesia. Periodic abstinence and withdrawal are common in the Democratic Republic of the Congo, Nigeria, Rwanda, and Haiti, and in Bolivia, periodic abstinence is the most commonly used method. Male sterilization is uncommon in almost all countries, with the exception of Nepal, where it contributes to 11 percent of the method mix.

Male-Controlled, Female-Controlled, and Cooperative Contraception at Last Sex

In 11 of the 16 countries with available data, the percentage of men using male-controlled and cooperative methods of contraception at last sex was higher than the percentage using female-controlled methods (**Figure 15**). The percentage of men using male-controlled or cooperatively controlled methods at last sex ranged from 5 percent in Indonesia to 53 percent in Gabon. The percentage of men using female-controlled methods ranged from 1 percent in Democratic Republic of the Congo to 58 percent in Indonesia. In Democratic Republic of the Congo, men who used contraception at last sex were 12 times more likely to use a male-controlled or cooperative method of contraception than female-controlled methods. In the remaining six countries, more men used female-controlled methods of contraception.²⁰⁷

Figure 15. Method mix of men's contraceptive use at last sex, according to the most recent DHS survey



Source: MacQuarrie, K. L. D., Edmeades, J., Steinhaus, M., & Head, S. K. (2015). *Men and contraception: Trends in attitudes and use* (DHS Analytical Studies No. 49). Rockville, MD: ICF International.

Men's contraceptive use is limited, and male sterilization has declined in recent years. An analysis of male contraceptive use based on surveys with married/in-union women aged 15 to 49 found that contraceptive methods that men use directly – condoms, withdrawal, fertility awareness, and male sterilization – account for one-quarter of all contraceptive use worldwide, ranging from a low of 6 percent in Africa to 29 percent in North America and 30 percent in Europe.²⁰⁸ Only 16 percent of contraceptive use among married/in-union women is used directly by men. In the 106 developing countries with trend data, the use of male methods increased from 10.7 percent in 1994 to 13.6 percent in 2015. Over this period, male sterilization lost ground, falling from 3.7 percent to only 1.9 percent. The total male contraceptive use increases by wealth quintile in every region, rising from an average of 33.8 percent in the lowest quintile to 49.1 percent in the highest. The condom is the most used male method globally, at 8 percent, followed by withdrawal at 3 percent, rhythm [sic] at 3 percent, and male sterilization at 2 percent. Research from Latin America suggests that men who are more involved in the care of children they already have are more likely to be vasectomy acceptors in some settings.²⁰⁹

Table 4. Male share of all contraceptive use and prevalence of each method, by region

| | Share (%) | Prevalence | | | | |
|--|---|--------------------|-------------|------------|--------|-------|
| | Share of total use due to four male methods | Male sterilization | Male condom | Withdrawal | Rhythm | Total |
| World | 24.8 | 2.4 | 7.7 | 3.1 | 2.6 | 15.8 |
| Least developed countries | 17.2 | 0.4 | 2.2 | 1.4 | 2.7 | 6.7 |
| Africa | 17.2 | 0.0 | 2.1 | 1.3 | 2.2 | 5.6 |
| Asia | 22.7 | 2.2 | 7.6 | 2.9 | 2.7 | 15.4 |
| Europe | 43.6 | 3.3 | 16.7 | 7.8 | 2.4 | 30.2 |
| Latin America and the Caribbean | 24.2 | 2.6 | 9.6 | 2.6 | 2.8 | 17.6 |
| North America | 39.2 | 11.9 | 11.9 | 4.3 | 1.2 | 29.3 |
| Oceania | 34.2 | 6.3 | 10.2 | 1.7 | 2.1 | 20.3 |

Source: Ross, J., & Hardee, K. (2016). Use of Male Methods of Contraception Worldwide. *Journal of Biosocial Science*, 49(5), 648-663.

Factors Influencing Methods of Contraception

Condoms are less likely to be used in marriage than with a casual acquaintance, girlfriend, or sex worker, and a drop-off takes place in men's contraceptive use with time in relationships.²¹⁰ Use of the pill, injectables, periodic abstinence, and withdrawal are higher among currently married men than among formerly married or never-married men.

Adolescents aged ten to 14 rarely use contraception, as an analysis of DHS data on youth shows, but adolescents (mostly girls) aged 15 to 19 use contraception to a significant degree in some places, up to 66 percent in Peru and 43 percent in Namibia.²¹¹ Condom use increases between the age groups 15 to 19 and 20 to 24 and declines with age thereafter. In all countries, condom use decreases the more children men have.²¹² For instance, in Gabon, condom use exceeds 50 percent among childless men and falls to 23 percent among men with five or more children. Condom use increases with men's household wealth quintile, urban residence, and level of education, rising in Burkina Faso, for example, from 9 percent among men with no formal education to 50 percent among men with some education. Female sterilization and male sterilization increase with age, and the use of the pill and injectables increases initially with age and then decreases (an inverted U-shaped pattern).

Gender-Related Attitudes and Men's Use of Contraception

Men's support for wives' agency in negotiating safer sex is positively associated with contraceptive use at last sex. The authors conducted an analysis of data from ten DHS countries for which data were available. Men were more likely to use contraception at last sex if they believed that a woman is justified in asking her husband to use a condom if she knows he has an STI. In the 12 countries that had survey data on men's attitudes toward wife-beating and on contraceptive use, contraceptive use at last sex was higher among men who do not justify wife-beating.

Contraceptive Access

Research estimated access to contraception for each widely used modern method: male and female sterilization, the intrauterine device (IUD), the pill, the injectable, and the condom.²¹³ The analysis found that sub-Saharan African countries have lower levels of access than the countries in other regions, which directly contributes to lower contraceptive use. Indeed, 23 of the 30 sub-Saharan African countries are below 20 percent prevalence, of which 11 Francophone countries are below 10 percent prevalence. Use of the IUD and female sterilization is more closely associated with access than other contraceptive methods, likely because they require clinical intervention.

Unmet Need

Unmet need measures the percentage of sexually active women who want to stop or delay childbearing but are not using any method of contraception. It is influenced by desired fertility and access to contraception, among other things. The challenge is that although unmet need is generally measured among women, partner preferences and couple dynamics contribute importantly to shaping it.

The global rise in contraceptive use has been accompanied by a decline in unmet need for family planning among women in unions, from 22 percent in 1970 to 12 percent in 2015. Unmet need in 2015 was highest in regions of Eastern Africa, Central Africa, Western Africa, and Melanesia, Micronesia, and Polynesia (above 20 percent). Unmet need was lowest in Eastern Asia, Northern Europe, Western Europe, and North America (below 10 percent). Couples who want to prevent pregnancy are often not using modern methods of contraception: In 54 countries, less than half of the total demand for family planning was being met with modern methods in 2015.²¹⁴

A comprehensive analysis of levels and trends in unmet need for modern family planning¹ since 1990 found that on average, 32 percent of married women are in need of modern methods worldwide.²¹⁵ Modern contraceptive prevalence varies dramatically by region, from 9 percent in West and Central Africa to 51 percent in Latin America. Albania had 72 percent unmet need for modern contraceptive methods, and Egypt had 14 percent.

Regional Trends in Unmet Need and Demand for Spacing and Limiting

The comparative study found that in Asia and North Africa, 11 countries had multiple surveys, showing mixed trends in unmet need for spacing and limiting births. Generally, most countries in this region experienced a decline in the unmet need for spacing births, indicating positive health implications for mothers and children. However, only half the countries experienced a decline in the unmet need for limiting births. With the exceptions of India and Pakistan, modern contraceptive use increased for both spacing and limiting births. There is an increasing demand for limiting births in most regions, with the exceptions of Egypt, Jordan, and the Philippines.

In Latin America and the Caribbean, six countries had multiple surveys, showing a decrease in unmet need for both spacing and limiting births. Modern contraceptive use increased particularly for the purpose of limiting births.

¹ The article classifies the use of withdrawal and periodic abstinence, also known as traditional methods of contraception, as nonuse, and it considers women who use traditional methods as having an unmet need.

In Africa as a whole, the unmet need for spacing exceeds the unmet need for limiting, and there is higher contraceptive use for limiting births than for spacing in seven of the 12 countries in this region.

Another analysis of levels and trends in unmet need among married and unmarried young women aged 15 to 24 in 47 countries found that total demand for family planning was highest in Latin America and the Caribbean (80 percent) and lowest in West and Central Africa (45 percent).²¹⁶ The highest unmet need for family planning among young unmarried women – whose unmet need is generally higher than that of married women – was in West and Central Africa (41.7 percent) and East and Southern Africa (39.8 percent) (see **Table 5**).

Table 5. Regional averages of unmet need for family planning among women aged 15 to 24 (data from most recent DHS surveys, 2000-2012)

| Factor | Married women aged 15-24 | | | | | | Unmarried, sexually active women aged 15-24 | |
|---------------------------------|--------------------------|---------|-----------|-------|---------------------------|-------|---|-------|
| | Education (%) | | | | Urban-rural residence (%) | | Urban-rural residence (%) | |
| | None | Primary | Secondary | Higer | Urban | Rural | Urban | Rural |
| West and Central Africa | 26.5 | 32.5 | 34.9 | 13.0 | 32.3 | 28.2 | 37.7 | 47.9 |
| East and Southern Africa | 26.0 | 27.1 | 23.5 | 16.5 | 22.9 | 26.3 | 33.1 | 44.4 |
| Middle East and North Africa | 15.1 | 13.8 | 12.5 | 6.4 | 9.9 | 11.1 | N/A | N/A |
| Eastern Europe and Central Asia | 30.1 | 23.3 | 15.9 | 14.6 | 14.5 | 18.4 | 17.4 | 11.9 |
| South and Southeast Asia | 22.2 | 24.3 | 23.5 | 20.0 | 21.2 | 23.7 | N/A | N/A |
| Latin America and the Caribbean | 26.7 | 28.1 | 22.7 | 13.9 | 23.7 | 25.9 | 22.4 | 32.5 |

Source: MacQuarrie, K. L. D. (2014). *Unmet need for family planning among young women: Levels and trends* (DHS Comparative Reports No. 34). Rockville, MD: ICF International.

Generally, with the exception of West and Central Africa, unmet need decreases with increasing education. Unmarried rural young women's unmet need is higher than that of their urban counterparts. An estimated 33 million women aged 15 to 24 have an unmet need for family planning in the countries included in this study, 21 million of whom live in the ten South and Southeast Asian countries.

Couple Dynamics in Contraceptive Decision-Making

Research on fertility and family planning historically focused on women, but the growing recognition that men play an important role in decisions about the number of children to have, birth spacing, and contraceptive use has yielded a much-needed body of research focused on couples and individual preferences. When men are on board with contraceptive use, contraception is more acceptable, its use is more effective, and its continuation is more likely.²¹⁷

Couple Agreement, or “Concordance,” on Number of Desired Children

Research in high-income countries finds that men aspire to parenthood as much as women do but have limited knowledge about factors influencing both male and female fertility.²¹⁸ Gender ideals that emphasize women as caregivers and men as authority figures place the burden of childbearing on women and are associated with a high ideal number of children among men.²¹⁹ A study in high birth rate countries found that even though women report men’s opposition to contraception, men report similar attitudes on contraception and reproductive aspirations as women,²²⁰ suggesting that the actual problem is the absence of discussion between spouses.

Concordance or Discordance in Reported Reproductive Intentions and Behaviors

An influential 1996 global analysis of agreement and difference between men and women as couples showed that the intention of *both* partners is essential in shaping reproductive outcomes.²²¹ This insight has driven recent research and interventions and a greater focus on couple dynamics.²²² Couples tend to agree at relatively high levels about reproductive *events* (like whether a pregnancy occurred, approximately 90 percent), whereas agreement on *subjective* experiences was lower (like whether the pregnancy was intended, 60 to 70 percent). When couples’ fertility desires are not in agreement, research points to the covert use of contraception by women and the possibility of reproductive coercion by men.

Covert Use of Contraception

Difficult spousal communication about contraception and low couple agreement on fertility preferences emerge as key determinants of covert use.²²³ Covert contraception serves an important means to preserve a level of agency for some women whose fertility aspirations or attitudes toward contraception differ from their husbands. However, covert use also carries significant and complex additional risks for women, including discontinuation of use, worry about their husbands’ suspicion, and fear of violence.²²⁴ These findings complicate the broad goal of increased male involvement in contraceptive decision-making in the context of persistently unequal gender norms and power relationships. On balance, the literature points to a need for confidential services for both men and women and for a sustained commitment to addressing gender inequality.²²⁵

Reproductive Coercion

Reproductive coercion is a form of gender-based violence comprising behaviors of male partners or family members that reduce girls’ and women’s control over their reproduction, including the decision to become pregnant, use contraception, or seek abortion.²²⁶ An estimated 10 to 40 percent of women experience reproductive coercion across low- and middle-income countries, and it is associated with physical and sexual intimate partner violence and contributes to unintended pregnancy and other poor reproductive health outcomes.²²⁷ In many locations, men’s fertility aspirations clearly outweigh women’s, and contraceptive use by couples is more likely when men want to avoid having children, though women’s education can mitigate this impact.²²⁸

Service providers need to more fully recognize and support men in playing roles that reaffirm their female partners’ choices.

Research suggests that the strength of traditional gender norms in the community partly determines the strength of men's influence on contraceptive use. A study in five Asian countries found that where traditional gender roles prevail, women face more difficulty opposing their husband's fertility aspirations.²²⁹ Thus, women may report agreement with their husband's fertility aspirations when they in fact disagree.²³⁰

Case Study

The *Bandebereho* program has worked directly with men to support women's decision-making in Rwanda.²³¹ The gender-transformative program engages men not just to overcome specific barriers to health but also to challenge inequitable gender and power dynamics that give rise to these barriers. Organized around discussion groups with men alone and with their partners, and evaluated via a randomized controlled trial, the program succeeded in improving a number of outcomes reflecting improved relationship power dynamics and women's decision-making: reports of past-year physical and sexual interpersonal violence declined by two-thirds, male accompaniment at antenatal care increased by half, both women's and men's modern contraceptive use increased by more than 50 percent, men were significantly more likely to participate in childcare and household tasks, and men were less dominant in decision-making.

Induced Abortion and Reproductive Coercion

Decision-making about the termination of a pregnancy can bring couples together – or destabilize their relationships – and poses challenges for service providers.²³² Some men's attitudes and assumptions about abortion can endanger women's health. However, important numbers of men, even in contexts of mainstream gender-unequal norms, are supportive of abortion and are engaged and supportive partners in ways that benefit women.²³³ Still, a study in urban Zambia found that while some men are supportive, many men may react negatively, and women desire confidentiality in obtaining abortions to avoid potential conflict with their partners.²³⁴ Men in Ghana were shown to either insist on abortion or deny paternity altogether, contributing to coercion, serious health consequences, and emotional isolation among women.²³⁵

Recent research on abortion decisions among unmarried men and women in India demonstrates the important role men can play in supporting their partners' access to services.²³⁶ The stigma surrounding premarital sex and limited mobility of the men's female partners motivates them to adopt the role of "all-in-one" service provider for their partners: they seek information about and purchase pregnancy tests and abortion pills, speak to doctors, accompany their partners to clinics, and pay for abortions. Qualitative interviews conducted with male and female abortion seekers and providers revealed the "tightrope" young men continually walk between a traditional masculinity and their own vulnerability. Service providers need to more fully recognize and support men in playing roles that reaffirm their female partners' choices.

Recent research on abortion decisions among unmarried men and women in India demonstrates the important role men can play in supporting their partners' access to services.

How Gender Context Influences Contraceptive Decision-Making

When a husband and wife agree on the number of children they want to have, women are less likely to report that they need contraception.²³⁷ Research in Ethiopia found that the highest levels of contraceptive use were found in couples where the husband did not want any more children, suggesting that male fertility preferences take precedence over female preferences.²³⁸

Men's desires do not always determine the number of children a couple will have. Qualitative research in Pakistan revealed that when spouses disagree, women's intentions tended to determine actions and outcomes of fertility.²³⁹ In Madhya Pradesh, India, husbands' fertility preferences exercised a strong, independent effect on their wives' decision to have an abortion, though wives' fertility preferences ultimately took precedence.²⁴⁰

Two new analyses were conducted for this report to explore the broader gender context in which women and men make decisions regarding contraceptive use.

Analysis 1. Gender Context and Contraceptive Use: A Multi-Country Comparison

New analyses of DHS data from eight countries² (Box 9) conducted for this report investigate how countries' gender context - measured through a multidimensional male dominance index - impacts both men's and women's SRH behaviors, including contraceptive use, and SRH outcomes. The analysis sought to answer the following questions: How does the level of male dominance within a couple impact contraceptive use for both men and women? Does this household-level male dominance matter more for this outcome than community-level norms around male dominance? Does male dominance in one domain impact contraceptive use more than in another (e.g., socio-familial versus economic)?

Box 9

Analysis Countries, Selected for Their Geographic Diversity

- Armenia - Eastern Europe
- Cambodia - Southeast Asia
- Colombia - Latin America and the Caribbean
- Côte d'Ivoire - Francophone West Africa
- Ethiopia - upper East Africa
- India - South Asia
- Rwanda - eastern Central Africa
- Zambia - Southern Africa

2 From the most recent DHS survey conducted in each country, using the couples dataset (a linked dataset based on surveyed men and women within a single household that declared each other as married or cohabiting partners).

Male dominance index scores were calculated by sub-domain across the eight countries. The sub-domains were **economic** (capturing relative earnings, control over income, and final say on major household purchases); **socio-familial** (including relative age, decisions about health care, education, mobility, and attitudes toward wife-beating); and **relationship control** (capturing demanding to know where the spouse is, jealousy if the spouse speaks to others, and limiting visits to family). Côte d'Ivoire had the highest composite index score of male dominance (mean of 6.5, standard deviation \pm 0.1), followed by Zambia (mean of 5.8, S.D. \pm 0.07), while Cambodia (mean of 2.4, S.D. \pm 0.05) and Armenia (mean of 2.9, S.D. \pm 0.1) had the lowest scores. The proportion of women who reported their male partner has the final say on decisions regarding her healthcare varied the most, ranging from 3 percent in Armenia to 64 percent in Côte d'Ivoire. The percentage of women who agreed that wife-beating is justified in at least one scenario ranged from 4 percent in Colombia to 36 percent in Côte d'Ivoire.

Women's current modern contraceptive use varies sharply across the eight countries, with over three-quarters using a modern method in Colombia, 50 to 63 percent in India and Rwanda, and only about 15 percent in Côte d'Ivoire (see **Table 6**). Armenia had the most even split of all countries in terms of non-users, traditional method users, and modern users. Nearly 81 percent of women are not using any method of contraception in Côte d'Ivoire but only 18 percent of women in Colombia are not.

Men's reports of contraceptive use at last sex are lower than women's overall, yet followed a similar pattern. Over 70 percent of men in Côte d'Ivoire and India reported not using a method, and about 50 percent or more of men reported the same in Armenia, Cambodia, Ethiopia, and Zambia. Men in Colombia were most likely to report modern contraceptive use at last sex (77 percent), followed by Rwanda (52 percent) and Zambia (43.6 percent).

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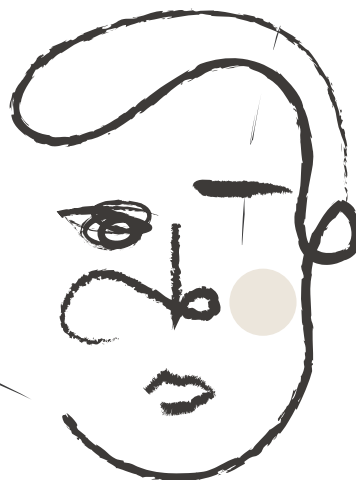


Table 6. Prevalence of women's current use of modern contraception and multi-level associations between male dominance at the individual (couple)-level and women's contraceptive use^a

| Country (survey year) | Armenia (2015-2016) | Cambodia (2014) | Colombia (2015-2016) | Côte d'Ivoire ^b (2011-2012) | Ethiopia ^b (2016) | India (2015-2016) | Rwanda ^b (2014-2015) | Zambia ^b (2013-2014) |
|---|-------------------------|-------------------------------|-------------------------------|---|---------------------------------|--------------------------------|------------------------------------|------------------------------------|
| Sample size (couples) | 311 | 1,972 | 7,136 | 974 | 1,100 | 13,427 | 1,117 | 3,518 |
| Prevalence of modern contraceptive use | 36.4 | 45.5 | 77.0 | 14.7 | 43.9 | 62.5 | 50.4 | 44.2 |
| | aOR (95% CI) | aOR (95% CI) | aOR (95% CI) | aOR (95% CI) | aOR (95% CI) | aOR (95% CI) | aOR (95% CI) | aOR (95% CI) |
| Individual-level | | | | | | | | |
| Male dominance index | | | | | | | | |
| Economic | 0.70 (0.32-1.49) | 0.91 (0.74-1.11) | 0.98 (0.86-1.12) | 1.06 (0.68-1.65) | 0.99 (0.72-1.36) | 0.92 (0.83-1.02) | 0.93 (0.70-1.22) | 1.00 (0.86-1.17) |
| Socio-familial | 1.40 (0.58-3.36) | 1.44** (1.14-1.82) | 0.80** (0.67-0.96) | 1.18 (0.74-1.89) | 0.87 (0.61-1.24) | 0.91 (0.81-1.01) | 1.02 (0.75-1.37) | 0.94 (0.80-1.11) |
| Relationship control | 1.13 (0.50-2.53) | 0.94 (0.73-1.22) | 0.94 (0.83-1.07) | 1.34 (0.86-2.09) | 1.19 (0.82-1.73) | 1.03 (0.94-1.12) | 1.08 (0.83-1.40) | 0.97 (0.80-1.17) |
| Composite | 1.60 (0.89-2.87) | 1.16 (0.94-1.44) | 0.97 (0.85-1.12) | 10.29 (0.77-2.13) | 0.92 (0.67-1.25) | 0.96 (0.87-1.06) | 1.02 (0.78-1.34) | 0.87 (0.75-1.01) |
| Community-level | | | | | | | | |
| High community economic index score | 0.60 (0.25-1.46) | 0.81 (0.90-1.12) | 1.34** (0.81-2.18) | 0.76 (0.41-1.43) | 1.23 (0.89-1.71) | 0.90* (0.83-0.98) | 1.08 (0.81-1.44) | 0.81 (0.54-1.20) |
| High community socio-familial index score | 0.71 (0.31-1.63) | 0.68* (0.48-0.96) | 0.76 (0.61-0.85) | 1.14 (0.69-1.87) | 0.98 (0.66-1.43) | 0.86*** (0.79-0.93) | 0.91 (0.68-1.21) | 0.82 (0.59-1.15) |
| High community relationship control index score | 0.97 (0.45-2.04) | 0.94 (0.68-1.29) | 1.09 (0.89-1.35) | 0.92 (0.47-1.80) | 0.99 (0.69-1.41) | 1.01 (0.99-1.02) | 0.77 (0.59-1.00) | 0.80 (0.59-1.08) |
| High community composite male dominance index score | 0.65 (0.31-1.36) | 0.81 (0.59-1.10) | 1.05 (0.85-1.30) | 1.26 (0.74-2.13) | 1.05 (0.75-1.47) | 0.85*** (0.78-0.93) | 0.96 (0.72-1.28) | 0.84 (0.58-1.21) |

Source: Most recent Demographic and Health Survey, 2011-2016, couple data sets; analysis by authors

Notes: Male dominance index items based on women's responses. Multi-level random effects models adjusted for the following covariates: women's characteristics (age, education level, religion, parity), men's characteristics (age, education level), and household characteristics (wealth quintile, urban versus rural residence). Models compare odds of current modern contraceptive use (versus non-use of modern method, which includes non-users and traditional method users) between those reporting "high" versus "low" male dominance in each domain, meaning above or at/below the mean country level. Models were run separately by country. "Community-level" was proxied by the sampling strata in each country (and by state in India) as the clustering unit. Community-level index scores were generated by aggregating mean scores of individuals in a sampling stratum ("community").

a. Source: Most recent Demographic and Health Survey couples data sets. All percentages are based on weighted estimates accounting for complex survey design.

b. Multivariate models in these countries were also adjusted for marital union type (monogamy versus polygamy).

c. Reports of contraceptive use include both woman- and man-controlled methods.

* p<0.05; **p<0.01; ***p<0.001; aOR=adjusted odds ratio

At the individual level, male dominance in the socio-familial domain was associated with women's use of modern contraception in two countries. Women in Cambodia reporting high male dominance in this domain had 44 percent increased odds of modern contraceptive use compared to women reporting low dominance, while in Colombia, women who reported high male dominance had 20 percent decreased odds of using modern contraception. The results at the community level contrast with the individual-level findings: women in Cambodia, Colombia, and India living in communities with high community-level male dominance in economic and socio-familial domains, as well as high dominance measured by the composite index, had *reduced* odds of modern contraceptive use compared to communities with low male dominance on average (except for Colombian communities with high levels of economic male dominance).

In the analysis of cross-level interactions, women in Colombia who reported high socio-familial male dominance in their relationships were 73 percent less likely to report using a modern contraceptive method if they lived in a community with high community levels of socio-familial male dominance versus similar women living in low-dominance communities (aOR: 0.27, 95% CI: 0.11–0.66) (results not shown).

The message of this analysis is that the normative context regarding gender and power in relationships *as well as* the gender dynamics between husbands and wives influence contraceptive use. Gender inequality and expectations operate on two levels to determine contraceptive use.

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Analysis 2. Gender Norms, Family Planning-Related Social Norms and Their Influence on Contraceptive Use in Nepal

The reproductive health literature identifies equitable gender norms and descriptive family planning-related (FP-related) social norms as positively associated with contraceptive uptake. However, most studies rely on women's reports to measure couple concordance (agreement) despite longstanding calls for interviews with both wives and husbands. Furthermore, while there is evidence that women who hold equitable gender norms and positive FP-related social norms are more likely to use contraceptives, to the authors' knowledge, no studies to date have examined the association between concordant gender norms and concordant FP-related social norms on one hand and women's contraceptive practices on the other. This analysis thus examined how agreement between partners and normative support in the community for family planning interact to influence contraceptive practice in Nepal.²⁴¹

Baseline survey data and qualitative formative research studies were conducted among 737 married couples among whom the wives (aged 18 to 49) were nulliparous (that is, had not had a child) or had a child under 5 and the husbands were resident. The outcomes of interest were women's current use of any family planning method, women's stated ideal family size, and an unmet need for a family planning method. The analysis asked whether concordant descriptive social norms, concordant gender equity scores, or both measures of concordance were associated with women's current contraceptive use, ideal family size, and unmet need.

Descriptive social norms that favor family planning were common, with at least three-quarters of women and men reporting that others in their community have small families, space their children at least three years apart, and use modern contraception. The one descriptive social norm that was not highly supportive of family planning use related to the perception that people in their community continue to have children until they have at least one son. Only 55 percent of the sample reported that people in their community do not engage in this practice, indicating widespread preference for at least one son. The responses of 71 percent of couples matched on three or more of the descriptive social norms questions that favored family planning use.

Study participants reported high levels of gender-equitable beliefs in their communities, and fairly high levels of agreement between wives and husbands, with well over half of couples giving the same response (whether agreeing or disagreeing) on statements such as “Daughters should be sent to school only if they are not needed to help at home,” “A woman has to have a husband or sons or some other male kinsman to protect her” (greatest disagreement, at 39.3 percent), “The only thing a woman can really rely on in her old age is her sons,” “A good woman never questions her husband,” or “I would like my daughter to be able to work outside the home so she can support herself if necessary” (greatest agreement, at 95.4 percent). The gender equity index divided people into “less equitable” if they agreed with zero to six statements (30.8 percent) and “more equitable” if they agreed on seven to 11 statements (69.2 percent).

Table 7. The relationship between gender-equitable beliefs/descriptive social norms and FP-related outcomes (adjusted odds ratios from multivariate models)

| | Outcomes of interest | | |
|--|-----------------------------------|-----------------------------|----------------------------|
| | Ideal family size aOR (95% CI) | Modern contraceptive use | |
| | | Current use aOR (95% CI) | Unmet need aOR (95% CI) |
| Gender equity (high versus low) | 0.58 (0.33-1.02) | 1.68* (1.11-2.53) | 0.61* (0.40-0.92) |
| Descriptive social norms (high versus low) | 0.73 (0.42-1.29) | 2.00** (1.31-3.04) | 0.69 (0.45-1.06) |
| Parity (reference category = one child) | | | |
| Two | 4.28** (1.73-10.61) | 1.47 (0.99-2.19) | 1.09 (0.73-1.63) |
| Three | 13.90*** (5.35-36.15) | 3.00*** (1.71-5.25) | 0.70 (0.40-1.24) |
| Four or more | 8.94*** (3.23-24.71) | 3.92*** (2.06-7.46) | 0.81 (0.43-1.52) |
| Constant | 0.06* (0.01-0.57) | 0.15** (0.04-0.62) | 1.89 (0.45-8.01) |
| N | 728 | 736 | 736 |

Source: Most recent Demographic and Health Survey data, analysis by authors
*p<0.05; **p<0.01; ***p<0.001; aOR= adjusted odds ratio

The multivariate model found that couple agreement on beliefs related to gender equality were positively associated with contraceptive use (Table 7). Multiple logistic regression analyses demonstrated that when couples agreed and shared gender-equitable beliefs, they were significantly more likely to be using modern contraception (aOR: 1.68; 95% CI: 1.11–2.53; N=736). Other explanatory variables positively and significantly associated with current contraceptive use were couple-concordant support for descriptive FP-related social norms (i.e., their support for the norm that others in their community were using family planning) (aOR: 2.00; 95% CI: 1.31–3.04; N=736), urban residence, living in the Terai region, and having three or more children. Couple-concordant gender-equitable beliefs were also negatively associated with unmet need (aOR: 0.61; 95% CI: 0.40–0.92; N=736).

This analysis makes an important contribution to the field by comparing the responses of both members of the dyad and not assuming that the wife's responses are an adequate proxy for those of the husband. These findings suggest that descriptive social norms and gender-equitable norms may have independent effects on women's family planning practices in Nepal. In addition to encouraging and enabling positive FP-related social norms and gender equity, social and behavioral change communication programs should consider interventions that purposively seek to engage both men and women and aim to enhance gender-equitable norms and positive FP-related social norms. Future research reporting on couple-level variables should continue to interview both members of the dyad and examine the role concordance plays in family planning practices.

Ensuring that boys' and men's sexual relationships, parenthood, and partnerships are equitable and healthy is key to the realization of sexual and reproductive rights.

Relationships: Conclusion

Ensuring that boys' and men's sexual relationships, parenthood, and partnerships are equitable and healthy is key to the realization of sexual and reproductive rights. Incorporating examples of sexual relationship dilemmas, and advice, encouragement, and skills for initiating difficult conversations on sex, disease prevention, and contraception into CSE could cultivate boys' and men's greater ownership over SRH and build their compassion and competency in engaging with sexual partners.

A new approach to assessing fertility preferences that includes the desires of both members of a couple should be used to tell a fuller story of how couples negotiate contraceptive use, pregnancy, and abortion. More research examining gendered values and norms around fertility and abortion decisions would help strengthen programs.

Two paradoxes around men and abortion require the deeper engagement of the SRHR field: the first is men's desire to be more involved in abortion decisions and the concurrent tendency of men to leave contraceptive responsibility to women.²⁴² The second is the SRHR community's desire to support men's positive involvement while also protecting women's privacy, rights, and health.

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- 241 The data were collected by the United States Agency for International Development Nepal Health Communication Capacity Collaborative (HC3) Project. Zoé M. Hendrickson, PhD, Lauren I. Dayton, MSPH, and Carol R. Underwood, PhD, from the Johns Hopkins Center for Communication Programs conducted these analyses.
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Men's Reproduction: Motivations and Intentions

A man's reproductive trajectory can have a profound effect on his life. This section deals with men's fertility aspirations, childlessness, timing and trends in their mean number of children, and son preference. A brief look at men's involvement in antenatal care and as fathers is followed by a discussion of the features of men's childbearing that are unique to their physiological and social experiences. How does men's reproduction differ from women's, and why? What lasting impact does mistimed or unintended childbearing have on the life course of men in different contexts?

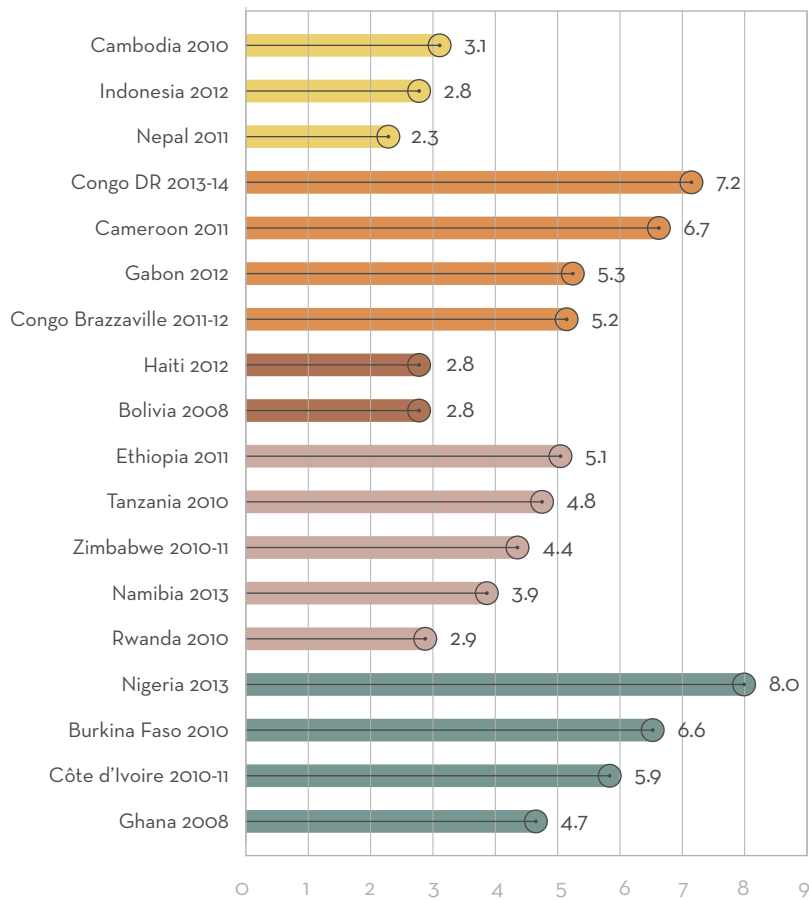
The Fertility Aspirations of Men

Although the evidence differs across countries, global evidence suggests that fertility aspirations – the number of children a person wants to have – are gendered. The cultural context and gendered roles men and women occupy affect how many children men want to have and whether they agree with their partners on this number. While most men will experience marriage, they differ from women, virtually everywhere, in tending to experience more relationships before marriage, more partners during marriage, and greater chances of remarriage and additional childbearing after a given marriage ends.²⁴³

Fertility aspirations in low-income countries – and actual number of children – are markedly higher than in high-income countries. Across all countries in **Figure 16**, however, it is clear that men's fertility aspirations sometimes affect fertility more than women's do. This makes it essential to understand the forces shaping men's fertility aspirations.

While most men will experience marriage, they differ from women, virtually everywhere, in tending to experience more relationships before marriage, more partners during marriage, and greater chances of remarriage and additional childbearing after a given marriage ends.

Figure 16. Men's mean ideal number of children (per most recent DHS survey)



Source: MacQuarrie, K. L. D., Edmeades, J., Steinhaus, M., & Head, S. K. (2015). *Men and contraception: Trends in attitudes and use* (DHS Analytical Studies No. 49). Rockville, MD: ICF International.

Gender norms and imbalances of power in the household are strongly associated with higher male fertility desires. Where discordance – disagreement about the desired number of children – exists, men tend to want more children than do women. Men’s tolerance of “wife-beating” is associated with a desire for more children regardless of income, education, or religion in research across five East African countries.²⁴⁴ A dominant masculinity is an important determinant of fertility in this region. Desires for spacing children can also differ by gender, with wives wishing to wait longer than husbands among discordant newlyweds in India.²⁴⁵

As described earlier, one explanation for the gender gap in fertility aspirations is that men do not bear the costs of childbearing the way women do. Men often reap the benefits of having children (i.e., security in old age) without having borne the burden of raising them. Another explanation is social status: for example, the wives of men in Northern Tanzania who pay a bride price have little say in the number of children they bear; the transaction set in motion by the bride price is “paid” by the children the woman bears, who are then “owned” by the husband.²⁴⁶

The variation in men’s fertility preferences in high-income countries may reflect two separate stages of movement toward gender equality.²⁴⁷ When women first start working and bear the double burden of paid and unpaid work, fertility rates decline; later, when – or if! – gender equality takes hold and men perform more unpaid domestic work, fertility may rise.

The fertility aspirations of LGBTQIA+ people are understudied. Research on the fertility aspirations of gay men in the United States show that institutions and norms around non-heterosexual couples’ childbearing have a significant impact on how many children they want, if any.²⁴⁸ For example, negotiations with birth mothers and adoption agencies affect aspirations.

The great majority of men in the world will someday become fathers, depending on factors that include personal preferences, age, relationship status, social and cultural norms, economic conditions, situational factors, unintended pregnancy, and infertility.²⁴⁹ Partners’ desires for children have a strong influence on fertility decision-making and outcomes.²⁵⁰ While most childbearing studies focus on women, it is often true that men have as much – or more – say in actual fertility outcomes than do women. Most men experience changes in their preferences and personal circumstances that make childbearing desires fluctuate throughout adult life, and wider macro-level forces and unintended outcomes merit greater emphasis in research and interventions.²⁵¹

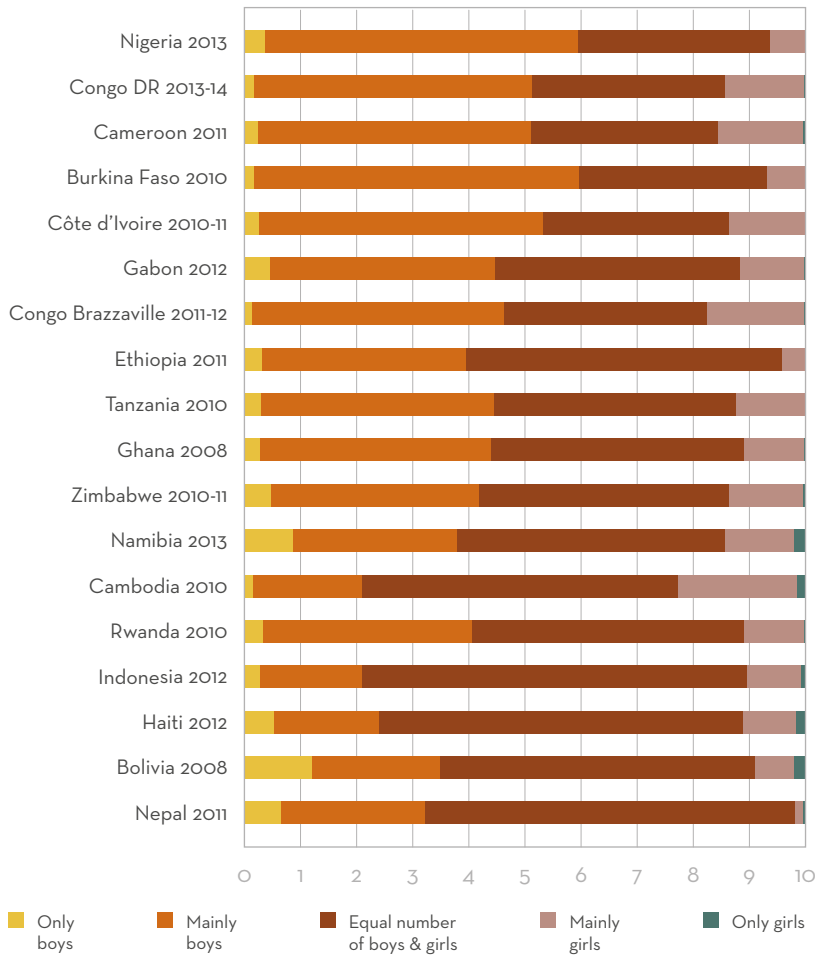
Intended Pregnancy

A growing literature is starting to question how clear the distinction between “good” planned babies and “not good” unplanned babies really is. Women’s and men’s desires for more children change as they go through life and are simultaneously influenced in opposing directions by age, childbirth, and age of the youngest child.²⁵² Research among men in the United States examined circumstances surrounding the conception of each of their children and found great ambiguity in the degree to which any birth was intended.²⁵³ The degree to which a pregnancy is wanted affects fathers’ engagement: men who did not want a pregnancy are less likely to exhibit fatherly affection, and men who wanted a pregnancy sooner are more likely to be nurturing.²⁵⁴

Sex Preference for Children

The number of children a person desires is related to their preference for daughters or sons. **Figure 17** presents data from 18 countries on the preferred sex composition of their children.²⁵⁵

Figure 17. Ideal sex composition among men with complete sex preference (per most recent DHS survey)



Source: MacQuarrie, K. L. D., Edmeades, J., Steinhaus, M., & Head, S. K. (2015). *Men and contraception: Trends in attitudes and use* (DHS Analytical Studies No. 49). Rockville, MD: ICF International.

Overall, there was little change in men's preference for a specific sex composition. The largest decrease in son preference was observed in Nepal, where 54 percent of men preferred only or mainly boys in 2001, and the figure was 37 percent in 2006. Cameroon witnessed an *increase* in men's preference for only or mainly boys, from 49 percent in 1991 to 58 percent in 1998 (more recent data are not available for Cameroon). Cambodia shows symmetry, with preference for mainly or only girls similar to the preference for mainly or only boys. Although men and women both have son bias in many regions, husbands' sex preference may be stronger than wives' in some settings, as it is in Ethiopia.²⁵⁶

Box 10

Sex-Selective Abortion: Men's Roles as Fathers and Physicians

Son preference, sex-selective abortion, and discrimination against women have led to huge disparities in the numbers of females and males, and millions of "missing women" in several countries around the world.²⁵⁷ The total number rose from 61 million in 1970 to 126 million in 2010 and is expected to peak at 150 million in 2035. The development of new laboratory and clinical techniques that overlap with assisted reproductive technologies, "selective reproductive technologies," are increasingly allowing for selective fertilization, implantation, and abortion of fetuses and are used to prevent or allow the birth of certain kinds of children.²⁵⁸ In spite of the rise in prenatal sex selection, neglect and discrimination remain the dominant reason there are so many missing females. The pursuit of sons becomes more intense as fertility falls and couples who desire sons have fewer children among whom sons must be represented.²⁵⁹

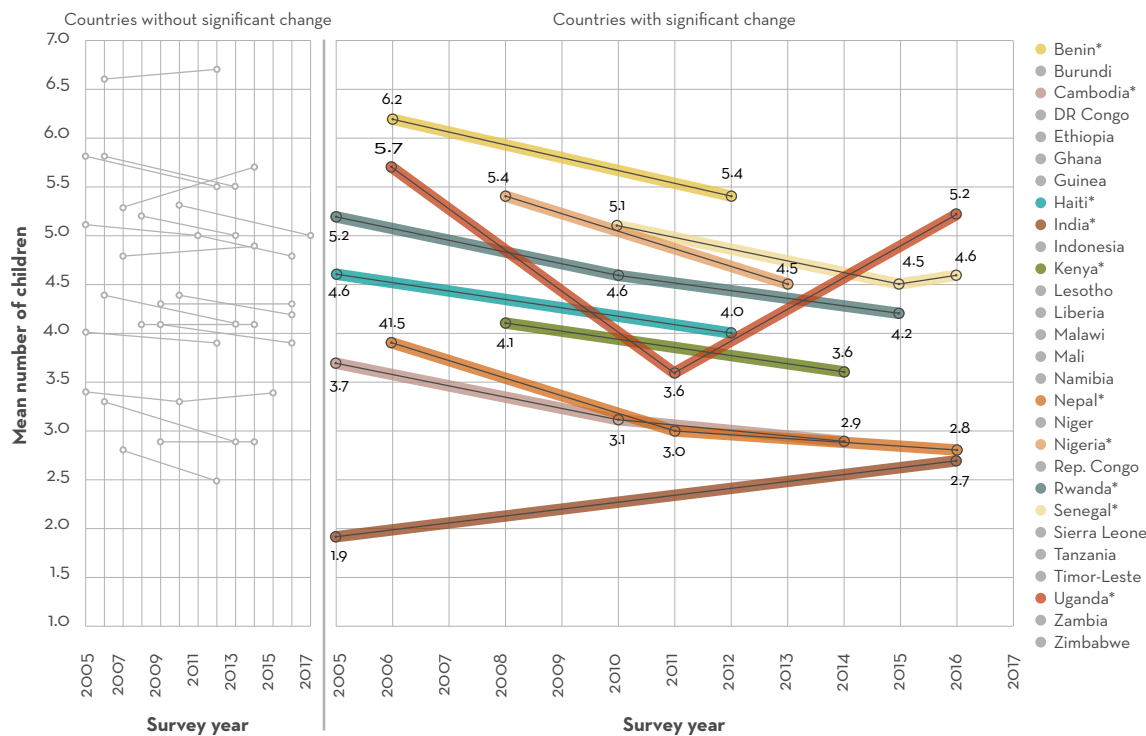
India has stood out for its high rates of sex-selective abortion and unusually high infant and child mortality among females. An analysis of the influence of fathers' and mothers' sex preferences on sex-selective abortions found that sex-selective abortions were used when the fathers preferred sons or both spouses did and that the neglect of girls was the preferred "strategy" when only the mothers preferred sons.²⁶⁰ In Pakistan, where son preference is also very pronounced, the evidence shows that couples continue childbearing to achieve a son, preferring to have more than one son and at least one daughter.²⁶¹ As a consequence, sex ratios at birth in Pakistan have remained stable compared to India's.

Higher levels of education could theoretically translate into more equitable attitudes and reduce son preference. Research on the sex ratio of births among Indian couples in which at least one of the spouses was a physician makes clear, however, that physicians are even more likely than the general population to use sex-selective abortion to produce their desired family composition.²⁶² The sex ratio of second children among these couples who had a first daughter was 519, and of third children among couples who had had two daughters, it was 455, dramatic evidence of strong son preference among physicians.

Men's Childbearing Patterns

The DHS data give us a good picture of trends in men's fertility over the past 15 years in low- and middle-income countries (see **Figure 18**).

Figure 18. Trends in men's mean number of children (2005-2017)



Source: Demographic and Health Surveys, analysis by authors

Notes: Analysis was conducted for 30 countries. All estimates are based on weighted design-based analyses to account for complex survey design. Inclusion criteria are in Annex 1.

*Countries with significant change over time at $p < 0.05$; p-value based on Rao-Scott second-order corrected Pearson statistics

Men's mean number of children registered little change in two-thirds of the countries in this analysis, while one-third saw significant declines. Niger maintained the highest overall number of children among countries in this sample and did not show significant change. Benin experienced a reduction in men's mean number of children, from 6.2 to 5.4 over roughly a six-year period. Cambodia experienced a decline in its mean, falling from 3.7 in 2005 to 2.9 in 2014; in Nepal, the drop was from 3.9 to 2.8 children over a ten-year period. Among countries showing anomalous changes, India rose from a low base of 1.9 in 2005 to 2.7 in 2016. Uganda's number went down substantially before reversing direction and rising again, but over the ten years covered in this survey fell from 5.7 to 5.2.

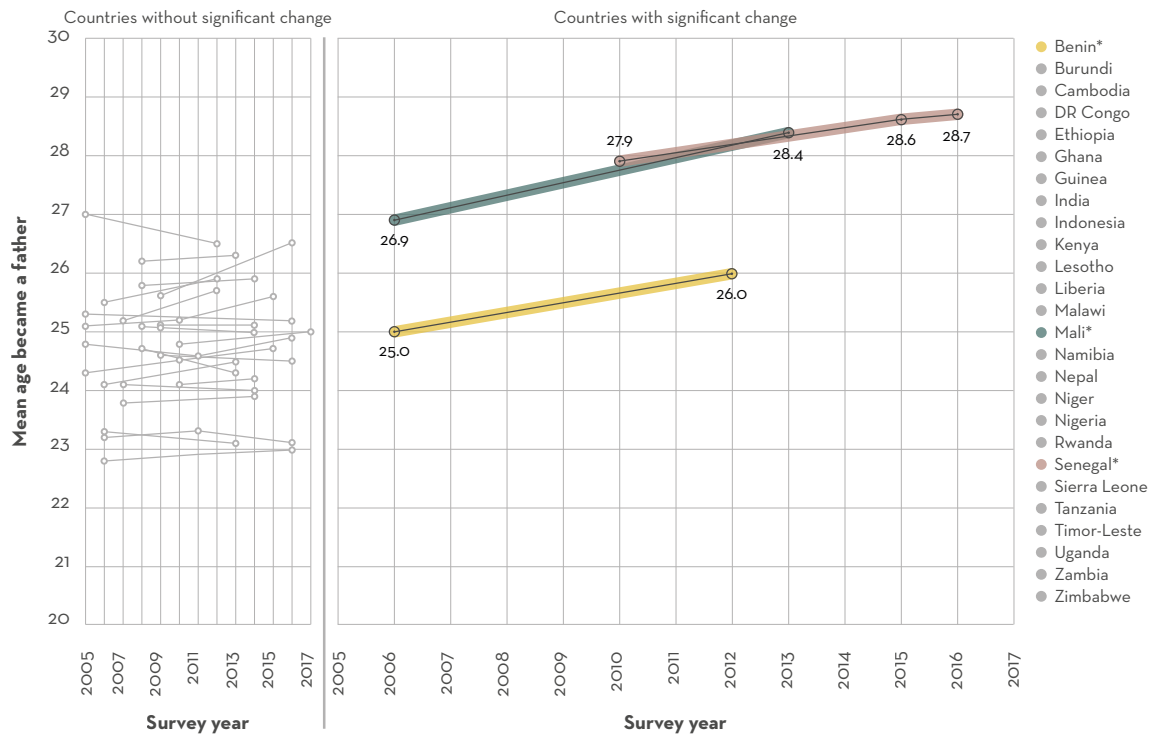
Diverse Modes and Models of Paternity

Men can and do have children across a wider age range and may be more likely to have multiple families, depending on their context. Further complicating the picture, men, unlike women, may have children they do not know about.

Men Have Children Across a Wider Range of Ages Than Women

In studies of adolescent childbearing, the focus tends to be on the impact of early pregnancy and parenthood for girls and their schooling, and data on outcomes for boys remain somewhat sparse. In Jamaica, where adolescent fertility is high, boys are more worried about preventing STIs, while girls' concern is with avoiding pregnancy.²⁶³ Low-income young men in Uruguay are more likely to make the transition to parenthood than wealthier boys and more likely to have two or more children.²⁶⁴ Overall, men's mean age at the birth of their first child has not changed for the vast majority of low- and middle-income countries (see **Figure 19**). In fact, what stands out in these data is the stable concentration of men's transition to fatherhood between the ages of 23 and 26.

Figure 19. Trends in the mean age at which men became fathers (2005-2017)



Source: Demographic and Health Surveys, analysis by authors

Notes: Analysis was conducted for 30 countries. All estimates are based on weighted design-based analyses to account for complex survey design. Inclusion criteria are in Annex 1

*Countries with significant change over time at $p < 0.05$; p-value based on Rao-Scott second-order corrected Pearson statistics

The country with the youngest mean age at first fatherhood was Ghana, which held steady at 23. In the group of countries that exhibited little change, Guinea had the highest mean age at 26/27. Among the three countries where there was a significant change, all increased in age by about one year. Benin rose from 25 to 26, Mali from 27 to 28, and Senegal from 28 to 29; Mali and Senegal are both well above the “average” for men in the countries included in this analysis. Factors that may have delayed childbearing include delays in marriage or the formation of stable unions, the inability to establish a household, and delayed achievement of sufficient economic stability.

Men’s Easier Remarriage Offers Them More Opportunities for Childbearing

Divorce and separation have been rising around the world, yet along with the separations come significant rates of remarriage for men, with new opportunities for having children. The sources of data on these experiences are focused studies with data that track sequential families and relationships among men.

One such survey in France permits an examination of the role of gender, age, and previous fertility among women and among men in predicting subsequent marriages or unions.²⁶⁵ It is well known that mothers are less likely to remarry than fathers, and they are also less likely to remarry than childless women. The research in France found that fathers who have primary custody remarry at almost the same lower rates as mothers who do. Couples’ decisions to have more children within those new unions is shaped not by the total number of children that members of the couple have but rather by whether each one has already been a parent.²⁶⁶

Research in the United States has actually quantified the reproductive advantage of men who engage in serial monogamy.²⁶⁷ Variance in the number of spouses and offspring was significantly higher among men (5 percent for number of spouses and 10 percent for number of offspring). Furthermore, men who had three or more spouses in sequence had nearly 20 percent more children than men with only one spouse, whereas women did not experience this same elevated reproduction with their spouses beyond the first partner. This effect was stronger among Black and Hispanic men than among White men.

Men who are particularly mobile (e.g., who work in trucking or other forms of transport or travel to market their goods or services) may be able to maintain families and households in multiple locations. This is anecdotally documented throughout Asia, sub-Saharan Africa, and Latin America, and it is known as a risk factor for the spread of HIV,²⁶⁸ but less is known about the impact of multiple concurrent partnerships on childbearing. One study of multiple and concurrent partnerships in ten countries in Southern Africa found that respondents in Zimbabwe and Tanzania reported on men’s “little houses” where they have a secret “wife” and sometimes children.²⁶⁹

Men May Have Children They Do not Know About

The possibility of uncertainty about fatherhood is an important difference between men’s and women’s reproduction. Research on paternal uncertainty in rural Senegal assessed the connections between father-child resemblance, fathers’ investment of resources in each child, and children’s health.²⁷⁰ Both face and other similarities between fathers and children were associated with increased paternal investment, and this higher investment was linked to the children’s better growth and nutritional status. Research on paternity

confidence and men's investment in children in Albuquerque in the United States found that men who were uncertain were more likely to divorce women, but controlling for divorce, did not generally reduce their one-on-one involvement with children.²⁷¹ In research among men in a court-mandated abuse treatment program in the United Kingdom, men described their control and sexual violence as responses to sexual jealousy and described their reliance on cues for affirmation of their paternity, including resemblance between a child and themselves.²⁷²

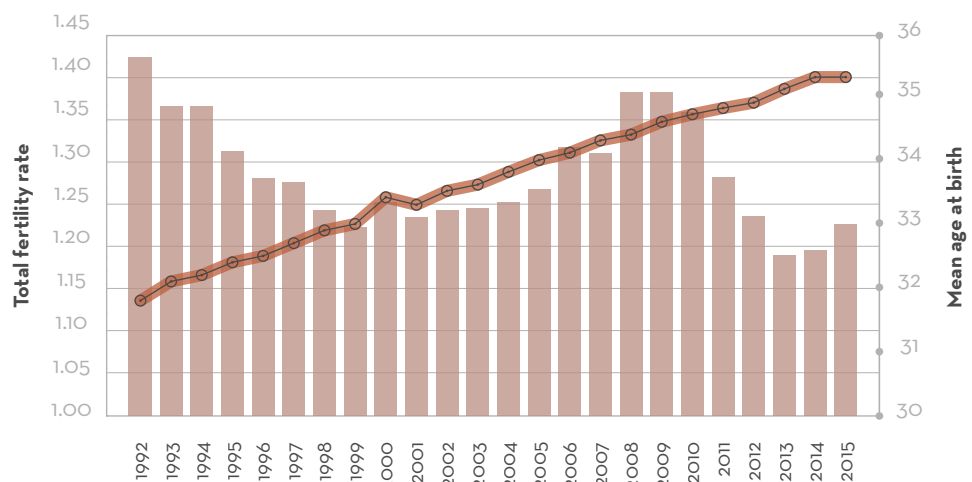
A nationally representative survey in the United Kingdom sub-sampled men not living with their children and found that fathers may not report children they have fathered because they are unaware of their existence or because they are denying or hiding the existence of these children from new partners.²⁷³ Research in the United States on low-income fathers who do not pay child support found that some nonresident fathers do not know they are fathers.²⁷⁴ Additionally, a study on male adolescent pregnancy in the United States acknowledged that the total population of men who had an adolescent pregnancy terminated may differ from those who registered an abortion because they may have been unaware of their partners' abortions.²⁷⁵

Socioeconomic Conditions and Fatherhood

An analysis of increasing age at fatherhood in Greece highlights the sensitivity of men's age at childbearing to economic and unemployment uncertainties.²⁷⁶

Figure 20 shows the remarkable increase in men's age at fatherhood, from 32 to 35, in Greece between 1992 and 2011, a period of great economic flux in that country. While total fertility fluctuated, it remained below 1.4, down to 1.15 in 2011.

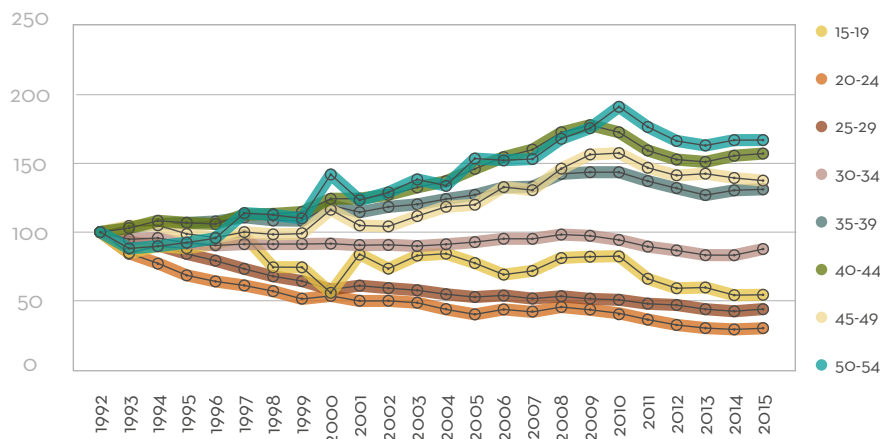
Figure 20. Male total fertility rate and mean age at fatherhood, Greece, 1992-2011



Source: Tragaki, A., & Bagavos, C. (2014). Male fertility in Greece: Trends and differentials by education level and employment status. *Demographic Research*, 31, 137-160.

A sharp peak in childbearing occurs for men at 30 to 34, with younger men's likelihood of having children declining and older men's rising, and a narrowing of the total span over which men are tending to have children: while in 1992, a significant number had children before age 20, that figure became extremely low in 2011, and the greatest increase occurred among 50 to 54 year-olds (Figure 21).

Figure 21. Changes in male age-specific fertility rates compared to 1992 (1992=100)



Source: Tragaki, A., & Bagavos, C. (2014). Male fertility in Greece: Trends and differentials by education level and employment status. *Demographic Research*, 31, 137-160.

These findings suggest that men evaluate their economic prospects when they consider having children: these Greek men have postponed childbearing to significantly older ages, compressing their period of reproduction and reducing the number of children they ultimately have. The employment conditions men face shape fertility outcomes, especially during periods of economic stress and in settings where male employment is most important to household living standards.

Infertility and Childlessness Not by “Choice”

Childlessness is often an inadvertent outcome shaped by education, employment, religion, and relationship experience rather than the product of a premeditated strategy. Few people express at an early age the intention to have no children; many more “end up” childless without having explicitly decided about having children.²⁷⁷ An analysis of high-income countries found that on average, men want at least two children but tend to delay their childbearing in ways that sometimes preclude achieving their fertility.²⁷⁸ In Sweden, more egalitarian men are likely to delay becoming fathers and do not necessarily “catch up” in their childbearing later on, increasing their chances of remaining childless over the long term.²⁷⁹ A recent analysis of childlessness among women and men in Italy and Britain showed that although childlessness is comparatively high in both of these settings, the reproductive trajectories are distinctive: More respondents in Italy were *provisionally* childless, while more intended to *remain* childless in Britain.²⁸⁰ Individual intentions, social and economic circumstances, and timing all contribute to involuntary childlessness.

Globally, 1.9 percent of couples experience “primary infertility” and are unable to achieve a first birth, while 10.5 percent experience “secondary infertility,” in which they are unable to achieve higher-order births.²⁸¹ A global decrease in sperm quality may be due to environmental, nutritional, or socioeconomic

factors.²⁸² While the quality of infertility data is generally low and its coverage limited, estimates for regions with better data suggest that about half of infertility cases are attributable to women and about 20 to 30 percent to men. The remaining cases are likely a result of combined male and female factors.²⁸³ The psychological and social implications of male infertility vary hugely by cultural context and personal vantage point.²⁸⁴

Childlessness is associated with improved socioeconomic positions for women,²⁸⁵ while an opposite pattern seems to apply for men. Additional education reduces women's likelihood of having children, while it increases this likelihood for men; the same pattern applies to long-term employment. Research on unemployment and childbearing in France highlights another interesting contrast between women and men: For women, their number of children is similar across employment history, indicating that unemployment does not prevent or encourage childbearing; for men, by contrast, employment history plays an important role, with men who have experienced unemployment for more than one year out of ten being over twice as likely to remain childless and less likely to have two or more children.²⁸⁶

In light of the pervasive normative view that being a parent is key to a fulfilling adult life,²⁸⁷ it is unsurprising that childless men sometimes face unflattering stereotypes about their motivations and quality of life.²⁸⁸ They are often assumed to be less connected and to offer less social capital than women, and so are viewed as less satisfied and fulfilled by their own personal experience.²⁸⁹ However, gender roles are so disadvantageous for women that the negative ramifications of not being a parent are often greater for women than for men.²⁹⁰ Intriguingly, the benefits to men of having children are often greatly exceeded in areas such as health by the benefits of having a lasting partnership. Differentiating the influences of partnership status and parental status is key to understanding life outcomes and satisfaction among childless men.²⁹¹

Childless by Choice

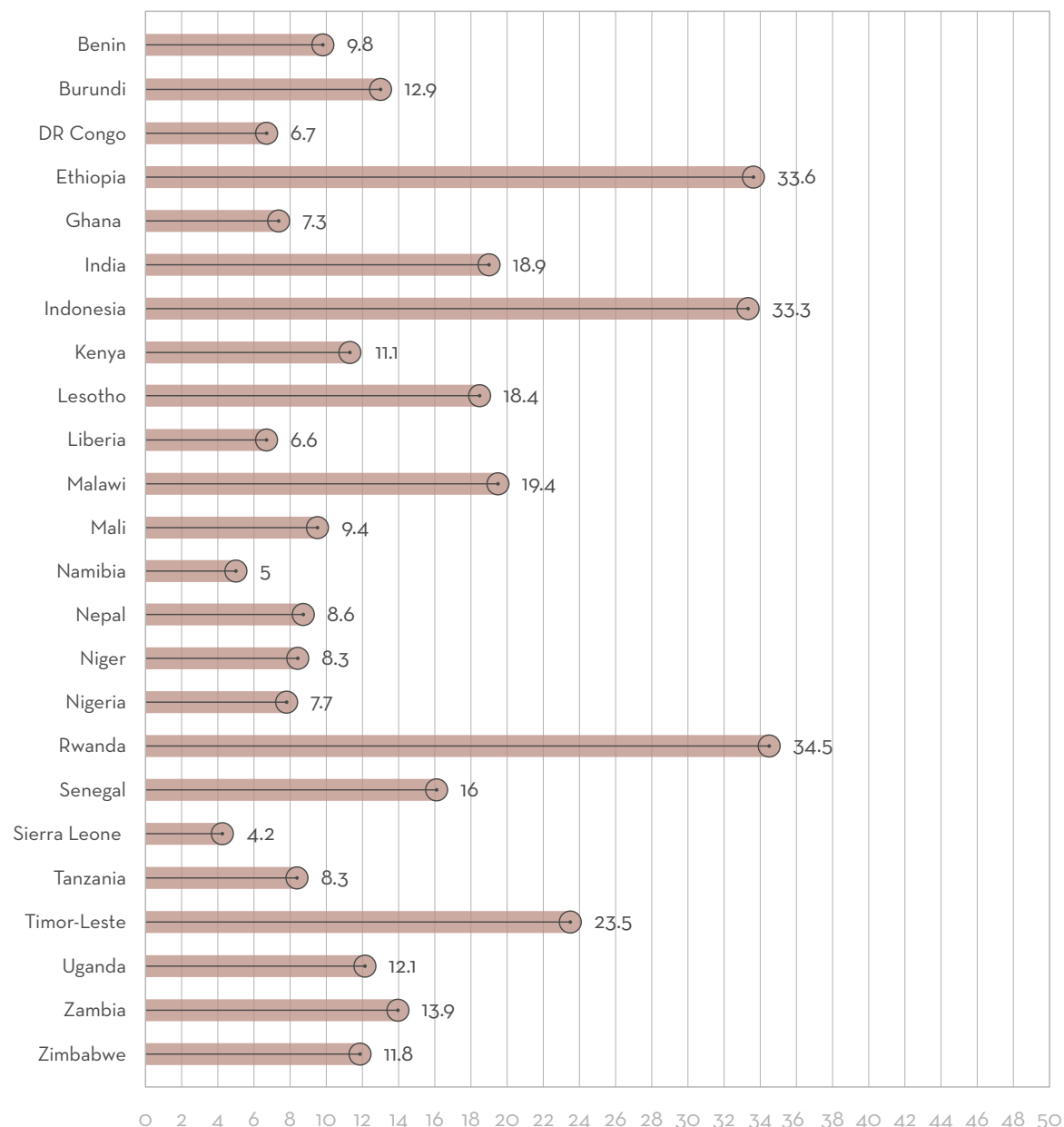
Studies of media representations in Sweden and Norway of childless men, women, and couples have analyzed social values underlying different representations of each; stereotypes highlight men's choices regarding childrearing as a lack of maturity or a wish to act young, meaning independent and free of responsibility.²⁹² Childless couples in European settings are often depicted as more satisfied and fulfilled than couples with children, and as devoting more time to maintaining happy relationships and leisure activities. Portrayals of childless women tend to emphasize an overemphasis on career²⁹³ or the loss of choice rather than personal agency and realization.²⁹⁴

Men's Use of Family Planning Services

Men play important roles in SRHR. However, "by distancing boys and men from the SRH domain, society and the health system further excuse them from responsibility and reinforce the notion that reproductive health is a women-only concern."²⁹⁵ In the United States, for example, the 2006–2010 National Survey of Family Growth found that among the 60 percent of men aged 15 to 44 who were in need of family planning, 70 percent had access to care and 72 percent had insurance coverage in the previous year; however, only 7 percent had a family planning visit, while 41 percent relied on partners who were consistently using contraception.²⁹⁶

The earlier analysis using DHS data showed that many men believe that contraception is “women’s business.” However, this report’s analyses of DHS data also show that in some settings, men have indeed “talked to a professional about family planning.” In no country in the low- and middle-income countries included do more than 40 percent of men report recently discussing family planning with a healthcare worker. Rwanda, Ethiopia, and Indonesia have the highest proportions of men who recently discussed family planning with a provider (~35 percent). The lowest proportions appear to be observed in Eastern and Central/Southern African settings. In the majority of countries, between 5 and 15 percent of men recently discussed this topic in a care setting.

Figure 22. Proportion of men who recently discussed family planning with a health provider



Source: Most recent Demographic and Health Surveys (2005-2017), analysis by authors

Notes: Analysis was conducted for 20 countries. Results are based on a “yes” response to the survey question: “Discussed family planning with a health worker in the last few months.” All estimates are based on weighted design-based analyses to account for complex survey design.

Men and Parenting

Fatherhood and childrearing can offer pathways to gender equality in private life. In high-income countries, a strong association between male domestic labor and higher household fertility has emerged (e.g., in New Zealand).²⁹⁷ Low-income men in the United States often want to be engaged fathers but are kept out despite multiple “tries” by weak relationships with the mother, poverty, inability to provide, and societal stigma.²⁹⁸ Young fathers in the United States tend to be more disadvantaged and less involved with their children than older fathers, and they are also less likely to be married, making engaged fatherhood more difficult.²⁹⁹

When Men Care for Their Children, Everyone Benefits

About 80 percent of the world’s men and boys will become fathers in their lifetimes.³⁰⁰ Their actions throughout their children’s lives can have profoundly positive effects for their own health and that of their children, for poverty alleviation, and for women’s economic empowerment.

When men participate more equally in unpaid care, *women* benefit.³⁰¹ Research has shown that equality in unpaid care work is linked with improvements in women’s health, including SRHR, maternal health, and physical and mental health.³⁰² This sharing also supports the development of relationships that are more grounded in equality.³⁰³

Men’s participation in antenatal visits has increased over time in low- and middle-income countries (see **Figure 23**). The large number of countries that experienced significant upward trends in men’s participation in antenatal visits is revealing, reflecting policy, institutional, and cultural changes. Men’s willingness to participate and opportunities to do so are both important achievements, since neither a cultural role for participating fathers nor institutional arrangements to make that possible in clinical settings were historically widespread.

Box 11

Men and Parental Caregiving

Promundo’s *State of the World’s Fathers* is a biennial research report and advocacy platform that aims to change power structures, policies, and social norms around care work and advance gender equality. The 2019 report uses global research to call for men to take up their full share of the world’s childcare and domestic work – across all societies and relationships – to advance gender equality.³⁰⁴ The headlines from the report include:

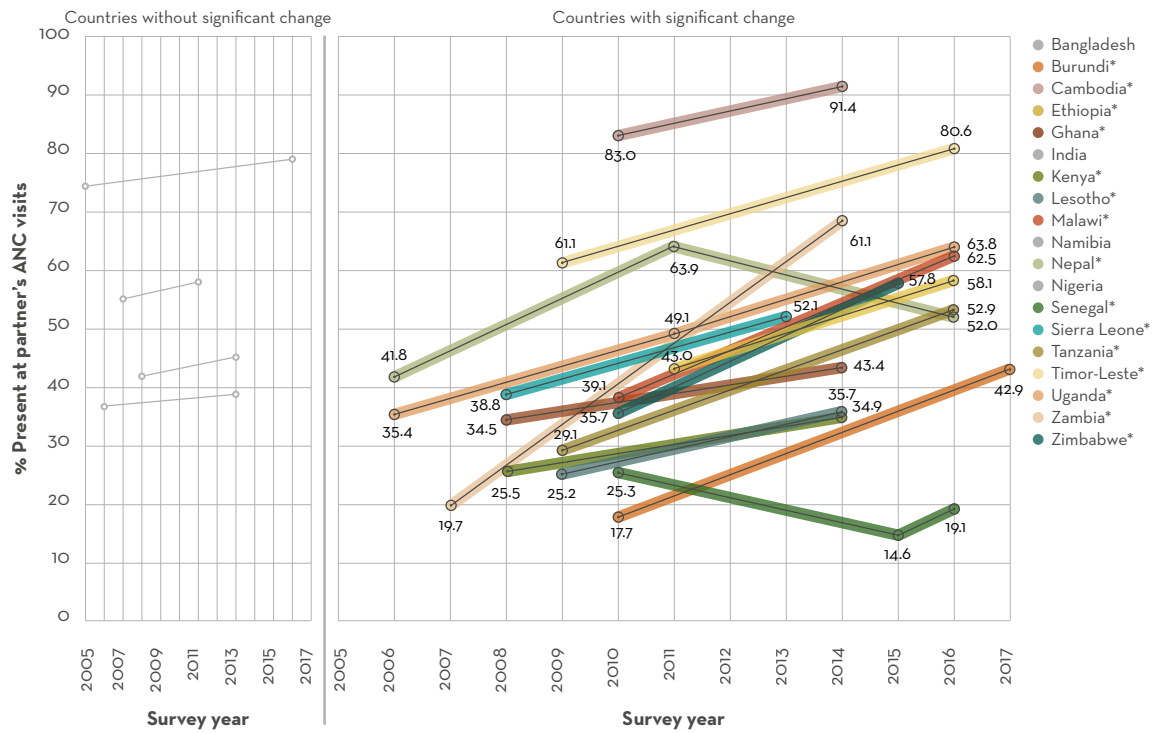
- Though some men around the world are taking up more of the unpaid work of daily caregiving, women spend on average 3.3 times – and up to ten times – as much time on unpaid care, volunteer, and domestic work. If women’s time were monetized, it would make up nearly 9 percent of Gross Domestic Product in many of

the world’s countries.³⁰⁵ Instead, women’s choices in school, paid employment, and public life are limited by these unpaid responsibilities.

- Though some men are stepping up to provide more care, data from 23 middle- and high-income countries shows that over a 15-year time span, the unpaid care gap between men and women has decreased by only seven minutes a day.³⁰⁶
- The norms that perpetuate the idea that caring for children is largely women’s work are very strong as captured in numerous surveys of men and women.
- Only 48 percent of the world’s countries offer paid paternity leave when a child is born or adopted, and often the leave offered lasts only a few weeks or a few days. Because fathers tend to earn more than mothers, they are less likely to take advantage of the parental leave.

A shift in power relations between women and men requires an urgent change in who does the daily care work at home.

Figure 23. Trends in the proportion of men present during partner's antenatal care visits (2005-2017)



Source: Demographic and Health Surveys, analysis by authors. Notes: Analysis was conducted for 19 countries. Inclusion criteria are in Annex 1. *Countries with significant change over time at $p < 0.05$; p-value based on Rao-Scott second-order corrected Pearson statistics

A strong commitment in national policy to men's roles in maternal health likely contributed to participation rates in Cambodia, which rose from 83 percent to 91 percent between 2010 and 2014.³⁰⁷ Timor-Leste follows, having risen from 61 percent to 81 percent from 2009 to 2016. Ethiopia showed one of the most rapid rates of change, rising from 42 percent to 64 percent before falling back to 52 percent, for an overall increase. Burundi figured among the countries that showed large increases, rising from 18 percent in 2010 to 43 percent in 2017. Policies like Brazil's national men's health program, described above, can encourage male participation in maternal health, family planning, HIV testing and treatment, and engaged fatherhood.

Box 12

Men's Involvement in Childbirth and Maternal Health

The involvement of fathers before, during, and after the birth of a child has positive effects on maternal health and on women's use of maternal and newborn health services.³⁰⁸ When men participate in prenatal visits and receive maternal health education, they can support their partners in lifesaving ways. Men's presence during prenatal care provides an opportunity to engage and inform them on the care of their partner and child and on contraceptive use. Multi-country research shows that men's involvement also leads to greater long-term support and involvement in the lives of their children, and to reduced maternal mortality and morbidity.

Furthermore, fathers' participation can make it possible for women to work less in the home,³⁰⁹ receive better nutrition,³¹⁰ and access skilled birth attendants and postnatal care more readily.³¹¹ Involved fathers can also be encouraged to provide psychological and emotional support that improves

their partners' experience of pregnancy and childbirth.

When men are not involved or are unsupportive of their female partners, they can prevent women from receiving care.³¹² Where women are reliant on men for money or transportation, uncooperative male partners can be decisive in shaping sub-optimal health outcomes for mothers and babies.³¹³ Local reproductive norms, including beliefs and taboos around pregnancy, also shape women's health-seeking and access to care.³¹⁴ A lack of social support is a risk factor for women's depression after birth and has also been linked to negative effects on fetal growth.³¹⁵

As rigid and unchangeable as some norms may seem, program experiences demonstrate that when women receive prenatal care that includes their husbands, health outcomes improve and men's attitudes tend to become more supportive. Studies have shown that when men learn the danger signs during pregnancy or delivery, they can act as life-saving agents by encouraging care during obstetric emergencies.³¹⁶ Efforts to engage men as partners have been shown to change attitudes and behaviors in settings as diverse as Niger, Scandinavia, Indonesia, Peru, Brazil, and South Africa, with positive results for women and families.³¹⁷

Children benefit from having more than one actively involved caregiver. Fathers involved in their children's lives from infancy are more likely to continue to be involved as their children grow up, enhancing children's physical, cognitive, emotional, and social development.³¹⁸ Seeing their fathers completing chores at home and seeing women participate in paid work contribute to boys' acceptance of gender equality and to girls' sense of autonomy and empowerment, creating a positive cycle of caregiving and equality.³¹⁹

The global trend is that men's involvement, as measured by daily caregiving, is higher in countries with lower fertility rates.³²⁰ The demographic story is that as men take on additional hands-on care of children, their fertility preferences reduce or become closer to those of women. At the same time, countries that support men (and women) in the care of children – for example, through subsidized childcare or extended paid parental leave – also see fertility increase slightly as families feel supported in the care of children.

Men themselves benefit from participating in unpaid care work, as they share in the pleasures of child-rearing and build more meaningful relationships with their communities, their friends and peers, their partners, their children, their own parents, and other caregivers. Parenthood is an interesting moment in anyone's life, as it provides an opportunity to envision a future quite different from the past a person has known, and this is important for shifting masculinities. It is a moment when men may break free of narrow and restrictive constructs of manhood, with positive effects on their mental and physical health.³²¹

The impact of unintended pregnancy and parenting on men's roles and identities has been studied extensively in the United States in ways that should be replicated in low- and middle-income countries.³²² Men's roles are changing

everywhere, yet their engagement in SRHR and in parenting and caregiving has too often been missing from public policies, from systematic data collection and research, and from efforts to promote women's empowerment.³²³

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Men's Lives: Reframing SRHR and What it Means to Men



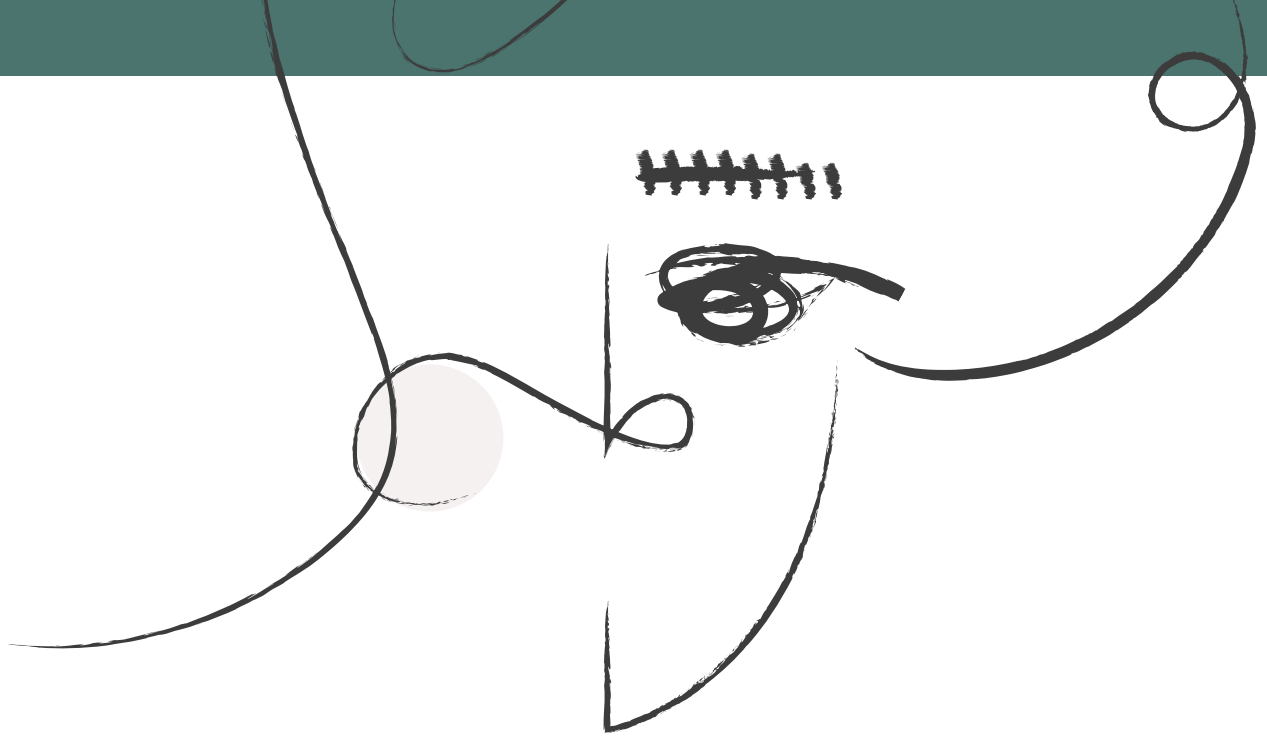
This report has arrayed the global evidence to make the case for how important men are to the achievement of SRHR for all and how important SRHR is to men's lives, including their lifelong participation – or lack thereof – in unpaid care work, as well as its importance to their relationships and happiness. From the moment boys begin to learn about how their **bodies** work, who they are, who they are attracted to, and how they will care for themselves and consider their desires to reproduce or not, they need information and support. Boys' and men's **relationships** – if, when, how many, and the nature of them – are influenced by expectations about masculinity and gender, their communication skills, and their connection with their sexual partners. How boys and men manage themselves in those sexual relationships has lasting implications for their health and well-being. Men's **reproduction** – whether or not they have children, when, and with whom (among other conditions), as well as how much they will be part of the care of any children – sends ripples throughout their lives that are only just beginning to be appreciated.

Men's recognition of the lasting impact of SRHR on other aspects of their lives could reframe the importance they and society give to SRHR. This section draws together the limited research – which is strongest with regard to their reproduction – on the impact of SRHR in areas beyond health and throughout men's lives.

Bodies

The lack of information, the awkward avoidance of sexuality-related topics by parents and other adults, body dissatisfaction, heteronormativity- and masculinity-related pressures to conform and perform, combined with a pieced-together understanding of SRHR sourced from peers and the Internet mean that young people face major obstacles to emerging as whole adults capable of managing healthy sexual and reproductive lives. These challenges are associated with poor physical and mental health, with repercussions for how men care for their relationships throughout life.

Negative reactions to disclosure of sexual orientation can affect mental health and school performance. Research in the United States indicates that negative reactions to disclosure of sexual orientation are associated with depression and lower self-esteem.³²⁴ Other research shows that the people to whom a person decides to “come out” or reveal their sexual orientation can affect school performance in the United States.³²⁵ A study in Italy of young gay men found that internalized sexual stigma was linked with dissociative disorders, types of mental illnesses.³²⁶



Relationships

The understandings a person develops about who they are and their place in the world affect their ability to initiate and sustain connections with sexual and life partners. Experiencing sexual assault as a minor has repercussions for positive romantic relationships and the perpetration of violence in the future.³²⁷ When men face livelihood insecurity and are unable to fulfil the traditional role of provider, they are at risk of depression and self-loathing, and other research even documents self-harm, including violence, alcohol abuse, and suicide.³²⁸

Son preference has had intergenerational relationship consequences for men.

Unfortunately, a deep and enduring preference for sons, sex-selective abortions, and female infanticide have generated long-term relationship consequences for some men. The “missing girls” epidemic in China and India shows that the devaluation of women’s lives has created gendered fertility trends, which have enormous consequences not only for those countries but – given that they make up 40 percent of the world’s population – the whole world.³²⁹ By 2020, demographers estimate that China will have 30 to 40 million involuntary bachelors, and that by 2030, more than 20 percent of men aged 30 to 39 will never have married, with the most affected men living in poorer provinces with the weakest social protection programs.³³⁰ This sex ratio problem is not new: Historical research on China during the 1800s found that the stresses caused by a high male-to-female sex ratio at sexual maturity were associated with the risk of higher mortality later in life, even when a specific individual eventually married.³³¹ Studies are already revealing the growing desperation, marginalization, and changing sexual practices of men forced to remain single in China and India.³³² This imbalance may have an effect on violence toward women, prostitution, human trafficking, cross-border migration, and the spread of HIV, as some studies suggest.³³³

Reproduction

The evidence on long-term impact in each of the three areas of this report’s framework is strongest for reproduction. It is easy to see how negotiating pregnancy, disagreeing with one’s partner (or not), having children (or not) by choice (or not), living with them (or not), and remarrying after a first union (or not) would all have significant effects on a person’s identity, health, educational attainment, income, and social relationships.

Adolescent fatherhood leads to fewer years of schooling and reduces the likelihood that a young man will receive a standard high school diploma.

The sparse literature on the lasting effects in boys' and men's lives of their reproduction initially focused on the long-term consequences of early, ill-timed, and unwanted pregnancy among adolescents in the United States,³³⁴ where concern with adolescent childbearing has driven the collection of longitudinal data.

Unintended pregnancy harms well-being and is related to some men's limited participation in caregiving. Given that approximately one-half of pregnancies in the United States are described by the women involved as unintended,³³⁵ it is fortunate that nuanced research on fathers' and mothers' experiences of unintended childbearing provides insights. Research on the mix of reactions on the part of mothers and fathers finds that both women and men experienced negative consequences for schooling and work due to childcare demands, though women experienced these more intensely.³³⁶ For men, the research highlighted the stress of having a child and the difficulties this posed in their relationship with the mother, and how in turn, a lack of a positive relationship with the mother placed them at a distance from their children, which caused them to worry that the children might suffer.

Unintended pregnancy harms mental and physical health. Research on unintended pregnancy, especially when partners disagree about it, indicates it can affect the mental health of both,³³⁷ and evidence from the United States shows that disagreement about if pregnancy was intended can affect the baby's health.³³⁸ Adults who experience unintended pregnancies are more likely to experience depression and other mental health problems (and 51 percent of all pregnancies in the United States are unintended).³³⁹

Pregnancy prevention supports college completion. A historical study of the impact of the contraceptive pill found that young women's use increased the likelihood that their *male partners* would complete college by about 2.5 percent.³⁴⁰ This connection is well documented for women.

Access to abortion may positively impact the educational attainment of adolescent men who report a pregnancy. Research in the United States using the National Longitudinal Study of Adolescent to Adult Health found that among young men who reported a live birth, 5.8 percent reported graduating from college and 32.4 percent had any post-high school education; these figures were 22.1 percent and 58.5 percent for young men who reported pregnancies that ended in abortions.³⁴¹

Adolescent fatherhood reduces schooling and long-term human capital development. Adolescent fatherhood leads to fewer years of schooling and reduces the likelihood that a young man will receive a standard high school diploma.³⁴² An analysis of the US National Longitudinal Survey of Youth compared the "schooling penalty" of unintended pregnancy among girls and among boys. It found that the larger schooling penalty for adolescent mothers in the earlier cohort declined over time, with the cohort of adolescent fathers born in 1997 experiencing a larger educational penalty than their peers nearly 20 years earlier.³⁴³ Schooling and work compete for young parents' time, especially when they do not live with two of their parents. When young men were primary caregivers, they were significantly *more* likely to graduate; if they were working at least half-time, they were *less* likely to graduate.³⁴⁴ While 97 percent of nonworking primary caregivers were predicted to graduate by age 26, only two-thirds of fathers who worked but were *not* primary caregivers were predicted to.

Early parenthood increases employment and contributes to reducing long-term income and employment prospects. Adolescent fatherhood also increases early marriage and cohabitation and increases full-time and military employment; these adolescent fathers may experience longer-term earnings and income differences as they age, with implications for their children. Longitudinal surveys from the United States show some adverse effects for young fathers of children born to adolescent mothers, with adolescent fatherhood often leading to fewer years of schooling and fewer employment choices.³⁴⁵

Unwanted pregnancy has been associated with marital dissolution, reduced income, and harmed child development. Research in the United States shows that unwanted pregnancies (as defined by men or women) are often associated with higher levels of marital dissolution and lower household income (and negative psychosocial effects on child development).³⁴⁶

Fertility and partnership are linked to various measures of well-being. Research in the Netherlands examined the impact of men's parenthood histories on men's economic, psychological, and social well-being.³⁴⁷ While fathers had higher incomes than childless men, it was men's partnership history rather than their childbearing trajectory that influenced their psychological well-being. Additionally, childless men had weaker social networks and were less engaged in their communities, with implications for challenges to their care and support in old age.

High fertility and early parenthood harm men's long-term health. The lack of data on men in the SRHR field may reflect the assumption that fatherhood has fewer health and other implications for men than motherhood does for women. However, longitudinal research in the United Kingdom indicates that having four or more children is associated with poorer health in the long term for both men and women.³⁴⁸ Early parenthood is also associated with poorer health for both men and women. For women and men who have at least two children, a birth interval of less than 18 months is associated with acquiring a health limitation. Men with more children may receive less support from their partners for their increased stress, emphasizing the need for life-history data on men.

Unplanned or unwanted fatherhood can contribute to poor mental health. Research on depression among Jamaican fathers of newborns found that approximately nine percent of fathers had mental health scores associated with depression.³⁴⁹ Factors associated with greater depression were lower wealth and youth; factors associated with lower depression were relationship quality and social support. Fathers may have normative postnatal depression, similar to what mothers experience, and their mental health may be similarly affected by unplanned or unwanted pregnancies.³⁵⁰ However, men who report close relationships with their children are less likely to experience depression.³⁵¹

Childbearing delayed may become childbearing foregone. Many men in high-income countries have inadequate knowledge about the limits of female and male fertility, despite the growing delay of childbearing until men's 40s or 50s.³⁵² Delays in childbearing may in some cases lead to fertility foregone if men believe that the age of only their female partners matters. Virility, strength, and vitality are seen as key to masculinity, and fertility is seen as a demonstration of these features.³⁵³ In most settings, the social construction of masculinity contains the expectation that a man will have children, and involuntary childlessness is a psychological hardship for men. The panel study from the United Kingdom referenced above indicates that childlessness is linked to poorer health in the long term for men and women.³⁵⁴

The lack of data on men in the SRHR field may reflect the assumption that fatherhood has fewer health and other implications for men than motherhood does for women.

Unintended childlessness may contribute to poor mental health in old age in rural areas. A study using the China Family Panel Studies attempted to differentiate between the long-term impact on depression among older adults of being childless versus being sonless.³⁵⁵ Parents who had both sons and daughters were faring the best, and there was a sharp divide between urban and rural areas, with both childless and sonless people faring poorly in rural areas, but parental status being less influential in urban areas.

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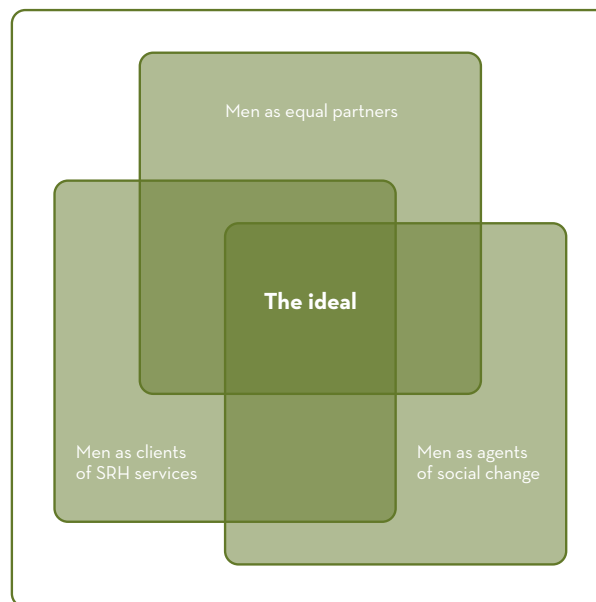
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Men and SRHR: Services and Policies

The global data reviewed for this report point to the need for services and policies that acknowledge men's contributions to SRHR and the importance of SRHR to men. A consensus has emerged that services and policies should involve men, but these do not engage men as meaningfully as they could.

Figure 24. Men's roles in sexual and reproductive health and rights



Source: Pascoe, L., Herstad, M., Shand, T., & van den Heever, L. (2012). *Building male involvement in SRHR: A basic model for male involvement in sexual and reproductive health and rights*. Cape Town, South Africa: Sonke Gender Justice Network.

Male engagement in SRHR historically suffered from a lack of conceptual clarity. Emergence of the “men as clients, men as partners, and men as agents of social change” framework brought greater precision.³⁵⁶ However, as gender-transformative programming gained more traction, the framework needed updating: Men could play all of these roles at the same time, as **Figure 24** shows.³⁵⁷ All programs that support men in these roles should be gender-transformative – that is, they should reflect an effort to address gender inequality and restrictive gender norms, the relational aspects of SRHR. Services and policies have an important role to play in realizing this vision.

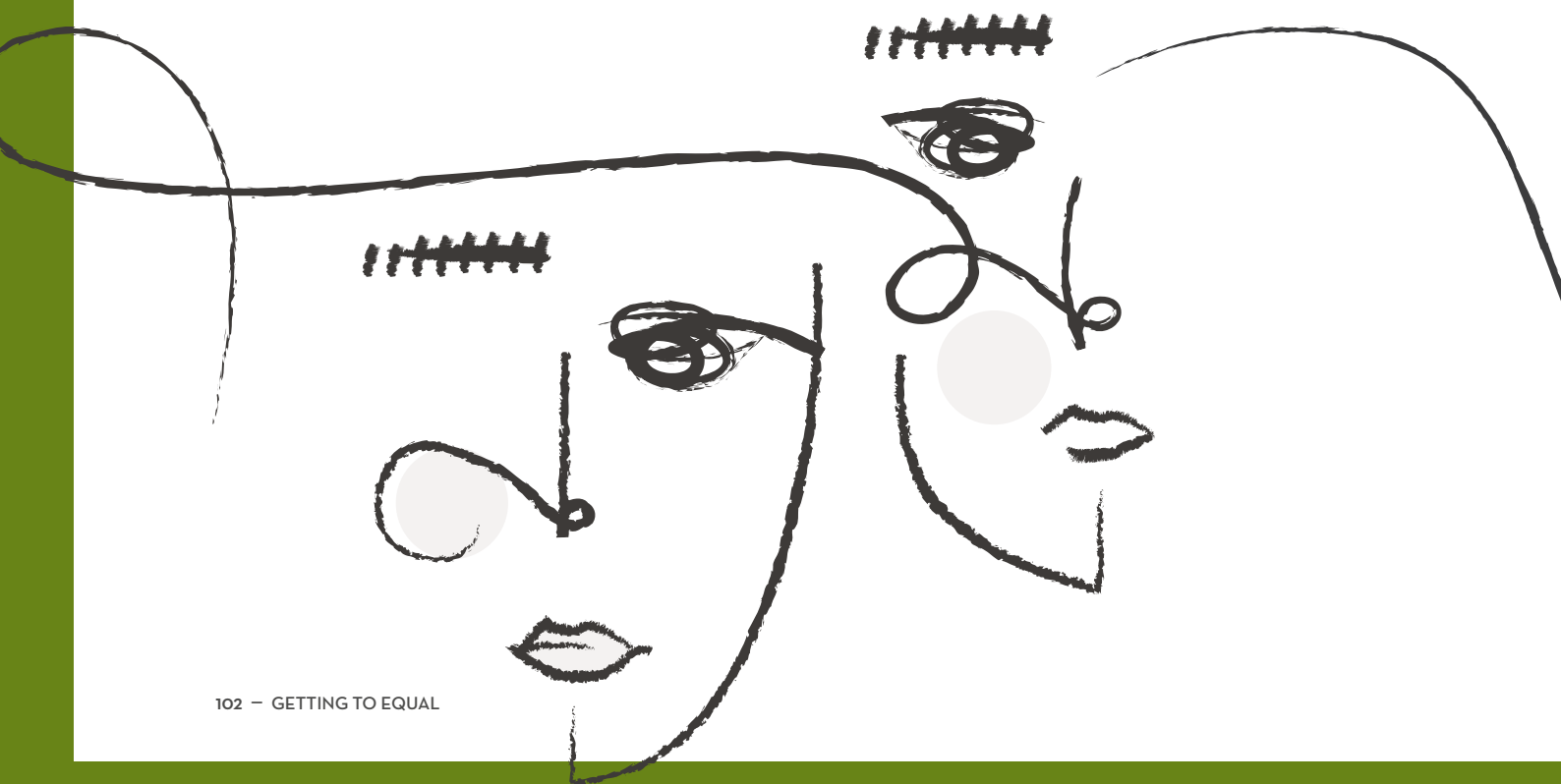
The purpose of this report has been to move beyond the perspective of the health system, and to try to reveal and highlight the importance of sexual and reproductive health and rights in men's lives. It is not surprising that men might be unresponsive to the SRHR field's vision of them as clients, partners, or agents of social change. Perhaps more will be possible when policymakers, service providers, researchers, and men themselves develop a greater appreciation for the centrality of SRHR to other aspects of men's lives.

The Contribution of Services to Men's Realignment With SRHR

*Service Challenges: Many Services Are Not Meeting the Needs of Men*³⁵⁸

Some of the same gender stereotypes that drive sexist attitudes and behaviors, and harm men's health and that of their partners, keep men on the fringes of SRH policies and programs. The SRH establishment has historically not placed much focus on boys and men, and **health systems** are designed in gendered ways.³⁵⁹ Where attention has been given to the service delivery needs of men and boys, it has often been by simply adding to existing services for women and delivering them in spaces traditionally occupied by female clients. The lack of health systems infrastructure specifically serving men is a barrier to men's access and use of services. SRH clinics are often perceived, by providers and the public, as "women's domain."

The **healthcare workforce** has been raised in the same communities as the general population – with the same gender inequalities and restrictive gender norms that must be challenged to improve SRHR – and the training challenges are substantial. The stereotype that women should be primarily responsible for sex and reproduction not only limits men's access to information and services but also constrains health research, data collection, and health systems.³⁶⁰ Judgments regarding adolescents and unmarried people similarly block access to information and services.

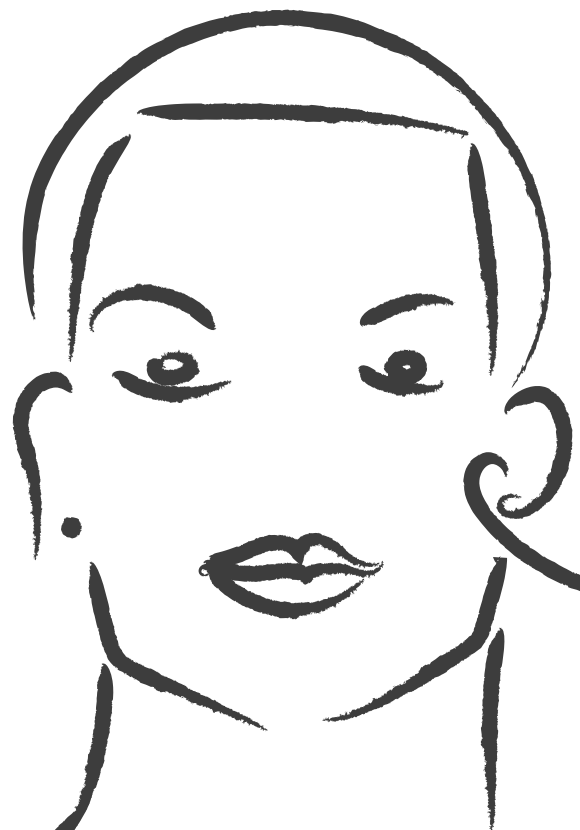


Relative to HIV, for example, the **infrastructure for surveillance** of other STIs is weak, especially for men. Many countries lack strong national STI reference laboratories or surveillance systems. This is complicated by the lack of engagement with STI services by some key populations at higher risk for STIs, such as MSM, and commercial sex workers and their clients, as well as by the frequency of asymptomatic infection, particularly among women.³⁶¹ Greater investment is needed to improve STI surveillance and reporting, including follow-up on partner notification and collecting and reporting on data separately for men and women on the duration of infection, asymptomatic infections, and antimicrobial resistance.³⁶²

Surveillance and **quality standards** for stigmatized groups such as LGBTQIA+ populations tend to be weaker.³⁶³ Many states are actively hostile toward LGBTQIA+ populations and permit clinicians to discriminate against clients and potential patients with impunity.³⁶⁴ MSM disproportionately experience HIV and other STIs, and programs need to emphasize a human rights approach, provide access to justice, and offer acceptable services.³⁶⁵

Family planning services suffer from the **outmoded idea that contraception is “women’s business.”** One review of whether services are working for men observed that the emphasis is on women as contraceptive users and men as partners, and there is comparatively little effort to reach men as contraceptive users themselves.³⁶⁶

Some of the same gender stereotypes that drive sexist attitudes and behaviors, and harm men’s health and that of their partners, keep men on the fringes of SRH policies and programs.



Box 13

Essential Elements of Services to Achieve SRHR

The Guttmacher-Lancet Commission on Sexual and Reproductive Rights laid out the essential elements of services that will be needed to achieve sexual and reproductive rights:

“A positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right. Essential sexual and reproductive health services must meet public health and human rights standards and should include:

- Accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;
- Information, counselling, and care related to sexual function and satisfaction;
- Prevention, detection, and management of sexual and gender-based violence and coercion;
- A choice of safe and effective contraceptive methods;
- Safe and effective antenatal, childbirth, and postnatal care;
- Safe and effective abortion services and care;
- Prevention, management, and treatment of infertility;
- Prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- Prevention, detection, and treatment of reproductive cancers.”³⁶⁷

Service Challenges: Men Need to Be Encouraged to Use the Services that Do Exist

Men’s sexual risk-taking, weaker health-seeking behavior, and perception that SRHR services are not for them certainly form a backdrop to their fuller engagement in SRHR. However, so do their interests in pleasure, good health, their partners, and their reproduction as reasons to seek out services and make other changes in their lives. Despite the evidence on men’s *comparative* reluctance to use services, the fact remains that they do use services and can be persuaded to use them more.

Simply increasing men’s knowledge of services makes a difference in their attitudes and behavior regarding SRHR. To cite an example, media exposure is shown to increase FP-related knowledge, attitudes, and behaviors. In an analysis of DHS data conducted for this report, at least 49 percent of men in Asia and Africa (this question was not asked in Latin America and the Caribbean) reported having heard about family planning within the last few months on the radio, television, or print media. Their recent exposure to this family planning messaging was strongly associated with their reports of using a modern method of contraception at last sex. Men in Western and Central Africa who had recently heard about family planning through the media were twice as likely to report modern contraceptive use at last sex as men who had not. Response ratios were smaller but significant in all of the other regions.

Knowledge is very important but not enough. Social norms around masculinity also limit men’s demand for, access to, and uptake of health services in general. Men’s health-seeking behaviors related to HIV and AIDS are a case in point. While these behaviors vary by geography, culture, and class, in most settings, men’s HIV testing rates are lower than women’s.³⁶⁸ In certain contexts, poverty also contributes to poor health-seeking behavior among men, when men are required to migrate for work or work long hours.³⁶⁹ Normative male attitudes keep men from getting tested for HIV across sub-Saharan Africa³⁷⁰ and restrain men from seeking out health care, disclosing their HIV status, or participating in peer support groups in Uganda.³⁷¹

Box 14

Vasectomy as a Lost Opportunity, at a Cost to Women

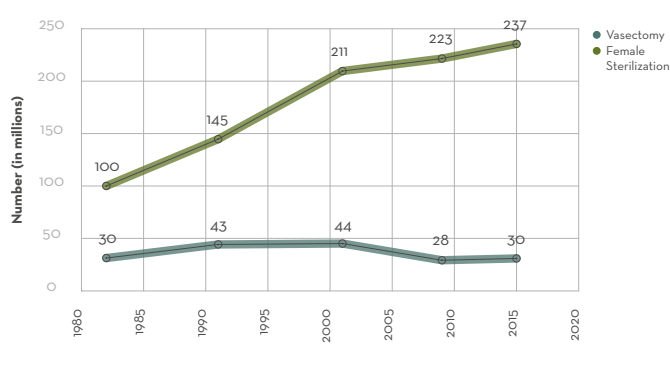
Vasectomy has been a casualty of the cultural framing of men as peripheral to SRHR. Female sterilization is a significantly more invasive, costly, and risky procedure than male sterilization and is somewhat less efficacious, yet its prevalence worldwide dramatically surpasses vasectomy except in North America and Western Europe, Australia and New Zealand, and Bhutan.³⁷² Recent data show that only 2.4 percent of men around the world use vasectomy;³⁷³ this figure is 0.0 percent in Africa.³⁷⁴

That female sterilization has become the norm while male sterilization is viewed with suspicion is a clarifying moment on gender inequity.³⁷⁵ This pattern of sterilization by sex is consistent with a widespread privileging of male sexuality and sexual concerns in programs in which female sexuality has been subordinated

or entirely invisible. Numerous gender-related factors within health systems that may contribute to higher levels of female sterilization, among them the prioritization of male sexuality and virility; health system efficiencies that favor sterilization by tubal ligation at the time of delivery or abortion; and

the role health services historically played in the coercive sterilization of women who came for other services. Household power relations are likely also relevant, including the divergent consequences of sterilization for how men and women are able to negotiate future sexual relationships.

Figure 25. Trends in male and female sterilization, 1982-2015



Source: Shelton, J. D., & Jacobstein, R. (2016). Vasectomy: A long, slow haul to successful takeoff. *Global Health: Science and Practice*, 4(4), 514-517; United Nations Department for Economic and Social Affairs. (2015). *Annex table III*. Retrieved from <https://www.un.org/en/development/desa/population/publications/pdf/family/trendsContraceptiveUse2015Report.pdf>

The Contribution of Policies to Men's Realignment With SRHR

Policies play an essential role in undermining or reinforcing traditional gender norms and bringing men closer to – or creating greater distance from – their sexual and reproductive roles.³⁷⁶ Their framing is essential for enabling or impeding a host of other actions in favor of men's engagement. Brazil's men's health policy is an exemplary integrated approach to working with men, drawing them in through a variety of channels – including their interest in fatherhood and caregiving – and then connecting them to services for their own health.³⁷⁷ Eighty percent of Brazilians use the national health system, and the National Policy of Integral Health Attention to Men focuses on adult men, whose life expectancy at the time the policy was put into place was 7.5 years lower than women's. National health plans should incorporate routine wellness visits – tailored to both men's and women's specific needs – into the organization of health services and give special attention to addressing any gender or cultural biases through training providers.³⁷⁸

The evidence arrayed in this report demonstrates the importance of engaging men and boys in SRH programming as a means of attaining SRH goals and of transforming unhealthy gender norms. Achieving full equality requires the participation of men as full, equitable sexual partners, invested in their own health and supportive of women's autonomy. So how are countries including or planning to include this critical approach to accelerate their SRHR program planning? The example in **Box 15** shows that recognition of this critical issue has not been followed by action to engage men more fully in family planning.

Box 15

Reference to Men in the FP2020 Costed Implementation Plans

Family Planning 2020 (FP2020) “is a global partnership that supports the rights of women and girls to decide, freely and for themselves, whether, when, and how many children they want to have.”³⁷⁹ Supported by core partners the Department for International Development of the United Kingdom, the United Nations Population Fund, the United States Agency for International Development, and the Bill & Melinda Gates Foundation, FP2020 set forth the goal in 2012 to reach an additional 120 million women and girls using modern family planning methods by 2020. Countries

were encouraged to make concrete commitments toward this goal; to implement these commitments, they developed costed implementation plans. To date, 47 countries have created costed implementation plans and associated action plans.³⁸⁰

A recent analysis of the country plans by Promundo and FP2020 reviews how countries are engaging men as users, partners, and advocates for women’s access to and use of services, and it suggests critical reforms that could drive rights-based family planning uptake.³⁸¹ The analysis shows that costed implementation plan frameworks could do much more to address the role of inequitable gender dynamics and masculinities in perpetuating poor SRH outcomes. The country-by-country findings of the analysis of six FP2020 country plans and three provincial plans appear in Table 8.

Table 8. Analysis of costed implementation plans: Summary findings

| | Ethiopia | Niger | Pakistan - Sindh | Pakistan - Kyber-Pakhtunkhwa | Pakistan - Punjab | Kenya | Senegal | Democratic Republic of the Congo | Nigeria |
|---|----------|-------|------------------|------------------------------|-------------------|-------|---------|----------------------------------|---------|
| Improving policy environment to facilitate male engagement | | | | | | | | | |
| Dedicated financing or governance structures to accommodate male engagement | | | | | • | | | | |
| Men as advocates for women’s SRHR | • | • | • | • | • | | • | | |
| Assess how gender norms affect male engagement in family planning | | | | | | | | | |
| Improving male knowledge and attitudes related to contraception and reproduction | • | | • | • | • | | • | • | • |
| Men as partners in women’s access to family planning | • | | • | • | • | | | | |
| Use of vasectomy, condom, withdrawal, and calendar-based methods | | | | | | | | | |
| Improving services to men, including male-friendly care and integrated services | | | | | | | | | |
| Effective measurement for tracking attitudinal and behavior changes as a result of male engagement activities | • | | • | | | | | | • |

• = Had specific details of male engagement approaches, including gender-transformative approaches

• = Few mentions of male engagement and/or few specific details provided; insufficiently gender-transformative

No dot = No mention of male engagement or missed opportunities for male engagement within priority areas

Source: Hook, C., Hardee, K., Shand, T., & Greene, M. (2019). *The role of men and boys in FP2020 costed implementation plans and country commitments*. Washington DC: Promundo-US.

Of the nine FP2020 country or province plans analyzed, not one had a robust male engagement program. Across the plans, the strongest aspects were those that engaged men as advocates for women’s access to and use of family planning services, and improved knowledge and attitudes

related to contraception and reproduction.

The most neglected aspects were the engagement of men as users of SRH services and efforts to tackle underlying gender norms that prevent men, women, and children from achieving the highest standard of health.

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Conclusion

Sexual and reproductive health and rights are fundamental to men. And men are fundamental to achieving sexual and reproductive health and rights for everyone.

The extensive global evidence reviewed in this report points to the need to reposition men in relation to their SRHR and the SRHR field in relation to them. This report has shed light on how men grow into their bodies, how they experience their sexual relationships, how they make choices relating to their reproduction, and how all of these dimensions come together to shape their lives.

Engaging with SRHR is part of being a whole person. Men's support for their sexual partners, their responsibility for their reproduction, their engagement in maternal health, and their caring parenting strengthen and draw them deeper into relationships with others. Poor SRH – sexual violence, STIs, limited HIV testing and treatment, and early, ill-timed, or unwanted pregnancy or childbearing by a partner – can have an important impact on a host of other decisions men make about schooling, migration, work, and future relationships.

Most men do not occupy the SRHR sphere as active citizens, and this harms them, their partners, and their children, as well as affects their lives, slows progress on SRHR global goals and targets, and impedes gender equality.

Achieving full equality requires men to assume responsibility for their own SRHR, to respect and protect the SRHR of others, and to engage with these issues as an important dimension of their lives and their humanity. Important returns will be won by men's greater involvement with SRHR and their participation in transforming the gender inequalities and restrictive gender norms that inhibit health and well-being. The health, rights, and well-being of individuals and couples can be enhanced by working toward gender equality. This report has shown that egalitarian sexual attitudes are positively associated with sexual satisfaction,³⁸² less sexual risk-taking, better communication and less conflict within couples, more successful contraceptive use, less unmet need for family planning, and more harmonious relationships. It is time to stop dividing men's SRHR decisions from their relationships with others, their caregiving roles, and other aspects of their lives.

Women's needs and rights must remain at the heart of SRHR even as the field advocates for men to step up and for services to serve them better. Though more male-friendly services are needed, services for women must remain a priority. While not necessarily female-friendly or gender-sensitive, services

for women tend to be heavily used, given women's physiology. Women's needs and rights must remain priorities around which the greater participation of men is amplified.

The programmatic evidence on men and SRHR is building and is pointing to what needs to be done. The field is developing a clear sense of the areas in which programs are focused and their approach to addressing men and SRHR. The extent to which family planning services are meeting the needs of men was assessed in a 2017 study.³⁸³ A new systematic review of interventions on men and SRHR found that the evidence base is distributed quite evenly across low-, middle-, and high-income countries, which is important for advancing this agenda globally.³⁸⁴ The review also found that much more gender-transformative work is needed; indeed, programs addressing gender-based violence constitute the one area in which a significant proportion of programs work with men in gender-transformative ways. The programmatic evidence on what works is also building and being increasingly rigorously evaluated.³⁸⁵

The more active integration of men's SRHR into other aspects of their lives fits perfectly with current global priorities. The SDGs' principle of universality affirms the need for this shift to occur everywhere in the world. The principle of leaving no one behind highlights intersectionality and the disadvantage specific groups of men face. Of the SDG principles, synergy stands out as a top priority that is well served by men's informed and equitable engagement with SRHR. It is an investment in health and well-being that can catalyze a host of improved outcomes for men, their partners and their children, and it should be prioritized. The commitment of United Nations member states to universal health coverage also highlights the role of national health programs for increasing attention to men's SRHR, and the roles they can play in supporting the SRHR of others.

The field's measures of success need adjusting and expanding to reflect new understandings. An approach to SRHR built on statistics alone is inadequate; rather, deep social transformation is required, and the gains from that transformation will go far beyond improved uptake of reproductive health services. In general, the statistical record on SRHR is weaker for men than for women (and for non-heterosexual and gender nonconforming individuals, adolescents, unmarried individuals, and so on through a range of identities). Data collection in the relationship and fertility arena is especially egregiously lopsided. The narrow focus on measures of women's marriages or unions, use of contraception, and childbearing limits research and services, and it obscures the need to address gender norms and transformation with individuals and couples.

As long as the outcomes of these services and policies are measured using data only on women, the center of gravity cannot shift toward engaging men more fully in SRHR. The reframing of SRHR in the lives of men should generate new measures and enrich the ways we think about SRHR numbers.

The realignment of men in SRHR must go hand in hand with a realignment of men's participation as equal caregivers. This shift must be measured in time spent, emotional load, life priorities, and the work-life trade-offs required to be fully involved, equitable caregivers of children. These two revolutions are the same: men as equal SRHR partners and men as equal partners in the care of children (and in other kinds of care, from care of the home to care of other family members).

Box 16

Data Gaps and Needs

Scanning the horizon for research on boys' and men's experiences and motivations in the SRHR arena, one is immediately struck by the sparseness of the data. Gaining a full picture of men's SRHR experience requires some sleuthing for a number of reasons that involve assumptions about their roles:

- In the DHS and other surveys that touch on SRH, it is often husbands of the women who are sampled rather than men in general.
- Assumptions about heteronormativity and monogamy strongly influence the treatment of the current union as the only one when data are collected on women or men.
- Little is known about adolescent boys aged 15 to 19, and virtually nothing about boys aged ten to 14, a time when many attitudes about gender and sexuality are being shaped and reinforced.
- Birth histories are not collected from men, in part because they are viewed as unreliable informants on their fertility experience since they might

have children they are unaware of and because of the assumption that their experience parallels women's.

- Men are not being asked fully in the DHS about their contraceptive use, requiring women's contraceptive use to serve as a proxy; this means there is not a contraceptive profile for men.
- Men are not asked *why* they do not use contraception, and much more information is needed on decision-making related to contraception in the context of a specific relationship.
- Few studies look at the long-term impacts of unintended pregnancy and of fatherhood on other aspects of men's lives.
- With regard to contraceptive use, more information is needed on how perceptions of masculine (and feminine) sexuality influence people's thoughts and feelings about using contraception in general and about using specific methods.
- More longitudinal surveys that look at men's long-term experiences should be a focus of research investment in low- and middle-income countries as these have been very valuable in South Africa and Malawi.

This report began by asking what people's sexual and reproductive lives would look like if everyone were able to acquire knowledge and skills; build self-esteem; enjoy access to services; conduct relationships with respect for their partners and their rights; avoid or embrace parenthood with intention and planning; and make decisions that take into account the impact of their choices throughout their lives and the lives of their partners and children. Looking toward the achievement of the SDGs and beyond FP2020 to achieving universal access, the world cannot afford not to invest in enhancing men's engagement in SRHR.

The evidence of the benefits of revisioning men's relationship with sexual and reproductive health and rights is extensive and powerful. Indeed, the immense body of evidence begs a more radical question: What would the world look like if the respect, mutuality, and connections established and reinforced through sexual intimacy could overcome the patriarchal inequalities within family, community, and society that harm health and limit well-being?

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Priority Action Areas to Advance Men’s Engagement in SRHR, while Protecting Women’s Privacy, Rights, and Health

| MEN’S BODIES | MEN’S SEXUAL RELATIONSHIPS | MEN’S REPRODUCTION |
|---|--|--|
| <p>ADVOCACY – CHANGING THE CULTURE OF MEN’S DISENGAGEMENT</p> <p>Overarching: To thrive as individuals and support the health of their families and communities, men and boys need to know significantly more about sexuality and healthy relationships and to question gender inequality and restrictive gender norms. Comprehensive sexuality education (CSE) is for everyone of any age.</p> | | |
| <ul style="list-style-type: none"> Promote lifetime CSE learning, with testing on this material built into school curricula. Encourage boys to wait for sex until they acquire knowledge and skills. Promote debates on and alternatives to pornography as a source of information. Challenge homophobia, transphobia, and biphobia. | <ul style="list-style-type: none"> Build boys’ and men’s skills in SRHR and communication (for example, by incorporating examples of sexual relationship dilemmas, advice, and encouragement on how to have difficult conversations). Cultivate strong relationship communication to help couples avoid risk³⁶⁶ and find greater sexual satisfaction and closeness. | <ul style="list-style-type: none"> Engage boys and men more fully in SRHR as a central part of their lives. Provide everyone with the opportunity to engage in life-planning and goal-setting that references reproduction. Confront sex preference. Cultivate men’s capacity as supportive partners and advocates for SRHR. |
| <p>SERVICES – SERVING MEN’S NEEDS AND PRIORITIZING GENDER-TRANSFORMATIVE PROGRAMS</p> <p>Overarching: SRHR services must challenge harmful gender norms in part by how they engage men, undermining violence against women and gender and sexual minorities in all their forms (see UNFPA and IPPF service package)³⁶⁷</p> | | |
| <ul style="list-style-type: none"> Increase men’s access to and use of family planning and STI and HIV prevention, treatment, care, and support. Welcome men, and make health services more relevant by addressing their concerns. Systematically incorporate gender equality and pleasure into CSE content and services. | <ul style="list-style-type: none"> Place the relationship context of gender norms front and center in service provision. Train providers on how to communicate about consent in all of their client interactions. Increase men’s uptake of existing male-cooperative contraceptive methods, with attention to protecting women’s choices. | <ul style="list-style-type: none"> Include and engage men in maternal, newborn, and child health. Support men in being more fully involved fathers by building their skills and confidence. |
| <p>POLICIES – REFRAMING THE CONNECTIONS BETWEEN MEN’S LIVES AND SRHR</p> <p>Overarching: Governments and advocates should frame and invest in health, education, sexuality, equity, autonomy, and empowerment for all as measures of success.</p> | | |
| <ul style="list-style-type: none"> Mandate and implement gender-transformative CSE. Increase access to SRHR services outside of health facilities by delivering them in schools, communities, workplaces, and other accessible venues. | <ul style="list-style-type: none"> Define, prioritize, and integrate indicators on a positive role for men in SRHR into FP2020 goals. Cultivate men’s support for women’s SRHR and women’s rights. Implement policies that combat the gender-inequitable terms and conditions of marriage. | <ul style="list-style-type: none"> Frame more gendered-informed policies related to SRHR services, parental leave, childcare, custody, and other relevant issues, building on <i>What Men Have to Do with It</i>, and reflecting on whether and how much the world has advanced. Establish an entity within national departments of health responsible for advancing and monitoring men’s health – like the men’s health directorates in existence in Brazil, Australia, and Scotland. |
| <p>RESEARCH – ADDRESSING THE BLIND SPOTS AND BUILDING THE EVIDENCE ON MEN’S CONTRIBUTIONS TO SRHR</p> <p>Overarching: Researchers and advocates should work to overcome systematic data gaps that reinforce stereotypes about disengaged men to drive a more comprehensive framing of men and SRHR across the life course and build global knowledge of what works to engage me.</p> | | |
| <ul style="list-style-type: none"> Collect data on adolescent boys aged 10 to 14 and 15 to 19, periods when attitudes and knowledge are being formed. | <ul style="list-style-type: none"> Expand the contraceptive technology mix for men and their partners. Study the limits that stereotypes and assumptions place on access to information and services. Conduct costing research on what it would take to include men fully in services. | <ul style="list-style-type: none"> Research the social and economic costs of men’s lack of engagement in SRH. Collect data on the fertility histories of men and links with other aspects of their lives. |

Annex 1.

INCLUSION CRITERIA FOR DHS TREND DATA THROUGHOUT ANALYSES

- DHS surveys conducted with male respondents
 - At least two completed DHS survey rounds between 2005 and 2017
 - Note: Trends analyses conducted for 30 countries unless otherwise noted
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This Report Is for Every Boy (and Everyone)

In a world where conservative and restrictive forces are moving against fundamental sexual and reproductive rights, especially those of women and girls, we need boys and men on board.

As a research and activist organization, we were led by the findings in this report to this single pressure point: **Start early with boys**. Provide them with information about their bodies and about sexuality. Talk to them about their worries and concerns, highlight the unfairness of gender inequality, and teach them to be tolerant, communicative, and compassionate. Engage them and support them to be allies now and in the future alongside the girls, women, adult men, and all individuals who are fighting for reproductive justice.

Global commitments on sexual and reproductive health and rights (SRHR) have been timid and unambitious when it comes to men and boys. None have targets for male contraceptive use, for example. Likewise, very few countries mention men and boys in their SRHR policies or create entry points for them to receive services. Few discuss challenging ideas about masculinity or questioning the power men have over women's bodies that so often shapes sexual and reproductive decisions.

Boys should be raised as allies and beneficiaries in the struggle for SRHR, and they need more information and support for their own sexual and reproductive rights and needs. We believe in every boy.

- Every boy should believe in and fight for gender equality and for reproductive rights – for himself, for women and girls, and for individuals of all gender identities and sexual orientations.
- Every boy should be aware that he is a sexual and reproductive being and know how his body and other people's bodies work.
- Every boy should have access to comprehensive sexuality education that includes discussions about healthy masculinity.
- Every boy should feel free to express his sexual identity and gender identity in ways free from coercion, repression, or discrimination.
- Every boy should be given the knowledge and skills to protect himself and his sexual partners from HIV and AIDS and other sexually transmitted infections.
- Every boy should be taught to develop a critical perspective about images and ideas he is likely to see in pornography.
- Every boy should see himself as needing reproductive services as much as any girl and should know about contraceptive methods and where to get them.
- Every boy should be brought up believing that caregiving is as much about him as it is about the women and girls in his life.
- Every boy should take up the struggle for SRHR as his own, because it is.

The pathway to change is through work with boys. Every boy.

