

**RESEARCH PROTOCOLS TO STUDY SEXUAL AND REPRODUCTIVE  
HEALTH OF MALE ADOLESCENTS AND YOUNG ADULTS  
IN LATIN AMERICA**

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## TABLE OF CONTENTS

|      |  |    |
|------|--|----|
| I    | INTRODUCTION   | 3  |
| II.  | STUDY METHODOLOGY  | 6  |
|      | A. Objectives  | 6  |
|      | B. Research Questions  | 7  |
|      | C. Design and Implementation   | 8  |
|      | D. Sampling  | 15 |
|      | E. Interview Guides  | 15 |
|      | F. Data Analysis   | 18 |
|      | G. Informed Consent Procedures   | 19 |
|      | H. Dissemination of Results  | 20 |
| III. | CURRENT KNOWLEDGE OF THE REPRODUCTIVE HEALTH AND<br>SEXUALITY OF MALE ADOLESCENTS AND YOUNG ADULTS | 20 |
|      | A. What are the Reproductive Health Needs of Adolescents and<br>Young Adults?                      | 20 |
|      | 1. Negotiating Puberty   | 20 |
|      | 2. Fertility Awareness   | 21 |
|      | 3. Self Care   | 22 |
|      | 4. Decision Making and Partner Communication   | 22 |
|      | B. How Can the Needs of Male Adolescents and Young Adults be Met?                                  | 24 |
|      | 1. Sex and Life Skills Education   | 24 |
|      | 2. Efforts to Improve Communication and Modify Traditional<br>Gender Roles                         | 25 |
|      | 3. Clinical Services and Counseling  | 26 |
|      | 4. Prevention of Sexual Abuse  | 27 |
|      | 5. Information, Education and Communication  | 27 |
|      | C. The Meaning of Masculinity  | 28 |
|      | 1. The Social Construction of Masculinity  | 28 |
|      | 2. Influence on Sexuality  | 29 |
|      | 3. Enforcement of Gender Roles   | 32 |
|      | 4. Gender Roles  | 33 |
|      | 5. Consequences  | 34 |

|  |    |
|--|----|
| D. Experience of Sexuality Among Male Adolescents and Young Adults | 35 |
| 1. Sexual Debut  | 35 |
| 2. Sexual Practices  | 36 |
| 3. Homosexual and Bisexual Experiences                             | 37 |
| 4. Correlates of Contraceptive Use                                 | 37 |
| 5. Sexually Transmitted Diseases                                   | 37 |
| 6. Factors which Protect or Promote Reproductive Health            | 38 |
| 7. Correlates of Risk Behaviors                                    | 39 |
| 8. Resiliency  | 40 |
| E. Teen Fatherhood   | 40 |
| 1. Prevalence  | 40 |
| 2. Attitudes Towards Teen Pregnancy                                | 41 |
| 3. Social Construction of Teen Fatherhood                          | 42 |
| 4. Response to Unintended Pregnancy                                | 43 |
| 5. Consequences  | 44 |
| F. Victims or Perpetrators of Sexual Abuse?                        | 44 |
| 1. As Victims  | 44 |
| 2. As Perpetrators   | 46 |
| 3. Socio-Cultural Factors  | 47 |
| Appendices   |    |
| 1. Focus Group Guides  | 48 |
| 2. Individual Interview Guides                                     | 64 |
| 3. Survey  | 79 |
| 4. Informed Consent  | 92 |

## I. INTRODUCTION

This protocol describes a proposed study of the reproductive and sexual health of male adolescents and young adults in selected Latin American countries. The results of this study will guide the development of policies and programs which promote the sexual and reproductive health of male adolescents through a better understanding of their knowledge, attitudes and practices, taking into account the influence of the social construction of masculinity in Latin America.

Relatively few studies have focused on male adolescents and young adults. This gap is particularly glaring in view of the voluminous literature on female adolescents. The limited body of scientific literature concerned with the reproductive health of adolescent males in Latin America consists of a few single city studies and even fewer individual country studies. These findings cannot safely be generalized, even to other cities in the region, let alone to rural populations or men in other regions and continents. The proposed study will attempt to overcome these limitations in the following way:

Focus group, life history and survey methodologies will be combined to provide information on social norms and behavior and to permit quantification and triangulation of findings.

- Information will be provided on a broad target group in both rural and peri-urban settings, rather than on specific populations such as university students or street kids.
- Finally, it is designed specifically to examine the interaction of gender roles and male sexual and reproductive health.

During recent years, there has been a renewed recognition of the role of men in the reproductive and sexual health<sup>1</sup> of women and the importance of including them in programmatic efforts. Interest in men in family planning has waxed and waned over the last three decades, but as the millennium approaches, the debate about male responsibility has taken a new turn and the question is increasingly being raised: What is in it for men?

The renewed focus on men in the family planning and reproductive health field is cogently expressed in the International Conference on Population and Development's action plan; "...the objective is to promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles" (Paragraph 4.25).

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<sup>1</sup>"Sexual health is defined as the enhancement of life and personal relations, and sexual health services should not consist merely of counseling and care related to reproduction and sexually transmitted diseases. ICPD 7.2 Reproductive health is defined as the "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive health system and to its functions and processes. People are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if when and how often to do so".ICPD 7.2

A better understanding of men and their reproductive behavior is essential to the achievement of one of the central policy goals of the ICPD. Nevertheless, little is known about how male adolescents behave in the reproductive health and sexual domain, and much less is known about their attitudes and feelings toward related behaviors and their social-cultural meanings. Although the Young Adult Reproductive Health surveys conducted by the Centers for Disease control provide essential information on sexual behavior and contraceptive use, they were not designed to cover the full breadth of reproductive health topics pertinent to male adolescents.

There is a notable lack of research on the meaning and significance of sexual activity, contraceptive use and other reproductive health issues for male adolescents and young adults. Information on coital experience and contraceptive use is only a small part of the picture, it may be even more important to understand the circumstances of sexual behavior, particularly its emotional dimension.

Most studies from the reproductive and sexual health field have examined males from the perspective of deficit; men need to do more or participate more. This discourse does not explain men's side of the story. Rather than understand what men believe or feel, men have often been studied from the perspective of what we could learn about them in order to convince them to participate in preconceived reproductive and sexual health or male involvement programs.

A review of the literature on men and family planning finds that it focuses almost exclusively on how men influence women's health. The literature reflects the assumption that meeting women's reproductive and other needs has been and will remain a priority of reproductive health and family planning programs. It also however, recognizes that research from diverse settings suggests that these goals will be difficult to accomplish without appropriate inclusion of men.

The justification provided for this position is that while women bear greater health hazards associated with reproduction than men, it is men who are largely responsible for contributing to these hazards - for example, in a situation where an unwanted pregnancy is followed by an unsafe induced abortion. Therefore, the field recognizes the need to increase male responsibility, particularly with regards to the consequences of their sexual actions for their partners.

Differing approaches to men and women in the reproductive health literature reflect the fact that men are conceptualized primarily as a "problem" or a means to an end. In the ICPD document, the language that refers to male responsibility and participation is familiar to those in the reproductive health field. Male involvement projects often approach the issue from the simplistic view that men in and of themselves are the obstacles to family planning or condom use. The literature tends to refer to the "Empowerment and Status of Women", while projects or research on men are labeled as "Male Responsibilities and Participation".

While the empowerment of women is fundamental, what is often lost is the idea that the hoped for transformation and expansion of men's roles will also benefit men. The fact that men

have sexual rights that are linked to freedom from oppressive norms, such as the right to show emotions without their virility coming into question, is seldom recognized. An exception to this is the work of Gary Barker (1996) and Benno Keijizer (1995) who suggest that the transformation and expansion of traditional sexual roles will be liberating for men. The reproductive health field should recognize that what is usually phrased as a responsibility or a duty (e.g. support women in family planning) can in many cases also be proposed as a right (e.g. the right to participate in deciding the number and timing of their children). A greater emphasis on male rights would lead to strategies to create the conditions in which men would be enabled to assume more responsibility.

When referring to male participation, it is important to recognize that men already are involved in reproductive health, albeit sometimes with negative consequences. Therefore, it is not merely a question of increasing male involvement, but rather profoundly changing the way in which men are involved. As family, community, religious, professional and political leaders, men are instrumental in promoting or hindering women's health. Therefore it is vital to bring men into positive decision-making with their partners, while neutralizing resistance which they pose to women.

Finally, talking about men alone – like talking about women alone - is an inadequate approach. As Judith Helzner argues, “In general, if little or no attention is paid to the general picture - including both sexes before the spotlight is focused just on the men – there is the potential for family planning programs to reinforce the status quo in gender inequalities” (1996). Some programs aimed at increasing male involvement have resulted in increased male control of their partners' decisions. Gender analysis reminds us to ask what consequences particular strategies would have for women partners' health and autonomy, and for the communication and sexual dynamic. In many countries, although men have little correct information on contraception they are the ones making many of the decisions. Some strategies may increase patriarchal decision-making at the expense of women's equality and right to make decisions affecting their lives.

## **Empowerment**

In this post-Cairo age, the nature of the discourse of male participation is changing. There is still no universally accepted understanding of what it means to include men in sexual and reproductive health efforts and what is sexually healthy for adolescents. However, there is an emerging awareness that reproductive health programs and services should reach out to men not only as a means of fulfilling women's reproductive health needs, but also to fulfill their own.

Recent research suggests that men's health needs, especially those of male adolescents, may be more pressing than commonly thought. In fact, Rutter (1990) suggests that masculine gender is a variable that generates greater vulnerability to risk. For example, overall in Latin America and the Caribbean, the health burden for men is 26 percent higher than it is for women (Keijizer, 1995). Much of this morbidity is associated with the social construction of masculinity: traffic accidents, homicides, injuries and cardiovascular diseases, often related to

alcohol use, stress and lifestyle. These trends suggest the need to work with male adolescents because many of the behaviors that lead to these health problems in adulthood emerge from patterns learned in childhood and adolescence.

Interest in men and sexual and reproductive health suggests the importance of designing interventions for male adolescents and young adults. It is widely recognized that intervention during the adolescent years can result in improved sexual and reproductive health during the adult years. Adolescence marks the onset of sexuality and the adoption of behavior patterns that may have lifelong implications for reproductive health. Empirical research suggests that early sexual habits and patterns of interaction in intimate relationships form the basis of lifelong habits and patterns. For example, research in the United States has found that consistency of condom use reported among teens is related to age at first sexual relations and earlier condom use. Males who started sexual activity later were more likely to use condoms and those who used condoms during their first sexual relations were more likely to use condoms consistently thereafter (Sonenstein, Pleck & Ku, 1995).

A focus on adolescent intervention prompts us to take a new look at male adolescents and young adults. How accurate is the popular image of male adolescents as “roving inseminators” who cause unwanted pregnancies and spread sexually transmitted diseases exclusively for their own sexual pleasure? More importantly, how does this perception influence our efforts to formulate programs that are effective in improving the sexual and reproductive health of women and men?

We have much more to learn about how male adolescents form their gender identity, how male socialization influences contraceptive use and HIV risk, how they weigh their conflicts and alternatives related to masculinity, what rewards and costs go along with changing their sexual behavior and attitudes, and what kind of fathers and husbands they want to become. Emerging research on domestic, dating and courtship violence has not offered sufficient insight on how to work with male adolescents to prevent domestic violence and sexual coercion. Very few studies have asked men their opinions about these issues, or about their own experiences of having been violent, with the aim of preventing relationship violence. Another priority area for research is the issue of peer interaction and sources of information on sexuality and family planning among youth. Research is needed not only to provide a fuller understanding of men and male sexuality, but also in terms of efforts to promote safe and more responsible sexual activity.

## **II. STUDY METHODOLOGY**

### **A. Objectives**

The literature on male adolescents and young adults provides useful information on contraceptive knowledge, sexual practices and family planning use in Latin America. Although a fair amount has been written on gender roles and their influence on reproductive health and sexuality, little empirical data exists to support this work. Most data comes from qualitative research with high-risk populations such as street kids or small surveys in school-based populations. Additional information on male adolescents comes from studies of adolescent

pregnancy/AIDS prevention among minority populations in the United States.

This study will focus on filling one of the most glaring gaps in our understanding; namely what masculinity means to young boys and how they experience bodily changes and initiation of sexual activity. It will also provide information on the context of behaviors documented by survey research such as early sexual initiation, multiple sexual partners and low contraceptive use. In addition, this research will explore several areas for which virtually no information is available, teen fatherhood and sexual abuse and coercion, both priorities for program intervention. Finally, information needed to develop programs will be collected, including an understanding of where male adolescents get information on reproductive health and sexuality and their expressed needs and preferences for information and services.

The overall goal of this study is to increase understanding of how the social construction and expression of masculinity among male adolescents and young adults influence reproductive and sexual health, and also to explore the attitudes of health providers regarding the needs of young men and the provision of services to them. The purpose of collecting this information is to guide the development of effective policies and programs for working with male adolescents and young men. Thus, the researchers will focus on collecting information that will inform programmatic initiatives, while expanding our understanding of the relationship between masculinity and reproductive and sexual health.

The specific objectives of this study are to:

1. Understand the significance masculinity holds for youth;
2. Identify socialization patterns that lead to the construction of distinct forms of masculinity;
3. Understand how the meanings of masculinity are manifested in sexual and reproductive health attitudes and behaviors, specifically:
  - a) puberty and development of sexual identity;
  - b) interpersonal relationships;
  - c) sexual expression;
  - d) paternity; and
  - e) sexual abuse and coercion.
4. Determine where boys and young men obtain information on reproductive and sexual health;
5. Explore the utilization of reproductive health services, and the opinions and preferences of youth regarding these services; and
6. Explore the perceptions of health providers regarding the behaviors and needs of youth in the realm of reproductive and sexual health, as well as their attitudes and suggestions related to the provision of services to this group.

## **B. Research Questions**

1. What is the meaning of masculinity and sexuality to male adolescents and young adults and how does it influence their reproductive health and sexuality? What



- are the rewards and costs to male adolescents of changing their sexual behaviors and attitudes?
2. How do male adolescents and young adults experience their reproductive health and sexuality, with regard to puberty, development of sexual identity, sexual debut, sexual activity and contraceptive use?
  3. How do male adolescents and young adults perceive teen fatherhood? Under what conditions does this perception vary?
  4. How common is the experience of sexual abuse and coercion among male adolescents and young adults?
  5. Where do male adolescents obtain information about reproductive health and sexuality? Where would they like to obtain information?
  6. How often, and how well do male adolescents and young adults communicate with their friends, partners and parents about reproductive health and sexuality?
  7. What reproductive health/sexuality concerns and problems do young boys identify? How do they prioritize these?
  8. Are young boys and men aware of available services? Do they perceive them as accessible? Do they utilize them? What type of services do youth desire?
  9. What are the knowledge and attitudes of health providers towards offering reproductive health and sexuality education and services to male adolescents and young adults?

### **C. Design and Implementation**

A team will be formed in each country to conduct this research. This team will be composed of researchers with experience in qualitative methodology, representatives of public and private sector programs working with youth, individuals involved with groups working with men to change traditional gender roles, and youth leaders or representatives of youth organizations (both service delivery and research). This team will serve as a technical advisory group to assist the researchers in identifying and reviewing existing data and experiences; adapting and focusing research objectives and methodology according to country needs; adapting and testing interview guides and questionnaires; facilitating access to adolescents and providers; interpreting data and drawing conclusions; and contributing to the dissemination and utilization of results.

Because this is a multi-site study, the researchers will meet to discuss study methodology and maintain close coordination throughout the study. A key objective of these meetings will be to define the study topics and methodology, and agree on target populations in each country.

Close collaboration during every phase of the study will facilitate development of a synthesis of study results at a regional level. A list serve will be established to facilitate contact between researchers.

The study design will be descriptive, using a combination of data collection methods. Qualitative methodology emphasizes the importance of understanding the meanings of human behavior and the social-cultural context of social interaction. While survey research already exists which quantifies adolescent sexual activity and contraceptive use, an understanding of the empirical social world as it actually exists for male adolescents rather than as researchers imagine it to be, is lacking. This is consistent with the conclusion of an ICRW report on their HIV/AIDS research among adolescents in developing countries, which concludes that a combination of qualitative and quantitative methods works best to collect information on sexual behavior among youth.

The study design is based on the combination of focus groups to learn about ‘ideal’ norms, and individual interviews to probe into the ‘real’ experiences of male adolescents and young adults. Use of focus groups and individual interviews will indicate differences between actual behavior and idealized social norms as well as discover the extent of knowledge about key topics. Focus groups tend to elicit more socially “correct” answers and produce good data on social norms, but the one-on-one interviews provide good data on actual knowledge and experience. For this reason, many researchers have concluded that community-based research on sexuality and reproduction should include both methods of data collection (World Health Organization, 1999).

Secondary analysis of existing country data will help focus the study on issues relevant in the specific context. A close-up conceptual understanding of sexual and reproductive health among male adolescents and young adults will be provided by the qualitative data and confirmed by small, targeted surveys. This study will be conducted in four phases:

- Phase 1. Review and secondary analysis of existing data
- Phase 2. Focus groups to identify cultural norms and patterns around reproductive health and sexuality issues among male adolescents. Focus groups with providers to identify their opinions and attitudes towards providing reproductive health services to male youth.
- Phase 3. Individual interviews with key informants to explore knowledge, attitudes and behaviors related to reproductive health and sexuality issues at the individual level.
- Phase 4. Small scale surveys targeting selected issues and population segments to quantify emerging issues.

## **Phase 1: Secondary Analysis**

As a first step in the research process, the researchers will collect and analyze research conducted in country pertaining to male adolescents and young adults, focusing on the area where the study will be conducted. This body of research may include national census or survey data, formative research conducted during the development of reproductive health programs, evaluation research from adolescent and youth programs, and social science research conducted by research institutions or universities, among others. The research team will synthesize and, if necessary, conduct secondary analysis of this data. Analysis of this data will: 1) provide background information for the research; 2) provide important descriptive and socio-demographic data on the male adolescent and youth population; and 3) help to refine research objectives and methodology, focusing on areas most in need of research. During this phase, the research team decide if it will apply only the core modules or add additional modules or questions to their study to meet specific country needs; taking into account existing research, health and other social development indicators, the information needs of stakeholders and on-going and planned programmatic initiatives. In addition, it will be necessary to focus on selected segments of the young male population, depending on local programmatic priorities.

Ideally, ethnographic research would be conducted in study communities before beginning the focus groups and in-depth interviews. Information provided by this research would be helpful in adapting the study instruments, conducting interviews and interpreting study results. However, it is unlikely that the research teams conducting this study will have the resources available to conduct this type of research. In order to compensate for this lack of information, researchers should actively seek existing information and conduct interviews with individuals who are familiar with the study population, perhaps from the service delivery organization or NGO facilitating the research.

## **Phase 2. Focus Groups**

During this phase, focus groups will be held with male adolescents and young adults to identify cultural norms and patterns concerning reproductive health and sexuality. Focus groups will also be held with health providers to determine their attitudes towards providing reproductive health education and services to male adolescents. The data from these focus groups will contribute to a better understanding of existing reproductive health policies and programs for adolescents and young men. This information will help to guide the development of future initiatives in this area.

A focus group is an interview with a small group of people on a specific topic. Groups typically consist of a relatively homogeneous group of six to eight people who participate in the interview for one-half to two hours. (Debus and Porter/Novelli, 1996). Participants hear each other's responses and make additional comments beyond their own original responses as they hear what others have to say. The object is to get high quality data in a social context where people can consider their own views in the context of the views of others (Patton, 1987). One advantage of this methodology is that the interaction of respondents often stimulates a rich response or new and valuable thoughts. In addition, the group/peer pressure present in the

discussion is valuable in challenging the thinking of respondents and illuminating conflicting opinions.

Focus group discussions are used primarily to investigate normative aspects of behavior. The behavior of individuals should not be investigated by this method. They permit exploration of ways in which people interact in discussion of a topic and of the extent of agreement in opinion and attitude. One advantage of group over individual settings is the greater breadth of ideas, opinions and experiences that are likely to be expressed. The content of an individual interview is limited by the experiences, recall, conceptual and verbal abilities of a single person. In a group discussion, there is obviously a bigger pool of experiences and verbal talents to draw on (World Health Organization, 1999).

The focus groups will be facilitated by a moderator who follows much the same procedure as in an unstructured interview, using a general discussion guide and eliciting details through probes. Participants will be sampled purposively to include segments of the male adolescent and youth population of particular interest to the study. Participants will be chosen who represent relevant similarities such as social class, life cycle, sexual activity, age, marital status and cultural differences.

In qualitative studies, study size is an important feature of design but there are not precise rules to provide guidance. Both data collection and analysis tend to be time-consuming, hence study sizes are usually small. But clearly, very small studies provide an inadequate basis for generalization. Ideally, qualitative studies should continue to collect data from groups or individuals until new information of importance is encountered. The aim should be to obtain information from typical members of each category of interest. Where focus groups are used, it is dangerous to rely on only one discussion for each study population. The minimum should be two or three focus group discussions. Approximately two to three focus groups will be held with each population segment of interest. If new insights are provided in the third group, fourth and additional groups may be conducted. Researchers will continue to collect data until the point of saturation, where they feel confident that they are learning little that is new from subsequent interviews (Glaser & Strauss, 1967 cited in Rubin, 1995).

Due to the breadth of study topics, a methodology will be utilized in which the same group of youth participate in several sessions of a focus group, usually two or three. This allows researchers to cover a broad range of topics with the same participants, permitting sufficient time to explore each topic in depth and gaining confidence among participants to permit the discussion of sensitive topics, such as violence and sexual coercion.

Because homogeneity in focus group participants is sought in terms of social class, educational level, age, or other variables which will affect the degree to which participants share information during the group discussion, the number of focus groups necessary increases exponentially according to the number of population segments of interest to the research. Given the research questions of interest to this study, the most salient characteristics will be age and geographic location of participants.

The following table shows that approximately eighteen focus groups will be conducted during this study. Therefore, a minimum of 36 focus group sessions will be conducted, assuming that all of the topics included in the guide can be covered in two sessions with each group of participants. All countries will conduct focus groups and individual interviews with youth between 13-14 and 15-19 years, in at least one rural and one peri-urban area. Inclusion of the 20-24 age group is optional. . Each country research team may decide to include additional population segments in the study

### **NUMBER OF FOCUS GROUPS BY POPULATION SEGMENT**

| <b>Age Range</b> | <b>Peri-Urban</b> | <b>Rural</b> | <b>Total</b> |
|------------------|-------------------|--------------|--------------|
| <b>13-14</b>     | <b>3</b>          | <b>3</b>     | <b>6</b>     |
| <b>15-19</b>     | <b>3</b>          | <b>3</b>     | <b>6</b>     |
| <b>20-24*</b>    | <b>3</b>          | <b>3</b>     | <b>6</b>     |
| <b>Total</b>     | <b>9</b>          | <b>9</b>     | <b>18</b>    |

**\*Optional**

Researchers will coordinate with community-based organizations, health services, NGOs, and mothers' clubs in the selected areas to recruit focus group participants. Clear criteria should be provided to the personnel doing the recruitment to ensure that the focus group participants represent the range of characteristics typical of the segment of the population that has been selected for the study. In other words, care must be taken that not all participants live close to the health center, are health promoters, are relatives of the auxiliary nurse, etc.

In addition, focus groups or individual interviews will be conducted with health care providers. A minimum of two focus groups with providers will be conducted in each geographic area. If the researchers decide that it is more feasible to conduct individual interviews, between ten and fifteen interviews should be conducted in each geographic area.

Two teams each consisting of a moderator and observer shall be recruited and trained in the study objectives and methodology. If trained and experienced focus group moderators are not available, the researchers should look for candidates among psychology or social work students. The moderators and observers must be trained in focus group methodology and well versed in the objectives of the study.

### **Phase 3. Case Study Interviews**

Focus groups provide rich information on cultural norms and ideals, but are not as useful in eliciting information about actual behaviors and attitudes of individuals. A number of studies on masculinity utilizing focus group methodology, such as the study of fatherhood conducted in Guatemala by Isabel Nieves (1992), have been unable to uncover information on how the

behavior of participants varied from ideal social norms. Thus, it is preferable to use individual interviews to provide information on actual behaviors. These interviews are usually organized around pivotal events or epiphanies in individual's lives. The researcher explores the meaning of these events, relying on the individual to provide explanations and searching for multiple meanings.

Individual interviews will be conducted with key informants to explore how they experience their reproductive health and sexuality. The objective of these interviews is to provide an understanding of the way in which adolescent males navigate their passage into sexual maturity. In case study interviews, respondents are encouraged to report on their own behavior. They are asked to relate, step-by-step, the processes surrounding and episodes or event of particular relevance.

The main advantage of in-depth interviewing over structured interviews is its ability to provide insights into and understanding of the context in which behavior occurs and the broader structural determinants (e.g. power relations) of behavior. Other advantages include: a) respondent determination of the salience of topics and themes; b) greater depth and detail of information; c) greater opportunity to share and understand the viewpoints of respondents and how their beliefs, and experiences and vocabulary relate to wider issues; and d) the possibility of discovering the unexpected, which is precluded in a highly structured approach.

There are, of course, some disadvantages. The successful application of this method requires highly skilled and trained interviewers, who themselves must understand the purposes of the research and indeed must become part of the research team rather than being merely mechanical data collection agents.

With complex or sensitive topics, it is often advisable to conduct repeated interviews with the same respondent to allow greater trust and rapport to evolve. The aim is to elicit as much narrative as possible. The emphasis is on getting people's own perspective on events, and on gaining a rich description of the context and situations in which these events and actions are taking place. Repeat contact with the same respondent will allow a deeper understanding of underlying motives of behaviors, since the researcher has ample time to probe for explanations, resolve apparent contradictions and obtain additional examples of events or actions. Attitudes and beliefs are often expressed spontaneously by informants while relating a specific life event.

In-depth interviews produce a very large amount of information and methods of recording and analysis are very time-consuming. Accordingly, sample sizes are usually small, typically in the range of 10-60 respondents. Inevitably, this feature may raise doubts about the representativeness of results, and great care should be taken to minimize these through a careful selection of respondents. Ensuring that the selected respondents are broadly representative in terms of education and other characteristics of the group from which they are selected can be done by sampling "typical" cases. However, when the objective of research is the understanding of social processes, representativeness is not the primary issue in systematic sampling of respondents, and should then not become one at the later stage of interpretation (World Health Organization, 1999).

## NUMBER OF INDIVIDUAL INTERVIEWS BY POPULATION SEGMENT

| Age Range    | Urban    | Rural    | Total     |
|--------------|----------|----------|-----------|
| 13-14        | 3        | 3        | 6         |
| 15-19        | 3        | 3        | 6         |
| 20-24        | 3        | 3        | 6         |
| <b>Total</b> | <b>9</b> | <b>9</b> | <b>18</b> |

A minimum of eighteen individual interviews will be conducted, including at least three from each population segment. It is expected that, like the focus groups, the interview will be completed over two sessions. Therefore, a minimum of 36 interview sessions will be conducted. The table above shows the minimum population segments to be included in the study – urban and peri-urban. A minimum of three individuals will be interviewed from each geographic area among the 13-14 year old and 15-19 year old age groups. If the research team chooses, they may also conduct groups with the 20-24 year old group and/or additional geographic areas.

Informants will be selected who represent a wide range of prototypical youth to be interviewed. These prototypes will be identified during the focus group research. For example, focus group results may show that youth can be classified based on a continuum of traditional to liberal/modern gender roles. Alternatively, a more meaningful classification may be those who are or are not sexually active or utilizing contraception, or those who have experienced a desired pregnancy vs. those who have not. In the first example, focus group participants representing traditional, neutral and modern gender roles may be selected for individual interviews. In the second case, the strategy may be to interview male adolescents who have and have not had sex and those who have and have not utilized a contraceptive method. Informants may be recruited from the focus group participants or identified in other ways, for example by community leaders. Informants should be selected based on their willingness and ability to share personal attitudes and experiences, as well as the fact that they represent a typical individual of the target group.

### **Phase 4. Small Scale Survey**

Finally, a representative survey targeting selected topics and populations will be conducted to quantify emerging issues. The first step of this phase will be for the researchers from each country to meet to identify the particular research focus and population segment(s) of interest. This step is critical because it is beyond the scope of this effort to cover all reproductive health and sexuality issues with a representative sample of male adolescents nationwide. Once the study population(s) have been determined, a statistician will be consulted to design the sampling strategy. Structured interviews will be utilized to ensure that all respondents are asked exactly the same set of questions in the same sequence. Training of interviewers will include

familiarization with the questionnaire, role-playing and experience in actually conducting interviews in the field under supervision. Supervisors will check all completed interview schedules for errors, omissions and discrepancies as soon after interviewing as possible. Respondents will be revisited to correct errors that cannot otherwise be resolved.

**D. Sampling**

The logic behind the purposeful sampling which will be used in the focus groups and individual interviews is quite different from the probability sampling which will be used for the utilized in the survey. The power of purposeful sampling lies in selecting information-rich cases for study. Thus, individuals will be chosen from whom we can learn a great deal about issues of central importance to the study. Maximum variation will be sought in order to capture and describe central themes or outcomes that cut across a great deal of participant variation. For the small samples required in qualitative research, a great deal of heterogeneity can be a problem because individual cases are so different from each other. Purposeful sampling turns this apparent weakness into strength by applying the following logic. Any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared aspects. With this type of sample, data analysis will yield two kinds of findings: 1) high-quality, detailed descriptions of each respondent which are useful for documenting uniqueness; and 2) important shared patterns which cut across cases and which derive their significance from having emerged out of heterogeneity.

**E. Interview Guides**

**1. Research Topics**

The following table presents the essential topics or modules included in the focus group guides for each age group. Researchers may include additional topics in the focus groups and interviews with the younger group, provided they are able to cover all of the topics with sufficient depth

**TOPICS BY AGE**

| <b>TOPICS/MODULES</b>     | <b><i>13-14</i></b> | <b>15-24</b> |
|---------------------------|---------------------|--------------|
| MASCULINITY               | X                   | X            |
| PUBERTY                   | X                   | X            |
| SEXUALITY                 | X                   | X            |
| TEEN FATHERHOOD           |                     | X            |
| SEXUAL ABUSE AND COERCION |                     | X            |
| SEXUAL DEBUT AND ACTIVITY |                     | X            |
| SERVICES AND INFORMATION  | X                   | X            |



The guides for the focus groups, in-depth individual interviews, and survey were designed to explore the study topics and questions listed below. It is important that the interviewers fully understand these research questions in order to lead effectively the focus groups and in-depth interviews.

**a) Masculinity:**

What is the meaning of masculinity to adolescent males and young men and how does it influence their reproductive health and sexuality? What are the rewards and costs to young men of changing their sexual behaviors and attitudes? How are male adolescents socialized into the social construction of masculinity?

**b) Puberty:**

How do male adolescents and young men experience their puberty and the development of their sexual identity? What do they know about the bodily changes that they are experiencing? How much do they know about male and female fertility? Where do they acquire information about these topics?

**c) Sexuality:**

What are community norms for the expression of sexuality among male adolescents and young men? What is the meaning of sexuality to them and how does it influence their reproductive health and sexuality? What are the rewards and costs to young men of changing their sexual behaviors and attitudes? How are male adolescents socialized into the socially constructed scripts of sexuality?

**d) Teen Fatherhood:**

How do male adolescents and young men perceive teen parenthood? Under what circumstances do they become involved in the pregnancy?

**e) Sexual Abuse and Coercion**

What is the relevance of sexual abuse and coercion to young men's sexual and reproductive health?

**f) Sexual Activity:**

What are the range of sexual experiences of male adolescents and young men? How do they feel about their sexual activity? What is the meaning of this experience to them?

**g) Services and Information:**

Where do male adolescents and young men obtain reproductive health and sexuality information? How often and how well do they communicate with their parents and partners about reproductive health and sexuality? What reproductive health and sexuality needs do young men identify? How do they prioritize them? What type of services do they desire? Are they aware of available services? Do they perceive them as accessible?

## **2. Qualitative Guides**

Focus group and interview guides are included in the appendices to ensure that essentially the same information is obtained from all respondents. The topic guide serves as a road map and as a memory aid for the moderator. A good moderator will have the flexibility and skill to stay on course and to cover all of the objectives of the focus group, yet allow the discussion to flow naturally and spontaneously from respondents and to pursue new issues raised by respondents if they are relevant to the research questions. The interview guide will provide topics or subject areas about which the interviewer is free to explore, probe, and ask questions that will elucidate and illuminate the subject. The issues need not be taken in any particular order and the actual working of the questions is not determined in advance. The guide serves as a checklist to make sure that all relevant topics are covered. The interviewer will adapt both the wording and sequence of the questions to specific respondents in the context of the actual interview. The guide will keep the interaction focused, but allow individual experiences and perspectives to emerge.

The guides for this study are written as a list of specific questions, although it is generally better to outline question areas or issues and then to include special probing questions under each of the key issues. The amount of detail in the guide depends on the experience of the moderator; an inexperienced moderator will need more detail in the topic guide and may need an actual list of questions. Anticipating that in some countries conducting this research, inexperienced moderators may be used, draft study guides include detailed, specific questions as well as supplementary probing guides to cover special topics of interest.

The final guide should be prepared jointly by the moderator and research team, and may be modified depending on the preferences and skills of the moderators. The moderator should be very well versed on the subject matter of the group and one the specific objectives of the research. The qualitative interview guides will be pilot tested by obtaining expert review of the content validity, questioning route and probes. Specific attention will be given to the logical and sequential flow of questions and to the ability of probes to elicit desired information. The second pilot test will be the first individual or focus group interview. At this time, the moderator will reflect on the wording and sequencing of the questions and make any changes needed.

## **3. Focus Group Guides**

Researchers will conduct focus groups with 13 to 14 year olds, 15 to 19 year olds and perhaps 20 to 24 year olds. Two focus group guides were developed, one to be used with the younger age group and the other to be used with the two older groups. The topics included in the guides will be covered during two or three focus group discussions with each age group. Although more topics are included in the guides than can be covered in one interview, only one guide was developed for each group so that the moderator can move from topic to topic as the discussion progresses naturally. Drafts of the focus group guides are included in Appendix 1. Note that the guides are quite long and include a number of alternative questions covering the same topic. Local researchers will want to revise, adapt and test the guides based on local context and needs, and may choose to eliminate some questions.

#### **4. In-Depth Interview Guides**

Individual interviews will be conducted with key informants. The purpose of these interviews will be to probe beyond attitudes and norms into actual knowledge and behaviors. Two guides were developed; one to be used with the younger groups and the other to be used with the two older groups (Appendix 2). It is expected that it will require two interview sessions to cover all of the topics in the guides.

#### **5. Survey Instrument**

An instrument for the survey interviews was developed which primarily utilizes already tested survey questions (Appendix 3). These questions come primarily from: 1) the young adult reproductive health surveys; 2) survey instruments designed by the Institute for Reproductive Health regarding fertility awareness; and 3) the Caribbean Youth Health survey and the Minnesota Health Risk Instrument. Depending on the literacy levels of the target population, the researchers must decide whether or not the instrument will be self-administered, and format it accordingly. The survey instrument will be pre-tested in each country with about fifteen respondents sampled purposively to ensure that the expected heterogeneity of the study sample is reflected in the pretest sample. It may be necessary to conduct more than one pretest if a pretest results in major revisions. Field supervisors will be utilized in the pre-testing in order to give them a clearer understanding of study objectives and to prepare them to assist in the interviewer training. The purpose of the pretest is to ensure that respondents are able to understand the questions and answer them usefully. Thus, each interview will be followed by a debriefing in which the interviewer asks about the respondent's understanding of questions that are likely to be misunderstood or that appear to have caused difficulty during the interview.

### **F. Data Analysis**

#### **1. Qualitative**

Interviews will be taped and the tapes will be transcribed verbatim by the interviewers and reviewed by accuracy by study supervisors. Transcriptions will be made in Microsoft Word and analysis will be conducted using a software package for qualitative analysis. PAHO will provide each research team with the software and technical assistance to learn how to use it.

Each research team will have their own style of analyzing qualitative data, however, in general the analytic steps described by Miles and Huberman (1994) will be followed:

1. Affixing codes to interview notes and transcriptions;
2. Noting reflections or other comments in the margins;
3. Sorting through these materials to identify similar phrases, relationships between variables, patterns, themes, distinct differences between subgroups, and common sequences;
4. Isolating these patterns and processes, commonalities and differences and taking them out to the field in the next wave of data collection;
5. Gradually elaborating a small set of generalizations that cover the inconsistencies discerned in the database.

The qualitative data analysis process consists of data collection, reduction and transformation. Data reduction is the process of selecting, focusing, simplifying and transforming the data in the transcriptions. The second phase of analysis is data display. This entails working to develop an organized, compressed assembly of information that will permit conclusion drawing. The most frequent form of data display in qualitative analysis has been extended text that is quite cumbersome to work with. Recently, qualitative researchers have found it much more effective to develop data displays in the form of matrices, graphs, charts and networks. This is analogous to the frequencies and scatter plots used in quantitative analysis. The final analysis phase consists of conclusion drawing and verification. Conclusion drawing is accomplished through a number of tactics which include making contrasts and comparisons, subsuming particulars into the general, noting relations between variables and finding intervening variables. Conclusions should be checked by ruling out spurious relationships, checking out rival explanations and getting feedback from informants.

The reliability and validity of the results will be assessed by checking for representativeness, examining potential researcher effects and triangulating across data sources and methods. In triangulation, researchers make use of multiple and different sources, methods, investigators and theories to provide corroborating evidence (Creswell, 1998). Reliability and validity will be maximized through blending of non-structured interviews (high validity) with more structured interviews.

## **2. Quantitative**

Data management and analysis will be conducted with the use of a computer program such as SPSS or EPI-INFO. After the data has been edited and cleaned, univariate and bivariate analysis will be conducted to test the conclusion and hypotheses that emerged from the qualitative phase of the study.

## **G. Informed Consent Procedures**

The research team will place priority on maintaining the privacy, confidentiality and anonymity of study participants. Privacy refers to maintaining an individual's control over their personal boundaries for sharing information. Confidentiality refers to the agreements made with a respondent concerning what may and may not be done with their data. Finally, anonymity refers to ensuring the lack of any information that might identify individual respondents.

During both the qualitative and quantitative phases of the study, researchers will respect the privacy and confidentiality of their respondents through the informed consent process. All respondents will be read an informed consent form that explains the basic nature of the study and seeks the agreement of the respondent to be interviewed. The consent form will explain the following: 1) the purpose of the study; 2) what participation in the study will involve; 3) how confidentiality will be maintained; 4) the right to refuse participation without jeopardizing their relationship with the institutions or individuals affiliated with the research; 5) the right to refuse to answer particular questions during the interview; and 6) the right to discontinue participation at any time. See draft form in Appendix 4.

Confidentiality and anonymity will be maintained by standard study procedures, including: 1) use of code numbers or pseudonyms; and 2) storage of all forms and data, in particular information with individual identifiers, in locked file cabinets.

## **H. Dissemination of Results**

The objective of this research is to provide useful information to administrators and policy makers so that programs can be implemented to meet the reproductive health needs of adolescents and young adults. To ensure that this study has maximum impact, the research team will develop a dissemination plan that answers three critical questions: 1) Who are the potential users (stakeholders) of the findings? 2) Which particular findings will be of most interest to each group of stakeholders?; 3) What are the best channels to reach each stakeholder group?

In order to increase the likelihood that study results will be utilized, the research team will undertake the following steps: 1) identify the decision-makers most likely to be interested in the research and inform them of the study objectives; 2) involve stakeholders in as many aspects of the study as possible in order to increase their commitment to using the results; 3) produce a brief, clearly written report which focuses on the major findings with programmatic implications; 4) include a section on study implications; and 4) conduct an end of study seminar which provides sufficient time for participants to discuss study results and develop an action plan.

## **III. CURRENT KNOWLEDGE OF THE REPRODUCTIVE HEALTH AND SEXUALITY OF MALE ADOLESCENTS AND YOUNG ADULTS**

### **A. What Are the Reproductive Health Needs of Male Adolescents and Young Adults?**

Given the limited number of programs designed to meet the reproductive and sexual health needs of male adolescents, it should not be surprising that there is little common understanding of their needs. A review of the literature resulted in the following topics that programs for male adolescents and young adults could address: 1) negotiating puberty; 2) fertility awareness; 3) self-care; and 4) decision-making and partner communication.

#### **1. Negotiating Puberty**

Puberty, the onset of adolescence, is marked by rapid physical growth and psychological changes that can have tremendous impact on young males' early sexuality and reproductive lives. An understanding of male adolescents' response to these changes is important in order to be able to identify their early reproductive health needs and provide services that address those needs. Data indicates that it is not always easy for boys to accept the changes they experience during puberty. For example, in a study of the psycho sexual characteristics of Brazilian university students, it was found that while 50% of young men held positive feelings toward their body development and sexuality, 23% were indifferent, and 17% insecure, anxious, or fearful about their body changes at puberty. Some young men reported concerns about penis size and getting and maintaining an erection, spontaneous erections at inopportune times and what they signify,

and fear that they could not live up to girls' expectations (Cerqueira Leite et al, 1995). Early feelings concerning physical development may be a determinant of acceptance of adult sexual identity and may impact future sexual behavior.

First ejaculation and masturbation, primary confirmations of masculinity, and feelings surrounding it may be indicators of positive psychosexual development. In a study of the sexual behavior of Colombian high school students, 56.3% of the males interviewed experienced their first ejaculation by masturbation, 25% during nocturnal emissions, and another 15.4% during sexual intercourse (Useche, 1990). Ninety-seven percent of the respondents affirmed that they did masturbate, and among those, 67% of respondents stated that they frequently masturbated. When asked about their feelings surrounding masturbation, the majority stated that they had feelings of pleasure and relief, yet 13% replied that masturbating elicited feelings of guilt which may arise due to concerns raised by the misconceptions which haunt adolescent boys: blindness, hair growth on their palms and the exhaustion of their supply of sperm (Madaras, 1995). Cerqueira Leite et al. (1995) found that 17% of respondents expressed anxious or fearful feelings regarding their first ejaculation. Studies suggest that adolescent males often express conflicting emotions regarding their developing sexuality that could lead to poor psychosexual adjustment and future reproductive health problems.

Issues of sexual identity are also of great importance during this stage as young boys face homosexual and bisexual manifestations of their sexuality. Various studies confirm that male adolescents who do not necessarily identify themselves as homosexual entertain homosexual and bisexual fantasies or experiences. In one study, 10% of adolescents and 13% of young adult males reported both heterosexual and homosexual experiences, and in another investigation, 28% of young men had reported such relations (Caceres et. al., 1997; Cerqueira Leite et al., 1995). These early homosexual feelings and behaviors may be considered part of sexual identity formation and are not necessarily indicators of long-term homosexual self-identification. Nevertheless, they may cause considerable anxiety among male adolescents and young adults.

The psychosexual development of male adolescents is an important issue to be raised as programs are designed to help male adolescents navigate through this tumultuous and confusing period. Educational programs designed for boys should include information about sexuality and should also discuss the routine care and maintenance of their genitals: cleaning, care of uncircumcised penises and treatment of jock itch (Madaras, 1995)

## **2. Fertility Awareness**

It is well documented that fertility knowledge is poor among youth. For example, surveys in Mexico City and Paraguay found that the most commonly used contraceptive method at first intercourse was rhythm; a method also commonly used in Brazil. Nevertheless, only a quarter of male adolescents and women could identify the most fertile period during a woman's menstrual cycle. Based on these results, Morris concluded that the combination of early sexual debut and lack of fertility knowledge points to the need for effective sex education programs in primary schools (Morris, 1988).

Sexually transmitted diseases can threaten the fertility and health of male adolescents and their partners. Male infertility accounts for 8 to 22 percent of infertility worldwide and men having unprotected sex outside of their primary relationship is the main cause of STDs, which may lead to devastating consequences.

In addition to infertility caused by unprotected sexual relations, males need to become aware of the potential dangers of the environmental hazards they encounter in the workplace. Every year new causes of male infertility are identified, including chronic exposure to high levels of arsenic and aflatoxins from fungi infecting agricultural crops. In addition to causing male infertility, exposure to these toxins can affect future offspring (Best, 1998).

### **3. Self-Care**

One factor which must be overcome in implementing effective preventative health programs for adolescent males may be the cultural and psychological barriers to health care utilization observed among adult men as they contemplate seeking health care: fear, denial, embarrassment and the threat to masculinity. For example, although in the United States men recognize that they will have 2.5 times more heart attacks than women, and that by the age of 65 one in three men will suffer from high blood pressure, they remain reluctant to have yearly check-ups and as a consequence men make 150 million fewer trips to doctors than women each year. Men may see a visit to the doctor as a threat to their pride, evidence that they are unable to adequately take care of themselves or that they are violating the masculine norm of stoicism.

Male attitudes towards health care utilization can be changed if they are instructed in health risks and become accustomed to practicing self-care when they are young. Initiation into such practices can begin with self-examination for testicular cancer (TSE). Testicular cancer is the most common cancer in 15 to 35 year old men (NCI, 1997). It is easily cured if diagnosed early, (Best, 1998) and early diagnosis can be made through a consistent self-examination (Madaras, 1995). Once adolescent boys become accustomed to performing this self-examination, the groundwork will be laid for them to accept the simple blood test and rectal examination which can diagnose prostate cancer and to adopt the healthy behaviors which reduce the possibility of stroke or heart attacks as they age. (Best, 1998.)

As adolescents pass through puberty they become more concerned about physical fitness and the role it plays in enhancing the quality of life. This is an opportune moment to help youth select a healthy diet with limited fat and cholesterol intake that will protect them throughout their lives. (Health Explorer, 1997).

### **4. Decision-Making and Partner Communication**

Another factor that complicates the ability of male adolescents to care for their health is the fact that family planning and sex are often difficult topics to discuss. In many cultures, sex-related issues are rarely discussed among young people, much less between spouses. In one study of family planning in Mexico, 35% of the total sample surveyed had never discussed contraception before the birth of their first child (Folch-Lyon et. al., 1981). In a study of sexuality conducted in Nigeria and Kenya, many of the young people interviewed said that it was impossible or extremely uncomfortable for them to talk about sexuality with their parents or

other family members (Barker & Rich, 1992). Similarly, Cerqueira, et al. noted that Brazilian boys express difficulty and discomfort communicating their desire to use condoms to their girlfriends because of the stigma associated with condom use (1995). In a study conducted in Mexico, both male and female adolescents reported that they were often afraid to talk about sex and contraception with their partner and needed guidance in how best to communicate their concerns. In fact, pregnant adolescents stated that they preferred to risk pregnancy rather than appear knowledgeable about sex and contraception (Pick, 1980)



## **B. How Can the Needs of Male Adolescents and Young Adults Be Met?**

Survey results highlight the critical need for sexual and reproductive health programs for male adolescents and young adults. For example, a study in Mexico City found that one fifth of all pregnancies occur among young adults less than 23 years of age, and that the age of sexual initiation is 16 for males and 17 for females, (Townsend, 1987). Other studies have shown that 20% to 60% of pregnancies and births to women under age 20 are mistimed or unwanted; the incidence of gonorrhea is highest among 15-19 year old females, and second highest among 15-19 year old males; and at least half of those infected with HIV are under 25 (Population Reports, 1995).

Controversy and fear of controversy have blocked large-scale service-delivery to youth in most Latin American countries. Reproductive health services for youth, whether out-reach clinics, condom distribution or contraceptive counseling have tended to be small, isolated efforts. However countries in northern Europe with national reproductive health programs for young people have the lowest youth pregnancy, STD, and abortion rates in the developed world. In these countries supportive social norms are combined with readily available services for young people (Population Reports, 1995).

Programs to improve male reproductive health must address the following considerations: 1) reach men where they are, often the school or workplace; 2) involve their peers, parents and social institutions; 3) assist men to find new ways to express themselves and work with men and women to create new gender scripts 4) create mechanisms in the health and education systems to meet the needs of male youth; and 5) provide special services to young and first-time fathers.

The specific types of programs needed include: 1) sex and life skills education; 2) efforts to change traditional gender roles; 3) clinical services and counseling; 4) sexual abuse prevention; and 5) mass media efforts.

### **1. Sex and Life Skills Education**

The information male adolescents and young adults have about sexuality, fertility and contraception is usually inadequate, and often inaccurate. They are more likely than women to mention lack of knowledge and are much more likely to say that it is their partner's responsibility to avoid pregnancy (Population Reports, 1995). Sex education for boys is a critical necessity. Educational programs can give young people the skills they need to postpone their sexual debut and, if they reach young people in time, increase contraceptive use (Population Reports, 1995).

Sex education aimed at preadolescents should address the important role of men in making decisions about sex and contraception, the dynamics of relationships and how an individual's behavior affects not only their own well-being, but also that of their partner (Aguma, 1996). Programs also must address male reproductive health issues, such as contraceptive use, STDs, forced sex, and unplanned pregnancy, as well as boys' perceptions of masculinity, responsibility and gender roles (Population Reports, 1995). Two important topics that are often overlooked are parenting and communication skills. Some men may not become involved in fatherhood because

they feel inadequate. This suggests the importance of discussion groups with young fathers or support where men can talk about, and feel positive about, their abilities as fathers, (Barker, 1996).

Experience and research has consistently shown that the most effective way to provide family life education to youth is through the life skills approach. The basis of this approach is that adolescents need specific skills to cope effectively with life. One such program, the Life Skills program developed by Dr. Gilbert Botvin, from Cornell University, provides an organized way for junior high students to learn these skills. This program teaches the knowledge and skills necessary to increase self-esteem, increase decision making and problem solving skills, communicate effectively, make new friends, and become more assertive.

Programs are needed for first-time and adolescent fathers, such as father preparation classes. Providing basic information on child care and child development has been found to be extremely important in helping young fathers feel better prepared to assume their new role. Hands-on experience in childcare has been proven successful in several programs for adolescent males. Servol, an NGO which works with low income youth in Trinidad and Tobago, as part of its vocational training and life skills training program requires that all adolescent men and women work part-time in its day care center. Through this experience, young men often have their first experience in caring for a young child, (Barker, 1996).

## **2. Efforts to Improve Communication and Modify Traditional Gender Roles**

Many of the health issues facing adolescent males, including violence, risk-taking and sexual behavior, are learned as a result of socialization. The general consensus is that some of these risks can be prevented, albeit not easily. An important programmatic area includes initiatives to change traditional gender roles. The most effective sexual health programs include information which helps youth to enhance communication and negotiation skills, clarify their values and change risky behaviors, (Barnett, 1997). One such example was the development of a series of non-verbal and verbal group activities with Brazilian men to help them express their feeling related to relationships, sexuality, fatherhood and their roles as men (Barker, 1996). Additional interventions in this area have included mentorship programs for young men; health education or family life education that includes discussions of gender roles and male-female relationships; and male responsibility groups or male discussion groups as part of school-based health clinics or family planning clinics.

A key element in these programs may be the provision of alternative role models. Research from Brazil and the U.S. has found that finding alternative role models for adolescent boys, whether they be teachers, family members or friends, is associated with becoming non-violent, more respectful of women and being more likely to take responsibility for contraception.

In a number of Latin American countries, male discussion groups have been formed with the goal of discussing their roles as men, questioning traditional gender roles and finding mutual support in confronting the pressures and frustrations they feel as men. Since most men have been socialized not to talk about their needs, not to express emotions, not to be “in touch with” their

bodies and not to question their role as men, most group coordinators have found it necessary to use non-traditional activities to facilitate communication between men (Barker, 1996).

In a study of men in Rio de Janeiro, Socrates Nolasco carried out interviews with low-income men and developed a module of consciousness-raising activities to help men learn to communicate, discuss their needs and question their roles. Nolasco also trained a group of facilitators to conduct these activities with other groups of men.

### **3. Clinical Services and Counseling**

Because so little is known about the needs and preferences of male adolescents for services, it is informative to look at concerns of adult men. Of those men seeking information at male reproductive health centers, major areas of concern have included premature ejaculation and impotence. Many come to clinics for information on: family planning, sexual arousal in women, impotence, high blood pressure, prostate cancer, male menopause and changing sex roles. They also seek job physicals and free condoms. In one study, one third of the men requested reproductive health counseling although the majority did not show a great interest in male involvement in family planning, (Gordon, 1984). Increasing interest in reproductive health services among males has been noted by some in the United States, may be caused by current epidemics of STDs and HIV; concern about prostate cancer, occupational hazards, male infertility and erectile dysfunction.

Programs should also offer counseling on domestic violence and coercive sex, (Schulte, 1995). In discussions with adolescents, coercive sex should be discussed in relation to the sexual impatience of virgin males (Danielson, 1990). The need for counseling on these topics was demonstrated by research in which men reported having had sex with someone "who was not very happy about having sex" and "having sex when you want to and she does not".

Experience in adolescent health clinics in New York has demonstrated that male adolescents and young adults respond to those things which traditionally attract adolescents to a health facility: 1) staff who respect their confidentiality; 2) activities (apart from health services) which interest them, such as basketball; and 3) participation of youth in the leadership and decision-making of the clinic. Staff sensitization was also found to be extremely important; staff needed to work on analyzing their own visions and values related to masculinity before they could work with male adolescents and young adults to address these issues (Barker, 1996).

Services designed for men should create an acceptable environment for men which addresses their perspectives and needs. They should address a wide spectrum of health-related issues and not be limited solely to contraception and family planning. A "youth friendly" environment can help attract and serve youth that may be embarrassed or intimidated to seek services, or may face practical obstacles such as lack of transportation and funds. Care must be taken to insure that providers are not judgmental about unmarried adolescents who are sexually active. Youth should be involved in as many stages of a project as possible, from the initial needs assessment and program design to implementation, evaluation and even training of providers.

Clinics wishing to expand their services to include male adolescents and young adults must work to overcome barriers by: providing a wide variety of services and informing men about them;

offering sensitivity training for staff members; establishing male only clinic times; familiarizing men with preventive care; and increasing funding. Another area to be addressed is the initiation of counseling and treatment of sexual problems, dysfunctions and diseases for men. Also, as family planning programs are expanded to include men, the issues which are raised by their new clients include shared responsibility and the need to be involved in the decision-making process and counseling when a pregnancy termination is under consideration (Aguma, 1996).

According to one author involved in the provision of services to male adolescents and young adults, clinics which are planning to serve this group, particularly with family planning services, should expect them to arrive in groups and to display a boisterousness bred of nervousness. Therefore, it may be appropriate to provide a separate area for waiting and counseling so that they can express their anxieties and obtain information and reassurance, (Seex, 1996).

In trying to attract males to reproductive health services, attention should be directed towards female partners and peers, as males more likely to rely on peers' recommendations. School and community education efforts have also been shown to bring in male clients (Finger, 1997). Community outreach and peer programs are also important. Various studies in Latin America have found that men respond well to peer and community based distribution of condoms. In fact these programs are more effective at reaching men than women (Townsend, 1987).

#### **4. Prevention of Sexual Abuse**

Prevention efforts must begin to move sexual abuse from the private family domain into the public health forum; collecting data to identify the extent of the problem; publicizing research findings locally and nationwide; engaging the community at all levels in addressing and responding to sexual abuse, and initiating and strengthening sex education for young people. Education and counseling programs can assist in preventing sexual abuse by including training in such skills as positive sex and gender roles and conflict resolution (Stewart, 1996). In designing and providing services, providers must not assume that their clients are engaged in mutually consensual sexual relations, (Moore, 1996).

There are several models for programs that have been developed to address the problem of sexual abuse. INPPARES developed an educational protocol for preventing sexual abuse among adolescents, including a video produced with their youth promoters. They have also developed procedures for multi-disciplinary teams to provide assistance to those who have experienced sexual abuse and to make referrals to other agencies for additional care. INPPARES also works to raise community awareness of the issue via meetings, workshops and video presentations. Staff and peer educators are trained to be sensitive to those who have experienced abuse and to implement standard policies and procedures. Finally, relationships have been established with agencies specializing in dealing with sexual abuse, in order to facilitate referrals (Stewart, 1996).

#### **5. Information, Education and Communication**

The mass media have become a major source of young people's information about sexuality. The influence of mass media can be used to provide accurate information and model responsible behaviors. Campaigns using public figures such as the Tatiana and Johnny in Mexico have been proven successful in raising the awareness of young people regarding the risks of sex and benefits

of family planning. Similarly, mass media campaigns promoting vasectomy have increased vasectomy use in Latin America. Other successful Information, Education and Communication strategies include providing information to men through workplaces and health services; community outreach: formal and informal discussions, home visits, film and video shows, condom distribution and motivating and gaining the support of male community leaders.

## C. The Meaning of Masculinity

### 1. The Social Construction of Masculinity

*“If femininity is understood as a natural force that needs only to be controlled and disciplined, masculinity is seen as anything but certain. Constantly threatened . . . the virility that marks mature male sexuality must follow a tortuous and troublesome path in coming to be: it must be cultivated through a complex process of masculinization beginning in early childhood”.* (Parker, 1991)

Among many cultures manhood is seen as a state of being which is earned rather than automatically conferred (Barker, 1996). During their development from boyhood to adolescents, men are often expected to prove their sexuality to their peers or elders. The behavioral expression of masculinity is not determined by biology; it is largely acquired through socialization leading to the internalization of a set pattern of "male" attitudes and values. Adolescent boys learn their society's definition of masculinity from parents, peers, the mass media and by observing adults. The developmental processes of the childhood and adolescent years, combined with the traditional requirements associated with masculinity, define the sexual scripts for many young males.

Nearly universally, manhood is defined on the basis of productivity or around the role of the financial or material provider (Gilmore, 1995). In a qualitative study conducted in the urban slums of Brazil, young male adults and women mentioned that there are two fundamental steps to becoming a man: 1) becoming sexually active; and 2) financially supporting oneself and one's family. For most young men interviewed, becoming sexually active was seen as by far the easier of the two requisites. Attaining the ability to provide financially for their family represents a source of considerable stress for young men in Latin America who perceive, often correctly, that they have limited abilities to acquire and maintain employment (Barker and Lowenstein, 1996).

In Latin America, “Machismo” is the term most commonly used to refer to the “deep structure” of masculinity. Machismo is generally equated with bravado, sexual prowess, protecting one's honor and a willingness to face danger, among other traits. These traditions emerged from the Latin-Mediterranean heritage of machismo which holds that the virility of a man is measured by the number of sexual conquests and offspring he has and by the behavior of the females around him.

Adolescence for a boy means leaving the world of his mother and of the women in the household and establishing a “Male” identity. This requires the gradual shifting of role models toward his father and adapting to those provided by other boys or adult males around him. During this socialization process, men are discouraged from expressing fear; pain, insecurity, sadness, or other emotions that might make them appear weak.

The traditional heterosexual definition of masculinity contributes to the dynamic, ongoing process of self-development and its gender identity component. Part of this process involves an effort to develop characteristics such as success, status, toughness, independence, aggressiveness, and dominance. Young males are not only encouraged to be independent, they are also more likely than girls to be reinforced in everyday life for their assertive, controlling, emotionally cool, competitive and aggressive behaviors (Marsiglio, 1988).

Cultural definitions of masculinity influence sexual scripts both directly and indirectly. For example, the prevailing theme of adolescence for many males is that they should be self-reliant and experienced. To the extent that adolescent males are encouraged to assert their independence, they may express these tendencies in the sexual realm by being more likely than females to engage in intercourse. It should not be surprising then; those males are less likely to report that their first sexual experience was in the context of a meaningful relationship. This apparent indifference or aversion to commitment in early romantic relationships is consistent with the idea that young males are searching for independence during this period. Moreover, this type of detachment complements a perception of sexual experience as critical rite of passage rather than an opportunity to know another person intimately (Marsiglio, 1988).

Another aspect of the male sexual script in Latin America is that the male supposedly is experienced and possesses vast amounts of information on sexuality. However, various surveys point out that many men, adult and young, think they possess adequate information about sexuality and reproduction, when in reality, they know very little (Figuerola, 1995; Garcia da Costa, 1995; Morris, 1993; Meijueiro, 1995; and Keijizer, 1995).

Before entering into a discussion of the interface between the social definition of masculinity and sexuality, it is important to note that there have been major changes in attitudes towards gender roles and sexuality during the past twenty years, particularly in urban areas of Latin America. Increasingly, men's behavior is guided by many "masculinities" rather than the traditional construction of masculinity described above. Recent research suggests that adherence to traditional gender roles is no longer as enforced as it once was. Nevertheless, differences still exist. Numerous studies have shown, for example, that males in Latin America and the Caribbean typically start their sexual activity earlier than women, although the gap is diminishing over time.

## **2. Influence on Sexuality**

A thorough understanding of male sexuality is key to the development of new efforts to improve the reproductive health of both men and women. The significance of sexuality for young boys' development during early and late adolescence is heightened by the fact that young males can use the sexual realm to affirm their masculinity (Marsiglio, 1988). Sexual performance has traditionally been a crucial factor in the maintenance of masculine identity.

Recognizing the rapid changes in cultural norms in the area of gender and sexuality, what are common dimensions of male sexuality in Latin America and their potential consequences in terms of reproductive health?

- ***Male sexuality is instinctive, uncontrollable, and aggressive.*** As a result, men engaging in sexual coercion or harassment may not believe that they are doing anything wrong. Men are not expected to be able to control their desires, and therefore are not expected to be monogamous, or to be faithful within a stable relationship. (Giffin, 1944b, Barker and Loewenstein, 1995)
- ***Violence, like male sexuality, is uncontrollable.*** Violence is also viewed as part of the social contract; for example, a man expects certain things from a woman in return for financial support. (Barker and Loewenstein, 1995; Shephard, 1996)
- ***Traditionally, “machismo” is organized around a social hierarchy of the passivity of women and the activity of men*** (Parker, 1991; Gilmore, 1990). Men are expected to take the initiative sexually. They should always be active, and never passive, with the corollary that women should not express desire.
- ***Male sexual desire is expected to be separated from affection and emotions.*** Many men feel humiliated when they can not perform even when feeling anxious or unconnected to their partner. (Marsiglio, 1988; Shephard, 1996)
- ***Men are expected to be sexually experienced.*** This leads some men to seek this experience at all costs, regardless of whether or not they feel affection or respect for their partners. Male adolescents may be encouraged by peers and even family members to become sexually active or to frequent commercial sex workers, while girls are admonished to remain chaste (Uriza, 1988). If a boy does not have sex by an “appropriate” age, his friends and family may question his masculinity. Whereas girls experience menstruation as a clear marker of their bodies’ transition to womanhood, boys have no comparable obvious physical transition, and so first sexual intercourse often serves as initiation into adulthood.
- ***Men are expected to dominate women, and are ridiculed if they don’t.*** Men are expected to be possessive and jealous, and in some contexts react violently to restore their honor if their partner is unfaithful. (Barker and Loewenstein, 1996; Ali, 1995)
- ***Men are expected to take risks,*** thus causing men to be less receptive to messages regarding safer sex. (Shephard, 1996)
- ***Machismo emphasizes viewing women as sex objects.*** A study of male adolescents in Chile found that they saw women as objects for sexual satisfaction. For these students, acting on their own sexual instincts was seen as legitimate, but they did not believe that women had the same right to exercise their sexuality (Mundigo, 1995).

As demonstrated above, expressions of the traditional social construction of masculinity have an important, often negative, influence on reproductive health. For example, these behavioral

expectations play an important role in certain instances of sexual coercion, especially within the context of courtship or dating. Boys are taught to be sexually aggressive and to view sex as a contest in which winning means convincing (perhaps coercing or even forcing) a girl to have sex.

One of the most harmful consequences of adherence to a narrow definition of masculinity involves the transference of aggressive behavior during a male's adolescence to the realm of sexuality. Since many men are unable to express their emotions (because they were never taught to do so) or believe that it is socially unacceptable to do so, they may show their frustration of anger through violence --which is often seen as a legitimate form of male expression (Nolasco, 1993). When men feel frustrated or powerless, they may turn to violence as a way to express these emotions; indeed, some studies in the U.S. have linked domestic violence with economic stress.

In his study among youth in Brazil, Barker found that males in general, and especially fathers, were seen as incapable of expressing emotions, and thus of demonstrating caring and empathy. Young men complained of the lack of an emotional bond with their fathers and a few young men mentioned their own inability to express emotions. In a large number of cases, young men said they had felt anger and wanted to resort to violence against women, however the vast majority did not report having used violence to resolve a domestic argument (Barker and Loewenstein).

Apparently, for many young men, violence is viewed as an uncontrollable and socially acceptable reaction to a difficult situation. Lacking other ways to express their emotions, violence is seen as an appropriate outlet for male frustration. Like male sexuality, male violence is often viewed as uncontrollable and thus, in most circumstances, acceptable or at least explainable (Barker and Loewenstein, 1996).

Another frequent manifestation of traditional norms is the "double standard". Men are not only generally free from the requirement of premarital virginity, they are expected to be sexually experienced before marriage. Thus, while males are encouraged to develop their sexual skills through a collection of premarital sexual experiences, women are expected to participate sexually, as it were, from instinct, or they are expected to be initiated into an active sexual life by an experienced male partner. Study results suggest that females tend to start sexual activities much later and carry them out in fewer numbers or with less frequency than their male counterparts (Morris, 1994; Useche, 1990). It would seem reasonable to assume that large gender differences in the overall reported rates of male and female sexual behaviors are a result of differential cultural conditioning (often called the "double standard"), particularly since more recent surveys indicate that gender differences in the incidence of premarital coitus have decreased or even become inverted.

The sexual double standard of proactive male performance and female passivity is contradicted by the physiological facts of sexuality as well as by more recent behavioral indicators of sexual activity for both sexes. Males and females share common sexual capabilities and patterns of sexual development from infancy through adulthood, and reports of experimentation with multiple forms of sexuality are increasingly similar for males and females throughout their developmental years (Bolton, 1988). Gender differences and changes in sexual behavior cannot be



well explained by biology and many researchers have attributed such differences to learning within specific socio cultural settings.

Yet despite this physiological reality, adolescent males are still confronted with the belief that masculinity is equivalent to sexual performance, especially in terms of heterosexual intercourse. This belief is accompanied by fears of femininity and homophobia because masculinity is, in part, defined by the absence of any trace of femininity or by any interest in males that could be interpreted as homosexuality. Developmental sexual experiences nonetheless often include behaviors that may be labeled as feminine or homosexual. As one researcher points out, it should not be surprising then that the development of their sexual identity is frequently confusing, vexing and difficult (Bolton, 1988).

Given the fact that male and female intimacy during adolescence is closely regulated by norms associated with the value of maintaining female virginity, it is likely that an understanding of coital experience and family planning use does not tell the whole story of adolescent sexuality. Nevertheless, with the exception of research on HIV/AIDS prevention and non heterosexual behavior, any mention of alternative forms of sexual expression such as masturbation, sex play, anal and oral sex is virtually absent in the literature. One exception is a study conducted in Sri Lanka under the International Center for Research on Women's "Women and AIDS Initiative". This study found that the majority of young people had heard of masturbation and did not believe myths associated with the practice. Furthermore, in an effort to protect the hymen, youth practiced interfemoral sex (inserting the penis between the partner's thighs), partial penetration, anal and oral sex. Men were socialized into sexual experience by engaging in sex play, anal and oral sex with male partners, older women and commercial sex workers in order to protect the virginity of young women. These findings suggest an important area of research to pursue in Latin America.

### **3. Enforcement of Gender Roles**

Society enforces cultural norms of masculinity by sanctioning men who do not conform to them. As mentioned previously, men must constantly "prove" their masculinity. While the behavior of young women is also prescribed/circumscribed by gender norms, gender roles for men tend to be even less flexible and more rigidly enforced. The literature has been consistent in finding that parents view cross-sex activities as being associated more strongly with homosexual activities for boys than girls (Bolton, 1988). Parental socialization practices of boys appear to set in place the foundation for fear of femininity, homophobia, the need to achieve and demonstrate consistent masculinity, and the double standard of behavioral expectations, including those for sexuality.

Various studies have shown that new models of female sexuality are appearing for women in Latin America. For example, in a study of the culture of adolescents in Lima, boys and girls were asked to name types of girls according to their sexual behavior. Both boys and girls generated a number of different names to describe different types of girls, suggesting that new models of female sexuality are appearing in which women take initiative, or are not so readily controlled by men. In contrast, there was no evidence in group discussions of a similar diversity of sexual types for boys. In general, the boys said that one is either a "man" or a "faggot" (a "maricon") (Caceres, 1995). Overall, research suggests that the male role seems to be an even tighter and more rigid straitjacket than the female role in these modern times.

The literature emphasizes the importance of peers in socializing men into their gender roles and sexual scripts. Many males perceive that they learn how to “be a man” from their male peers. This is particularly true in the absence of a meaningful relationship with their fathers or other adult males and other sources of information on sexuality. Unfortunately, however, the male peer group frequently presents only the traditional form of masculinity and tends to impose extremely rigid expectations on its members. Questioning the male peer group and its values can result in being called a homosexual and being expelled from the group. Many studies illustrate the role of misogyny and homophobia in the social control of men’s gender behavior. Misogyny is hatred and disrespect for women; homophobia is hatred of men who step out of traditional male role, and a fear of strong physical or emotional attachments between men. Peruvian studies confirm that young men who drastically depart from traditional ideas about male sexuality are almost automatically suspected of being homosexual, and risk being marginalized by their peers. The fear of being denied male status may be one of the main reasons why a movement among men, similar to the women’s movement, to support transformation of traditional ideas about masculinity has been slow in coming (Caceres, 1995).

Because manhood is often seen as something that is achieved under pressure and which requires performance or presentation to the male peer group, peer groups may encourage adolescent males to prove their masculine sexuality before they are ready. Boys in Brazil discussed at length the public pressure they face to be “real men.” In the United States, adolescent males (26%) were found to be significantly more likely than females (seven percent) to feel pressure from friends to have sex, while teenage women report feeling pressured by their male partners (Feltey, 1991). This finding is supported by research in various countries, which suggests that adolescents who associate with sexually experienced colleagues are themselves much more likely to be sexually experienced (Kiragu, 1993; Marsiglio, 1988).

Another factor, which may influence sexual behavior, is the typically competitive nature of the male social world. Boys socialized to espouse standard virtues of traditional male friendships as competition, dominance, and aggression will tend to experience sexuality differently than those socialized to appreciate androgynous and feminine friendship attributes. In the competitive setting, Marsiglio suggests, sexual experiences with young females, and even the females themselves, are commonly exploited for the purpose of self-aggrandizement (1988). This finding is supported among university students in Brazil where the status a young man achieves among his friends when he is dating can be more important than the feelings involved in the relationship. (Leite, 1995).

#### **4. Gender Roles**

In the traditional male role, the husband is responsible for the economic well being of the family, while the wife is in charge of everything else, including reproduction and especially child rearing and home care. Research in Mexico suggests that most men view their wives principally as mothers of their children, as housewives, and as a “objects” to be “used” for sexual gratification rather than as companions or social equals. (Folch-Lyon, 1981). Another important aspect of gender roles is that men, both young and old, tend to conduct their social life with friends separate from family and marital life (Folch-Lyon, 1981). This reinforces the importance of peers in socializing and enforcing gender roles. Gender power relations affect sexual behavior and

reproductive health, including the types of sexual expression and the degree of coercion or violence that may be considered acceptable within a relationship. Although traditional gender roles are changing quickly, most adolescent boys lack role models or scripts which allow them to take on new roles as fathers and spouses which provide them with the same sense of personal identity that the provider role has.

## **5. Consequences**

The research on gender and reproductive health from throughout Latin America has highlighted how the machista construction of sexuality presents direct risks to women, subjugates them and denies them the right to pleasure and autonomy over their bodies. For the most part, however, we have failed to recognize that many men are also subject to the forces of machismo and to stereotyped notions about acceptable behaviors for men. Albeit in very different ways than women, men are subject to social norms and systems that proscribe and enforce -- often in narrow terms -- what they can and cannot do as men.

Furthermore, various studies around the world have documented that since most societies define a man's principal role as breadwinner, young men face considerable stress when they are unable to fulfill that function. In his study among young men in urban slums in Brazil, Barker found many young men who reported examples of adolescent fathers who abandoned their families and turned to alcohol as a result of being unable to fulfill their socially designated role of provider (Barker and Loewenstein, 1996).

Traditional masculinity may also inhibit the emotional growth of men. Seidler (1987) and Nolasco (1993) suggest that in their efforts to adhere to gender norms, men often close off their emotions. Men who behave differently, by openly expressing affection and tenderness with their male friends may undergo pressure to conform with societal norms, sometimes being subjected to gay baiting and ridicule. Shephard (1996) proposes that men exert pressure on each other to drink alcohol together to create a shared social space where normally proscribed behavior for men, such as crying and expressing hurt and anxiety, is accepted. In this setting, boys may be hindered from pursuing deep emotional friendships with other males, as well as with girls. By distancing themselves from their male peers for fear of exposing their weaknesses, boys effectively curtail their opportunities to discuss their sexuality openly and honestly with their friends.

Barker describes the experience of young men in Brazil as follows, "Another feature of the social construction of gender in Brazil is the division of the world into the secular and the rational, which are defined as masculine, and domestic and emotional affairs, which are defined as feminine... as a result of this social construction men often close off their emotions. This psychological distance on the part of the male can eventually become an emotional exile from which it is difficult to return; a man who never learns how to express his emotions and become actively involved and present in the lives of his family has a difficult time learning to do this later in life." (Barker and Loewenstein, 1996)

## **D. Experience of Sexuality among Male adolescents and Young Adults**

### **1. Sexual Debut**

#### **a) Age**

Various studies conducted in Latin America have examined the age of initiation into sexual debut but few explore in depth male adolescents and young adult's experiences and feelings surrounding their first sexual relations. In general, sexual experience begins earlier for males than for females, with one quarter to three quarters of male adolescents initiating sexual intercourse before their 15th birthday (Population Reports, 1995)<sup>2</sup>. Morris (1994) found that the mean age of first intercourse for males varied from 12.7 years in Jamaica to 16 years in Santiago, Chile. The mean age of first premarital intercourse for males in Costa Rica was 15.3, in Quito 15.1, in Guayaquil 14.8, and Rio de Janeiro 15. Ages of first intercourse were significantly lower for males than for females in all of the countries surveyed, with the mean age of first intercourse for females ranging from 15.6 years in Jamaica to 17.9 years in Santiago, Chile. According to data from the Caribbean Adolescent Health Survey, more than two out of five sexually active teens report age of sexual debut below the age of 10 and an additional 20% at 11 or 12 years of age (PAHO).

#### **b) Partner**

Males tended to seek older partners - from 0.6 years older in Jamaica to 6.2 years older in Guayaquil (Morris, 1992). Younger males were more likely to seek out older females who were sexually experienced. In one study, 21.9% of males reported that their first sexual partner was a steady girlfriend, 62.2% responded that it was a friend, and 9.8% reported it was a prostitute (Useche, et. al., 1990). Various studies report that 42% of male adolescents in Guatemala City had their first sexual relationship with a prostitute. In another study, it was found that 60% of the respondents had their first intercourse with a classmate or with someone with whom they had no emotional ties, and it was an impulsive or casual act in 52% of the cases. For this reason, the experience has been frustrating or traumatic for many male adolescents, not to mention potentially dangerous and risky (Herold et al, 1988; Cerqueira Leite, et. al., 1995).

During adolescence, males are often expected to prove their sexuality. Such pressure may lead to first acts that are unsatisfying and devoid of emotional content and may include sexual abuse or violence. In one study, a majority of men reported that they expected that women to have sex with them if they had spent money on her

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<sup>2</sup>Based on data from the Young Adult Reproductive Health Surveys conducted in five Brazilian cities, Chile, Costa Rica, the Dominican Republic, El Salvador, two cities in Ecuador, Guatemala City, Haiti, Jamaica and Mexico City from 1985 to 1992.

(Mundigo, 1995). In a study of the sexual attitudes of Guatemalan teens, 92% of males approved of sexual relations with an attractive and willing partner, even without love, as opposed to only 5% of the female respondents (Berganza, et al., 1989). In a 1987 survey of Colombian high school students, 60.9% of males reported that sexual desire was their primary reason for initiating sexual intercourse for the first time, while 27.2% reported curiosity, and 10.7% love (Useche et. al., 1990). These findings are supported by other studies which indicate that males tend to engage in sexual activities for the sake of pleasure (i.e. recreational sex), independent of a romantic or committed relationship (Berganza, et. al., 1989).

**c) Contraceptive Use**

Morris (1994) found that few males reported using contraception at first premarital sexual intercourse. Contraception use ranged from 11% in Jamaica to 32.5% in Costa Rica. In Guatemala City, 14.9% of the young men reported using contraception during their first sexual intercourse, while in Rio de Janeiro, 21.8% doing so. In general, the method most often used at first premarital sexual intercourse in Latin America was the condom, followed by oral contraceptives, and then the rhythm method. However, in Mexico City and Santiago, Chile, the method most often used during first sexual intercourse was the rhythm method, in Sao Paulo withdrawal, and in Guatemala City, the pill. Low rates of contraceptive use, in particular the condom, places male adolescents and young adults at risk for unwanted pregnancies and STDs. This, combined with the fact that men's first sexual experience is often with an older, more experienced female or with a prostitute, spells potentially serious consequences. In the Caribbean, one study reported that half of all sexually active youth report no use of contraception at last intercourse (Caribbean Adolescent Health Survey, PAHO).

**2. Sexual Practices**

Rates of contraceptive use among sexually active male adolescents and young adults have been found to be relatively high, ranging from 56% in Costa Rica and Rio de Janeiro to 82% in Mexico City. Not surprisingly, the most common method used by male adolescents was the condom (Morris, 1994). Cerquiera Leite (1989) reported that 82% of male university students in Brazil take precautions to prevent a pregnancy, yet another study of Guatemalan teenagers reports that only 10% of sexually active couples were using some type of contraception (Berganza, et. al., 1989).

Widespread early sexual debut among boys and adolescents does not necessarily imply promiscuity. The average reported frequency of intercourse among sexually active young males in Latin America was found to range from two and five times per month, with between 8 and 33 percent of male adolescents reporting more than one sexual partner during the previous month (Morris, 1994). Males consistently reported multiple partners and intercourse with casual acquaintances more frequently than females. Men were also more likely than females to engage in sexual intercourse outside of a committed, loving relationship and to approve and engage in recreational sex. In another study, for example, 96% of Guatemalan girls planned to marry their current sexual partner while only 5.5% of males planned to do so (Berganza, et. al., 1989).

### **3. Homosexual and Bisexual Experiences**

There is very little information on the prevalence of the types of sexual activity adolescent males engage in, such as anal and oral sex, and their experiences with homosexual or bisexual practices. However, in one study, 6% of the subjects were currently in homosexual or bisexual relations and 20% reported homosexual experiences at some point in early adolescence (Cerqueira Leite, 1995; Cáceres, et al., 1997). Cáceres, et al. found that 38% of those who reported homosexual behavior reported experiencing anal sex (only 20% used a condom always). Interestingly, 76% of those maintaining homosexual relationships reported heterosexual experiences as well. Although not frequently included in surveys, it is hypothesized that a significant percentage of adolescents engage in anal sex in order to prevent pregnancy and preserve a young woman's virginity. More research in this area is needed in order to understand better the health risks associated with the sexual experiences of young people.

### **4. Correlates of Contraceptive Use.**

Results of a number of studies suggest correlates to adolescent use of contraceptive methods. Morris (1994) reported that most male adolescents who did not use contraception at first intercourse did not expect to have intercourse at that time and thus were not prepared to use contraception. Other investigators have found that when adolescents are asked to explain their failure to use contraception, the most common reasons given were; lack of knowledge, difficulty in obtaining methods, ambivalence, and the fear of discussing sexual matters with adults, including professionals (Berganza, 1989). Peleaz found that the primary reason for not using a condom was the perception of sensation loss, followed by the belief that it was the responsibility of the female to take care of contraception (1997). Barker (1996) presents empirical data suggesting that male adolescents and young adults who adhere to "machista" values are less likely to use contraceptive methods, that those who started sexual activity later were more likely to use condoms, and that those who used condoms during their first relations were more likely to do so consistently thereafter. Other investigators have found that young men from more affluent neighborhoods and from higher socioeconomic backgrounds were more likely to use an effective contraceptive method during their last sexual encounter. Those who had higher grades, a more secure relationship with their last partner, and held stronger religious beliefs were also more likely to have used an effective contraceptive method (Cáceres, 1997; Marsiglio, 1993). Additionally, Marsiglio (1993) found that young men who have stronger traditional attitudes toward gender roles are less likely to use condoms and are more likely to view contraception as the female domain and thus the female's responsibility.

### **5. Sexually Transmitted Diseases (STDs)**

#### **a) Prevalence**

While early pregnancy may have the largest impact on an adolescent's life, early initiation of sexual relations presents other risks as well, such as exposure to sexually transmitted diseases. According to WHO, 1 in 20 teenagers worldwide in acquires an STD each year. A survey in a Peruvian town found that 23 % of secondary school males had an STD (Koontz & Conly, 1994). Cáceres et al. (1997) found that 18% of subjects surveyed had experienced symptoms or had been diagnosed with an STD, with respondents of lower socio-economic status showing

higher rates. In a study of the sexual practices of street youth in Brazil, one fifth of the respondents said they had contracted an STD and that half of their friends had one previously (Raffaelli, et al, 1993). Furthermore, at least 6 million people infected with HIV are under the age of 25 and it is likely that most of the one million cases of AIDS worldwide contracted the disease during their teen years.

**b) Knowledge**

In the Young Adult Reproductive Health Surveys carried out in Latin America, knowledge of STDs and, in particular, HIV/AIDS was found to be high. Almost three-fourths of males agreed that a person can be infected without having clinical symptoms, and knowledge of the principal modes of transmission was known by over 90% of young adults. However, there was also misinformation concerning transmission by mosquito bites, sharing eating utensils, or using the bathroom of an infected person (Morris, 1994). In another study, although a majority of the respondents demonstrated basic knowledge of the principal forms of HIV transmission, only 38% of those sexually active reported practicing preventive measures (Cerqueira Leite et al., 1995).

**c) Perception of Susceptibility**

In Brazil, more than three quarters of sexually active males believed that sexually active young persons had a high risk of contracting HIV as opposed to only 29.5% in Chile. However, only 1% to 5.2% of males perceived themselves at risk, suggesting a gap between the risk attributed to others and their self-perceived risk (Morris, 1994) The common practice among youth of serial monogamy may contribute to their sense of invulnerability. Adolescents who are in a mutually monogamous relationship may not consider themselves to be at risk of contracting HIV, even if these monogamous relationships change every six months. Cerqueira Leite, et al. (1995) found that the majority of respondents (75%) indicated that contracting AIDS presented a great risk for young people in general; however, 87% considered this risk to be non-existent or minimal for themselves. Nevertheless, data from the Caribbean Adolescent Health Survey show that AIDS is a significant concern among sexually active youth in the Caribbean (PAHO).

**6. Factors which Protect or Promote Reproductive Health**

Several factors associated with adolescent development jeopardize the ability of male adolescents to protect their health. Often adolescents feel invulnerable to risks, while at the same time maintaining a fatalistic perspective. These attitudes lessen their control over the choices they make for themselves (Caceres, et al, 1997). An adolescent's degree of cognitive maturity may place limits on his or her ability to plan for sexual relationships, clearly articulate personal values, negotiate with a partner, and obtain contraception and condoms (Haffner, 1995). Burak describes adolescence as a period of exploration that may include taking risks that are not necessarily perceived as dangerous by young people (1997). For example, adolescents may begin to experiment with alcohol and drugs, which often leads to poor decision-making concerning their sexual and reproductive health. Additionally, communication skills of adolescents are lacking due

to their inexperience. Their weak communications skills are compounded by cultural taboos regarding sexuality (Clark, Zabin, & Hardy, 1984).

There are many cultural norms and barriers in Latin America, which prevent male adolescents from maintaining their reproductive and sexual health. Many men face social expectations that they should be sexually experienced and knowledgeable and therefore should not need to seek out information regarding their sexual health (Barker, 1996). Indeed, they fear that by seeking out such information they would admit their sexual ignorance. Culturally, Latino communities often mark male coming of age by tolerating and even encouraging sexual activity and experimentation (de la VGA, 1990). Also, many cultures dictate that girls should be responsible for contraception and discourage male participation in decision making regarding contraception (Helzner, 1996; de la Vega, 1990). Men in Latin America tend to have more traditional attitudes toward gender roles that restrict their behavior in close relationships. Marsiglio found that young men with traditional attitudes concerning gender roles tend to take more risks in their sexual and contraceptive behavior (1993). Cáceres found that cultural norms suggest condom use with casual partners only because condom use is associated with prostitution and STDs (1997).

## **7. Correlates of Risk Behaviors**

It is important to understand the correlates of risk taking behaviors that influence reproductive health such as engaging in unprotected sex. As previously mentioned young men from more affluent neighborhoods were more likely to have used at least one effective contraceptive method during their last sexual encounter. Those with higher grades, a more secure relationship with their last sexual partner and strong religious beliefs were more likely to have used a contraceptive method. In a study of street youth in Brazil, the investigators found that these youth engage in various risk taking behaviors, such as anal intercourse, sex with multiple partners, and unprotected sex. The youth surveyed reported having lower levels of education, living in dangerous, inadequate environments, and lacking parental support (Raffaelli, et. al., 1993). In a study of school-age adolescents in Kenya, it was demonstrated that risky sexual behaviors were correlated with socializing in a sexually experienced peer group, a weak religious commitment, attitudes tolerant of premarital sex, and an unstable family environment (Kiragu & Zabin, 1993). Ooms suggests that young males that engage in risky behavior often have few positive relationships with their fathers and older males who can serve as role models and mentors (1997). In Mexico, Pick and Palos found that parent-child communication concerning sexuality significantly influences the age of sexual debut in children, as well as adolescent pregnancy and the use of contraceptives (1995). Other factors cited in the literature which are associated with engaging in risky sexual behaviors include intra family violence and conflict; low self-esteem; early school dropout; and a high external locus of control (Burak, 1998).

It has been demonstrated that for youth in general, the use of drugs and alcohol is associated with a higher risk of STDs as well as pregnancy. Cáceres, et al. found that frequent sex under the influence of drugs or alcohol was associated with reproductive health problems, including STDs and unwanted pregnancies (1997). In a study of adolescent sexual activity in Kenya, it was found that the single most important predictor of early sexual initiation was prior use of illicit drugs, and that sexually active subjects were more likely to use drugs, marijuana, alcohol, and cigarettes. Also, within a dominantly heterosexual environment, certain forms of sexuality tend to emerge only when



individuals are under the influence of alcohol or drugs and lead to risky behavior (i.e. not utilizing condoms). Studies in the United States find drug use to be associated with other high risk behaviors, such as multiple partners, frequent intercourse, and inconsistent condom use (Ku, Sonenstein, & Pleck, 1993). In this study, over 25% of sexually active young men reported that they had been drinking before their last intercourse, 3.5% had used drugs, and 2.3% had used both drugs and alcohol.

## **8. Resiliency**

Adolescent reproductive health research has tended to focus on the identification of risk factors associated with poor health outcomes. Just as there are factors in a youth's environment and background that increase the likelihood of problems, there are also factors that protect young people from negative influences, known as protective factors. Individuals with a number of risk factors associated with their environment or background, who, despite those challenges, develop healthy behaviors, have been termed "resilient".

Burak (1998) summarizes those characteristics and protective factors commonly identified in resilient individuals. Such individual factors include self-esteem and a high internal locus of control (feeling confident that your own efforts will produce the desired effects). Protective familial factors include the absence of marital discord, family cohesion, and a good relationship with at least one parent. An important protective factor is being connected with a parent or other adult. The results of the Caribbean Adolescent Health Survey, for example, showed that parental connectedness, feeling that mom and/or dad cares makes a difference. Important crosscutting risk factors included the absence of feeling cared for by a parent, and worry that parents might leave (PAHO). Other examples of protective factors include: a satisfactory level of education; good nutritional status; good environmental sanitation and personal hygiene; employment; religious values and norms; strong networks of family and friends; and political and legislative norms which are favorable to children (PAHO, 1997).

Efforts to combat social problems have traditionally focused on tertiary prevention, targeting single issues such as early childbearing or STD infection, while failing to take into account the familial and social contexts in which behavior occurs. Single focus programs are generally inefficient and more expensive on a per client basis because of service duplication because many problems have common, interrelated origins (PAHO, 1997). Based on the relatively new research surrounding these protective factors and their relationship with an individual's resiliency, adolescent health programs have begun to emphasize primary prevention programs which focus on human development and health promotion within the context of the family, social, and political environment.

## **E. Teen Fatherhood**

### **1. Prevalence**

Unintended adolescent pregnancy is widely recognized as a major problem. In a study of six Latin American and Caribbean countries, between 40 and 50 percent of births to adolescent women were unintended. Globally, abortions among girls aged 15 to 19 are estimated to account for at least 5 million of the roughly 50 million induced abortions that occur each year (Population Action

International, 1994). Recent studies on adolescent pregnancy show fertility rates among females between 15-19 ranging from 84/1000 in Mexico to 139/1000 in Guatemala. (Pick de Weiss, et al, 1988). For other countries in Latin America and the Caribbean, 22-42 percent of ever-married women 15-24 years of age who have had at least one live-born infant had premarital conception. In South America, this proportion ranges from a low of 25 percent in Guayaquil, Ecuador to 63 percent in Santiago, Chile (Morris, 1994).

**a) According to Girls**

Since women bear the actual pregnancy, males are seldom asked questions about their own reproductive behavior, therefore data on the percentage of male adolescents and young adults who become fathers are more difficult to come by. Respondents in a study of pregnant adolescents in the United States reported a mean age at first intercourse of 13.8 years, significantly lower than the mean age at first intercourse of 16.2 years among sexually active 15-19 year old adolescents in the general population. They reported that their partners' mean age at the time was 17.9 (Boyer, 1992).

**b) According to Boys**

According to recent data from Brazil, 10 to 20 percent of unmarried 15-24 year old males in Rio de Janeiro, Recife and Curitiba reported that they made their partners pregnant. A considerable proportion of these young men (between 37 and 57 percent) reported that they provided neither financial nor moral support to the mother (Morris, 1993). The same surveys found that over one half of young men in two cities and almost one-third of young men in a third city reported being responsible for a pregnancy that had been terminated (Population Action International, 1994).

**2. Attitudes Towards Teen Pregnancy**

While a vast literature exists on the prevalence, causes, meanings and consequences of an unwanted pregnancy among young women, almost no data is available on young fathers. While the tendency is to be concerned about adolescent pregnancy, it is important to remember that some of these pregnancies may be desired, even if unintended. Male adolescents and young adults may judge themselves ready to form a family. They may feel that pregnancy will enhance their self-esteem, make them feel like a “real” man, and increase their control over their partner.

The literature suggests that socioeconomically disadvantaged young men are more likely to view paternity as a source of self-esteem, and therefore more likely to believe that fathering a child would reinforce their sense of masculinity. Empirical research has shown that young men who adhere to strict machista values are less likely to use contraceptive methods, with the exception of using condoms in their “casual” relationships (Sonenstein, Pleck and Ku, 1995). Similarly, in an analysis of data from a national survey of adolescent males conducted in the United States in 1988, Marsiglio found that male adolescents and young adults with traditional gender roles tended to manifest attitudes and behaviors supportive of a risk-taking orientation toward heterosexual relationships and procreation (Marsiglio, 1993).

### **3. Social Constructions of Teen Fatherhood**

Young males are often criticized for not being more involved in their partner's pregnancy, yet prevailing social norms may not expect them to do so. In many contexts, adolescent males are socialized to believe that they are not responsible for either pregnancies or children which result from their first sexual activity (Barker, 1996). Social institutions such as families, schools and the health care system tend to support this view, taking punitive actions against girls but not their partners for an out of wedlock pregnancy. In contrast to the situation young women must face, male acceptance of paternity is often conditional, contingent upon proof of paternity, the quality of their relationship with the mother; parental and societal expectations, and their ability to provide economic support.

For example, in focus groups conducted in Guatemala, men indicated that the assumption of responsibility for an unplanned pregnancy was conditioned on establishing that the child was theirs (Nieces, 1993). Social norms and pressures also played a determining role. These young men felt that the most important source of advice and support regarding their paternal role was their own parents. They feared they would disillusion their parents if they failed to act according to their expectations. They were also susceptible to social pressure, fearing that they would set a bad example and fail their loved ones and community.

Research from Latin America has found that a young man's employment situation influences to a large extent the level of responsibility he accepts for a child. A study of babies born to adolescent women in Chile found that 42% of fathers were not providing any child support six years after birth and that the father was five times more likely to support the child if he worked (Engle and Breaux, 1994). Due to the difficulty young men often have in finding employment in Latin America, this may mean that teen fathers frequently find no viable paternal role to fill (Engle and Breaux, 1994; Barker and Lowenstein, 1996).

Marsiglio in his study of procreative responsibility found the three factors related to accepting responsibility for a pregnancy: education, neighborhood quality and strength of belief in traditional male gender role. (Marsiglio, 1993).

#### **a) Fatherhood**

Research on the socialization patterns of boys in the Caribbean and in parts of Latin America shows that boys are largely raised to be free of responsibility and are generally not taught how to nurture. When they become adults and fathers they are then told that they are irresponsible and do not know how to care for children. Thus, they are criticized for not being able to do those things which were explicitly left out of their upbringing -- i.e. nurturing, responsibility and fidelity, (Barker and Loewenstein, 1996.)

In focus groups with Guatemalan men, it was found that even when they were not married to the mother they felt that they would continue to maintain responsibilities for the child even when the relationship ended, but that their

responsibility to the mother ended. They also indicated concern with the moral and ethical components of ideal fatherly behavior as well as the economic implications. The characteristics of a good father they identified included setting a good example by working hard, teaching children to be honest, not smoking, drinking alcohol or taking drugs, and not womanizing, (Nieves, 1992). When Guatemalan men were asked about their own experiences, many of the men had fathered children with whom they were no longer living and they had not continued to provide support for them. These men defined primary responsibility for children as economic; the concept of providing love and nurturing was not mentioned.

An important finding from several studies is that the earlier a father becomes involved with his child, the more likely it is that he will remain committed to the child. A longitudinal study of Mexican adolescent fathers found that if the father was present at the birth of the child, suggesting his acknowledgment of responsibility, he was more likely to stay involved with the child; of the fathers who were present at the birth of the child, 75% were still present four years later (Engle and Rico, 1994).

#### **b) Father as Provider**

In Latin America and in most industrialized nations, when a father cannot sufficiently provide for his children, his partnership with the mother is weakened and his authority and relationship with his children become tenuous. In most cases, when fathers cannot fulfill their role as provider they feel they have no other contribution to make to the family and to their children. A study in Brazil with 300 father-child pairs found that the poorer the father, the less likely he was to be involved with his children (Engle and Breaux, 1994). Similarly, ethnographic research in Jamaica found that men's role as economic provider was paramount, if they were unable to fulfill this role, they found no other role in the family for themselves (Brown and Newland, 1995). Qualitative research from Brazil has further confirmed that men see their primordial role in the family as being the provider (Nolasco, 1993; and Barker and Loewenstein, 1996).

#### **4. Response to Unintended Pregnancy**

The percentage of young men who accept responsibility for an unintended pregnancy is unknown. Nor is it known what this responsibility entails or how long it lasts. Research on female-headed households suggests that support and involvement diminishes over time, particularly in the absence of a strong relationship with the mother (Engle and Breaux, 1994).

The reaction of young men and adolescents to an unintended pregnancy may range from denial, a desire for abortion or adoption, acceptance of their responsibility, to full participation as a parent. Their attitude will influence the actions of young women both indirectly and indirectly. The attitude of her partner towards the pregnancy is usually a key factor in a girl's decision of how to handle an unintended pregnancy. Qualitative research in Mexico found that among adolescent women, the boyfriend was typically the first person the young woman turned to for advice (Enhrenfeld, 1994). This is congruent with research from Peru which shows that 78% of women

included their partner in the decision regarding whether or not to have an abortion. Furthermore, even if their partners did not participate in the abortion decision-making process, the relationship with the male and his attitude toward the pregnancy were central in her decision-making process (Cordich, 1993).

This data suggests that men often play a key role in the abortion decision-making process. The degree to which the male decides to provide financial support for the future child seems to be the key factor in the male's attitude toward abortion and the woman's decision to seek an abortion. Tolbert (1995) suggests that men in Latin America are involved in abortion decision-making as, "gatekeepers, financial backers and determiners through their absence." The results of the Young Adult Reproductive Health Surveys conducted in Latin America found that between 32 and 60% of young adult males reported that at least one of their partners had had an abortion (Morris, 1993). In Rio de Janeiro and Recife, Brazil, 59% and 24% of males who reported that their partner had terminated a pregnancy respectively said that they had participated in the abortion decision-making process.

## **5. Consequences**

The negative consequences on young women of early pregnancy have been well documented. Compared with a woman who delays childbearing until her twenties, the woman who has her first child before twenty is more likely to obtain less education; have fewer job possibilities and lower income; and live in poverty (Population Reports, 1995). In addition to the economic risks, young unmarried mothers may find themselves trapped in unstable or intended marriages or they may find themselves stigmatized, (Population Reference Bureau 1992). Virtually no attention, however, has been paid to the impact of unintended pregnancy on boys. For young men, the consequences of early fatherhood may include lost opportunities for education or future economic advancement. Those who marry may leave school to support their new families. Young men may be trapped in a life of poverty with a large family and an unhappy marriage. Furthermore, the stress of this situation may be manifested in substance abuse, violence and other behaviors detrimental to their health and that of their family. (Population Reports, 1995)

On the other hand, a possible, often overlooked, benefit of father involvement is the tremendous and largely untapped potential to encourage men to become responsible, sympathetic, mature and nurturing. The benefits for children of paternal involvement have been documented. For example, a study in Barbados of 333 children of adolescent mothers found that children who received the support and interest of their father performed better in school, fared better in their social and emotional development and their health and overall well being is improved (Engle and Breaux, 1994).

## **F. Victims or Perpetrators of Sexual Abuse?**

### **1. As Victims**

While there has been increasing recognition of the problem of sexual coercion and abuse among adolescent girls, less consideration has been given to the abuse of boys and the effect such abuse may have on their interaction with female partners in the future. Recent studies suggest that sexual abuse of both males and females is significantly higher than previously thought. Data reveal

that a significant proportion of women, girls and sometimes boys are forced, coerced or tricked into having sex. According to the Caribbean Adolescent Health Survey, by 16-18 years, 16% of boys report having been physically abused and 7.5% report sexual abuse (PAHO). Males are less likely than women to report experiencing non-voluntary intercourse. Nevertheless, one third of the men interviewed in a Canadian study had experienced some form of sexual abuse (Stewart, 1996) In the United States, estimates indicate that 15% of males have been sexually abused as children compared to the estimate of 28% for females. In contrast to women, sexual abuse of males tends to occur after the initiation of voluntary sex (Moore, 1996). It is important to note as well that significant numbers of lesbian, gay male and bisexual youths report having been verbally and physically assaulted, raped, robbed and sexually abused (Savin-Williams, 1994).

The literature shows that boys who have been abused are more likely to become abusers themselves (Stewart, 1996). An intergenerational component has been documented with studies showing that abusive parents are more likely than non abusive parents to have been abused themselves, that child abuse and family violence are intergenerational in nature and that women who were sexually abused are much more likely to have children who are physically and sexually abused (Boyer, 1992).

Recent research has shown that sexual abuse is one of the underlying causes of sexual risk-taking behaviors (Stewart, 1996). Handwerker found that sexual abuse in childhood emerged as the single most important determinant of high-risk sexual activity during adolescence for both women and men (Heise, 1995). Sexual abuse is strongly correlated with earlier age at first sex; multiple partners; age disparity between partners; frequent use of alcohol and drugs, which can lead to high-risk sexual behavior; less frequent use of contraceptives; and an increased risk of infection with STDS and HIV (Moore, 1996; and Stewart, 1996). A study in the United States showed that male victims of childhood abuse are at twice the risk of HIV infection as male non-victims (Zierker, 1991). A study in Barbados showed that physical, emotional and/or sexual abuse in childhood was highly correlated with men's lack of condom use in adulthood (Stewart, 1996).

The psychological consequences of sexual abuse of children can include anxiety, fear and a sense of feeling dirty (Stewart, 1996). The victim feels vulnerable, unloved, worthless, and powerless. They have difficulty distinguishing sexual behavior from affectionate behavior; they have difficulty maintaining clear and appropriate personal boundaries, especially in relation to their bodies; they feel unable to refuse unwanted advances such as from someone wanting sex; they have trouble trusting others, they may experience feelings of shame, guilt or fear about sexual activities, especially if these might be pleasurable; and they may experience other mental health problems (Stewart, 1996). Psychological traits which have been associated with male abusive behavior include personality disorders, low impulse control, and assertiveness deficits, (Barker, 1996).

Clearly, the psychological problems associated with sexual abuse may prevent appropriate actions in a sexual context. Both Boyer and Stewart present data that indicate a strong correlation between sexual abuse or coercion and adolescent pregnancy. Girls and women who have been sexually abused exhibit a sense of disassociation, or lack of physical connection with their body. They also have lower self-esteem and often feel unloved (Moore, 1996). A person manifesting

these characteristics, be they male or female, is unlikely to make wise choices regarding contraceptive practices, safe sex or voluntary sexual activity.

## **2. As Perpetrators**

Violence against girls and young women by men their age and by adult men is a major problem around the world. Although data on sexual assault and rape is incomplete in Latin America and the Caribbean, a picture emerges of young women as frequent victims of sexual coercion and rape, including data on courtship violence, perpetrated by young men. While little data is available, various reports indicate that the majority of perpetrators are persons who are known to the victim (Heise, 1994). About 30 well-designed studies from around the world, including several from Latin America, show that between one-fifth and one half of women interviewed have been beaten by a male partner (Heise, 1994). In Brazil, over half of all women murdered are killed by a current or former partner, (Barker, 1996). While little data is available on the age of these abusers, it can be inferred from studies of adolescent mothers who reported their partner's mean age at 17.9 that abuse among adolescent girls is frequently perpetrated by young men (Boyer, 1992).

## **3. Socio-Cultural Factors**

Socio-cultural factors play an important role in condoning or encouraging sexual coercion and abuse. As mentioned earlier, the social construction of male sexuality supports the abuse of women. By making women sex objects, male sexuality denies recognition of women's rights and power in the sexual realm. Keijzer (1995) suggests that in Mexico, sexual mores objectify women; male sexuality does not promote the sexual relationship as an encounter, but rather as an "exercise of power and an affirmation of masculinity based on potency and the size of his genitals".

The belief persists in many quarters that male sexuality is inherently predatory: men need frequent sex, preferably with multiple partners, whereas women are essentially passive, (Heise, 1995). Research in Brazil has found that both young women and young men see male sexuality as something "animal-like" and out of control; men, once aroused must have sexual relations, (Barker and Loewenstein, 1996). Male socialization, peer pressure, the media and the military virtually breed violent behavior in men. This 'Masculine Mystique' encourages toughness, dominance and extreme competitiveness at the expense of honest emotion, empathy and communication. It is 'male conditioning' and not the 'condition of being male' that appears to be the problem (Heise, 1995).

Cultural stereotypes of acceptable female behavior also play into the dynamics of coercive sex. Both boys and girls learn from a young age that 'good' girls are not supposed to admit to wanting sex. The traditional 'sexual script' says that girls have to pretend 'no' even when they mean 'yes', which gives boys the perfect excuse to ignore 'no'.

Furthermore, limited research from Latin America confirms that many men see domestic violence as part of an informal marriage or cohabitation contract, and may consider sexual coercion as a "normal" part of courtship and male-female sexual relations. Adolescents in a study conducted in Brazil, for example, believe that if a man supports the household, his partner is expected to take care of the house and be sexually faithful to him. Violation of this contract by the woman is seen by many as grounds for male violence. (Barker and Loewenstein, 1996).

In considering the socialization of young men as it relates to domestic violence and sexual assault, research suggests that several factors are related to domestic violence: the absence of positive male role models; a lack of information and positive socialization about sexual and male and female relationships; and having observed violence or been a victim of violence in one's family of origin, (Barker, 1996). The importance of socio-cultural factors is supported by research which shows that many adolescent males who father children or who have had coercive sex with an adolescent female believe in traditional gender roles, (Heise, 1995).



## Appendix 1

### FOCUS GROUP GUIDE (13-14 years)<sup>3</sup>

#### 1. Introduction

- Welcome
- Introduction of moderator and observer
- Objective of the focus group

We are going to talk today about topics related to your reproductive health and sexuality. The purpose of this discussion is for you to share your ideas and experiences with me so that we can design programs to help young boys and men grow up in a healthy manner. We'll discuss topics such as what it means to be a man, the changes you experience as you're growing up, your sexuality and where you might go for information or help on these topics.

- Participation  
*There are no right or wrong answers to the questions I'll be asking you. Please feel free to answer exactly as you feel.*
- Confidentiality, respect for each other  
*Anything you say here will be kept private and confidential. We'll never mention your name outside of this room. If you prefer not to answer any particular question, that's fine. If you need to leave at any time, that is okay.*
- Consent to tape/note taking
- Introduction of participants (name, age, school/work, etc.)

#### 2. Services and information: sources, need and demand for

- Where do boys your age learn about their body and how to take care of it? Where do they learn about sex? (Probe for mass media, parents, friends, teachers, religious figures. Probe for type of information they receive and their opinion of the information)
- Do you think boys and girls learn about their health and sexuality from the mass media? (Probe for movies, television and radio)
  - Which media influences youth the most? Why?
  - What messages do the media send to young people? What do you think of them? Are they realistic?

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<sup>3</sup>To be utilized over the course of at least two group sessions with the same participants.

- If there were a place to learn about sex and your body, what would you like to know? Who would like to talk to?
- If you needed a family planning method, where would you go? Why?
- Most reproductive health and family planning services are designed for women or adults. I want you to pretend that this group has been asked to design the ideal health services for male adolescents and young men. What would they be like? (Note comments on a flip chart sheet)

Probe for:

- *services provided*
- *hours and scheduling procedures*
- *physical structure*
- *separate from women/adults*
- *privacy/confidentiality*
- *prices*
- *provider characteristics*

Probe: Would these services be different than those for girls? From services for adults? In what ways?

- 3. What does it mean to be a man? How do boys learn to act like men? (sources and models) What happens if boys act differently than they are “supposed” to? (probe for rewards and costs of changing behaviors and attitudes)**

*Note: For the next two questions use brainstorming techniques writing down answers on a flip chart. Record these to use in pile sorts during individual interviews.*

- I’d like to learn what it means to you and your friends to be a man here in (name of community). Name everything you can think of and I’ll write it down on this paper. Do your parents and teachers think the same? (Probe for different perspectives)

Probes:

- Sexual activity, financial provider
- Need to prove masculinity
- What happens to boys who don’t act like this (indicate list of words)?
- What does it mean to be a woman? How is it different from being a man?
- How would you feel if you woke up tomorrow as a girl/woman? Why? Is it better to be a man or a woman? Why? Would girls say the same?

- How do you think "real" men act? Can you describe someone you think is a "real" man? Would you like to be like him? Someone who isn't? Would you like to be like him? (probe for role of sexuality in masculinity). (*Record on paper for pile sorts*).
- Would you say that a man who acts differently from what you have described is less of a man? Why is that?
- How important is it to you to be recognized as a "real" man? Is it difficult? Why? What would happen if you were not?
- How do boys learn how to act like "real" men?
  - from others (fathers, brothers, role models)
  - from television, movies
  - sources of information
- When a girl begins to menstruate, she is considered to be woman. How do boys know when they have become men? When does your family recognize you as a man? Your friends?
- Are there people who you wouldn't consider to be a man or a woman? What are they like? What do you think of people like this? Why?

**4. Experience during puberty and the development of sexual identity. How do boys feel during puberty? What are their concerns? How do boys feel about the development of sexual desire? What do they know about the bodily changes that they are experiencing?**

- What concerns boys like you about their physical development and sexuality? (probe for penis size, STDs, being virgins, homosexuality, wet dreams, being normal, masturbation, spontaneous erections) What information do they need?
- What do you think girls worry about?
- Have you received any information about your body or your sexuality? When? Where? About what? Was it helpful? Is there something else you would have liked/or would still like to learn about?
- What is the most important thing you would tell a younger brother to help him go through the changes that you have experienced? Why? Did any one tell you about that?
- What do boys your age think/feel about having sex? Is there anything about sex that concerns them? What? Why?
- Is it important to boys that their girlfriends be virgins? Future wives? Why?

## 5. Development and Expression of Sexuality

We're going to talk about Bob now. I'd like you to help me make up a story about him. Bob is a boy like you and your friends. Bob is 14 years old and he lives here in your neighborhood. He is starting to have sexual feelings and think about sex.

- Bob is seeing his body develop. What changes does he notice? How does he feel about them?
- Does Bob think about sex? What does he think about? What makes Bob think about sex? How does he feel about sex?
- What does he do to satisfy his sexual feelings? (probe for masturbation) How does he feel about what he is doing? (probe for social norms)
- What do his parents and teachers tell him about sex? His friends?
- Bob is worried about some things in his life. What does he worry about? Why? Does Bob talk to anybody about his feelings? Who? Why/why not?
- What do his friends tell him about his feelings? What about his parents? How does this make him feel? (explore social pressure)
- Does Bob think about girls? What does he think about?
- What does Bob think about having sex? Would he like to have sex? Is he anxious about it? Pressured? Excited?
- Has he ever had sexual feelings for other boys? How does this make him feel?

Now let's talk a little bit more about Bob and you and your friends.

- How did Bob know he was starting to feel sexually mature? How did he feel about this?
- Do all boys act like Bob? If not, what other ways do they act?
- What do you think about the way Bob acted? (probe for: masturbation, having sex) What would your parents think?
- What does the word sex mean to you? (probe for: coitus, masturbation, touching, kissing, etc.)
- Do boys your age have sexual desires? How do they satisfy them?

- Some boys feel sexually attracted to other boys. Do you know anyone like this? What do you think about this?
- Some boys/young men your age have already had sexual relations, others haven't. Do you think it is common for boys your age to have had sex? Who do they have sex with? Do they use family planning?
- In your opinion, what is the right moment for a boy/man to have sex for the first time? Why? What about women? What do your parents think?
- Do you think there are any advantages to postponing the first time you have sex? What are they?
- Do boys your age ever have sex with prostitutes? What do you think about that?

**6. Wrap Up: Explore feelings during discussion today and determine interest and need for more information.**

- How did you feel during our discussion today? Have you ever talked with anyone about the subjects we discussed today? (Probe for father, mother, friends). How did you feel talking about them? How do you and/or your parents feel during these conversations? What do you talk about? Would you like to talk to your parents more about these topics?
- Would you like more information on anything we discussed today? What would you like to learn about? (Probe to prioritize information needs.) How would you like to learn about these topics? Who would you like to discuss them with?

*Thank you for sharing your thoughts and experiences. If any of you would like to talk to me about where you can go to get more information on any of the topics we discussed today, please see me or...(local contact).*

## Appendix 1

### FOCUS GROUP GUIDE (15-24 years)<sup>4</sup>

#### 1. Introduction

- Welcome
- Introduction of moderator and observer
- Objective of the focus group

We are going to talk today about topics related to your reproductive health and sexuality. The purpose of this discussion is for you to share your ideas and experiences with me so that we can design programs to help young boys and men grow up in a healthy manner. We'll discuss topics such as what it means to be a man, the changes you experience as you're growing up, your sexuality and where you might go for information or help on these topics.

- Participation

*There are no right or wrong answers to the questions I'll be asking you. Please feel free to answer exactly as you feel.*

- Confidentiality, respect for each other

*Anything you say here will be kept private and confidential. We'll never mention your name outside of this room. If you prefer not to answer any particular question, that's fine. If you need to leave at any time, that is okay.*

- Consent to tape/note taking
- Introduction of participants (name, age, school/work, etc.)

#### 2. Services and Information: sources, need and demand for

- Where do boys your age learn about how their body changes during puberty and how to take care of themselves? Where do they learn about sex? (Probe for mass media, parents, friends, teachers, religious figures. Probe for type of information they receive and their opinion of the information)

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<sup>4</sup>To be utilized over the course of at least two group sessions with the same participants. This guide should be adapted according to the age of the focus group participants.

- Do you think boys and girls learn about their health and sexuality from the mass media? (probe for movies, television and radio)
  - Which media influences youth the most? Why?
  - What messages do the media send to young people? What do you think of them? Are they realistic?
- If there were a place to get information or advice about sex and your body, what would young men like to learn about? Who would they like to talk to?
- Where would you go if you wanted a family planning method? Why?
- Most reproductive health and family planning services are designed for women or adults. I want you to pretend that you have been asked to design the ideal health services for male adolescents and young men. What would they be like? (Note comments on a flip chart sheet)

Probe for:

- services provided
- hours and scheduling procedures
- physical structure
- separate from women/adults
- privacy/confidentiality
- prices
- provider characteristics

Probe: Would these services be different than those for girls? From services for adults? In what ways?

**3. Masculinity: What does it mean to be a man? How do boys learn to act like men? (sources and models) What happens if boys act differently than they are “supposed” to? (probe for rewards and costs of changing behaviors and attitudes)**

*Note: For the next two questions use brainstorming techniques writing down answers on a flip chart. Record these to use in pile sorts in individual interviews.*

- I’d like to learn what it means to you and your friends to be a man here in (name of community). Name everything you can think of and I’ll write it down on this paper. Do your parents and teachers think the same? (Probe for different perspectives)

Probe:

- Sexual activity, financial provider
- Need to prove masculinity

- What happens to boys who don't act like this (indicate list of words)?
- How is being a woman different from being a man?
- How would you feel if you woke up tomorrow as a girl/woman? Why? Is it better to be a man or a woman? Why? Would girls say the same?
- How do you think "real" men act? Can you describe someone you think is a "real" man? Would you like to be like him? Someone who isn't? Would you like to be like him? (probe for role of sexuality in masculinity). (*Record on paper for pile sorts*).
- Would you say that a man who acts differently from what you have described is less of a man? Why is that?
- How important is it to you to be recognized as a "real" man? Is it difficult? Why? What would happen if you weren't?
- How do boys learn how to act like "real" men?
  - from others (fathers, brothers, role models)
  - from television, movies
  - sources of information
- When a girl begins to menstruate, she is considered to be a woman. How do boys know when they have become men? When does your family recognize you as a man? Your friends?
- Are there people who you wouldn't consider to be a man or a woman? What are they like? What do you think of people like this? Why?

**4. Experience during puberty and the development of sexual identity. How do boys feel during puberty? What are their concerns? How do boys feel about the development of sexual desire? What do they know about the bodily changes that they are experiencing?**

- What concerns young men like you about their physical development and sexuality? (probe for penis size, STDs, being virgins, homosexuality, wet dreams, being normal, masturbation, spontaneous erections) What information do they need?
- What do you think young women worry about?
- What happens to boys to let them know they are becoming men? (masturbation, first ejaculation, wet dreams, losing virginity, spontaneous erections) Probe for feelings and meaning of these experiences.



- What is the most important thing you could tell a younger brother to help him go through the changes that you have experienced? Why? Did any one tell you about that?
- What do young men your age think/feel about having sex? Is there anything about sex that concerns them? What? Why?
- Is it important to you that your girlfriend be a virgin? Future wife? Why?

## 5. Development and Expression of Sexuality

I would like you to help me make up a story about a boy named Bob. Bob is a boy like you and your friends. Bob is 16 years old and he lives here in your neighborhood.

- Does Bob think about sex? What does he think about?
- Does Bob think about girls? What does he think about?
- What does Bob think about having sex? Would he like to have sex? Is he anxious about it? Pressured? Excited?
- What does he do to satisfy his sexual feelings? (probe for masturbation, sex) How does he feel about what he is doing? (probe for social norms)
- What do his parents and teachers tell him about sex? His friends?
- Bob is worried about some things in his life. What does he worry about? Why? Does Bob talk to anybody about his feelings? Who? Why/why not?
- What do his friends tell him about his feelings? What about his parents? How does this make him feel? (explore social pressure)
- Has he ever had sexual feelings for other boys? How does this make him feel?

Now let's talk a little about what you think about sex.

- Do most boys act like Bob? If not, what other ways do they act?
- What do you think about the way Bob acted? (probe for: masturbation, having sex) What would your parents think?
- What does the word sex mean to you? (probe for: coitus, masturbation, touching, kissing, etc.)

- How do young men your age satisfy their sexual desires?
- Do young men your age ever have sex with prostitutes? What do you think about that?
- Some boys feel sexually attracted to other boys. Do you know anyone like this? What do you think about this?
- Some boys/young men your age have already had sexual relations, others haven't. Do you think it is common for boys your age to have had sex? Who do they have sex with? Do they use family planning?
- In your opinion, what is the right moment for a boy/man to have sex for the first time? Why? What about women? What do your parents think?
- Do you think there are any advantages to postponing the first time you have sex? What are they?
- To you and your friends, when a girl says "no", does that sometimes mean "yes" or "later"? Why? How do you know the difference?
- Do you think there are any situations in which girls sometimes should agree to have sex? (probe for: leading the boy on, exchange for boy's money or gifts, number of times they've gone out, etc.)
- Do young men and women who are going out together talk about sex? What do they talk about? How do you feel talking about sex? What would make it easier or harder?

## **6. Sexual Debut: Explore context, feelings, and social norms**

Now we're going to make up a story together, the story of Mario and Yolanda. Mario is 16 years old and Yolanda is 15, they both live in ....., and they are going out together. They just had sex for the first time.

- How long have they been together? Where did they meet? How do they get along?
- How did they come to have sex the first time? Did they come to agreement? Who proposed it? What did he say, what did she say? Where? When did they have sex? What happened?
- Was the experience positive or negative for Mario? For Yolanda? Why? How did he feel? How did she feel? Is it what he expected? Why or why not? (probe for satisfaction, nervousness)
- Were either of them worried about having sex? (probe for fear of STDs, pregnancy, performance anxiety, social norms)

- Did either of them feel pressured to have sex? Who? Why?
- Did they use any protection? Why/Why not? Which? Who proposed it? How did they obtain it? (probe for partner communication, male involvement, sources of support or information)
- Why did they chose that method?

## 7. Teenage Fatherhood

Let's say that Yolanda misses her period and finds out she is pregnant.

- How does she feel? What does she do?
- Does her family know? How do they find out? How do they react? (if they don't know, why doesn't she tell them?)
- How does Mario find out that she is pregnant? Does she tell Mario?
- How does Mario feel? How does he react? What does he do?
- Who does he talk with? What do they tell him?
- Does his family find out? How do they find out? How do they react? (If they don't know) Why doesn't he talk to them?
- What do they decide to do? (*explore both options below, starting with the one the group chooses*)

If they decide to have the baby:

- Why did they decide to have it? Who made the decision? Who do you think should have the final decision, Yolanda or Mario?
- How are they going to live? Will they live together? Where? If studying, will they stay in school? Will anyone help them?
- If they decide to have the baby, but not live together or marry, what will Mario do? Will he support Yolanda and the baby or not? Will they continue together or break up?
- How do you think this will effect Mario's life right now? In five years? In ten years? How will it effect Yolanda's life? How will their lives' be different because of the baby?

If they decide not to have the baby: (explore both options)

- Why did they decide that?
- Which of them did not want the baby?
- What are they going to do not to have it? Where? With whom?
- Who have they talked to this about? Who will support them? How?
- Who pays for it?
- Will they go together, or will she go alone, why?

Now, I want to ask you some questions about what happened to Mario.

- Do you think what Mario did was right? What should a boy do if his partner is pregnant? Why? Do they usually do this? Why/why not?
- Do you think Mario would be a good father? What would a good father be like?
- What do you think about young men who become fathers before they are married? What do their parents think? The community?

## **8. Family Planning**

- How often do you think most young men use a family planning method? Why don't they use one every time?
- Why? What methods do they use? Why? Are they concerned about pregnancy, disease or both? Who initiates contraceptive use?
- Do you think it is easy or hard to get a family planning method? Why? How easy would it be to use one?
- How easy or hard would it be to talk with your partner about contraception? What would make it harder? Easier?
- In what situations do you think a young man would use a contraceptive method? When wouldn't he?

- What kind of young men use contraception? What kind do not? What kind of girls use something?
- If you could invent the perfect contraceptive method, what would it be like? What type of contraceptive do you think girls would invent?

**9. Wrap Up: Explore feelings during discussion and determine interest and need for more information.**

- How did you feel during our conversations? Have you ever talked with anyone about the subjects we discussed today? (Probe for father, mother, friends). How did you feel talking about them? How do you and/or your parents feel during these conversations? What do you talk about? Would you like to talk to your parents more about these topics?
- Would you like more information on anything we discussed today? What would you like to learn about? (Probe to prioritize information needs.) How would you like to learn about these topics? Who would you like to discuss them with?

*Thank you for sharing your thoughts and experiences. If any of you would like to talk to me about where you can go to get more information on any of the topics we discussed today, please see me or...(local contact).*

## Appendix 1

### TOPIC GUIDE FOR PROVIDERS

#### Introduction (5 min.)

- Introduction

- Objective of interview

*I would like to talk with you about providing reproductive health and sexuality education to boys and young men. The purpose of these discussions is to learn about your ideas and experiences so that we can design programs to help young boys and men grow up to be healthy adults.*

- Participation

*There are no right or wrong answers to the questions I'll be asking you. Please feel free to answer exactly as you feel.*

- Confidentiality and privacy

*Anything you say here will be kept private and confidential. I will never mention your name outside of this room. When we tell people what we have found out from the interviews, we won't use names, we'll talk in general terms, like most of the health providers suggested....If you prefer not to answer any particular question, that's fine.*

- Consent to tape/note taking

### **1. Introduction: Warm up (10 min.)**

- What is your profession?
- How long have you been working in it?
- How long have you been working in this \_\_\_\_\_?
- What do your responsibilities entail?
- What do you like best about your job? Least?

### **2. Attitudes towards Young Men and their Reproductive Health and Sexuality**

- If you were a young person, would you prefer to be a boy or a girl? Why?
- What is your opinion of male adolescents and young men today? Is this different from when you were young? How? What do you think about their sexual behavior? Why do you think they act the way they do?

### **3. Perceptions of the Reproductive Health Needs of Male Youth**

- What do you think this group's needs are in relation to reproductive health and sexuality? (Generate and prioritize list using a brainstorming exercise)
- Do you think this group has any particular needs that are different from girls? From adults?
- How important do you think it is to provide sexual and reproductive health education and services to adolescent males and young men? Why? Is it more, less or equally important to providing services to young women or adults? How should services for this group differ from those for girls? For adults?

### **4. Knowledge and Opinions of Existing Services**

- Could you name any organizations in this community that provide services/education to male youth? What services do they offer? How would you rate the quality of these programs?

- How adequately do you think these services and programs meet the needs you listed previously?

#### **5. Experiences Providing Services for Youth**

- Have you ever provided services to adolescent males or young men? What did you do? What was it like? What did you like about it? What didn't you like about it?

#### **6. Attitudes towards Services**

- How would you feel about providing services to adolescent males? For young men? What services/education would you offer?
- Do you feel that you are adequately prepared to do so? What type of training would you like to receive before working with young men? What type of support would you need from your organization?
- What ideas do you have on what these services should be like? What changes would you need to make in your clinic/organization? Is there anything your organization/clinic needs to be careful about if you start to provide services for male youth?

*Thank you for sharing your thoughts and experiences with me. They will be important to us as we plan new reproductive health services for boys.*



## Appendix 2

### INDIVIDUAL INTERVIEW GUIDE (13-14 years)<sup>5</sup>

#### Introduction (5 min.)

- Introduction

- Objective of interview(s)

*I would like to talk with you about your experiences as you have been maturing and developing sexually. I am also talking with other boys your age. The purpose of these discussions is to learn about your ideas and experiences so that we can design programs to help young boys and men grow up in a healthy manner. We'll talk about what it means to be a man, the changes you experience as you're growing up, your sexuality and where you might go for information or help on these topics.*

- Participation

*There are no right or wrong answers to the questions I'll be asking you. Please feel free to answer exactly as you feel.*

- Confidentiality and privacy

*Anything you say here will be kept private and confidential. I will never mention your name outside of this room. When we tell people what we have found out from the interviews, we won't use names, we'll talk in general terms, like most of the boys think....If you prefer not to answer any particular question, that's fine.*

- Consent to tape/note taking

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<sup>5</sup>To be utilized over the course of at least two interviews with the same respondent.

## 1. Introduction: Warm up (10 min.)

- How old were you on your last birthday?
- Do you work, go to school, or do both?
- *(If he studies)* What was the last grade of school you completed?
- *(If he works)* What kind of work do you do?
- Who do you live with?
- What do you like to do for fun?
- What do you imagine your life will be like in about ten years?

## 2. Perceptions of Masculinity and Becoming a Man

- When I say the word “man” to you, what comes to your mind? (Probe for a list of words)
- How should a man act? (Probe for sexual activity, financial provider, need to prove masculinity) Do you act this way? Why or why not? How do you feel acting that way? Is it easy or difficult? What happens if you act differently (give examples)?
- How will you know when you have changed from a boy to a man? When will your family recognize you as a man? Your friends?
- *Pile sort:* I’m going to give you a pile of cards with words written on each one which describe characteristics of men. *(Use concepts from focus group free listing).*
  - Please separate the cards into piles that are similar to each other. You may group the cards any way you want. *(After he finishes sorting the cards, ask why he sorted them that way).*
  - Now, I’d like you to put them in order from the most important to the least important characteristics of being a man.
- How are you learning to be a man? (probe; from fathers, brothers, other role models, television, movies)

### **3. Fertility Awareness**

- Have the respondent draw a picture of a male body on a piece of paper. (Probe/add missing organs). For each body part ask the following questions.
  - What do you know about this? What do you call it? What is its function? How should you take care of it? How does it change during puberty? (Referring to external organs) Do these look the same on all boys/men? How do they vary among individuals? Have you ever heard of a testicular self-exam?
- Can you explain to me how babies are made (a woman gets pregnant) (probe for understanding of sperm, ovum, menstrual cycle)?
- What do you know about how a woman's body works? Probe to discover knowledge of ovulation, secretions, fertile phase). When during her cycle (the month) is a woman most likely to get pregnant? Where did you learn about this?
- When do you think a girl is old enough to get pregnant? When is a boy able to get a girl pregnant?
- Do you know any ways to prevent a pregnancy? What are they? (Probe for understanding and opinions of each method). Do you know anyone who uses these methods? Which? Why/Why not? Where did you learn about these methods?
- Have you heard of sexually transmitted diseases? Tell me what you know about them.
  - names, symptoms, consequences, means of transmission, means of prevention
  - what about HIV or AIDS?
  - how common are they?

### **4. Services and Information: Sources, Need and Demand**

- As you have been growing up, how have you learned about how your body changes during puberty? How to take care of yourself? Where have you learned about sex? (Probe for mass media, parents, friends, teachers, religious figures. Probe for type of information received, timeliness and opinion of the information.)
- Have you ever gone to a doctor or health clinic to get advice about how your body is developing? About anything related to sex? Can you tell me about your experience? (probe for sources, opinion) For a family planning method?
- Do you know where boys can go if they want to talk to someone about their development? About sex? Have you ever used them?

- What was it like? Did you get the help you wanted? How comfortable did you feel? How were you treated?
- We need your help to design reproductive health services for young men. I'm going to give you these cards, each of them has a word which describes health services written on it. For example – affordable, private, safe, or friendly.<sup>6</sup> Your job is to put them in order on the table according to how important they are to you. You may put aside those which aren't at all important. (Note: Try to generate additional comments as well.)
- Now that we have a list of characteristics that are important to you in a health clinic, I want to be sure to understand what these characteristics mean to you. Please give me examples and explain to me the meaning of each.
- Is there anything you would like to learn about your sexuality and health? (Repeat the same exercise, prioritizing information needs).
- How would you like to learn about them? Who would you like to discuss them with?

## 5. Puberty and Development of Sexual Identity

- You are at the age where your body is maturing. What changes in your body have you noticed? How do you feel about them? Is there anything that you don't understand or that worries you? Has anyone talked to you about these changes? Who? What did you talk about?
- As you have been growing up, what has been the most difficult, confusing or embarrassing part of your development? What have you been the proudest of? What has been the most fun? Why?
- Is there anything specific that worries or concerns you about your health and development? (probe: normal development, first ejaculation, wet dreams, spontaneous erections, masturbation, homosexuality, virginity, penis size)
- Have you ever heard of masturbation? What do you think about it? What about your parents/friends?
- Do you daydream about sex? What do you think about? Boys, girls or both?
- Many young boys feel sexually attracted to other boys sometime during their youth. Have you ever had that experience? How did you feel about it?

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<sup>6</sup>Note: These phrases will be generated during the focus group discussions and the cards must be prepared prior to the interviews.

- What have you learned about sex? When? Where? About what? Was it helpful? Is there something else you would like to learn about?

**6. Sexuality – I would like to talk with you about how you are developing your sexuality. Can you tell me what you have noticed about your sexual development? How have you felt about these changes? Did you understand what has happening? Would you like to have had more information?**

Probing questions: (use if respondent doesn't bring up spontaneously)

- Do you ever think about sex? What do you think about? Why? (Probe for concerns, social pressure)?
- When is it the right moment for a boy to have sex? Why? For a girl? Would your parents agree with you?
- Do you have a girlfriend now, or have you ever had one? **(If no, go to Section 7)**
- Have you ever talked about sex with her? What did you talk about? How did you feel talking with her?
- How do/did you express your feelings for each other?
- Have you ever kissed her on the mouth or touched her body? How was that? How does she feel about being physically intimate with you?
- Have you ever had sex? How did it happen the first time? How did you come to an agreement? Who suggested it? Where was it? What time? What happened? *(If he has never had sex, go to Section 7)*
- Was it what you expected? What do you remember best about it? (partner, feelings, satisfactory/disappointing, use of family planning) How did you feel? How do you think she felt? Did you use any method? Why not? Which? Who proposed it?
- Have you continued to have sex? Could you tell me about that? (partners, frequency, feelings) Do you use any kind of protection? (methods, who took initiative, who obtained)
- Have you ever felt pressured to have sex? Do you think your girlfriend ever feels pressured to have sex? Why? Do you think she worries about sex? What about you?

## 7. Violence and Sexual Coersion

Some people experience violence in their personal relationships. Others are coerced or forced to have sex. This is not easy to talk about, but I'd like to discuss this with you to find out if it is a problem for young men in this community and what we might do to help them.

- Has any one in your family ever been violent? (probe for domestic abuse – wives, children)  
Could you tell me about it?
- Sometimes people have a hard time controlling their anger. Has that ever happened to you?  
Can you tell me about it?
- Have you ever gotten so angry or frustrated with a girl that you wanted to hit her? What happened? How did you feel about it?
- Do you believe that boys are sometimes justified in using force with their girlfriends? Probe for reasons and circumstances.

Here in the community we have heard of cases of sexual abuse.

- What do you consider sexual abuse? (probe for social norms)
- Has it ever happened in your family? Do you think anyone in your family has been forced to have sex against their will? What happened? (Probe for details, feelings, norms)
- What about you, has anyone ever forced you to have sex when you didn't really want to? (Probe for feelings, details) What happened?
- Have you ever had sex with someone who didn't really want to? Could you tell me what happened?
- If someone were hitting you or forcing you to have sex against your will, what would you do?
- If a boy wants to have sex and his girlfriend doesn't, what should he do? (Probe for circumstances, reasons)
- Have you ever talked about these things before? Who did you talk with? What did they tell you? How do you feel talking about it?

## 8. Wrap Up

- How did you feel during our discussion today?
- Have you ever talked with anyone about the things we talked about? With whom? (probe for mother, father, friends, teacher) How did you feel during these discussions? What did you talk about? Would you like to talk with your parents about these things? Could you?
- If you wanted more information on the topics we're discussing today, where would you go/who would you go to?

*Thank you for sharing your thoughts and experiences with me. Would you like to know where you can get information on any of the topics we discussed today? If nothing occurs to you now, you can contact...(local contact) in the future.*

## INDIVIDUAL INTERVIEW GUIDE (15-24 years)

### Introduction (5 min.)

- Introduction

- Objective of interview(s)

*I would like to talk with you about your experiences as you have been maturing and developing sexually. I am also talking with other boys your age. The purpose of these discussions is to learn about your ideas and experiences so that we can design programs to help young boys and men grow up in a healthy manner. We'll talk about what it means to be a man, the changes you experience as you're growing up, your sexuality and where you might go for information or help on these topics.*

- Participation

*There are no right or wrong answers to the questions I'll be asking you. Please feel free to answer exactly as you feel.*

- Confidentiality and privacy

*Anything you say here will be kept private and confidential. I will never mention your name outside of this room. When we tell people what we have found out from the interviews, we won't use names, we'll talk in general terms, like most of the boys think....If you prefer not to answer any particular question, that's fine.*

- Consent to tape/note taking



## 1. Introduction: Warm Up (10 min.)

- How old were you on your last birthday?
- Do you work, go to school, or do both?
- (*If he studies*) What was the last grade of school you completed?
- (*If he works*) What kind of work do you do?
- Who do you live with?
- What do you like to do for fun?
- What do you imagine your life will be like in about ten years?
- Do you have a girlfriend? How long have you been together?

## 2. Perceptions of Masculinity and Becoming a Man

- When I say the word “man” to you, what comes to your mind? (Probe for a list of words)
- How should men act? (Probe for sexual activity, financial provider, need to prove masculinity) Do you act this way? Why or why not? How do you feel acting that way? Is it easy or difficult? What happens if you act differently (give examples)?
- Do you consider yourself a boy or a man? How will/did you know when you have changed from a boy to a man? When will your family recognize you as a man? Your friends?
- *Pile sort:* I’m going to give you a pile of cards with words written on each one which describe characteristics of men. (*Use concepts from focus group free listing*).
  - Please separate the cards into piles that are similar to each other. You may group the cards any way you want. (*After he finishes sorting the cards, ask why he sorted them that way*).
  - Now, I’d like you to put them in order from the most important to the least important characteristics of being a man.

### **3. Fertility Awareness**

- Have the respondent draw a picture of a male body on a piece of paper. (Probe/add missing organs). For each body part ask the following questions.
  - What do you know about this? What do you call it? What is its function? How should you take care of it? How does it change during puberty? (Referring to external organs) Do these look the same on all boys/men? How do they vary among individuals? Have you ever heard of testicular self-exam?
- Can you explain to me how a woman gets pregnant (probe for understanding of sperm, ovum, menstrual cycle)?
- What do you know about the menstrual cycle. (probe beyond the answer “menstrual bleeding” to discover knowledge of ovulation, secretions, fertile phase). When during her cycle is a woman most likely to get pregnant? Where did you learn about this?
- When do you think a girl is old enough to get pregnant? When is a boy able to get a girl pregnant?
- Do you know any ways to prevent a pregnancy? What are they? (Probe for understanding and opinions of each method). Do your friends use these methods? Which? Why/Why not? Where did you learn about these methods?
- Have you heard of sexually transmitted diseases? Tell me what you know about them
  - names, symptoms, consequences, means of transmission, means of prevention
  - what about HIV or AIDS?
  - how common are they?

### **4. Services and Information: Sources, Need and Demand**

- As you have been growing up, how have you learned about how your body changes during puberty? How to take care of yourself? Where have you learned about sex? (Probe for mass media, parents, friends, teachers, religious figures. Probe for type of information received, timeliness and opinion of the information.)
- Have you ever gone to a doctor or health clinic to get advice about your sexual development or reproductive health problem? Can you tell me about your experience? (probe for sources, opinion) For a family planning method?
- Do you know of anywhere that offers reproductive health services for young men? Have you ever used them?

- Tell me about your experience with these services. Did you receive the help you wanted? Was it hard or easy to get help? How comfortable did you feel using them? How were you treated by the staff?
- We need your help to design reproductive health services for young men. I'm going to give you these cards, each of them has a word which describes health services written on it. For example – affordable, private, safe, or friendly.<sup>7</sup> Your job is to put them in order on the table according to how important they are to you. You may put aside those which aren't at all important. (Note: Try to generate additional comments as well.)
- Now that we have a list of characteristics which are important to you in a health clinic, I want to be sure to understand what these characteristics mean to you. Please give me examples and explain to me the meaning of each.
- We also need to know what aspects of your sexuality and health you would like more information about. (Repeat the same exercise, prioritizing information needs).
- How would you prefer to learn about these topics? Who would you like to discuss them with?

**5. Puberty and Development of Sexual Identity: Explore what it was like for them as their body was developing during puberty.**

- What changes in your body did/have you noticed as you have been developing? How do you feel about them? Is there anything that you didn't understand or that worries you? Has anyone talked to you about these changes? Who? What did you talk about?
- As you have been growing up, what has been the most difficult, confusing or embarrassing part of your development? What have you been the proudest of? What has been the most fun? Why?
- Is there anything specific that worries or concerns you now about your health and development? (probe: normal development, first ejaculation, wet dreams, spontaneous erections, masturbation, homosexuality, virginity, penis size, sexual performance)
- What do you think about masturbation?. Have you ever masturbated? How do you feel about it? What do you think your friends/parents would think if they knew you were masturbating?
- When you daydream about sex, do you think about boys, girls or both?

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<sup>7</sup>Note: These phrases will be generated during the focus group discussions and the cards must be prepared prior to the interviews.

- Many young boys feel sexually attracted to other boys sometime during their youth. Have you ever had that experience? How did you feel about it?

**6. Sexuality Development and Debut– I’d like to talk with you about how you are developing your sexuality. Can you tell me what you have noticed about your sexual development? How have you felt about these changes? Did you understand what has happening? Would you like to have had more information?**

Probing questions: (use if respondent doesn’t bring up spontaneously)

- What do you think is the right moment for a boy to have sex? Why? For a girl? Would your parents agree with you? What advice have your parents given you?
- Have you ever had sex?
- Is there any reason you have chosen not to have sex, or have you not had the opportunity yet? (Skip the next question)
- Can you tell me about the first time you had sex? (Encourage him to keep talking until he has discussed his feelings as completely as possible, then probe)
  - Relationship with partner, age, how they met, where, when
  - How did it compare to what you expected?
  - How did you feel about it? How do you think she felt about it?
  - How satisfactory was it – for him? for her?
  - How did it come about? Who suggested it? Did you want to?
  - *(Probe if he pressured her and if so, how and why did he think this was appropriate.)*
  - Did you talk about sex or family planning with the girl beforehand? What about? Afterwards?
  - Was there anything that concerned you? (disease, pregnancy, performance)
  - Contraceptive use (who initiated, what method, for STD or pregnancy prevention, where/how obtained, feelings using it)
  - If no use, why not?
  - If he obtained, feelings obtaining/proposing/using the method? Communication with partner? When? Partner reaction?
- Do you now or have you ever had a girlfriend?
- Have you ever spoken with your girlfriend about sex? What do you talk about? How did you feel during the conversation? How do you think she felt? What would have made it easier or harder to do.
- How do/did you express your feelings for each other?

- Have you ever kissed her on the mouth or touched her body? How was that for you? How does she feel about being physically intimate with you?
- Have you ever had sex? How did it happen the first time? How did you come to agreement? Who suggested it? Where was it? What time? What happened? (*If he has never had sex, go to Section 7*)
- Have you continued to have sex? Could you tell me about that? (partners, frequency, feelings) Do you use any kind of protection? (methods, who took initiative, who obtained) Do you always use it? If not, why not?
- Have you ever felt pressured to have sex? Do you think your girlfriend ever feels pressured to have sex? Why? Do you think she worries about sex? What about you?
- Is there anything that concerns you about your sex life? Anything you would like to change about it?

## **7. Teen Fatherhood: Explore attitudes, experiences and social norms**

- Have you or someone close to you ever thought that they had gotten someone pregnant? What happened? How did you/they react? What did you/they do? Who did they/you talk to?
- What would you do if you found out that your girlfriend was pregnant? How would you feel? How would she feel? Is there any situation where your reaction might be different? What?
- Do you feel prepared/ready to be a father? Why/why not? When will you be ready?
- What is your father like? Would you say he is a good father or not? How good of a father would you say he is? Why? Would you like to be the same kind of father or different? Why?
- What would a good father be like?

## **8. Violence and Sexual Coercion**

Some people experience violence in their personal relationships. Others are coerced or forced to have sex. This not easy to talk about, but I'd like to discuss this with you to find out if it is a problem for young men in this community and what we might do to help them.

- Has any one in your family ever been violent? (probe for domestic abuse – wives, children) Could you tell me about it?

- Sometimes people have a hard time controlling their anger. Has that ever happened to you? Has anyone ever hit you? Can you tell me about it?
- Have you ever gotten so angry or frustrated with a girl that you wanted to hit her? Can you tell me what happened? How did you feel about it?
- Do you believe that boys are sometimes justified in using force with their girlfriends? With their wives? Probe for reasons and circumstances.
- If someone were hitting you or forcing you to have sex with them against your will, what would you do?
- If you found out this was happening to a friend or relative, what would you do?
- What would you advise someone who was being hit by her partner? What if she were being forced to have sex?
- Are there any resources in your community to help people in this situation?
- Have you ever talked with anyone about violence and sex? Who? What did you talk about?

Here in the community we have heard of cases of sexual abuse.

- What do you consider sexual abuse? (probe for social norms)
- Has it ever happened in your family? For example, has anyone ever been forced to have sex against their will? What happened? (Probe for details, feelings, norms)
- What about you, has anyone ever forced you to have sex when you didn't really want to? (Probe for feelings, details) Would you tell me what happened?
- Have you ever had sex with someone who didn't really want to? Why? Could you tell me what happened?
- If someone were hitting you or forcing you to have sex against your will, what would you do?
- Have you ever talked with anyone about this topic before? Who did you talk with? What did they tell you? How do you feel talking about it?

## 9. Wrap Up

- How did you feel during our conversations?
- Have you ever talked with anyone about the things we talked about? With whom? (probe for mother, father, friends, teacher) How did you feel during these discussions? What did you talk about? Would you like to talk with your parents about these things? Could you?
- If you wanted more information on the topics we're discussing today, do you have somewhere to go?

*Thank you for sharing your thoughts and experiences with me. Would you like to know where you can get information on any of the topics we discussed today? If nothing occurs to you right now, you can always get in contact with... (local contact) later.*

## Appendix 3

### REPRODUCTIVE HEALTH SURVEY INSTRUMENT (10-24)

*This survey will help us understand your thoughts and concerns about reproductive health so that programs can be developed to better serve young men across the country. The questions in this survey represent a wide range of experiences and concerns faced by adolescents. Some of these may or may not be applicable to you. Your name will NOT be on the survey so no one will know your answers. Please feel free to answer exactly as you feel. Your participation is voluntary and you do not have to answer any particular questions if you prefer not to.*

*Thank you, your help today is VERY IMPORTANT to us.*

#### ABOUT YOU

*These are some general questions about you and your life.*

- 1) How old were you on your last birthday? \_\_\_\_\_
  
- 2) Are you currently single, living with someone, separated, divorced/widowed?
  - a) Single
  - b) Living with someone
  - c) Separated/Divorced
  - d) Other: \_\_\_\_\_
  
- 3) Do you have a girlfriend?
  - a) Yes
  - b) No
  
- 4) How many people live with you? Count yourself. \_\_\_\_\_
  
- 5) Are your biological parents:
  - a) Living together/married
  - b) Divorced
  - c) Separated
  - d) One of my parents is dead
  - e) Both of my parents are dead
  - f) I don't know
  
- 6) Are you currently attending school?
  - a) Yes
  - b) No
  
- 7) What is the highest grade you successfully completed, not counting the current grade you are in?  
\_\_\_\_\_



8) Do you currently work outside of the home?  
a) Yes  
b) No

9) How many hours a week do you work?  
a) I don't work  
b) 1-4 hours a week  
c) 5-9 hours a week  
d) 10-20 hours a week  
e) over 20 hours a week

10. Do you listen to the radio regularly?  
a) Yes  
b) No

11. What station do you listen to? \_\_\_\_\_

12. Do you watch television?  
a) Yes  
b) No

13. How often do you watch television?  
a) Hours a day \_\_\_\_\_  
b) Not every day

## **ABOUT YOUR HEALTH**

*These are questions about what you know and feel about topics related to your reproductive health and sexuality.*

14. Before you were 18 years old, did you ever talk with one of your parents or other adult about...?  
(Mark all that apply)

- a) Menstrual Cycle
- b) How pregnancy occurs
- c) Methods of birth control
- d) Sexually transmitted diseases
- e) HIV/AIDS

15. Before you were 18 years old, were you ever been taught at school about: (Mark all that apply)

- c) Menstrual cycle
- d) Female reproductive system
- e) Male reproductive system
- f) How pregnancy occurs
- g) Contraceptive methods

- h) Sexually transmitted diseases
- i) HIV/AIDS
- j) Birth control

16. Have you ever attended a lesson, course or lecture on sex education outside of school?

- a) Yes
- b) No
- c) Don't remember

Where did you get this lesson, course or lecture? \_\_\_\_\_

17. Do you know at what age a woman can become pregnant?

- a) Yes
- b) No

Will you please tell me what you know about this:

18. Do you know at what time of a woman's menstrual cycle a woman can become pregnant?

- a) Yes
- b) No

Will you please tell me what you know about this?

19. Do you know how to determine the fertile days of a woman?

- a) Yes
- b) No

How would you do this? \_\_\_\_\_

20. From whom did you learn this? \_\_\_\_\_

21. As far as you know, are there any diseases that can be transmitted through sexual intercourse?

- a) Yes
- b) No
- c) Don't know

22. What are the common signs and symptoms of sexually transmitted diseases?

\_\_\_\_\_

23. Have you ever experienced any of these symptoms yourself?

- a) Yes
- b) No

24. Have you ever heard of HIV or AIDS?

- a) Yes
- b) No

25. As far as you know, what are the ways people get HIV/AIDS? (*List all you can think of*)

- a)
- b)
- c)
- d)
- e)

26. What are some ways of protecting yourself from sexually transmitted diseases including HIV/AIDS? (*List all you can think of*)

- a)
- b)
- c)
- d)

27. When do you think a boy or young man should first have sexual intercourse?

- a) Only after he is married
- b) Only if he plans to get married
- c) If he is in love regardless plans of marriage
- d) If he dates a girl but is not in love

28. When do you think a girl or young woman should first have sexual intercourse?

- a) Only after she is married
- b) Only if she plans to get married
- c) If she is in love regardless plans of marriage
- d) If she dates a boy but is not in love

29. Who do you think should be responsible to avoid pregnancy?

- a) The woman
- b) The man
- c) Both
- d) Don't know

30. When you think or daydream about sex, do you think about:

- a) Males
- b) Females
- c) Both

31. Which of the following best describes your feelings?

- a) 100% heterosexual (attracted to persons of the opposite sex)
- b) Mostly heterosexual
- c) Bisexual (equally attracted o men and women)

- d) Mostly homosexual
- e) 100% homosexual (gay/lesbian; attracted to persons of the same sex)
- f) Not sure

32. This question asks you how much you worry about different things in your life. For each question, tell how much you worry about it: Not at All, Very Little, Somewhat, Quite a Bit, Very Much.

- a) I worry about...
- b) How my friends treat me
- c) Not being able to get a good job when I'm older
- d) How well other kids like me
- e) Whether my body is developing (growing in a normal way)
- f) My looks
- g) The economic conditions where I live
- h) One of my parents hitting me so hard that I will be hurt
- i) Getting someone pregnant
- j) Getting AIDS
- k) All the violence in my home
- l) My body is not developing as fast as my friends
- m) My body is developing much faster than my friends
- n) I worry that someone may force me to do sexual things I don't want to do.

33. Have you ever tried to get help or advice for any of these concerns?

- a) Yes
- b) No

## **ABOUT YOUR SEXUALITY**

*Sex is often an important part of people's lives. Though it is very private, we hope that you will share some information with us so we can better understand your personal needs, concerns, and questions. Remember that your answers will be kept private*

34. Have you ever had any kind of sexual experience with a male?

- a) Yes
- b) No

35. Have you ever had any kind of sexual experience with a female?

- a) Yes
- b) No

36. Have you ever had sexual intercourse?

- a) Yes (**Go to 38**)
- b) No

37. Are there reasons why you have not chosen to have sexual intercourse? (Mark all that apply)

- a) I am not emotionally ready for it
- b) I don't want the risk of pregnancy
- c) I haven't met anyone I want to do it with
- d) I haven't had the opportunity
- e) Fear of disease
- f) My religious values are against it
- g) My parent's values are against it
- h) I want to wait until I am older
- i) I want to wait until I am married

### GO TO 38

*Now, I'd like to ask you some questions about the first time you had sex.*

38. At the time you had first sexual intercourse, what was your relationship with your partner?

- a) Wife
- b) Fiancé
- c) Girlfriend
- d) Friend
- e) Acquaintance
- f) Just met
- g) Relative
- h) Forced intercourse/rape
- i) Other \_\_\_\_\_
- j) Don't remember

39. The first time you had intercourse, were you forced into it against our will?

- a) Yes
- b) Sort of
- c) No

40. How old were you the first time you did it?

41. How old was the person with whom you had intercourse for the first time?

\_\_\_\_\_ years  
\_\_\_\_\_ Don't know

42. How long were you and your first partner dating when you first had sexual relations?

- a) \_\_\_\_\_ Days
- b) \_\_\_\_\_ Weeks
- c) \_\_\_\_\_ Months
- d) \_\_\_\_\_ Years
- e) \_\_\_\_\_ First time we met
- f) \_\_\_\_\_ Don't remember

43. Before you had sex for the first time, did you and your partner talk about using contraception?

- a) Yes
- b) No
- c) Don't remember

44. At the time you had first sexual intercourse, did you or your partner use any birth control method?

- a) Yes (**GO TO 46**)
- b) No
- c) Don't remember

45. What was the main reason for not using birth control?

- a) I just didn't think of it
- b) I didn't think she would get pregnant
- c) Having sex was unprotected/no time to prepare
- d) She wants to get pregnant
- e) My partner does not want to use birth control
- f) It is wrong to use birth control
- g) I was embarrassed to try to get birth control
- h) I couldn't afford to get birth control
- i) We were worried about the side effects of birth control
- j) It is my partner's problem, not mine

46. Which birth control method did you or your partner use at first intercourse?

- a) Withdrawal (pulling out)
- b) Foam only
- c) Condoms only
- d) Foam and condoms together
- e) Natural family planning \_\_\_\_\_(specify)
- f) Birth control pills
- g) Injectables
- h) Douches
- i) IUD

47. Did you use this method in order to prevent pregnancy, a sexually transmitted disease or both?

- a) pregnancy
- b) STD
- c) Both

48. Who made the decision to use contraception at that time?

- a) You
- b) Your partner
- c) Both you and your partner
- d) Don't remember

*Now, please answer some questions about the LAST time you had sex.*

49. The last time when you had intercourse, what was the relationship with your partner?

- a) Wife
- b) Fiancée
- c) Girlfriend
- d) Friend
- e) Acquaintance
- f) Just met
- g) Sexual partner
- h) Relative
- i) Forced intercourse/rape
- j) Other

50. The last time when you had intercourse, did you have any alcoholic drinks prior to intercourse?

- a) Yes
- b) No

51. The last time you had sex, did you or your partner use any of the following methods of birth control or protection?

- c) Yes (**GO TO 53**)
- d) No
- e) Don't remember

52. What was the main reason for not using a birth control method at your last intercourse?

- a) I just didn't think of it
  - b) I didn't think she would get pregnant
  - c) Having sex was unprotected/no time to prepare
  - d) She wants to get pregnant
  - e) My partner does not want to use birth control
  - f) It is wrong to use birth control
  - g) I was embarrassed to try to get birth control
  - h) I couldn't afford to get birth control
  - i) We were worried about the side effects of birth control
  - j) It is my partner's problem, not mine
- (GO TO 55)**

53. What birth control method did you or your partner use the last intercourse?

- a) Foam only
- b) Condoms only
- c) Foam and condoms together
- d) Natural family planning \_\_\_\_ (specify)
- e) Birth control pills
- f) Injectables

- g) Douches
- h) IUD
- i) Withdrawal (pulling out)

54. Did you use a method to prevent pregnancy, a sexually transmitted disease or both?

- a) pregnancy
- b) STD
- c) Both

*Finally, let's talk about what your sexual activity in general.*

55. How often do you have sexual intercourse?

- a) Once or twice
- b) Rarely (a few times per year or less)
- c) Sometimes (1-4 times a month)
- d) Several times per week
- e) Not sure

56. How often do you and/or your partner use a birth control method?

- a) Always **(GO TO 58)**
- b) Quite often **(GO TO 58)**
- c) Sometimes
- d) Rarely

57. If you are having sex and you and/or your partner do use birth control sometimes or rarely, what is the main reason for not using birth control more often? *(Mark only one)*

- a) I just don't think of it
  - b) I don't think she can get pregnant
  - c) Having sex is unplanned/no time to prepare
  - d) She wants to get pregnant
  - e) My partner does not want to use birth control
  - f) It is wrong to use birth control
  - g) I am embarrassed to try to get birth control
  - h) I can't afford to get birth control
  - i) We are worried about the side effects of birth control
  - j) It is my partner's problem, not mine
- (GO TO 60)**

58. What kind of birth control do you and/or your partner most often use? *(Mark only one)*

- a) Withdrawal (pulling out)
- b) Foam only
- c) Condoms only
- d) Foam and condoms together
- e) Natural family planning\_\_\_\_\_(specify)
- f) Birth control pills



- g) Injectables
- h) Douches
- i) IUD

59. Did you use this method to prevent pregnancy, a sexually transmitted disease or both?

- a) pregnancy
- b) STD
- c) Both

60. How many people have you had sex with during your life? \_\_\_\_\_

61. Please indicate whether you agree or disagree with the following statements about condoms.

- a) Condoms reduce the pleasure of sex
- b) Condoms are messy to use
- c) Condoms requires one's partner to have self control
- d) One can use a condom more than once
- e) People who use condoms sleep around a lot
- f) It is embarrassing to buy condoms in pharmacy or store
- g) It is embarrassing to ask for condoms in Family Planning clinics
- h) Most women do not like to use condoms
- i) Most men do not like to use condoms
- j) Using condoms with a new partner is a good idea
- k) Using condoms is not necessary if you know your partner
- l) Women should ask their partners to use condoms
- m) Discussing condom use with prospective partner is easy

62. Would you like more information about contraceptive methods?

- a) Yes
- b) No
- c) Don't know

63. If you were going to use birth control, where would you feel the most comfortable getting it?  
(Mark only one)

- a) Clinic
- b) Pharmacy
- c) Etc. depending on site

## **ABOUT VIOLENCE**

*Many people experience violence in their personal relationships. Others are coerced or forced to have sex. I'd like to discuss this topic with you to find out if it is a problem for boys and what we might do to address it.*

64. Have you ever gotten so angry or frustrated that you wanted to hit a woman?

- a) Yes
- b) No

65. Do you believe that men are sometimes justified in using force with their partner?

- a) Yes
- b) No
- c) Not sure

66. Have you ever been physically abused or mistreated by anyone in your family or by any one else?

- a) Yes
- b) No

67. Have you ever discussed this problem with anyone?

- a) Yes
- b) No

68. With whom did you discuss this problem? (Mark everyone you have spoken with)

- a) Family
- b) Close friend
- c) Teacher
- d) Health provider
- e) Minister or priest
- f) Other\_\_\_\_\_

69. Have you ever been sexually abused? Sexual abuse is when someone in your family or someone else touches you in a place you did not want to be touched or does something sexually which they should not have done.

- a) Yes
- b) No **(GO TO 72)**

70. Have you discussed this problem with anyone?

- a) No go to
- b) Yes

71. With whom did you discuss this problem? (*Mark all that apply*)

- a) Family
- b) Close friend
- c) Teacher
- d) Health provider
- e) Minister or priest
- f) Other

## ABOUT BEING A FATHER

These are questions about what make a good father and being a father.

72. Have you ever gotten someone pregnant?

- a) Yes
- b) No (**GO TO 78**)
- c) Don't know/Not sure (**GO TO 78**)

73. How many times have you gotten someone pregnant?

- a) I don't know
- b) One time
- c) Two time
- d) Three or more times

74. What was your decision regarding the pregnancy? If you have caused more than one pregnancy, refer to the most recent pregnancy.

- a) She kept the baby
- b) We are raising the baby together
- c) Her family is raising the baby
- d) My family is raising the baby
- e) The baby was placed for adoption
- f) She ended the pregnancy
- g) She had a miscarriage/the baby died
- h) She is pregnant now, I'm not sure what we will do
- i) Other: \_\_\_\_\_

75. How often do you spend time with your child?

- a) Every day
- b) A few times a week
- c) Once a week
- d) A few times a month
- e) Once a month
- f) Less than once a month
- g) Never

76. Do you give anything towards your child's support?

- a) Yes
- b) No

77. If yes, what do you give? (*Mark all that apply*)

- a) Money
- b) Food
- c) Babysitting and child care

- d) Clothes
- e) Other

## **ABOUT SERVICES**

78. Where would you go if you had a problem with... *(Fill in chart with options, depending on setting)*

- a) Your family
- b) Pregnancy
- c) Depression (feeling really sad)
- d) Needing birth control information
- e) Anger feeling out of control
- f) Sexual/physical abuse
- g) Drugs/alcohol
- h) Relationships boyfriend/girlfriend
- i) Physical health
- j) Sexually transmitted diseases

*Thank you for sharing your thoughts and experiences with me. Would you like to know where you can get information on any of the topics we discussed today? If nothing occurs to you now, you may get in touch with \_\_\_\_\_(local contact) at a later time.*

## Appendix 4

### INFORMED CONSENT AGREEMENT

Good morning/afternoon. My name is \_\_\_\_\_ from \_\_\_\_\_. We are conducting interviews with boys and young men about their sexual and reproductive health. The purpose of this study is to gather information to help us to develop services and educational programs to promote the health of boys and young men.

I would like your permission to talk with you today about your ideas and experiences related to your reproductive health and sexuality. It is up to you if you wish to answer any or all of my questions. No one will charge you for your participation or give you any money, whether or not you agree to the interview. You may end our discussion at anytime. Everything you say will be kept private and confidential.

I want also to assure you that your participation will not affect the services that you receive from \_\_\_\_\_.

If you have any questions you may ask me or contact \_\_\_\_\_ at \_\_\_\_\_.

If you agree to participate in this interview, please initial this page. Your name will not be used in any report, but your ideas and suggestions will help us to better meet the needs of boys/young men like you. If you do not wish to participate, thank you for your time.

\_\_\_\_\_ Yes, I agree to the interview

\_\_\_\_\_ No, I do not agree to the interview

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