MEN AND CONTRACEPTION IN SUB-SAHARAN AFRICA

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Abstract

This dissertation explores the caveats of men’s sexual lives in sub-Saharan Africa, with an emphasis on contraception. For too long, men have been thought of only as obstacles to women’s contraceptive use, but as I show in the following pages, men’s desired family size has decreased over the last several decades. They have a need for contraception and attitudes about its use. The dissertation focuses on men as individuals, and examines the differences between demographic sub-groups. Men are also treated as individuals in terms of their sexual life course. The following research recognizes men, not only as husbands or partners, but as people with their own motivations and attitudes.

The dissertation is broken into three chapters which look at the different ways we can study men and fertility. The first chapter takes a measure commonly applied to women, unmet need for contraception, and looks at the challenges of adapting this measure to men. The second chapter creates a measure more suitable to men and their unique sexual experiences, a measure of attitudes towards contraception. This attitude measure can be applied to all men, regardless of their relationship status or fertility desires. Finally, the period surrounding young men’s sexual lives is the focus of the third chapter. As data concerning these men is limited, this chapter takes a qualitative research approach, analyzing in-depth interviews conducted in the North Region of Cameroon to understand how men learn about sex and contraception and how they conduct themselves during their sexually active lives prior to marriage.
Men are individuals, with their own motivations, desires, attitudes, and actions, and it is necessary for us to include them in sexual and reproductive health and fertility research in this way.
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This dissertation is above all dedicated to the men in sub-Saharan Africa who have shared their life experiences with the Demographic and Health Surveys and the 23 individuals in Cameroon who took time from their lives to sit and explained to some strange girl how life really works.
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Introduction

Men have sex. They participate in reproduction, family planning, and transmission of disease. They do not do this as blind agents, but as individuals with their own knowledge, attitudes, and desires. This dissertation explores the caveats of men’s sexual lives in sub-Saharan Africa, with an emphasis on contraception. For too long, men have been thought of only as obstacles to women’s contraceptive use, but as I show in the following pages, men’s desired family size has decreased over the last several decades. They have a need for contraception and attitudes about its use. The research in the following three chapters scratches the surface on the heterogeneity of men’s sexual lives and establishes a conversation about the role men play in sexual relationships, both as partners and individuals. In this introduction, I will explain the motivation for this dissertation and preview the work to come.

In 1994, the International Conference on Population and Development, in its objective to promote gender equality, spoke of the need to “encourage and enable men to take responsibility for their sexual and reproductive behaviors and their social and family roles.” (4.25) For decades in demographic research, men had been ignored in the study of fertility. As Greene and Biddlecome explain in their review of men in the demographic literature, men, especially in developing countries, posed a problem because their sexual relationships often did not follow western norms. Fertility data was collected from women, who were more likely to be home and have a more direct role in reproduction. However, as Green and Biddlecome argue, the failure of the demographic transition theory to explain the lack of fertility decline in many places, as well as the rise
in the HIV/AIDS epidemic, has brought about an interest in men in demographic fertility research. Men, in many heterosexual relationships, also maintain a power advantage over their female partner, as found in research by Johnson and Gu across sub-Saharan Africa. In 9 out of 16 countries included in their work, the majority of men believed wives could not refuse to have sex with their husbands. Ignoring men’s role in sexual and reproductive relationships obscures our understanding of fertility and sexual health practices across the globe.

In this dissertation, the focus rests on sub-Saharan Africa. In no way does this choice diminish the important role men play in sexual relationships in other regions, but the fertility patterns in sub-Saharan African remain high, with 37 of the world’s 40 highest fertility countries located in the region.

It must be noted that there is incredible heterogeneity across the continent, both between and within countries. Because of these differences, the dissertation focuses on men as individuals, and examines the differences between demographic sub-groups, not countries. Men are also treated as individuals in terms of their sexual life course. The following research recognizes men, not only as husbands or partners, but as people with their own motivations and attitudes.

Demographically, differences exist between men and women in sub-Saharan Africa. In early data exploration for this dissertation, I calculated Singulate mean ages of different demographic events: first sex, cohabitation/marriage, and birth. These results are presented for the two genders below (Table 1).
Table 1 Singulate Mean Ages of First Demographic Events for Men in Women in Sub-Saharan African Countries surveyed by the Demographic and Health Surveys:

<table>
<thead>
<tr>
<th>Singulate mean age at first:</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>19.5</td>
<td>18.4</td>
</tr>
<tr>
<td>Cohabitation/Marriage</td>
<td>25.6</td>
<td>20.6</td>
</tr>
<tr>
<td>Birth</td>
<td>26.4</td>
<td>20.8</td>
</tr>
</tbody>
</table>

What can be seen is that, on average, men experience fertility related demographic events later in life than women. Another key finding is the much longer span of time for men between first sex and first cohabitation/marriage; this “playtime,” as it was termed by an interview subject from the qualitative work in Cameroon (chapter 3), is a key distinction between the sexual lives of young men and women.

Turning to men on the continent and changes over time, Figure 1 presents changes in the men’s desired fertility\(^1\) and the total fertility rates for different countries, as calculated from the Demographic and Health Surveys. The point for each country starts at the first survey with available data, and the arrow extends to the most recent, therefore the time frame varies by country, ranging from 5 to 19 years. For most countries, both the total fertility rate and men’s desired number of children have decreased. Dramatic declines in men’s desired number of children have occurred, though are still quite high, in countries where polygamy is common, such as Chad and Niger. However, this figure illustrates

\(^1\) Non-numeric responses are estimated to have a numeric value of one standard deviation above the mean of numeric responses for each survey, as first utilized by Westoff, Bietsch, and Koffman (2013).
that men are not a pronatalist block, subscribing to an “up to God” concept of reproduction.

Figure 1: Male Desired Fertility and Total Fertility Rates for DHS countries in sub-Saharan Africa

Therefore, what I aim to do in this dissertation is to explore the desires and actions of different groups of men. I identify those who would like smaller families but are not accessing contraception, as well as those who would still like a large family but, at least in general, approve of family planning.

The dissertation is broken down into three chapters which look at the different ways we can study men and fertility. The first chapter takes a measure commonly applied to
women, unmet need for contraception, and looks at the challenges of adapting this measure to men. The chapter analyzes unmet need for men in three sections: unmet need for married men, unmet need for never married men, and unmet need for protection against sexually transmitted infections. To examine individuals, the chapter employs a new application of sequential logit models to identify demographic sub-groups at risk for unmet need and to see if this need is met. The second chapter creates a measure more suitable to men and their unique sexual experiences, a measure of attitudes towards contraception. This attitude measure can be applied to all men, regardless of their relationship status or fertility desires. Finally, the period surrounding young men’s sexual lives is the focus of the third chapter. As data concerning these men is limited, this chapter takes a qualitative research approach, analyzing in-depth interviews conducted in the North Region of Cameroon to understand how men learn about sex and contraception and how they conduct themselves during their sexually active lives prior to marriage. These chapters, while only a glimpse into men’s sexual and reproductive lives, provide a spark to the debate about men’s role in the sexual and reproductive health field.

Data for the majority of this dissertation comes from the Demographic and Health Surveys, which have been interviewing men in sub-Saharan Africa since 1991. In the beginning, subjects were restricted to husbands of women interviewed, but this practice stopped after only a few surveys, and since then men are interviewed regardless of their marital status or relationships to others in the household. Male questionnaires are, in general, much shorter than those of women, and in an ideal world would contain much more information about their sexual, romantic, and reproductive lives. However, much
can still be learned from the available information. In sub-Saharan Africa, over 90 nationally representative surveys have included men in a total of 33 countries.

For the quantitative portion of this dissertation (Chapters 1 and 2), I focus on 4 demographic variables of interest: age, education, religion, and marital status. Age patterns of fertility are well documented for women, but also exist for men (Zhang 2010). Male fertility rises, peaks, and falls across the life course. The types of sexual relationships men enter also vary greatly by age. Thus, age serves as a key unit of analysis in this dissertation. Education’s effects on fertility are seen globally, and in sub-Saharan Africa, where educational levels range for no education among some individuals to numerous advanced degrees, this socioeconomic variable is key to the study of men’s sexual and reproductive lives presented here. Religion is not as common in the study of fertility as some other indicators, but as I have shown in work with Charles Westoff (Westoff and Bietsch 2015), distinct patterns are seen in numerous fertility indicators in sub-Saharan Africa by those of different religious affiliations. Finally, this dissertation examines the association of contraceptive use and attitudes with various marital statuses. Men’s sexual lives vary with their marital statuses, and this dissertation looks at men who are never married, previously married (divorced and widowed), married, and living with a woman as if married. As the forthcoming chapters show, major differences emerged between the demographic sub-groups for different ages, educational statuses, religious affiliations, and marital statuses. These offer an insight to the heterogeneity of men in sub-Saharan Africa and key insights for policy implementation.
Over the next 100 plus pages, this dissertation presents motivations and means for the study of men’s sexual and reproductive health in demographic research. It highlights the data available to answer many of our questions, while bringing into focus the gaps in knowledge that still exists. Much can be learned by including men in our understanding of fertility, contraception, and sexual health. Men are individuals, with their own motivations, desires, attitudes, and actions, and it is necessary for us to include them in sexual and reproductive health and fertility research in this way.
References


Westoff CF, K Bietsch, and D Koffman. 2013. Indicators of Trends in Fertility in Sub-Saharan Africa. DHS Analytical Studies No. 34. Calverton, Maryland, USA: ICF International.

Chapter 1: Unmet Need for Contraception among Men in Sub-Saharan Africa

Introduction

This chapter explores sub-Saharan African men’s reproductive desires and behaviors with the creation of several definitions of male unmet need for contraception. Using data from over 76 Demographic and Health Surveys, I calculate measures for married men, never-married men, and men at risk for sexually transmitted infections. To examine demographic characteristics associated with unmet need, sequential logit models are used to divide unmet need into two components; desire to delay or limit childbirths and modern contraceptive use to achieve this goal. I examine several demographic and socioeconomic variables in the analysis, including age, marital status, education, and religion, each of which have a significant association with the components of unmet need. This chapter aims to produce a more nuanced understanding of men’s unmet need for contraception and deepen our understanding of sexual and reproductive health in sub-Saharan Africa.

Literature Review

The 1994 International Conference on Population and Development sought to “encourage and enable men to take responsibility for their sexual and reproductive behavior” (Section 4.25) as an objective in its Program of Action. Two decades later, this research on men is still lacking. Men comprise half of the population, often have a disproportionate voice in sex practices (Blanc 2001), and have different motivations and behaviors than their
female counterparts (Leigh 1989). By including men in this type of research, we will deepen our understanding of all people’s sexual and reproductive health.

One region that will benefit from greater knowledge of men’s sexual behaviors and needs is sub-Saharan Africa. With 37 of the 40 highest fertility countries in the world², understanding the reproductive desires and contraceptive use patterns of all people across the region is an important component in the world’s reproductive health agenda.

Moreover, the study of men is particularly salient in sub-Saharan Africa, where gender norms give men control over many household decisions. Johnson and Gu (2009) examine 1995-2004 male Demographic and Health Surveys (DHS) from 11 sub-Saharan countries and find that less than half of men in each country think that couples should make joint decisions on large household purchases. In an analysis of 16 countries, the authors also find that between 33% and 80% of men believe wives could not refuse to have sex with their husbands³. The study concludes that “the fact that significant proportions of men agree with wife-beating and do not recognize a wife’s right to refuse sex attests to the socialization of men in traditional gender-role norms giving husbands rights over the behavior and bodies of their wives” (Johnson and Gu 2009, Page 19). Therefore, to understand the nature of fertility and reproductive health in sub-Saharan

² 2012 Total Fertility Rates, reported by the World Bank (http://data.worldbank.org/indicator/SP.DYN.TFRT.IN)
³ Men were given 4 specific reasons for possible refusal, and were considered to believe in the right to refuse if they agreed with any. Reasons included knowing that the husband had a sexually transmitted disease, knowing that he was sleeping with other women, recently giving birth, and being tired or not in the mood (Johnson and Gu 2009).
Africa more fully and to inform policy decisions, it is necessary to include in the discussion the desires, attitudes, and actions of men.

Recognizing the contribution of men to reproductive decisions and practices, this chapter develops several definitions of unmet need for modern contraception for men in sub-Saharan Africa. Unmet need exists, broadly speaking, for those who do not want to have a birth in the near future, but are not using contraception\(^4\). I focus on unmet need because it accounts both for desire (to delay or avoid a birth) and action (the use or non-use of contraception). Specifically, I focus on three individual-level measures of unmet need, namely, unmet for married men, unmet need for never-married men, and unmet need for protection against sexually transmitted infections (STIs). Country level results across time are also calculated for married men.

Measurement of unmet need has gone through several iterations in terms of defining the at-risk population and the desire to space or avoid childbearing. Measures are generally created for married women due to data availability, but analyses have in some cases been extended to all women and never-married, sexually active women. Original measures of unmet need included only the desire to avoid additional childbirths, known as the unmet need for limiting (Westoff 1978). Later, unmet need for spacing childbirths became a commonly included measure. Spacing is generally defined as desiring to delay an additional birth for two years (Bradley, Croft, Fishel, and Westoff 2012), though Westoff (1992) finds this length of time arbitrary and potentially excessive.

\(^4\) This definition is an overly simplified. An examination of the development and changing definitions of unmet need is discussed in the next section.
Several articles have debated the inclusion of pregnant and postpartum amenorrheic women in these measures. Westoff and Bankole (1995) argue that pregnant and amenorrheic women should be included, as they contribute to the unmet need measure based on the intention and timing of their most recent pregnancy. By excluding them from the analysis, they argue, unmet need will be underestimated. In 1999, Bankole and Ezeh proposed a current need measure, which would classify pregnant and amenorrheic (up to a certain point postpartum) women into the group with no demand for family planning. The 2012 revised definition of unmet need by the Demographic and Health Surveys includes pregnant and amenorrheic women, classifying them by the intention of their most recent pregnancy (Bradley et al. 2012).

Need status has have been developed for women with different relationship statuses (never-married, widowed, divorced, etc.). The key with these measurements is to identify the group exposed to the risk of pregnancy: the sexually active individuals, or in the case of the Westoff and Bankole perspective (1995), those engaging in sexual intercourse in the last month. For these less studied sub-populations, data limitations exist because of the survey questions asked. For DHS surveys in the early 1990s, unmarried women were not asked about pregnancy or future childbearing timing intentions, thus it is impossible to separate unmet need for spacing from limiting. However, since most of these women are young, have not yet begun childbearing, and desiring to remain nulliparous is rare in these countries, it is assumed that their need was for spacing (Westoff and Bankole 1995).
A health-based measure of unmet need developed by DeGraff and de Silvia relies not on women’s desire for additional children, but identifies women who would face adverse health consequences with another pregnancy (DeGraff and de Silvia 1996). Those at risk include women, their expected child, and their older children, all of whom may be put in danger because of maternal age, short birth interval, or high birth order.

Unmet need has also been calculated for couples (Bankole and Ezeh 1999). This measurement presents a number of unique challenges, especially when partners provide conflicting responses in terms of contraceptive use and fertility intentions. In Becker’s review of couples’ studies, he finds that couples give identical reports of reproductive events less than 90% of the time (Becker 1996). When couples state different desires for timing of their next childbirth, a problem arises over whose unmet need to count. Becker (1999) suggests two possible solutions: the minimum level of unmet need for couples where both partners want to delay or avoid future childbearing, and the maximum level when either partner wishes to delay an additional childbirth. A final problem of couples’ studies in sub-Saharan Africa is polygamous marriages (Greene and Biddlecom 2000). Some researchers choose a wife at random (Speizer and Yate 1998) or simply remove this group from their data (Bankole and Singh 1998), but because polygamy can contain as many as 53% of married women in a population\(^5\), removing these people from analyses may seriously bias results. In many cases, sex is occurring outside of monogamous, long-term relationships, and by limiting the study of unmet need to these couples, large parts of the population in need of contraception are being ignored.

\(^5\) Guinea Demographic Health Survey 2005
Two studies have previously compiled unmet need estimates for men. Ngom (1997) constructed unmet need measures in Ghana and Kenya for married, monogamous and polygamous men. Confining contraception to modern methods, he finds high levels of unmet need for men, though slightly lower than for married women in the same population. A 2003 report by the Guttmacher Institute on sex, marriage, and fathering in sub-Saharan Africa offers the most detailed analysis of men's unmet need to date. They define unmet need broadly as men who are sexually active (sexual intercourse in the last 3 months), fecund, wish to avoid or delay childbirth, and are not using contraception, and calculate country-level estimates. The report determines that men “have many needs: for better information, for improved access to services for preventing and treating infection and other conditions that impair their sexual and reproductive health.”

In research on unmet need, men are often discussed only in terms of spousal opposition to contraceptive use because of their desire for large families (Bongaarts and Bruce’s 1995 study estimates that husbands’ disapproval accounts for 9% of unmet need for women in 13 developing countries). However, not all men are pronatalist, and most men want fewer children than the maximum “up to God” response at the top of the desired number of children spectrum. Men's ideal number of children has been declining in many sub-Saharan African countries over the last several decades (Westoff, Bietsch, and Koffman 2013). Figure 1 illustrates the relationship over time between the total fertility rate and men’s ideal number of children in 21 Sub-Saharan African countries. In most countries,

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6 Non-numeric responses are estimated to have a numeric value of one standard deviation above the mean of numeric responses for each survey, as first utilized by Westoff, Bietsch, and Koffman (2013).
both measures have declined in recent years, as shown by the change between their first and most recent Demographic and Health Surveys. Notably, large absolute declines in men’s desired number of children have taken place in countries with the highest fertility, including Chad and Niger.

Shifts in the ideal number of children imply changing risk for unintended pregnancies. As desired fertility declines, men spend a larger portion of their lives at risk of unintended pregnancies and births. Thus, their potential level of unmet need increases.

The second component of unmet need, the use of contraception to avoid unwanted pregnancies, also applies to men. Men may face barriers in accessing contraception because institutions surrounding reproductive health are often focused on women; Schulte and Sonenstein (1995) identify several barriers to utilizing family planning clinics in the United States, including resource restrictions and negative staff attitudes towards men. Contraceptive use patterns are potentially more complicated among men than women in terms of methods used with multiple partners. For example, a woman using hormonal contraception is protected against the risk of pregnancy with any of her sexual partners, but a man with multiple partners may protect against pregnancy in one relationship with a woman’s hormonal contraceptive and condoms in another. In studies of couples, husbands are more likely to report contraceptive use than wives (Ezeh and Mboup 1997, Bankole 1998), particularly condom use (Becker and Costenbader 2001).

Because men hold more sexual decision making power in many heterosexual relationships (Blanc 2001) in Sub-Saharan Africa and may dictate use of condoms (and

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7 The time frame between the first and most recent surveys varies from 5 to 19 years.
other contraceptives), identifying barriers to men’s access to contraception could provide valuable information for family planning programs.

The remainder of this chapter expands the research on men's unmet need, analyzing both country level measures across time and exploring unmet need on an individual level for men from Demographic and Health Surveys in Sub-Saharan Africa, providing a more detailed view of men's reproductive health needs.

**Data and Methods**

Data for this chapter come from the Demographic and Health Surveys (DHS) of Sub-Saharan men conducted between 1991 and 2013, a total of 92 surveys from 33 countries. In 89 surveys, men are interviewed regardless of their marital status; in the remainder, only husbands of respondent women are interviewed. Although the structure of the DHS is fairly similar across countries and waves, some questions vary between surveys, limiting the number of surveys in different measures constructed below (see Table 1 for a complete list). Additionally, the age range of men interviewed varies between surveys. For uniformity in the analysis of individuals the age range is restricted to men aged 15-49.

**Constructing Measures on Unmet Need for Men**

This chapter constructs measures of unmet need separately for married/cohabiting men\(^8\), never-married men, and all men for sexually transmitted infection protection. The current definition of female unmet need (Bradley et al. 2012) provides a starting point for

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\(^8\) Distinction between these statuses is self-identified by the interviewee.
defining male unmet need, but differences in male and female Demographic and Health Survey questionnaires prohibit the creation of identical measures. For example, most men are not asked about the intentionality of a partner’s current pregnancy. In the limited number of surveys asking men this question, there is wide heterogeneity in those who, at the time of current pregnancy, wanted a child later or not at all (ranging from 6% in Senegal to 46% in Comoros). As the goal of this chapter is to look at the difference between men and not difference between men and women, I exclude men whose main partner is pregnant from the analysis of married men so that it more clearly defines the group of men at risk for unmet need and the comparison between different groups of men. In another departure from the female definition, I rely on self-reports of men and their partners’ infecundability for the analysis of both married and never-married men.

An additional consideration when creating a measure of unmet need for men is fertility desires and contraceptive use among multiple partners. If women have multiple partners but are using a non-coitus-dependent female method (such as the pill or injectables), they are protected against pregnancy with all their partners. But men may use a male method with one partner, and a female method with another, etc. In a subsection of surveys, men are asked how many partners they have had in the last year and provide detailed information about contraceptive use with up to three partners (but not fertility desires). Examining these surveys, I find little change in need status (from met to unmet need) when including additional partners. Therefore, measures of unmet need for married and never-married men focuses only on and contraceptive use with the main/most recent partner and assumes that the stated fertility desire refers to this partner. Unmet need for STI protection takes into account the presence of additional partners.
My analyses use 76 of the 92 available DHS surveys. Surveys are excluded if they lack information on contraceptive use, pregnancy status, future fertility preferences, or the socioeconomic and demographic indicators of interest\(^9\). Additionally, many surveys do not ask identical questions to married and never-married men, requiring the separate analysis of unmet need measures for married and never-married men.

**Individual analysis of unmet need**

To examine differences between demographic groups, I conceptualize unmet need for contraception as the result of two components: the desire to delay/avoid future births and the use of modern contraception to satisfy this desire.

Generally, the level of unmet need varies across the demographic transition with a low level at the beginning of the fertility transition (when desire to delay or avoid childbirths is low), a high level of unmet need during the transition (when the desired number of children decreases but contraception is not widely used), and again a low level at the end (when contraception is widely used to avoid undesired childbearing).

To account for this variation, each of the following analyses is comprised of a series of logistic regressions. The first regression investigates whether a respondent is potentially at risk of having unmet need\(^10\). Subsequently, among those who have a risk, a logistic regression examines whether or not the need is fulfilled. Demographic characteristics of

\(^9\) Most of the surveys excluded are from the early 1990s, when the questionnaires given to men were much shorter than more recent surveys. However, two of the most recent surveys (Tanzania 2010 and Niger 2012) are excluded because of their lack of information on religion.

\(^10\) For married men, an additional regression is included to examine whether the desire is to space or limit
interest in this analysis include age, education, religion\textsuperscript{11}, and marital status\textsuperscript{12}.

Descriptive statistics, including demographic characteristics and unmet need status, of individuals included in the analyses for married men, never-married men, and need for protection against sexually transmitted diseases are presented in Table 2.

**Married Men**

A measure of unmet need is constructed for all fecund men who are married or cohabiting, whose wife/partner is not pregnant (and fecund), and who provide information on contraceptive use and fertility timing desires (to distinguish between an unmet need for spacing and limiting).

The sequential logit model for married men (illustrated in Figure 2) looks first at whether or not men wish to have a birth in the next two years (A). Of those men wishing to space or limit, the second regression looks at factors associated with the desire to limit versus space (B). Finally, logistic regressions are carried out separately for those who wish to limit (C) and space (D), and examine the association of several demographic covariates with the use of modern contraception.

These men come from 62 surveys in 32 countries (listed in Table 1) which ask about (main) partner’s current pregnancy status, contraceptive use (both male and female),

\textsuperscript{11} Broadly categorized as Muslim, Christian, and Other

\textsuperscript{12} For the analysis of married men, men living with their partners but not married are distinguished from married men. Note that these marital statuses are self-reported by the interviewee. For the analysis of unmet need for protection against sexually transmitted diseases, marital status is divided into never-married, current married, living with a woman but not married, and formerly married (widowed, divorced, or no longer living with a woman).
future fertility desires (with timing), marital status, and demographic characteristics including age, education, and religion.

**Never-Married Men**

Constructing a measure of unmet need for never-married men\(^\text{13}\) differs from their married counterparts in several aspects. Since unmarried men are not always in sexual relationships, I consider men to be at risk if they have been sexually active in the last year.

Most surveys do not ask fertility desires of never-married men. Childbearing outside of marriage is considered undesirable among many African women (Meekers 1994), indicating a wish among sexually active, unmarried individuals to space or limit births. 93.5% of never-married men report having no children\(^\text{14}\) and a Guttmacher report (2004) suggests that very few men with no children wish to remain at that parity. Therefore, I assume all never-married men have a desire to delay childbirth. In general, surveys exclude single men from questions about intention of current pregnancy of their partner, making it necessary in this measure to ignore information on pregnancy status.

As Figure 3 illustrates, The measure of unmet need for never-married men is divided into those with no risk for unmet need (that is, individuals who have not been sexually active in the last year) (A), and those with either a met (active but using contraception) or unmet

\(^{13}\) This section does not include divorced or widowed men. They are a small proportion of the single population in these surveys and are at a different point in their lives than most never-married men. However, they are included below in the measurement of unmet need for protection against sexually transmitted infections.

\(^{14}\) Author’s calculation of the never-married men interviewed in the surveys included in the never-married men analysis.
(active and not using contraception) need (B). This measure is constructed for 25 surveys in 21 countries, listed in Table 1.

**Sexually Transmitted Infection Protection**

This measure includes all men regardless of marital status and aims to identify those with a potential need for protection (condoms), and if that need is met (illustrated in Figure 4). Those who need protection against STIs are defined as single men who have had sex with more than one woman in the last year or married men who have had sex with a woman who was not their wife in the last year(A)\(^{15}\). A year, while a wide window, is chosen for data uniformity across surveys. Among these men, need is considered met if a condom was used during last intercourse (B). Alternative definitions including condom use with secondary or tertiary partners were considered, but a simplified definition is preferable due to recall bias. A total of 56 surveys from 27 countries are included in this measure and are listed in Table 1.

**Results**

**Country Level Results**

Eight sub-Saharan African countries contain three or more male DHS surveys with adequate information to construct unmet need for married men across time: Burkina Faso, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Uganda, and Zimbabwe (Figures 5 through 12). With the exception of Zimbabwe, nearly half of all married, fecund men with non-pregnant partners have an unmet need for contraception in each country's most

\(^{15}\) This definition is similar to the one employed in the 2003 Guttmacher report “In Their Own Right: Addressing the Sexual and Reproductive Health Needs of Men Worldwide.”
recent survey. These numbers are not comparable to female measures of unmet need since a sizable portion of the population (men with pregnant partners) is excluded. To relate men’s unmet need with some female measure of fertility, figures include the total fertility rates (TFRs) for the three years prior to the surveys.

As the proportion of men with no demand for contraception declines, this situation leads either to an increase in unmet need (as in Malawi between 2000 and 2004), or an increase in met need (such as Uganda between 2006 and 2001). The ratio of met to unmet need has increased in several countries over this time period, especially in Ethiopia from 2000 to 2011, primarily due to a substantial increase in met need for spacing and limiting. Uganda also experienced an increase in the ratio of met to unmet need. Here, unmet need stayed fairly constant over the decade, but the proportion of men with a met need for contraception increased. Also evident is the increasing desire for spacing in countries such as Ghana from 2003 to 2008 and Mozambique from 2003 to 2011.

In several countries, notably Uganda and Zimbabwe, a correlation between men’s unmet need and the total fertility rate is apparent. In Uganda, the proportion of married men with no need for contraception declined between 2000 and 2011, along with the total fertility rate. The level of unmet need stayed relatively constant, while the proportion with met need rose. In Zimbabwe, the total fertility rate, the proportion with no demand, and the proportion with unmet need all fell between 1994 and 2005, and when fertility increased between 2005 and 2010, so did the level of unmet need. Other countries show a less clear relationship between male unmet need and the total fertility rate. Ethiopia has seen large declines in male unmet need and increases in met need, though little change in
the TFR. Ghana experienced a decrease in TFR between 2003 and 2008, but an increase in unmet need and relatively little change in the proportion of men with no demand.

While in most countries the proportion with no demand for contraception has declined over time, the proportion of men with unmet need has changed little or has even increased in the surveys available. These time trends, linked with changing or stalled fertility, illustrate the desirability for further exploration of unmet need for men, looking not only at the characteristics of men associated with unmet need, but also the reasons for lack of contraceptive use among these men. Both are explored in the following sections.

**Individual Level Results**

**Married Men**

Looking at Column 1 in the summary statistics (Table 2), we see that less than 30% of married men with non-pregnant partners want to have a child in the next two years. This leaves 70% of men with the need for contraception. And of these men, the majority of their need is unmet.

Individual level unmet need for married and cohabiting men is analyzed through a series of four logistic regressions (as illustrated in Figure 2), each examining the significance of demographic and socioeconomic characteristics (age, education, marital status, and religion). Dummy variables for each survey are included in all regressions. Regression results are presented as odds ratios in Table 3.

The first regression (A) includes all married or cohabiting men who report a non-pregnant main partner, and shows the desire to delay (2 plus years) or avoid additional
childbirths versus the desire to have a child within 2 years, controlling for demographic and socioeconomic characteristics. The second regression (B) includes only those men who want to delay or avoid childbirth, and finds the odds ratios of the desire to avoid future childbirths versus spacing. Finally, the last two regressions include men who want to avoid future childbearing (C) or space future childbearing (D) and displays the odds ratios of whether a modern method of contraception is used or not, among these men. This analysis allows unmet need among men to be divided into demand for limiting/spacing childbearing and the fulfillment of this demand. The results present odds ratios to show the differences among demographic sub-groups at each stage of establishing unmet need, controlling for the other demographic and socioeconomic characteristics.

Age patterns of unmet need for married men, controlling for other variables, are found in Table 3. In Regression A, there is a greater desire among older men relative to younger men to space or limit births. When limiting the population to those who wish to space or limit, older men are more likely to desire to limit versus space than younger men. However, among both those wishing to limit and space, contraceptive use is greater (controlling for all over variables) among younger men, as seen in Regressions C and D. Thus, unmet need is seen to be greater among the older men (controlling for other characteristics), who are more likely to be at risk than younger men and less likely to use contraception when at risk.

Education is divided into four categories: no education, some or completed primary education, some or completed secondary education, and higher education. Results for
education patterns are also presented in Table 3. Increasing levels of education are associated with higher odds of desired to delay or avoid childbearing (Regression A). Among married men with this stated desire, higher levels of education are associated with greater odds of desire to limit versus space births, while those with lower education have smaller odds (compared to those with a primary education) of wanting to limit versus space (Regression B). Regressions C and D show that among those who wish to avoid or delay, higher and secondary education are associated with higher odds, and no education with lower odds, compared to those with a primary school education of using modern methods of contraception. Therefore, while men with higher levels of education have greater potential unmet need (because they are more likely to desire to avoid or delay than their less educated peers), they do not have high unmet need because of their high levels of contraceptive use. For men with lower levels of education, they are less likely to desire spacing or avoiding additional children, but those who do have such a desire are less likely than men with education to be using contraception.

Although both men who are married to their main partner and men who are cohabiting as if married are included in this analysis, their fertility desires and contraceptive use patterns appear to differ. Married men, as would be expected, are more likely to wish to limit versus space compared to men living with women (Regression B). However, of men who want to limit, men living with women (controlling for the other demographic controls) are more likely to report using contraception.

The prevalence of religious affiliations vary across sub-Saharan Africa, and have been loosely grouped here into three categories: Muslim, Christian, and other (generally
composed of those with traditional or spiritual beliefs and those with no religion).

Among married men and controlling for other demographic characteristics, differences appear between religious affiliations and their associations with different stages of unmet need. Christians are more likely to report wishing to space or limit versus have a child soon compared to Muslims, while those practicing other religions are less likely to report so (although the difference between others and Muslims is only marginally significant). For men who want to avoid a birth in at least the next two years, Christians and others are both more likely to wish to limit versus space compared to Muslims. No statistical difference appears between Muslims and others in terms of contraceptive use for those with demand, but Christians wishing to space or limit are both more likely to report contraceptive use than Muslims (all else equal).

This analysis of married/cohabiting men identifies both groups who have less demand for spacing or limiting childbirths than others in demographic sub-groups (those with no education, younger men, and non-Christians) and those who, if they have demand, are not using modern methods of contraception (older men as well as those with no education, married men, and non-Christians). This analysis identifies men who can be targeted for programs either to increase demand for family planning or to increase contraceptive use among those with such demand. An exploration of why unmet need exists for these men is analyzed later in this chapter. The next section continues the individual demographic analysis with unmet need for never-married men.

Never-Married Men
From the summary statistics in the second column of Table 2, we see that almost 70% of single men reported sexual activity in the last year. When looking at their contraceptive use, less than half of these men report themselves or their most recent partner to be using contraception, suggesting a major unmet need for contraception in this population.

The regression results for the analysis of never-married men’s unmet need for contraception is presented in Table 4 (following the diagram shown in Figure 3) and includes control variables for age, education, and religion. The first regression (A) shows the odds ratios of being sexually active\(^{16}\) versus inactive, with those who are sexually active considered “at risk” of having unmet need. Those who are sexually active are included in the second regression (B), which estimates using versus not using modern contraception. As in the analysis for married men, both regressions in Table 4 include survey dummy variables.

For young, never-married men, sexual activity is lower among 15-19 year olds than those between 20 and 39, controlling for education and religion, and those teenagers who are sexually active are less likely to be using a modern method of contraception than their older, single peers.

Education patterns show lower odds ratios of sexual activity among single men with no education and similar odds for those with secondary and higher compared to primary. For sexually active single men, the odds of modern method use are higher for each level of educational achievement, compared to primary education.

\(^{16}\) Sexual intercourse in the last year
When controlling for age and education, religious differences are seen in the sexual activity and contraceptive use of never-married men. Christian men are less likely to have been sexually active in the last year compared to Muslims, and no statistical difference is found between Muslims and others. For never-married men who have been sexually active, no differences are found between Christians and Muslims or others and Muslims in terms of reporting use of modern methods of contraception. Therefore, this analysis finds higher unmet need among Muslims and “others” than Christians, because the first two are more likely to be sexually active and when sexually active are just as likely to be using modern contraception.

A limitation to calculating unmet need for single men in this way is that it assumes these men do not currently wish to conceive. It also does not distinguish between partner type, which may influence both contraceptive use and fertility desires. There may be underreporting of female methods, as single men may have less knowledge of their partner’s non-coital dependent methods than married men. The next section looks at an area of sexual health where men can play a large and active role: the use of condoms to prevent the spread of sexually transmitted infections.

**Sexually Transmitted Infection Protection**

Finally, when looking at the summary statistics in Column 3 of Table 2, we see that less than a fifth of men reporting being in a sexually risky relationship in the last year. But, of these men, almost two thirds did not report using a condom at last intercourse. The multivariate analysis explores this further.
Analysis of protection against sexually transmitted infections (Table 5) is similar to the earlier sequential logit models in this chapter in that it first defines a population at risk for unmet need and then looks at if this need is met. The first regression (A) takes all men regardless of marital status and predicts if individuals are at risk of contracting a sexually transmitted infection, defined here as having more than one partner in the last year for single men and at least one non-marital partner in the last year for married men\textsuperscript{17}. The second regression (B) includes at risk men and examines if they are protected, defined as using a condom at last intercourse. Both regressions are shown with controls for survey, age, education, religion, and marital status.

Odds ratios of age show the highest risk among men 20-29 (controlling for other characteristics). However, odds of condom use by those at risk is also highest in this age group. Older men are less likely to be at risk for an STI by having multiple partners, but those that are have lower odds of using a condom at last intercourse than younger men.

Education patterns are similar to earlier measures, with increasing risk, but higher condom use for those at risk, at each additional level of educational attainment.

The odds ratios of religious affiliation show others and Christians both having significantly higher odds than Muslims of being at risk for an STI. Additionally, for those at risk, Christians and others both have lower odds than Muslims of using a condom at last intercourse. These two regressions show that Christians and others are much more

\textsuperscript{17} This definition distinguishes between extramarital relations and polygamous marriages. Men in polygamous marriages are only considered in the “at risk” group if they have sex with a woman who is not one of their wives in the last year.
likely to have an unmet need for protection against sexually transmitted infections than Muslims.

Differences in marital status provide significant results in the analysis of unmet need for STI protection. With never-married men as the reference group, married men have lower odds of being at risk for need to protect against STIs. Both formerly married men (widowed, divorced, or no longer living together) and those currently living with a partner as if married have higher odds than never-married men of being at risk. Men who are living with women as if married have significantly higher odds of being at risk, and as seen Regression B, but are much less likely to use condoms at last intercourse (if at risk) than never-married men. These results make men who are living with women but not married the highest risk group for having an unmet need for protection against STIs.

Defining met need as using a condom during last intercourse may bias the estimate of unmet need, however it limits recall bias. Additionally, more information on current condom use and history of condom use by partner are not available in most surveys. This topic is explored more in the next section, which examines the causes of male unmet need for all three measures discussed in this chapter.

Exploring Why Unmet Need Exists

In order to address unmet need among men, the reasons for not using modern methods of contraception among the population at risk must be identified. In many surveys, men who are not using contraception are asked for the main reason why this is the case.

Married Men
For married men, the most common explanation for unmet need comes from restricting contraception to modern methods, many men report using traditional or folklore methods of contraception (for an average of 16% across the surveys, ranging from almost no men in Sao Tome and Principe (2008-2009) to half of the men in Kenya (1998)). If the goal is to reduce unmet need for modern methods, promoting these among traditional and folklore users may lower unmet need in a population that shows desires to use methods to avoid childbirths.

In a limited number of surveys (all conducted before 2006), men not using contraception (including traditional methods) are asked the main reason. A popular response in the 23 surveys (see Table 1) for not using contraception is the desire for additional children.\(^{18}\) The frequency of this response varies from 12.2% in Kenya 2003 to 45.86% in Guinea 1999. This finding highlights the importance of dispelling myths about non-permanent contraception, as men who wish to space may be apprehensive about using a method if they believe it could reduce their or their partner’s future fecundability. Religious opposition is also given by many men as their main reason for not using contraception (from less than 1% in Tanzania 2004 and to over 29.66% in Chad 2004). While fear of side effects is cited as a main cause by over 10% of men with unmet need in Ghana 1998, in several surveys less than 1% of men give this response. Finally, some men with unmet need, from less than 2% in Kenya 2003 to over 20% in Niger 1998 and Chad 2004, report knowing no method or source of contraception.

**Never-Married Men**

\(^{18}\) Though they report elsewhere in the survey that they do not want a birth in the next two years
Many never-married men with unmet need who are not using any sort of contraception report “not married” as the main reason for not using contraception (the majority in 7 out of 15 surveys). This finding suggests obstacles to unmarried men, whether psychological, cultural, or institutional, in accessing contraception. As with married men, a large group of never-married men with unmet need are classified in this category because of their reliance on traditional or folklore methods (as high as 48% in Cameroon 1998). Infrequent sexual activity is also a common reason given among never-married men with unmet need who are using no methods of contraception (as high as 29% in Gabon 2000). These combine together to demonstrate the importance of making modern methods (especially coitus dependent) easily available and culturally acceptable among never-married, sexually active men.

**Sexually Transmitted Infection Protection**

Identifying reasons for unmet need for STI protection is more challenging, as most DHS surveys do not ask men their reasons for not using condoms. Almost all men with unmet need for protection against STIs surveyed by the DHS\(^\text{19}\) have heard of condoms (Ethiopia 2000 was the lowest at 64 percent, but by 2005 this prevalence had increased to 85%, and in 2011 was 98%). Ever use was less than 15% in Ethiopia 2000 (rising to 32% in 2005), but most countries\(^\text{20}\) had much higher percentages of every use of condoms among these men, as high as 82.3% in Zimbabwe in 2005.

\(^{19}\)Excludes surveys from Cameroon 2004 and Guinea 2012.

\(^{20}\)See Table 1 for a list of surveys with available information
To identify why unmet need for sexually transmitted infection protection exists, I compare men with met and unmet need (those who used and did not use condoms at last intercourse), restricting this analysis to those deemed at risk. In all surveys, condoms are much more likely to be used with girlfriends and casual partners than wives and live in partners. In almost all surveys, men who are at risk but used a condom at last intercourse are more likely to say that using condoms during sexual intercourse reduces the chance of contracting AIDS\textsuperscript{21}. For this same question, men with unmet need are much more likely than those with met need to answer “I don't know.”

Therefore, in order to reduce unmet need for STI protection among all men, disseminating information on the benefits of condoms is needed as well as sensitization in order to destigmatize using condoms with all types of partners.

In all three measures of unmet need, increasing information and availability of modern methods of contraception has the potential to reduce levels of unmet need among those at risk.

**Conclusion**

This chapter explores unmet need among men in Sub-Saharan Africa. As men possess large amounts of power in contraceptive use decisions and fertility outcomes, understanding their attitudes and actions is essential for constructing a clearer picture of sexual and reproductive health in this region.

\textsuperscript{21} Excludes Zimbabwe 1999
The analysis of unmet need demonstrates that childbearing (or lack there of) results from a combination of desires and actions. By analyzing components individually, I find that some groups of men are more likely to wish to space or limit births, while others may be more likely to use contraceptive methods when at risk. With the addition of unmet need for STI protection, this analysis expands “demand” to action, not just desire. The goal, in any case, is to define an “at risk” group and then look at their use of protection against this risk.

In terms of policy application, unmet need should be broken down into its components. Increasing the availability of contraception will have a large impact on unmet need when aimed at those individuals who desire to space/limit births, but are not using contraception, but will do little good among those looking to have a birth in the near future.

It is important to note that levels of unmet need for modern methods of contraception are high in most of the countries included in this chapter. Demographic and socioeconomic characteristics such as age, education, marital status, and religion are all found to influence desires and actions. Looking at age, older married men have high levels of unmet need as they are more likely than younger men to wish to space or limit childbirths, but when at risk as less likely to report using contraception. Men in their twenties are the most likely to have multiple partners, controlling for other characteristics, but of the men at risk are the most likely to report using a condom at last sex. Educational gradients are found in both risk (higher educated are more likely to wish to space or limit among married men, more likely to be sexually active among
never-married men, and more likely to be at risk for an unmet need for STI protection because of multiple partnerships), however, there is also an educational gradient in all three analyses in terms of greater contraception (and condom) use with increasing levels of education. Differences in marital statuses found large disparities in terms of multiple partnerships and condom use between married men and men living with women as if married, with the cohabiting men at much higher risk. Finally, religious affiliation mattered in terms of risk for STIs, with Muslim men less likely to engage in a relationship outside of their wives than Christians and those of other religions. Among married men, Christians are more likely to desire to space or limit births, and more likely to report contraceptive use when this desire is present. The importance of all these socioeconomic and demographic variables illustrates the heterogeneity of the male population in Sub-Saharan Africa, and the importance of studying differences between men as opposed to limiting research of men to the comparison with women.

Men in Sub-Saharan Africa, and across the world, play integral roles in sexual relations. Additional research focusing on men as individuals, as well as partners, is needed to achieve better sexual and reproductive health for all.
References


Tables and Figures

Table 1: Male Surveys Conducted by the Demographic and Health Surveys in Sub-Saharan Africa and Their Inclusion in this Analysis

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
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* Surveys interviewing husbands of female interviews only

** Surveys asking the main reason for non-use of contraception

*** Surveys asking men if they have ever used a condom
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Not Sexually Active       31%
Sexually Active, Using Contraception 30%
Sexually Active, 39%
### Not Using Contraception

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Table 3: Sequential Logit Models for Sub-Saharan African Married Men’s Unmet Need
Regression A: Odds ratios for married, fecund men with fecund partners, the desire to want to space/limit childbearing versus have a child in the next two years
Regression B: Odds ratios for men who want to space or limit childbearing, the desire to limit versus space
Regression C: Odds ratios for men who want to limit childbearing, the use of modern contraception versus no use of modern contraception
Regression D: Odds ratios for men who want to space childbearing, the use of modern contraception versus no use of modern contraception

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N 101721 71516 48220 48220

Notes: Includes survey control dummy variables. Data from 62 Demographic Health Surveys in 32 Sub-Saharan African countries.
* Significant at the 10% level
** Significant at the 5% level
*** Significant at the 1% level
Table 4: Sequential Logit Models for Sub-Saharan African Never-Married Men’s Unmet Need

Regression A: Odds ratios for never-married, fecund men, of being sexually active in the last year versus no sexual activity in the last year

Regression B: Odds ratios for never-married men who have been sexually active in the last year, the use of modern contraception versus no use of modern contraception

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Notes: Includes survey control dummy variables. Data from 23 Demographic Health Surveys in 21 Sub-Saharan African countries.
* Significant at the 10% level
** Significant at the 5% level
*** Significant at the 1% level
Table 5: Sequential Logit Models for Sub-Saharan African Men’s Unmet Need for Sexually Transmitted Protection

Regression A: Odds ratios for all men, of being sexually active with 2 or more partners (if single) or a non-marital partner (if married) in the last year versus not

Regression B: Odds ratios for at risk men (see definition in above), the use of condom at last sexual intercourse versus no condom used

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<tr>
<td>Christian</td>
<td>1.17 (0.03)***</td>
<td>0.79 (0.03)***</td>
</tr>
<tr>
<td>Other</td>
<td>1.37</td>
<td>0.63</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Coefficient</td>
<td>Standard Error</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Married</td>
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<td>0.23</td>
</tr>
<tr>
<td>Living Together</td>
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<tr>
<td>Divorced/Widowed</td>
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</tr>
<tr>
<td>Constant</td>
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<td>2.30</td>
</tr>
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</table>

N 172952 30631

Notes: Includes survey control dummy variables. Data from 56 Demographic Health Surveys in 27 Sub-Saharan African countries.
* Significant at the 10% level
** Significant at the 5% level
*** Significant at the 1% level
Figure 1: Changes in Men’s Desired Number of Children and Total Fertility Rate for 21 Sub-Saharan African Countries

Data: Demographic and Health Surveys

Note: Non-numeric responses are estimated to have a numeric value of 1 standard deviation above the mean for each survey, as first utilized by Westoff, Bietsch, and Koffman (2013)
Figure 2: Sequential Logit Model of Unmet Need for Married Men

Desire to Space or Limit Childbearing

Yes

No

No Need

Desire to Limit

Desire to Space

Using Contraception

Not Using Contraception

Using Contraception

Not Using Contraception

Met Need for Limiting

Unmet Need for Limiting

Met Need for Spacing

Unmet Need for Spacing
Figure 3: Sequential Logit Model of Unmet Need for Never-Married Men

Sexually Active in the Last Year

Yes

No

Using Contraception

Not Using Contraception

Met Need

Unmet Need

No Need
Figure 4: Sequential Logit Model of Unmet Need for Protection Against Sexually Transmitted Infections

Multiple Partners in the Last Year*

Yes

No

No Need

Used Condom at Last Sex

Did Not Use Condom at Last Sex

Met Need

Unmet Need

* For single men: more than 1 partner.
   For married men: at least 1 non-marital partner
Figure 5: Unmet Need for Married Men in Burkina Faso 1998, 2003, 2010.

Data: Demographic and Health Surveys
Figure 6: Unmet Need for Married Men in Ethiopia 2000, 2005, 2011.

Data: Demographic and Health Surveys
Figure 7: Unmet Need for Married Men in Ghana 1998, 2003, 2008.

Data: Demographic and Health Surveys
Figure 8: Unmet Need for Married Men in Kenya 1998, 2003, 2008.

Data: Demographic and Health Surveys
Figure 9: Unmet Need for Married Men in Malawi 2000, 2004, 2010.

Data: Demographic and Health Surveys
Figure 10: Unmet Need for Married Men in Mozambique 1997, 2003, 2011.

Data: Demographic and Health Surveys
Figure 11: Unmet Need for Married Men in Uganda 2000, 2006, 2011.

Data: Demographic and Health Surveys

Data: Demographic and Health Surveys
Chapter 2: Men’s Attitudes towards Contraception in Sub-Saharan Africa

Introduction

This chapter creates and explores, demographically, a measure of contraception that can be calculated for all men, at any point in their lives, regardless of marital status, sexual activity, or fertility desires: men’s attitudes towards contraception.

When studying men’s sexual lives in sub-Saharan Africa (and elsewhere), benefit exists in examining attitudes as well as behaviors. The first chapter of this dissertation constructed measures of unmet need for men in sub-Saharan Africa; however, due to skip patterns in questionnaires limiting the kind of men asked each question, it was necessary to construct measures of unmet need separately for married and never-married individuals, as well as to exclude men with pregnant partners from the analysis.

In contrast to studying contraceptive use, general attitudes towards contraceptive use are not partner specific, accurate reporting of contraceptive use is not required, and positive attitudes can exist even among individuals desiring children in the near future. This last point is especially important in sub-Saharan Africa where fertility in many countries remains high. By examining attitudes towards use, we have a preview of potential actual use as the desired family size decreases.

Literature Review

Studies are often hindered by men’s inclusion only as partners of women and the limited definitions of partnerships considered, for example restricting couples to those who are in
long-term unions, monogamous, or legally recognized (Bankole and Singh 1998, Greene and Biddlecom 2000). Men are more likely than women to report non-marital sexual relations, and unmarried men are more likely than unmarried women to report causal partners (Curtis and Sutherland 2004). Therefore including men outside of long term relationships is essential when constructing a non-biased picture of men’s sexual activities and attitudes.

In marriage, many men interviewed by the Demographic and Health Surveys (DHS) report more than one wife (ranging from 1.7% in Madagascar 2008 and Lesotho 2009 to 30.5% in Guinea 2012\(^{22}\)), while a woman having two husbands is rare enough to warrant international news coverage (BBC News 2013)\(^{23}\). Bingheimer (2010) finds that multiple partnerships are more common among men living with women than those married to their partners in sub-Saharan Africa. This finding is consistent with the previous chapter which finds that men who are living with women have much higher odds of needing protection against sexually transmitted infections than those who are married.

Bingheimer also finds higher rates of multiple partnerships among never-married men than married (non-polygamous) men and that formerly married men have high rates of multiple partners in countries he studies in sub-Saharan Africa.

Men’s multiple partnerships complicate sexual health research because of the difficulty in determining their need for and use of contraception. While a woman using a non-coitus

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\(^{22}\) Calculated using the most recent DHS survey for all countries in sub-Saharan Africa as provided on statcompiler.com

\(^{23}\) Two men in Kenya were persuaded into marrying the same woman after she refused to choose between them.
dependent method is protected against pregnancy with all partners, a man, for example, may rely on one partner to use a female method, while using condoms with a second, and no method with a third. McGinn, Bamba, and Balma (1989) find this situation to be common with abstinence following childbirth; men in their Burkinabe focus group report that while wives may practice abstinence, men “take care of themselves elsewhere” (McGinn et al. 1989).

Attitudes are also an ideal way to study men’s sexual and reproductive health as information on contraceptive use is not required. By not studying use, we remove the potential bias of covert female use of contraception as well as the bias in men’s own reporting- Ezeh and Mboup (1997) find gaps in contraception use reported by men and women in the five Demographic and Health Surveys they review.

In areas with high fertility and low contraceptive use, attitudes can indicate the reception of family planning by the community. Attitudes offer information about reproductive health of individuals wanting children in the near future (those who in an unmet need analysis are labeled as having no demand for family planning). Mahmood and Ringheim (1996) find that while most men in Pakistan want more children, the majority also approve of family planning. Here, attitudes are an indicator that family planning methods could be accepted by many and lead to lower fertility if the desired family size decreased.

Approval of family planning as a precursor to use is especially important in sub-Saharan Africa where many countries still have high fertility or have seen their fertility levels fall and then stall (Bongaarts 2006). As the previous chapter discusses, unmet need may be low due either to high levels of contraceptive use or to low demand for contraception.
because of the desire among many people to have another child soon. Analysis of attitudes can offer insight in this latter scenario, where most people have little need for contraception because of high fertility desires. Their attitudes, however, offer a potential view of what might happen if their fertility desires did decline. Of course, for contraceptives to be used to delay or avoid births, they must be available and affordable, but approval of their use in general is a first step in the actual use of contraception.

Several studies look at men’s attitudes towards family planning in sub-Saharan Africa and worldwide. In interviews with urban Sudanese men, Khalifa (1988) finds that most men (91%) approve of family planning if their wife’s health were in danger, while only 57% approve of use of family planning because of limited economic resources. In Pakistan, Mahmood and Ringheim (1996) report that more husbands than wives approve of contraceptive use.

Most research on male attitudes relies on wives’ reports of their husbands’ beliefs. Joesoef, Baughman, and Utomo’s (1988) paper on the determinants of contraceptive use in several Indonesian cities finds that husbands’ approval is the most important determinant, though the authors caution that wives may misperceive their husbands’ approval, or project their own approval onto their perception of their husbands’. In Niger and The Gambia, Cotton et al. (1992) find husband’s disapproval to be a primary reason given by women who discontinue use of contraception. Husbands’ approval is shown to be an important, though not the most important, determinant of contraceptive use in other research. In qualitative interviews in the Philippines, Casterline, Perez, and Biddlecom (1997) find that while husbands’ attitudes are not often cited as a primary reason for not
using a contraceptive method, husbands’ preferences are repeatedly mentioned by women in interviews when discussing reproductive matters.

Earlier studies from sub-Saharan Africa (Khalifa 1988 and Adamchak and Adebayo 1987) find that many men believe that women should not use contraception without their husband’s consent. The Sudanese men in Khalifa’s study also believe that husbands should provide contraception if it is to be used. This finding differs from those from other research in other countries on the continent. Mbizvo and Adamchak’s (1991) analysis of Zimbabwean men finds that while respondents believe that men should make decisions concerning the number of children to have and the use of contraception, women should obtain the family planning methods. This finding is similar to results from Maharaj’s 2001 study in South Africa, where men report that the responsibility of obtaining contraception belongs to their wives.

Hulton and Falkingham (1996) propose that men may misunderstand methods and services, have little or no communication with their spouses about family planning, and believe that if their wives used contraception they would become promiscuous. Men’s fears surrounding their wives’ faithfulness is also found in many qualitative interviews conducted by Silberschmidt (1992) in the Kisii district of Kenya, who reports that husbands fear their wives will engage in sexual relationships with other men if they are allowed to use contraception. At the same time, many women report using family planning covertly to avoid their husbands’ disapproval (Silberschmidt 1992).
Men in South Africa are found to have varying attitudes for different contraceptive methods (Maharaj 2001). Most men approve of family planning to regulate fertility, but are resistant to condom use as they associate condoms with promiscuity.

Two other recent studies examine men’s attitudes in sub-Saharan Africa, not towards contraception, but gender. In a 2009 analysis of Demographic and Health Survey male surveys, Johnson and Gu find that men who are supportive of women’s rights are less likely (though only slightly) to report having had a sexually transmitted infection in the last year. Snow, Winter, and Harlow (2013) observe an association between men’s tolerance of wife beating and higher fertility aspirations in five East African countries. These studies suggest that men’s broader attitudes towards gender are also related to their sexual and reproductive health.

This chapter will examine the association between several demographic characteristics and approval of family planning. In addition, methods in which men learn or communicate about contraception will be explored, as well as the interaction effects between these modes of communication and men’s demographic characteristics. Means include passive forms of communication (radio and television) and active communication (friends and partners).

Oni and McCarthy’s (1991) study in Ilorin, Nigeria finds 60% of the men interviewed report learning general information about family planning from radio, television, or newspapers. In a review of 24 interventions targeting men’s sexual health knowledge and practice, Strenberb and Hubley (2004) conclude that large-scale media campaigns may be one option to reach and engage men. According to recent Demographic and
Health Surveys, listening to the radio at least once a week is a common activity among men living in sub-Saharan Africa- ranging from 38% in Ethiopia (2011) to 90% in Kenya (2008-2009)\(^3\). Watching television is increasing in popularity, and recent surveys find that viewership ranges from 14% in Chad (2004) to 91% in Gabon (2012)\(^3\). Hearing about family planning from the media is reported by a majority of men in 20 out of 36 sub-Saharan African countries with Demographic and Health Surveys\(^24\). Among the men included in the following analysis, 66% and 32% report hearing about family planning on the radio and television respectively (see Table 1).

While media can reach a large number of men with a general message, men also learn and talk about contraception with the people around them. A survey of American teenage males (Finkel and Finkel 1975) finds that male peers are the most commonly cited source of information about sex and reproduction. In sub-Saharan Africa, McGinn \textit{et al.} (1989) suggest friends and family members can sensitize and familiarize those around them about family planning. 22% of men in our analysis report friends or neighbors as someone with whom they have discussed contraception, though we are unable to know who began the conversation or its content.

Most studies that look at discussion of family planning focus on couples, and many find positive associations between spousal communications and contraceptive use. In Oni and McCarthy’s study of men in Ilorin, Nigeria, spousal communication about family planning is associated with current contraceptive use, men’s correct reporting of their

\(^{24}\) Calculated using the most recent DHS survey for all countries in sub-Saharan Africa as provided on statcompiler.com
partner’s use, and use of both male and female methods. In Becker and Costenbader’s (2001) 23 country analysis of couples’ reports of contraceptive use, discussion of family planning between spouses is a predictor of concurrence in reporting the same method of contraception. Kimuna and Adamchak (2001) analyze couple communication in the 1993 Kenya DHS and find a significant increase in the likelihood of ever using contraception (net of other controls) when men report discussing family planning with their partners. In an earlier survey (Kenya DHS 1989), Lasee and Becker (1997) show that one partner’s prediction of the other’s approval of family planning is more likely to be correct if the couple discussed family planning than if they did not. Additionally, Salway’s (1994) analysis of couples in Ghana finds a positive association between discussion of family planning and contraceptive use, even after controlling for confounding variables.

Partners who do not discuss contraception may make assumptions about their partners’ attitudes. For example, Bongaarts and Bruce (1995) show that 68% of women (from six DHS surveys in sub-Saharan Africa) who report their husbands’ disapproval of family planning have never discussed the subject with them. However, discussion of family planning does not necessarily lead to the correct knowledge of partner’s attitudes. In an analysis of the 1989 Kenyan DHS, Lasee and Becker (1997) find that while 82% of couples report discussions of family planning, only 75% of husbands correctly identify their wives’ attitude towards contraception, and even fewer women correctly report their husbands’ (67%).
One problem with the structure of the DHS questionnaire and other surveys surrounding spousal discussion is that only the occurrence of discussion is questioned, not who initiated or the outcome of the conversation. Because of this structure, several problems occur when studying spousal communication. The first is the issue of reverse causality—does discussion of contraception use occur because couples are already using contraception, perhaps when a problem arises with their method of use? Another issue is that couples may discuss contraceptive use, and one partner can voice disapproval, which may lead the couple not to use contraception. An additional issue that is identified in the literature is that partners may incorrectly assume their partner’s approval because of their willingness to discuss contraception. This misperception is found by DeRose et al. in a 2004 analysis of 21 sub-Saharan African countries in which women who discuss family planning with their husbands are less likely to correctly report their husband’s disapproval than those who do not. The authors suspect that a husband’s willingness to discuss family planning may signal his approval of contraceptive use to his wife, leading to an unrecognized conflict between the spouses. Only 11% of men in our data reported discussing family planning recently with a partner.

The goal in this chapter is to examine these modes of communication and approval of family planning and also to introduce interactions between modes of communication and a variety of demographic characteristics to see the relative importance of communication for different groups.

Attitudes towards contraception can also play a role in understanding men’s unmet need for contraception. Approval of contraception may lead to use when desiring to delay or
avoid additional births. Also, approval may be related to fertility desires themselves. Therefore, this analysis looks at attitudes towards contraception in relation to unmet need for men, as developed in the first chapter. By including the three measures of attitudes towards contraception, this chapter examines the relative importance of approval of family planning and its use. As stated by Speizer and Yates (1998) “It is critical to understand men’s role in the reproductive process before effective strategies to reduce unmet need can be developed.” The goal of these analyses is to produce a fuller view of men’s attitudes towards contraception in sub-Saharan Africa, adding to our understanding of men’s sexual and reproductive health.

Data and Methods
Data for this chapter are from the Demographic and Health Surveys conducted in sub-Saharan Africa. DHS has conducted surveys of men, independent of marital status, in the region since 1991. Inclusions of questions regarding attitudes towards and communication about family planning vary across surveys. In earlier surveys, the only contraception attitude question included was “would you say that you approve or disapprove of couples using a method to avoid getting pregnant?” In later surveys, additional statements were given and men were asked to agree or disagree with each. These statements addressed more gendered attitudes towards contraception, such as “contraception is women's business and a man should not have to worry about it.”, “Women who use contraception may become promiscuous.”, and “A woman is the one who gets pregnant so she should be the one to use contraception.” The last of these statements was given in only a handful of surveys and is therefore not included in the following analysis.
Trends in country level averages for the three questions are shown in Figures 1-3. For the country-level data presented in Figure 1, a regression with country fixed effects finds a statistically significant increase in approval, around 6 percentage points per decade. As can be seen, this question was commonly asked from the early 1990s till the mid-2000s. Figure 2 shows the percent of men in each survey who disagree with the statement that contraception is women’s business. This question was asked in fewer surveys, and the trend, while not statistically significant, is nearly the same as for the first question, with an average 6 percentage point increase per decade. Figure 3 shows the last attitude question included in this chapter, the percent of men who disagree with the idea that contraception makes women promiscuous. The trend in country approval (found with a regression that contains country level fixed effects) is significant and larger than the previous two, with an estimated 15 percentage point increase per decade. The latter two questions were asked more commonly in the new millennium. In the early to mid-2000s, the general approval question along with gender statements were included in many male surveys and are the focus of the remainder of this chapter. Approval levels among these men are presented in the summary statistics in Table 1.

The regression analyses in this chapter combine seven surveys that include all questions of interest: Burkina Faso (2003), Ghana (2003), Malawi (2004), Mozambique (2003), Niger (2006), Nigeria (2003), and Tanzania (2004-2005). Together, these surveys interview 23,311 men. Excluding those over age 50 (thus restricting the analysis to men 15-49) and those with missing information on variables of interest (115

\[25 \text{ Not all surveys interviewed men over the age of 50. Thus, they are excluded here to maintain uniformity across surveys.}\]
observations) results in a final sample size of 21,019 men. Descriptive statistics about these men are presented in Table 1.

A measure of attitude towards contraception is created by combining responses from three attitude questions:

1. Would you say that you approve or disapprove of couples using a method to avoid getting pregnant?
2. (Do you agree or disagree-) Contraception is women’s business and a man should not have to worry about it.
3. (Do you agree or disagree-) Women who use contraception may become promiscuous.

To construct the measure, respondents are given one point for each positive attitude towards family planning. Positive attitudes are considered approval of the first question and disapproval of the second and third. During the interview, subjects are also given the option to answer “no opinion” to any of the three questions. Following Joesoef et al.’s (1988) example, lack of opinion is considered a negative opinion towards family planning. Combining these responses together, each man is assigned a family planning attitude score ranging from 0-3. With the additive attitude score as the outcome variable of interest, ordered logit models are used for the first set of analyses.

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26 A Guttman method of combining attitudes together was also considered, ordering the questions from general approval to contraception as women’s business to promiscuity. Approximately 75% of responses fell into the correct order, lower than the general Guttman threshold. An alternative analysis conducted using a Guttman score showed no substantively different results from the additive analysis.
The following regressions include indicators for age, marital status, education, and religion. Categorical variables for age are separated into 5 year groups, with 30-34 serving as the reference group. Marital status is divided into never-married, married (reference group), living together as if married, and divorced or widowed. Educational categories are cut at no education, some or completed primary education (reference group), some or completed secondary education, and higher. Religious affiliations include Muslim (reference group), Christian\textsuperscript{27}, and other\textsuperscript{28}.

Forms of communication are included in the analysis as dummy variables. In the questionnaires, interviewees are asked if they have heard about family planning on the radio in the last few months. The same format is used for television. Interview subjects in these seven surveys are asked an open ended question about who they have discussed family planning with in the last few months, allowing them to list as many people as they have talked to. These responses are used to create dummy variables for friends (including neighbors) and partners. Men do not indicate the type of relationship they have with the partner with whom they discuss family planning. There is a potential bias in that only men with some sort of partner can discuss family planning with a partner. It is difficult to measure partnership here, though 4,608 of the 21,019 men in the analysis, have reportedly never engaged in sexual intercourse\textsuperscript{29}. This finding does not mean,

\textsuperscript{27} The following analyses were also conducted seperating Catholics from other Christian denominations. As in Westoff and Bietsch (2015), differences between the groups were minimal, and thus combined.
\textsuperscript{28} Categorization of religion varies across surveys. Those classified as “others” are generally animist or state no religion.
\textsuperscript{29} The countries vary in the proportion of their sample that has never had sex. The proportion ranges from less than 10\% in Mozambique to over 30\% in Niger.
however, that they have never had a partner with whom they could discuss family planning.

Interaction effects between the modes of communication and demographic variables are created to examine the relative importance of each mode in different sub-groups. Modes of communication are examined in their own interaction model (though all 4 modes are included).

To examine the relationship between attitudes and unmet need, attitudes move from dependent to independent variables in the last section of analysis. The analysis of unmet need follows the same structure as in Chapter 1, separating married men, never-married men, and need for protection against sexually transmitted infections, and each is analyzed through a series of sequential logit models (flow charts of which are presented as Figures 4-6). Only a sub-set of the seven surveys is used in each analysis because of data availability\textsuperscript{30}. The three attitudes are ungrouped and represented as dummy variables (again with “no opinion” classified as a negative response). This classification allows for the association between the different types of attitudes and the unmet need outcomes to vary by model.

\textbf{Results}

Regression results from the ordered logit analyses are presented in Table 2. The ordered logit results can be interpreted as shifts in a latent distribution of family planning

\footnotesize{\textsuperscript{30} For married men, surveys include Burkina Faso, Ghana, Malawi, Mozambique, and Tanzania. For single men, the analysis is limited to the Burkina Faso. For protection against sexually transmitted infections, surveys include Burkina Faso, Ghana, Malawi, Mozambique, and Nigeria.}
approval, so along with coefficients and standard errors, Table 2 presents the shift in standard deviations (SD) of the latent distribution for each variable. This measurement is calculated by dividing coefficients by \( \frac{\pi}{\sqrt{3}} \). Column I displays results from the regression including only demographic and social variables. The distribution of approval scores by age (controlling for the other variables) are lowest in the youngest age group (0.52 standard deviations lower than the reference group, age 30-34), increase to age range 30-44, and then are again statistically lower for the oldest age group (-0.07 SD).

By marital status, there are no statistically significant differences between married men (the reference group) and never-married men and those living with women but not married. Men who are divorced or widowed have a statistically lower distribution of scores on the approval of family planning scale than married men, with a decrease of 0.12 SD on the underlying latent scale. While men with no education have a coefficient less than zero (and therefore an expected approval score lower than those with primary education, all else equal), men with secondary and higher education have positive coefficients. Finally, for the three religious categories, Christians have statistically higher approval scores than Muslims (controlling for other characteristics), while the non-Christian, non-Muslims have lower scores than Muslims.

Column II introduces the four modes of communication about family planning into the model. All are positive and highly statistically significant, indicating a positive association between communication about family planning and approval. The largest shift in the underlying scale of the four dummy variables belongs to conversation with partner (0.37 SD), followed by radio (0.33 SD), friends (0.16 SD), and television (0.12
The demographic variables included in both models show fairly similar results, the one exception being marital status, where in the later model, those who are never-married have a positive and significant coefficient (in reference to married men), and there is no longer a statistical difference between married and formerly married men.

Columns III-VI explore interactions between the modes of communication and demographic variables. In all cases, the main effect of all four discussion and communication variables are positive and highly statistically significant.

Looking at the interactions between marital status and radio, never-married and formerly married men show positive interactions (both in reference to married men), though the main effects are both negative. For formerly married men, combining the interaction and main effect closes the gap (there is no longer a statistical difference in the underlying distribution) with married men who also hear about family planning on the radio, while for never-married men the interaction closes and exceeds the main effect difference: the main effects shift the latent distribution by 0.46 SD for married men and 0.46-0.19 SD for never-married men. But the interaction shifts the distribution for never-married men who hear about family planning on the radio by an additional 0.39 SD, resulting in an underlying distribution for approval by never-married men who hear about family planning on the radio (for a combined shift of the latent distribution by 0.66 SD) to be statistically higher than the distribution of approval for married men who hear about family planning on the radio (0.46 SD). The interactions for the various martial groups and hearing about family planning on television are not statistically significant. When the focus shifts to active forms of communication with friends and neighbors, looking at
the coefficients for the main effects, only formerly married men have a statistically different association with approval than married men (a shift downwards of 0.18 SD), and this relationship is negative. But in terms of interactions, both formerly married and never-married men have positive and significant interactions (0.35 SD and 0.33 SD, respectively), suggesting that the importance of communication with peers may be more important for those who are unmarried than for those who are married. Finally, for discussion with partners, while the main effect for men living, but not married to, a woman is negative (-0.06 SD), the interaction with discussion is positive (0.37 SD), highly statistically significant, and the combined main and interaction effect is a statistically higher distribution than the distribution of responses for men who are married to their partners, controlling for all other variables.

When examining the interactions between the different modes of communication and education, we see in most cases a reversal of the main effect. For those who hear about family planning on the radio, the size of the coefficients for the interaction effects are lower with higher levels of education. For those with no education, the interaction effect is positive and statistically significant (0.09 SD); this finding is in comparison to those with primary education who hear about family planning on the radio. On the other side, the interactions for secondary and higher education and radio are negative and statistically significant. The interaction latent shifts (-0.20 and -0.43 SD, respectively) are smaller than the main effects (0.42 and 0.92 SD, respectively), and statistically, the distribution of approval scores for those with primary education who report hearing about family planning on the radio is lower than that among those with secondary and higher education who report similar experiences. This finding suggests that while hearing about
family planning on the radio is associated with higher approval of family planning, it does not close the gap in education status and approval. For television, only the interaction term for those with no education is statistically significant. This positive association is nearly as large as the main effect for the comparison of those with no education to those with a primary education (0.16 SD for the interaction compared to -0.13SD for the main effect), and for men who hear about family planning on the television, there is no statistical difference in the distribution of approval for those with no and primary education. In the interaction regression with peers, there appears no difference in interactions based on educational attainment. For discussion of family planning with partners, the only statistically significant interaction exists for men with no education, an interaction so large that for men who discuss family planning with their partners, the distribution for men with no education is statistically higher than for those with primary education. Examining modes of communication and education, the largest interaction effects (with primary education as the reference group) are for those men with no education.

Turning to religion, the main relationships between religious groups and family planning approval remain constant through the four regressions with interactions, with Christians having statistically higher coefficients compared to Muslims, and others having statistically lower. Looking at the interaction effects between religious groups and radio, the interaction for others is positive and statistically significant, though not large enough to close the gap between others and Muslims and approval when both hear about family planning on the radio. For television, the interaction for Christians is negative and significant, and equivalent to the main effect of Christians compared to Muslims, so that
when both religions hear about family planning on the television, there is no statistical
difference in the distribution of their approval scores. For friends and neighbors, the
interaction for Christian is also negative and statistically significant. The interaction
between religious groups and discussion of family planning with a partner shows no
statistically significant differences, though the pattern of main effects remains the same.

We now move from exploring attitudes as an outcome to attitudes as predictors, Tables 3
through 5 present unmet need analysis for married men (Table 2)\textsuperscript{31}, never-married men
(Table 3)\textsuperscript{32}, and protection against sexually transmitted infection (Table 4)\textsuperscript{33}. This
analysis was initially developed in the first chapter but now includes three family
planning attitude variables as predictors of being at risk for unmet need and if that need is
satisfied. The attitude variables are no longer grouped together, but allowed to vary
independently. By separating the three measures, we are able to see the relative
importance of each for different measures of unmet need and at the different steps in each
sequential logit model. The same demographic controls are included as before.

For married men, approval of family planning is statistically significant in most of the
regressions. Men who approve of family planning have odds almost twice as high as
otherwise identical men who do not approve of family planning to wish to space or cease
childbearing compared to having a child in the next two years. Of men who desire no
births in the next two years, those who approve of family planning have 124\% higher
odds than those who do not to wish to stop childbearing versus space. Columns III and

\textsuperscript{31} Surveys include Burkina Faso, Ghana, Malawi, Mozambique, and Tanzania
\textsuperscript{32} This analysis is limited to Burkina Faso
\textsuperscript{33} Surveys include Burkina Faso, Ghana, Malawi, Mozambique, and Nigeria
IV show that for both groups of men who wish to space or stop childbearing, approval of family planning is positive and highly significant in terms of the association with actual use.

For never-married men, none of the three measures of approval is significantly associated with increased odds of being sexually active (sexual intercourse in the last year), though both general approval of family planning and disagreement with the statement “contraception is women’s business and a man should not have to worry about it” are highly statistically significant in their positive associations with use of family planning.

Turning to unmet need for protection against sexually transmitted diseases, all three measures are statistically significant in their association with having more than one partner (or a non-marital partner for married men), with general approval and disagreement with the idea that contraception is only women’s business being positively associated, and disapproval with the statement that contraception makes women promiscuous being negatively associated with having multiple (not including multiple wives) partners. Of the men at risk, both approval and believing that contraception is not just women’s business are positively associated with use of condoms at last intercourse.

**Discussion**

Results presented in the previous section point to varying levels of approval of family planning among demographic sub-groups in sub-Saharan Africa.

Looking first at the age pattern that appears throughout the regression analyses, the results suggest that adolescents, the youngest men in the analysis, have the lowest level of
approval, controlling for other demographic variables. This finding may occur because adolescents are the least likely to be sexually active, married, to have children, or to ever have used contraception, and have therefore have not thought about contraception, its use, or their attitudes towards it\textsuperscript{34}.

While the relationship between the never-married group (highly correlated with the youngest age group) and married men are not statistically different when looking at the main effects, in all four interaction regressions the coefficients for the never-married interaction with mode of communication are positive (though only significant for radio and friends/neighbors). It may be that never-married men are more amenable to outside influence on their attitudes about family planning. Alternatively, there may be a shift in the generations in terms of acceptability of discussing family planning and the influence of others on your opinions\textsuperscript{35}.

The relationship between formerly married men and married men in these analyses is similar to that with never-married men. Both interactions with radio and friends/neighbors are positive and significant, again suggesting that men not living with women may be more amenable to outside influences.

\textsuperscript{34} A multinomial logit model for the three original outcomes (approve, disapprove, and do not know) with categorical ages (and survey controls) as the independent variables finds that men under 20 are more likely to answer “don’t know” compared to “disagree” then men in the reference group (30-34). Additionally, they are less likely to answer “agree” compared to “disagree.”

\textsuperscript{35} To answer this question, we would need information on family planning attitudes asked in DHS surveys across time. Unfortunately, general attitudes towards family planning have not been asked for many years.
For men who live with women but are not married to them, the main difference with married men is the positive interaction for discussion of family planning with partners. The reason for this finding is debatable. It could be that married men are less open to their partners shifting their opinions than men living with women. Additionally, the type of conversation could be fundamentally different. As marriage is, in general, a child-bearing institution in sub-Saharan Africa, conversations in marriage could consist of men voicing their disapproval of contraception because of pronatalist tendencies. Men who are living with women but not married to them may be more willing to discuss and approve of family planning as the relationship is less permanent. Whatever the case, this result brings to mind a finding from Chapter 1’s study of sexually transmitted infections—men who are living with women are much more likely to have additional partners than married men (excluding polygamous men’s multiple wives). Both of the analyses illustrate that differences exist between married men and men living with women in terms of their sexual actions and attitudes.

Turning to education, there appears a consistent pattern of higher levels of education associated with higher levels of approval. This pattern mirrors results found in the previous chapter, where higher levels of education were associated with higher odds ratios of desires to space/limit versus have a child soon, limit versus space (of those not desiring a child in the next two years), and use of contraception among those with demand for contraception. When looking at the interactions between modes of communication and approval, the educational gradient declines—interactions between modes of communication and lower educational statuses have larger coefficients than
higher levels of education. This finding is especially true when comparing those with no education to those with primary education.

With religion there is a pattern of acceptance, from highest among the Christians, to the Muslims in the middle, and the “others” at the lower end. This ordered pattern was also observed in the first chapter in terms of desire to space/limit childbirths and use of contraception. Looking at the interaction models for the different modes of communication, there is no discernible pattern, though for television and friends/neighbors, Christians receive less of an impact than Muslims.

Moving to the analysis of unmet need in this chapter, general approval of family planning appears to be the most important of the three measures in terms of association with the different layers of unmet need. For married men, general approval is associated with higher risk of unmet need (these men are more likely to wish to space or limit childbearing); this finding is a logical result, as fertility control must be in the realm of conscious choice (Coale 1973) for men to express the desire to delay or avoid a birth. For the second half of the analysis of men’s unmet need, it follows that men who approve of family planning in general are more likely to use family planning when they do not wish to conceive. Therefore, their risk is not actualized into a high level of unmet need.

The results do not show an association in the never-married men’s analysis between general approval and sexual activity, suggesting that approval of contraception is not about approval of sexual activity but about fertility control. As with married men, never-married men at risk for unmet need are more likely to use contraception when they approve of family planning (thus shifting them into the “met need” category).
The results of the unmet need for protection against sexually transmitted infections show that general approval is associated with increased odds of being at risk for an STI (i.e. having multiple partners). This finding may be because approval of contraception lowers in people’s minds the cost of multiple partnerships (as they are then more likely to use contraception and avoid the negative outcomes of sexual activities). This result is seen in the second section, where those at risk who approve of family planning are more likely to have used a condom at last sex than those who do not.

Looking at the belief that contraception does not lead to women becoming promiscuous, the results are generally insignificant in the unmet need analyses. The exception is for protection against STIs. Men who believe that women who use contraception become promiscuous are more likely to be at risk for an STI (have multiple partners) than men who disagree. This result may be because these men are having sex with multiple women who could be having sex with multiple men (especially if the sex is transactional) and these women may be more insisting on contraception which protect against STIs (condoms), or they may use a non-coitus dependent method to avoid pregnancy in a non-permanent relationship. However, there is no statistical difference in condom use based on the promiscuity opinion.

Disagreement with the idea that contraception is women’s business only comes into the realms of significance in the analysis of never-married men and risk of STIs. For never-married men, those who are sexually active are more likely to report using a contraceptive method if they disagree with the statement that contraception is women’s business. A possible explanation for this finding is that contraception for non-marital sex
often involves condoms (which may be easier to obtain than non-coitus dependent methods for non-married individuals and are also easier to use if sexual activity is infrequent) and condoms require the willing participation of the male partner. Thus, those who are more approving of men’s involvement would be more willing to use condoms. The same is true for men engaging in multiple partnerships. These men reduce the risks (sexually transmitted diseases) by participating in the contraceptive method decision-making and are more likely to use condoms.

In concluding this discussion of approval of family planning and unmet need for contraception, one remaining question is what would happen to unmet need if approval increased? As we have seen in these analyses, positive family planning attitudes are associated with contraceptive use. However, they are also associated with increased risk of unmet need- since positive attitudes are associated with desire to delay or limit births and engagement in multiple partnerships. Therefore, if approval of family planning increases without an increase in access to services, we may see an increase in unmet need. This possibility does not mean that we should not promote acceptance of family planning, but rather that we must increase access to contraceptive services, so that when people move out of the “no demand” category, they move into “met need” and not “unmet need.”

**Conclusion**

This chapter has constructed a new measure of contraception for men in sub-Saharan Africa. Because of the low reported use of contraception and complicated sexual partnerships, examining men’s attitudes offers a universal means of analyzing men’s
sexual and contraceptive behaviors. This chapter has shown variation in attitudes by demographic characteristics and the outside influences that may shape these attitudes. Additionally, studying attitudes has added to our understanding of the measures of unmet need developed in the first chapter. As the trends have shown, positive attitudes towards family planning are increasing throughout sub-Saharan Africa, and with decreasing desired number of children and increasing access to contraceptive services, positive attitudes may translate into increased contraceptive use and declines in fertility in a region with some of the highest fertility in the world.
References


Joesoef, Mohamad R, Andrew L Baughman, and Budi Utomo. 1988. "Husband's Approval of Contraceptive Use in Metropolitan Indonesia: Program


Tables and Figures

Figure 1: Trends in Approval of Family Planning by Africa Men
Figure 2: Trends in Disagreement with the Idea that Contraception is Women’s Business
Figure 3: Trends in Disagreement with the Idea that Contraception Makes Women Promiscuous
Figure 4: Sequential Logit Model of Unmet Need for Married Men

Desire to Space or Limit Childbearing

- Yes
  - Desire to Limit
    - Using Contraception
      - Met Need for Limiting
    - Not Using Contraception
      - Unmet Need for Limiting
  - Desire to Space
    - Using Contraception
      - Met Need for Spacing
    - Not Using Contraception
      - Unmet Need for Spacing

No Need
Figure 5: Sequential Logit Model of Unmet Need for Never-Married Men

- Sexually Active in the Last Year
  - Yes
    - Using Contraception
      - Met Need
    - Not Using Contraception
      - Unmet Need
  - No
    - No Need
Figure 6: Sequential Logit Model of Unmet Need for Protection Against Sexually Transmitted Infections

Multiple Partners in the Last Year*

Yes

Used Condom at Last Sex

Met Need

Did Not Use Condom at Last Sex

Unmet Need

No

No Need

* For single men: more than 1 partner.
For married men: at least 1 non-marital partner
<table>
<thead>
<tr>
<th>Table 1: Descriptive Statistics of Individuals Included in Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>15-19 24%</td>
</tr>
<tr>
<td>20-24 17%</td>
</tr>
<tr>
<td>25-29 16%</td>
</tr>
<tr>
<td>30-34 14%</td>
</tr>
<tr>
<td>35-39 11%</td>
</tr>
<tr>
<td>40-44 10%</td>
</tr>
<tr>
<td>45-49 8%</td>
</tr>
<tr>
<td><strong>Marriatal Status</strong></td>
</tr>
<tr>
<td>Married 49%</td>
</tr>
<tr>
<td>Never Married 42%</td>
</tr>
<tr>
<td>Living Together 6%</td>
</tr>
<tr>
<td>Divorced or Widowed 4%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
</tr>
<tr>
<td>None 29%</td>
</tr>
<tr>
<td>Primary 38%</td>
</tr>
<tr>
<td>Secondary 28%</td>
</tr>
<tr>
<td>Higher 4%</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
</tr>
<tr>
<td>Muslim 40%</td>
</tr>
<tr>
<td>Christian 49%</td>
</tr>
<tr>
<td>Other 11%</td>
</tr>
<tr>
<td><strong>Heard about family planning on or discussed family planning with:</strong></td>
</tr>
<tr>
<td>Radio 66%</td>
</tr>
<tr>
<td>Television 32%</td>
</tr>
<tr>
<td>Neighbors 22%</td>
</tr>
<tr>
<td>Partner 11%</td>
</tr>
<tr>
<td><strong>Positive Attitudes Towards Family Planning</strong></td>
</tr>
<tr>
<td>Approve of Family Planning 75%</td>
</tr>
<tr>
<td>Does Not Make Women Promiscuous 54%</td>
</tr>
<tr>
<td>Not Just Women's Business 64%</td>
</tr>
<tr>
<td><strong>N</strong> 21,019</td>
</tr>
</tbody>
</table>
Table 2: Ordered Logit Regressions for Approval of Family Planning (on a score of 0-3) for men in 7 Sub-Saharan African Countries

<table>
<thead>
<tr>
<th>Interaction Type</th>
<th>Radio</th>
<th>Television</th>
<th>Friends</th>
<th>Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model:Age 55-59</td>
<td>0.09</td>
<td>0.04</td>
<td>0.05</td>
<td>0.01</td>
</tr>
<tr>
<td>Model:Age 25-34</td>
<td>-0.08</td>
<td>-0.05</td>
<td>0.07</td>
<td>0.03</td>
</tr>
<tr>
<td>Model:Married</td>
<td>0.04</td>
<td>0.11</td>
<td>0.02</td>
<td>0.04</td>
</tr>
<tr>
<td>Model:Education</td>
<td>-0.35</td>
<td>-0.14</td>
<td>0.16</td>
<td>-0.26</td>
</tr>
<tr>
<td>Model:Christian</td>
<td>0.08</td>
<td>0.21</td>
<td>0.09</td>
<td>0.16</td>
</tr>
<tr>
<td>Model:Religion</td>
<td>-0.33</td>
<td>-0.19</td>
<td>-0.27</td>
<td>-0.24</td>
</tr>
<tr>
<td>Model:Secondary</td>
<td>-0.49</td>
<td>-0.02</td>
<td>0.06</td>
<td>0.04</td>
</tr>
<tr>
<td>Model:Higher</td>
<td>0.33</td>
<td>0.15</td>
<td>0.03</td>
<td>0.05</td>
</tr>
<tr>
<td>Model:Other</td>
<td>0.67</td>
<td>0.05</td>
<td>0.37</td>
<td>0.39</td>
</tr>
</tbody>
</table>

Includes dummy variables for surveys
Data from the Demographic and Health Surveys
Table 3: Sequential Logit Models for Sub-Saharan African Married Men’s Unmet Need Including Approval of Family Planning Measures

Regression I: Odds ratios for married, fecund men with fecund partners, the desire to want to space/limit childbearing versus have a child in the next two years

Regression II: Odds ratios for men who want to space or limit childbearing, the desire to limit versus space

Regression III: Odds ratios for men who want to space childbearing, the use of modern contraception versus no use of modern contraception

Regression IV: Odds ratios for men who want to limit childbearing, the use of modern contraception versus no use of modern contraception

<table>
<thead>
<tr>
<th></th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coefficient</td>
<td>SE</td>
<td>Odds Ratio</td>
<td>Coefficient</td>
</tr>
<tr>
<td>Approve of family planning</td>
<td>0.65***</td>
<td>0.07</td>
<td>1.91</td>
<td>0.80***</td>
</tr>
<tr>
<td>Does not make women promiscuous</td>
<td>0.35</td>
<td>0.06</td>
<td>1.04</td>
<td>-0.04</td>
</tr>
<tr>
<td>Not just women's business</td>
<td>-0.03</td>
<td>0.07</td>
<td>0.97</td>
<td>0.05</td>
</tr>
</tbody>
</table>

N       6992  4996  1569  3424

Controls include: age, education, religion, marital status (married versus living together) and survey

Surveys include Burkina Faso, Ghana, Malawi, Mozambique, and Nigeria

Data from the Demographic and Health Surveys
Table 4: Sequential Logit Models for Sub-Saharan African Never-Married Men’s Unmet Need Including Approval of Family Planning Measures

Regression I: Odds ratios for never-married, fecund men, of being sexually active in the last year versus no sexual activity in the last year

Regression II: Odds ratios for never-married men who have been sexually active in the last year, the use of modern contraception versus no use of modern contraception

<table>
<thead>
<tr>
<th></th>
<th>Regression I</th>
<th></th>
<th>Regression II</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coefficient</td>
<td>SE</td>
<td>Odds</td>
<td>Coefficient</td>
</tr>
<tr>
<td>Approve of family planning</td>
<td>0.38</td>
<td>0.25</td>
<td>1.46</td>
<td>1.06***</td>
</tr>
<tr>
<td>Does not make women promiscuous</td>
<td>0.35</td>
<td>0.25</td>
<td>1.41</td>
<td>0.09</td>
</tr>
<tr>
<td>Not just women’s business</td>
<td>-0.08</td>
<td>0.26</td>
<td>0.92</td>
<td>0.95***</td>
</tr>
</tbody>
</table>

N: 713, 558

Controls include: age, education, and religion
Analysis includes only Burkina Faso
Data from the Demographic and Health Surveys
Table 5: Sequential Logit Models for Sub-Saharan African Men’s Unmet Need for Sexually Transmitted Infection Protection Including Approval of Family Planning Measures

Regression I: Odds ratios for all men, of being sexually active with 2 or more partners (if single) or a non-marital partner (if married) in the last year versus not

<table>
<thead>
<tr>
<th>Coefficient</th>
<th>SE</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approve of family planning</td>
<td>0.25***</td>
<td>0.12**</td>
</tr>
<tr>
<td>Does not make women promiscuous</td>
<td>-0.12**</td>
<td>0.17</td>
</tr>
<tr>
<td>Not just women’s business</td>
<td>0.16**</td>
<td>0.11</td>
</tr>
</tbody>
</table>

Regression II: Odds ratios for at-risk men (see definition in above), the use of condom at last sexual intercourse versus no condom used

<table>
<thead>
<tr>
<th>Coefficient</th>
<th>SE</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approve of family planning</td>
<td>0.78***</td>
<td>0.28</td>
</tr>
<tr>
<td>Does not make women promiscuous</td>
<td>0.17</td>
<td>0.11</td>
</tr>
<tr>
<td>Not just women’s business</td>
<td>0.36***</td>
<td>0.11</td>
</tr>
</tbody>
</table>

N = 10656

Controls include age, education, religion, marital status, and survey (Burkina Faso, Ghana, Malawi, Mozambique, and Nigeria).

Surveys include Burkina Faso, Ghana, Malawi, Mozambique, and Nigeria.

Data from the Demographic and Health Surveys.
Chapter 3: Young Men’s Sexual Lives in the North Region of Cameroon

Introduction

In the first and second chapters of this dissertation I analyzed men’s need for, use of, and attitudes towards contraception in sub-Saharan Africa. When writing these chapters, it became increasingly apparent that while we might know a good deal about husbands, and increasingly more about non-married men, there still exists a gap in our knowledge of young men’s sexual lives, especially concerning how they learn about sex and how they live their lives prior to marriage. In the introduction to this dissertation, I have calculated Singulate mean ages of first sex, cohabitation (or marriage), and birth for men and women in sub-Saharan Africa. What I found was that men spend much more of their lives sexually active but unmarried compared to women (with a gap of almost 7 years for men and only 2.4 for women in the synthetic cohort measure). With the majority of previous research observing men as husbands, we have only a partial view of men’s sexual lives. The objective in this last chapter is to explore this distinctively male period of life: with whom they spend time, what they know about sex and how they learn it, and what determines when this period of their lives ends. These questions could not be answered with the Demographic and Health Surveys, so in early 2014 I spent six weeks in the North region of Cameroon conducting in-depth interviews with men and women of all walks of life to paint a fuller picture of men’s sexual and reproductive life course. The research uncovered multiple, changing pathways in which boys obtained information about sex, reproduction, and contraception. Many men experience a period in their lives after they finish school but before they marry, where they are free from the responsibility
of a wife, and “want first to play, amuse themselves, do sports, discover the world, play with motos, and look for money” before marrying. After this period (which varies dramatically in length depending on education, occupation, and geographical location), men generally wished to marry. Finally, many interview subjects discussed the changes in men’s desired number of children. A real divergence was found, from the old, pronatalist, “up to God” ideal to a much smaller, defined number of children more compatible with the increasing cost of living. These interviews provided a small, but detailed view of young men’s lives, the fitting ending to a dissertation striving to better understand men and their role in the reproductive health programs throughout sub-Saharan Africa. This chapter begins by summarizing the current literature on young men’s sexual habits and health throughout sub-Saharan Africa (with a special focus on Cameroon), then describes the methodology used in this project, presents results focusing on the main themes emerging from the interviews, and concludes with a discussion of the many societal changes affecting young men’s lives.

**Literature Review**

The majority of previous studies of young men in sub-Saharan Africa view young men in comparison to young women (for example: Camlin, Snow, and Hosegood 2014; Magadi 2011; Magadi 2013; Mudingayi, Lutala, and Mupenda 2011; Peer et al. 2013), as payees in transactional sex (Atwood et al. 2012; Jenness et al. 2011; Jewkes et al. 2012; Potgieter et al. 2012; Watt et al. 2012), in their use or non-use of condoms (Dellar et al. 2014; Delva et al. 2013; Nkomazana and Maharaj 2013; Nyembezi et al. 2014; Smith et al. 36 Interview subject Issa, male, aged 42
2014), and above all in their role in the spread of HIV/AIDS (to name only a few: Adam 2014; Grabowski et al. 2014; Jemmott et al. 2014; Kaufman et al. 2014; Kincaid, Babalola, and Figueroa 2014).

Many studies compare men’s and women’s sexual experiences, especially the timing of sexual initiation. Meekers and Calves (1999) find that men in their Cameroonian study tended to report beginning sexual activity earlier than women, but by age 18 the majority of both sexes are sexually experienced.

Gender differences in societal attitudes have also been reported with regard to purchasing condoms. In her study in Edea, Cameroon, Calves (1999) reports that girls who carry condoms are deemed “prostitutes,” but that while a condom may make a boy seem promiscuous, he might also be regarded as careful and responsible. Gender differences are also observed in moral norms towards premarital sexual relations. A study of several churches in KwaZulu-Natal, South Africa finds that young girls believe that moral norms applied to them more than their male peers, as boys’ needs for sexual experiences are more understood (Eriksson et al. 2013).

Another common topic is the prevalence of risky sexual activities, such as multiple partnerships and married partners. In a study of sexually active urban Malian youth, Boileau, Zunzunegui, and Rashed (2009) find twice as many men as women report multiple partnering in the last six months (this is similar to results found by Meekers and Calves (1999) in Cameroon). Higher partnering by men is also observed in a multiple country study using Demographic and Health Survey data across sub-Saharan Africa by Doyle et al. (2012). Women are found to be more likely to date married individuals;
Calves, Cornwell, and Enyegue (1996), in their study in Yaounde, Cameroon, find that half of the young women (age 21-26) they interviewed had ever gone out with a married person, compared to 29% of young men. Meekers and Calves (1997) explore the type of relationships in which young people engage in urban Cameroon. These include “main girlfriends” for men, who they may intend to marry, and their other female partners with whom they have no such intention. For women, Meekers and Calves highlight sugar daddies, typically older, wealthy men who will pay for school fees, clothes, etc., and faitman (hand made), who are generally younger (aged 20-30) but also successful businessmen.

Both genders report engaging in multiple partnerships in order to minimize emotional disappointment if a relationship ends. In a Zambian qualitative study (Nshindano and Maharaj 2009), many young people agree that there is nothing wrong with multiple partnerships as long as people obtain what they want from the relationship. They point out differences by gender in what people might want; women may be financially motivated to engage in multiple relationships, while men may gain status. Transactional sex is discussed repeatedly in the literature, with small gifts often given by men to women (and also, though less commonly so, from women to men) whom they are or wish to be involved. As Meekers and Calves (1997) find in their qualitative work in urban Cameroon, these gifts can range from paying for drinks or food to “explicit exchange for sexual favor.”

A major recurring theme in previous studies is the risks of young men’s sexual behavior and their use or non-use of condoms for the protections of themselves and their partners. Condom use is found to be common with casual partners, though rare in stable
relationships (Calves 1999). This finding is similar to results for all men from Chapter 1, which finds that condom use is much more common among partners with a less established relationship, among those in multiple partnerships. Other factors are found to influence condom use: Boileau et al. (2009) find that poor peer communication is associated with decreased likelihood of condom use at last sex. Condom use is a common topic of interest among young men in sub-Saharan Africa because of the role men play as users of condoms and the protection condoms give against HIV/AIDS. The epidemic has changed the discussion of sex in many places in sub-Saharan Africa, moving it from a taboo subject to a public health concern (see Bastien, Kajula, and Muhwezi (2011) for a multi-decade review of the literature surrounding parent-child communication about sex and HIV/AIDS on the continent). Though timing of marriage (or cohabitation) may vary, never marrying is rare among men in sub-Saharan Africa (less than 1% of men aged 45-49 in the DHS surveys used in this dissertation have never married), in fact, Bongaarts, Frank, and Lesthaeghe (1984) declare it “for all intents and purposes universal.” Remaining sexually abstinent prior to marriage is also uncommon. In Calves et al.’s (1996) focus groups, the question of male virginity was met with laughter. Zimbabwean boys report that they must “practice having sexual intercourse” prior to marriage in order to “gain more skills” (Chikovore et al. 2013). Therefore, many men establish a sexual life prior to marriage. This period ends when men are ready to marry, and marriage may carry large financial costs. Many communities in sub-Saharan Africa, and especially the north of Cameroon, practice bride price, where a husband makes a payment to a bride’s family to compensate for the woman’s labor and future reproduction (Anderson 2007). While in the past, extended family contributed to this
expense, now, Anderson believes, more wage-earning men are paying bride price themselves, a change that may cause a delay in the timing of marriage.

This study delves further into men’s lives, exploring how they learn about sex, how they lead their sexual lives prior to marriage, the determinants of timing of marriage, and, finally, their changing ideals of family size.

**Data and Methods**

From January to March 2014, in-depth interviews were conducted in rural and urban areas of the North region of Cameroon. The region has a relatively high total fertility rate (6.5 as compared to 5.1 for the country as a whole in 2011). There is also a great deal of heterogeneity in the region, including many local languages, a mix of Catholics, other Christians, and Muslims, as well as urban and rural areas. The capital of the region, Garoua, contains many industries and factories, while subsistence farming is common in the more rural areas.

Looking at young men (ages 20-25) interviewed in the region during the 2011 Demographic and Health Survey, more heterogeneity emerges. 11% of these men had no education, while 34% had at least some secondary schooling. 23% were not currently working, while 42% were self-employed, and 19% worked as manual laborers. The sexual history of these men also varied: 65% reported ever engaging in sexual intercourse and 1/3 of these men said they used a condom the last time they had sex. Among the sexually experienced, 62% had more than one lifetime sexual partner, with an average of 3.1. One in five of the young men had ever lived with a woman and one in ten was a father.
For the research presented in this chapter is not intended to be representative of the entire population, but information from the 2011 Cameroon Demographic and Health Survey is included in the discussion section. For the qualitative portion of this chapter, interview subjects included 7 women and 16 men, ranging in age from 18 to 52. Occupations and education varied from subsistence farmers with less than primary school education to government employees with advanced degrees. Many of the interview subjects were informed observers, adults who worked with youth or health programs, including two American Peace Corps volunteers. Over half of the subjects were under the age of 35, and 5 were still pursuing education. Other subjects were older adults reflecting back on their own lives and discussing what they observed in their current society. A list of the interview subjects including pseudonym, age, sex, and occupation is presented in Table 1.

Participants were recruited via convenience sampling. A Peace Corps volunteer made initial introductions between me and many individuals working in youth health education. Additionally, a translator was employed to conduct interviews with those from more rural areas where French was not spoken. Interview subjects often contacted other potential participants to arrange additional interviews. Subjects therefore ranged in their expertise and knowledge about young men’s sexual lives from personal to professional. Individuals were contacted either in person or by phone, and all agreed to be interviewed in person. All interview subjects agreed to take part in the study and gave informed consent to be interviewed. Participants were compensated with a snack and drink during the interview and were free to end the interview at any time and keep their meal. Human subject approval was granted by the Institutional Review Board at Princeton University.
Interviews lasted between 10 and 60 minutes and were conducted by me and two assistants. Interview languages included English, French (and then translated into English by me and an assistant), or Dowayo (and translated on the spot into French by an assistant and then translated later into English by me). As much as possible, interviews were translated word for word, which, while potentially losing some meaning, allows the meaning of each interview to not only be under the interpretation of the translators (myself and assistants), but by the reader as well. Interviews were conducted in a variety of locations, including restaurants, offices, shops, and markets. Although subjects were not asked about personal experiences directly, many responded with their own histories. As much as possible, interviews were conducted out of earshot of others. Only one participant did not wish to have his interview tape recorded, so notes were made throughout the interview. The remaining interviews were audio recorded then translated and transcribed after. Following the conclusion of interviews, emerging themes were identified and a transcript coding guide was developed. Atlas.ti 7.0 software was used for coding and transcript management.

**Results**

Interview subjects in the North region of Cameroon provided a rich view of young men’s lives. Individuals provided observations of society, stories they had heard from those around them, and in some cases, their personal experiences. Combing through all of this information, four major themes emerged: 1) How young men learn about sex; 2) Men’s sexual activity prior to marriage; 3) The varying determinants of timing for marriage for men; and 4) Men’s changing desired number of children. Each one of these themes
includes numerous sub-points and speaks to the heterogeneous nature of men’s lives in Cameroon.

**How young men learn about sex**

In the North region of Cameroon, as in Calves et al.’s 1996 study in Youande, the capital of Cameroon, westernization has changed young people’s lives. They receive more information from the media (especially television, with a sizeable population able to access the internet), and are under less parental control than in the past. But, as with Chikovore et al.’s findings (2013), there are still large areas where the youth lack the knowledge or harbor misconceptions. One major change in all people’s lives in the region is the presence of HIV/AIDS. While the region has a lower than average prevalence (2.4% compared to 4.3% nationally), HIV/AIDS is constantly discussed by individuals, organizations, and the media. Thus sex, a traditionally taboo subject, is forced into public discourse, and HIV/AIDS is changing the ways people talk about sex and live their sexual lives.

While many studies (Boileau et al. 2009; Calves et al. 1996; Calves 1999; Doyle et al. 2012; Defo and Dimbuene 2012) have previously looked at the influence of those around young men on boys sexual behaviors (age at first intercourse, condom use, multiple partnerships, etc.), less attention has been paid to how young men acquire knowledge about sex and contraception. Asking all interview subjects about this subject, the answers included friends, parents, the media, sexual instincts and self-discovery, and organized sexual education.
In adolescence, friends and peers spend a large portion of their time together—before, during, and after school. In these setting, boys are able to exchange stories, share tips, and be open about their sexual experiences. As François, a 33 year old male who worked as an organizer of peer educators, said: “[They talk] with their friends because the youth find themselves together. When they are together there are discussions of subjects…and most [often] it is the subject of sexuality which emerges.” Boys can use this time to fill in gaps in their knowledge. Robert, a 36 year old male preacher, explained boys’ sexual learning as such: “at school they can teach it in hygiene and science. Like that people can learn at school, [but it is] the friends who can say ‘it is like that’ and ‘one does that.’”

The idea that boys teach each other the important aspects of sexual knowledge was echoed by Pierre, a 30 year old male teacher, who said: “In the conversations, they learn how to have relations with girls, with a woman… Someone who already has sex with a woman [says], ‘it’s like that it’s like that,’ therefore one must pass on. There are methods to pass that… for example caresses or other things.”

Eriksson et al. (2013) also find that young men believe their friends to be “good teachers.” In the search for information, boys will often venture out of their immediate circle of friends when they have specific questions, as illustrated in this quote by Bernard, who is a 36 year old male and the director of a youth center: “It is necessary to remark that men first learn sexual practices from conversations with their friends. From those who are the same age and older than them… When they have questions they then go approach those who are a little bit bigger than them. And there they are going to ask questions to know how it is that is practiced. But, once they have problems of real difficulty, they can reference those who are even bigger.” This chain continues as youth
are apprehensive about approaching adults to ask for information or help. “When they meet the adults, they hide the problems because they are afraid they know they are already sexually active,” said Peter, a 48 year old male government employee. While boys may feel safe, and even “heroes” (as Eriksson et al. (2013) term it), in talking to their friends about sex, one major problem is the spread of misinformation, as Chikovore et al. (2013) find among youth in Zimbabwe. However, friends are not the only means in which men learn about sex, as will be explained shortly.

While many studies have pointed to the benefit of communication surrounding sex between parents and children (Dimbuene 2011a, Dimbuene 2011b, Sidze and Defo 2013), a major barrier exists in the uncomfortable nature of the discussion felt by parents and their own limited knowledge of sexual health (Namnambi 2011). Several interview subjects spoke of the fear children face in discussing sex with their parents. For example, Georges, a 33 year old male barber, said “They are afraid of the family…It is not from the family. It’s from friends.” Issa, a 42 year old male who is well-educated and works for an international aid organization, explained it further: “There is no discussion between the parents and the children. The children must not pose questions to their parents because a child that poses questions is not a child who is well educated.” He explained that in traditional parent/child relationships, children are expected not to ask their parents about such a taboo subject. But as Aboubakary, a 47 year old male government employee, pointed out, children observe and ask questions. He said, “I have my small children who ask why we don’t have any more children… They are very small but they ask. The last one is eight and he asks certain questions.” Aboubakary also said that even if parents do not talk to their children about sex, the children still learn from
their parents, who are sexually active in the home: “When children are in families where there is not a lot of space in the house, so when the children maybe see or hear, they are curious. And that incites questions or the discovery.” As most rural homes are self-constructed and small, there is little doubt that children gain an understanding of sex from their family, even if the parents do not discuss it openly.

Traditions surround sexual learning for many young people in North Cameroon, though there is a distinction by gender: menstruation for girls and circumcision for boys. Bernard said, “the girl is going to start to learn that from her mother because already there is the menstruation cycle that starts with the girl and the mom starts to attract her attention towards that which she must know, how to control it, if she goes outside and if there are blood stains, that can make her dirty, people are going to mock her, while the boys don’t yet know that.” Remaining clean during menstruation is very important, and a mother teaches her daughter the things necessary as she comes of age. This relationship (with grandmothers as well) has been seen in other studies (McMahon et al. 2011 in Kenya, Nambambi and Mufune 2011 in Namibia), though discussions around sex do not often extend far beyond menstruation.

For boys, traditional circumcision, which varies in timing by tribe and area but often occurs during adolescences, is a passage to adulthood (Wilcken, Keil, and Dick 2010). As Bernard described it: “there are the families that have ritual ceremonies where it’s necessary to do the circumcision, calling the children into the bush, and then when those children, when they come back, they become men.” As Halimatou, a 25 year old female radio host and peer educator says “When he is already circumcised, he already starts to
ask questions.” Circumcision introduces boys (if they hadn’t already been introduced) to male sexuality, and can prompt them to question more.

While the traditional aspects of sexual education are declining in importance with increasing Westernization, another force is changing the parent-child relationship surrounding sex: HIV/AIDS. As David, a 33 year old male graduate student said “Before it was very taboo in the north to talk about sex and that is changing now. So now young people are even starting at age 8 or 10 to talk about it and are beginning to hear about sexual reproduction. AIDS had a lot to do with it.” The epidemic has forced sex to move from a taboo subject to a public health topic, and, as Ali, a 29 year old male radio host explained “Before AIDS it was always difficult. And during the years of AIDS, one has seen that it is really necessary to talk about sexuality with the children.” Of course, just because parents are talking to their children about sex does not mean the information is complete or being absorbed. As Kajula et al. (2013) find in work in Tanzania, parents’ messages are often scare tactics. As many parents are still not discussing, partially or completely, sexual education with their children, gaps remain in young boys’ understanding. However, other changes are occurring in Cameroon which result in increased delivery of information to adolescents.

Media are penetrating the lives of adolescents in Cameroon. While the format varies (televisions in urban areas, radios in more rural areas), an increasing numbers of adolescents are learning about sex and sexual health through these means. Nambambi and Mufune (2011), in their study in Namibia, find that parents are forced to discuss sex with their children because the children were exposed to it by the media. Information is often transmitted about HIV/AIDS, but also regular programs commonly discuss themes
of a sexual nature. As Ali said, “Generally, here there is an influence of media. Media, the television, the radio. That is often the first contact... On cable there is access to many channels from elsewhere, from other countries. But there is also the Cameroonian media.” The programs can cause concern among parents, who are not able to know what is about to be shown on television, this is found by Glik et al. (2014) in Senegal, and is also a concern among Cameroonian parents, as Peter explained “I want to say that, this time, nearly all Cameroonians learn about sex at very early ages because of the exposure to television. The television shows pornographic films, and you find yourself watching the film with your own children, and because you didn’t know exactly what was going to come on next you feel embarrassed when you find certain scenes they show. And the students are very keen on it. And most of them watch these films when we are not there. When we try to put on the TV they don’t care, but as soon as we are not around then they are interested in those channels.” In some rural communities, electricity is not available or unreliable, making satellite television less common. But, media still inform young men through pornographic films brought from the city into the village. Pierre explained the circumstances “In the north in any case … every weekend, one goes to see the film, you have to pay 25 francs per film. Somebody will bring the video for people; you have to pay to enter. He puts the pornographic film on. And those who don’t dare use a recording [later] that you can listen to or watch. You see, for example, for a boy… I can have information, as a boy, about sex.” The films are diverse in origin (Cameroon, other African countries, the West), but all provide information, and entertainment, to the young men. Pornography is not commonly discussed in sub-Saharan Africa, but a study by Kheswa and Notole (2014) in South Africa finds that boys are influenced by the media,
especially pornography, to harass girls and “force sex upon them.” Again, as with friends
and parents, while boys may learn about sex from the media, the information may not
necessarily be correct or complete, though the next subject discussed avoids the role of
learning from people completely.

While asking men in more rural areas about the means by which boys learn about sex,
several looked at me with a puzzled expression and, as Paul, a 32 year old male farmer,
told me “You learn it personally. You don’t talk about it.” This sentiment was echoed
by Gaston, 52, also a male farmer, who said, “No one. He learns personally, by himself.”
Understanding of sex was described as an instinct, something that one will understand
when it is time. Robert explained, “One learns that personally. No one can tell him, but
when you grow up, it is when the age arrives, we know that you should do this.” While
the idea of an instinct to have sex was discussed among the more rural interviewees; in
urban areas, participants went a step further and talked about how instinct among boys
was often before they had the ability to find a sexual partner. As Peter said “The
difference is that boys have that feeling, that natural instinct to have sex, but sometimes
they are not courageous enough to talk to girls, they feel shy, and then they stay and wait
until they are courageous enough.” This waiting led, as Ali explained, to self-discovery
“It is that they already have a sexual attraction but there are boys for example that are
afraid of going to see the girls, for him then it is as he is afraid. It is what he finds to give
pleasure, it is masturbation… With the boys it is more frequent.” While it is becoming
uncommon for boys not to have some exposure to sex in their lives (and to only base sex
on their instincts), because of friends, family, and the media, it remains in some older
men’s minds as the only way they know how to conduct themselves sexually at a young
age; whether this is a bias in their recollection or a generational change is unknown. Additionally, young boys in the area, as elsewhere, experience sexual desires prior to engaging in sexual relationships.

A final way in which boys (and girls) learn about sex is through organized sexual education, both in and out of school. In the past, formal sexual education in school was nonexistent. As Aboubakary recalled from his childhood: “We didn’t talk about it in school. When I went to school, the crisis was too young.” He refers to the fact that changes in sexual education were motivated by the HIV/AIDS epidemic, which Peter described as the reason for sexual education to be offered at younger ages: “In school, youths talk about sex, especially with their biology teachers… in our curriculum we have introduced the teaching of sex education in secondary schools... In primary schools too, we have introduced the AIDS aspect of sexual education... so that students can be exposed to some. Much still has to be done.” Sexual education outside of HIV/AIDS education is restricted to older ages and certain courses. François says, “there is a science program that talks about sexual reproduction and genital parts of the child.” This reaches some, but not all, as Phillippe, a 22 year old male student explained, “If, for example, if you are doing the science track, you learn about that. But, for me, in technical school, one doesn’t do that. For me, it’s only with friends and classmates.” Students are gathering their information from multiple sources, and problems exist within formal education that need to be addressed so that students have access to information before becoming sexually active.

With the HIV/AIDS crisis, money is focused by international agencies on increasing correct understanding of protection. One ongoing project organized by Laura, an
American Peace Corps volunteer, in collaboration with many local Cameroonians, focuses on correct understanding of sex. She said “So, for instance, I organize HIV/AIDS soccer tournaments/camps. So we invite different soccer teams or clubs from the surrounding area. They come, with the premise of playing soccer and battling each other, but in between tournament games we have hour, hour and a half long educational sessions. In these education sessions, the teachers start with the assumption that the youth know nothing, and begin with basic anatomy, but continue out to types of sexual encounters, as well as contraception.” Sports and peer educators are popular means by which organizations are attempting to disseminate useful and accurate knowledge to the youth. Several of the interview subjects worked in training peer educators, including François, who described his profession as: “I train the children in youth development and emancipation in the sports world.” Halimatou described her training of male peer educators as follows: “Right now we train them about self-esteem, leadership, contraception, sexuality, and even knowing the tools used. We teach them how to use a condom because they have a poor knowledge of contraception or the consequences. There are STDs, HIV/AIDS, pregnancies that are early or not wanted. We also teach them to respect women. She is not an object just for his desires.” By training youth educators, these organizations are attempting to access the “friend and peer” channel of sexual learning, to avoid the taboo of talk about sex between generations, and to spread correct knowledge among the youth. Another attempt to educate the youth came from a local radio show, sponsored by Association Camerounaise pour le Marketing Social (see Van Rossem and Meekers 2000 for another example of their work), which Halimatou and Ali hosted, and talked about various sexual health issues. Halimatou described the topics
discussed as such: “On the subject of access of reproductive health of adolescents. On contraception… This month we are talking about people who are HIV positive… We have received messages of encouragement, because it is one of the rare programs that talks about sexuality, in particular sexuality in the north of Cameroon. People encourage us and people send us messages about their problems so that we can help them… it’s been more than ten years. Yes, it is one of the leading programs.” The program allows individuals to text anonymous questions to the hosts to be answered on the air. Additionally, the show attracts a large audience by playing current hit music from Cameroon, other African countries, and the United States and Europe. This program is another example of organized sexual education outside of formal schooling which is funded, at least in part, out of fear of the HIV/AIDS epidemic and attempts to reach youth with accurate information surrounding sex and reproductive health.

As this chapter illustrates, there are many avenues by which young men learn about sex. These means do not always provide the most accurate information, and these means are constantly shifting with increasing exposure to the media and societal changes accompanying the HIV/AIDS epidemic. What is apparent is that many young men (and women) are still not receiving all the information necessary at the appropriate ages (prior to becoming sexually active) that would allow them to lead safe sexual lives. The next section turns to these young men’s sexual lives. It focuses on men’s lives prior to marriage and includes themes discussed in interviews such as sex before being “mature,” playtime, sex in exchange for gifts, and condom use.
Men’s sexual lives before marriage

As shown earlier, men spend a larger portion of their sexually active lives non-married compared to women. This time is also growing- Meekers and Calves (1997) explain that as more and more individuals reject arranged marriages and choose their own partners, and as marriages take place later, people have opportunities for multiple or sequential non-marital sexual relationships. Other gender differences have been observed that necessitate the detailed study of young men’s sexual lives independent from partners. Meekers and Calves (1999) find that men and women differ in patterns of sexual behavior and therefore are exposed to different risks. Boileau et al. (2009) finds that among youth in Mali, 62% of men reported multiple partners in the last half year, compared to only 32% of women. Boys are also perceived to have more freedom in their sexual decisions, and are not as stigmatized for “sleeping around” (Meekers and Calves 1999).

When I asked interview subjects if most men engaged in sexual activity prior to marriage, the answer was a resounding “yes.” Percentages given were quite high “There are exceptions. Maybe it is 90%, 95% it is before marriage” said François, while some did not believe any men remained virgins until their wedding night. As Phillippe responded “I would say all the men.” Similar answers have been given in other pieces of qualitative work from Cameroon (Meekers and Calves 1999, Calves et al. 1996). In fact, many people believe it to be bizarre if a man did not have “practice” (to take a term from Chikovore et al. 2013). As Patricia, 34, a housewife, told me: “Men must know first sexual relations outside before being married.” The question then became, who are their sexual partners? As Halimatou said, partners can come from anywhere: “at school, kids
from the neighborhoods, the girls who sell little things.” From these interviews, it is apparent that sex is expected of men prior to marriage, but what is not accepted is the idea that boys would have sex before “being mature.” This is the time in their lives when boys, typically uneducated, would have sex without knowledge or care to protect against disease or pregnancy. An age threshold was clearly defined in terms of acceptability to begin sexual relations, as Robert said, “normally a boy should have at least 18 years to start. But when he is that empty, he can have 13 or 14 years to start.” By empty, Robert is referring to a lack of education, either formal or informal, which can cause boys to act in a self-destructive manner, with little care towards the future. David elaborated on this idea “If the child is growing up with street children or their parents don’t talk to them, they start earlier to do stupid things. It depends on the level of education. If they are well in a good framework than they will wait until they achieve an age of maturity, like 18 or 20.” Education, as will be discussed later on, is a recurring theme in the extension of the protection of youth and delay into adulthood (whether it be sexual initiation or marriage). The major problem with engaging in sex before being mature is that this is thought to be unsafe sex. As Nicole, a 30 year old female nurse said, “from 12 to 14 they become more active. More or less they don’t protect themselves, because rather their pleasure is to know what sex is, not what protection is.” The sexually active youth, she described, are not putting enough emphasis on the long term risks of the actions, but merely enjoying the short term benefit. This emphasis may be because more of the negative costs of sex are paid by the female partner if a pregnancy occurs, said Bernard. The girl must choose between an illegal and unsafe abortion or caring for a child and derailing her education. Because a young man may not recognize the child as his own,
the costs are substantially lower for him. Another issue raised is, as Bernard explained, that “the sexual practice preceded responsibility. … The thing is that when he practices sexuality there are risks that he becomes sick. And if he is sick it is possible that he hasn’t mastered the symptoms of the disease, that he doesn’t take the courage to go tell his parents, a doctor, and such like that.” Because, as an earlier section on parent-child communication demonstrated, the youth are afraid to admit their sexual activity to adults, they are not likely to seek treatment. Youth pregnancy and disease were voiced as the two main issues with sexual activity among the young, but once men are deemed “mature” (usually around 18), there is not as strong an objection to sexual activity. And as men spend, on average, many years of their lives finished with education, working, and unmarried, there emerges a period in their sexual lives in which they may engage in multiple or serial partnerships while uninterested in marriage, a phase termed by one interview subject as “playtime.”

Marriage, as Issa said, takes a level of maturity different from the maturity to have sex discussed above. He said, “they are also not early stable in the head to think that they are capable to have a family, because they want first to play, amuse themselves, make sport, discover the world, play with motos, and look for money.” There are many things men want to do in their lives before the stability and demands of marriage. Much of this time is spent thinking about women, as well as other sorts of entertainment. Issa expanded on this idea: “They amuse themselves, they discover the world, they hunt girls, they look for all the girls who are pretty, all the girls who are young. They amuse themselves, they party…he thinks about the holiday of Ramadan that is coming, with what girl he is going to party? What is he going to wear? Or is he going to go have a picnic? And do a
safari? He travels. He does all that during those years, during that period. And it is during that period that he will be conscious that he has played a lot, and now he must stabilize himself. He must have good work. He must save a little bit of money because during that period there are people who earn lots of money with small activities, the small activities that they do. But they don’t think it is important to be economical, to organize a good business. But they are always taken by the young girls… So it is an ensemble of things that happen during that period or puberty, youth, and all that. So one thinks that one has the time to play, to amuse oneself.” During this time, most young men express little seriousness in either a permanent partner or profession. However, as Issa explained, it is necessary to earn some money in order to support activities with women. As Calves et al. (1996) find, young men often complain when they cannot find the means to have as many girlfriends as they wish.

Women interviewed did not express such positive views towards men’s sexually active period prior to marriage, as they thought men at this time were irresponsible and acted disrespectful towards women. As Halimatou explained, after she stated that males typically began having sex about 14 but married around 28. “What do they do in this time? They play with girls. They know those girls before being serious. Like that they lead their lives…Because, they aren’t afraid to say to the women, ‘there are lots of women outside.’ He can change women when he wants to, he can… He feels free to do wrong to a young girl because he knows that he will have one girl or another… They often say that a young man is not bothered when he makes a girl pregnant. The girl is going to stop her studies because she has fallen pregnant, he will continue his life. Sometimes he doesn’t recognize the child.” Here, even when men are deemed “mature”
enough to engage in sexual relations, they may still not take responsibility for their actions.

An even stronger statement against young men’s sexual activities was given by Nicole, who was originally from the south of Cameroon, and explained the difference she saw in the North region, as well as the danger of delayed marriage, “Among my people, the Bamilieke, the men marry very young. 22, 23 years, 24 years…That avoids that sexual vagabondage. That also avoids that he makes girls pregnant everywhere… if he is not married, he’s going to vagabond. He will live in disorder.” So, while men see this period in life as an opportunity to grow and explore prior to the responsibilities of marriage, women view this as an unequal time where girls are at risk of unrecognized pregnancies which may derail their future.

If the costs are so high, why do women participate in these relationships? As many authors have previously shown, there are commonly economic transfers in romantic relationships, generally flowing from men to women (Meekers and Calves 1997, Boileau et al. 2009, Calves et al. 1996). These can range, as Meekers and Calves (1997) explains, from paying for food and drink while on a date to “explicit exchange of money for sexual favors.” Issa detailed in his description of “playtime” how women will seek out men with means. He said, “if the young girl also looks for a young boy, and when they know that you, you are a boy that has a good moto, a good car, who has a little bit of money, one is going to go eat good things together. And then the other girls can see that she is with you, they are a little bit jealous.” Therefore, having one visible relationship signals a man’s economic situation, and can attract other women towards him.
These types of relationships can develop early in young men’s lives. As Peter explained: “Most girls like to exchange… to have sex with boys in exchange for money, even though they may not ask for that directly. But a boy who comes regularly to a girl, giving a girl some gifts every day and so on, most of that leads to sexual relations. And so most of the boys have discovered that this is the shortest way to get a girl… so they come and they give little gifts, share with girls, and then attract their attention and their sympathy.”

Young men learn that money and goods can attract women towards them. Interviews also suggested that young women may balance multiple relationships in order to achieve what they wish from different partners, and some of these wishes are for companionship, not money, as Ali said, “there are the boys that the young girls like just to accompany. Then there is another boy that the young girls like just because he gives her something. So that makes it so a young girl can have 3 boyfriends. 3 boyfriends at the same time.”

Men continuously brought up in interviews the need for men to have multiple partners because their partners (not wives) have multiple partners. This result is also found by Calves et al. (1996) who says that multiple partnerships protect individuals from the emotional damage of their partner being unfaithful. This sentiment was shared by Pierre, who took the sentiment further, as he explains women’s unfaithfulness as a motivation for men to visit prostitutes. He said “If a girl juggles her boyfriend, she hides the reality from her boyfriend … the boy is obligated to go look elsewhere. He notices that his girlfriend is not faithful, so he is going to do that… a girl who has 10 boyfriends, ‘you are with 10 boyfriends, I can no longer be with you, I am going to go look elsewhere.’ So… the single ones, they go towards those women who prostitute.”
Prostitution was visible in the North region of Cameroon, especially in the capital, Garoua, where they frequented drinking establishments. When I followed up with Pierre about his statement, and asked him which type of men visited prostitutes, he said “It is everyone. It could be a married man or an unmarried man that frequents a prostitute here.” Men can also be motivated to engage with a prostitute merely because he finds her attractive, as Peter said “They don’t care. They look at the physical appearance of the girl. If she is beautiful, whether she is a prostitute or not, it is not their concern. They go out with her and they go out with other young girls.” This finding ties back to the idea of playtime being about exploration and enjoyment, where men want to meet and have fun with beautiful women, while maintaining a distance from marriage or commitment.

While economic exchange generally flowed from men to women, both in my interviews and in other research (Meekers and Calves 1997, Calves et al. 1996), instances were discussed of men receiving goods from women, generally older, wealthier women. Pierre described a possible scenario, “Usually those women whose parents are rich, or their husband is really rich, or a widow who has lost her husband… It’s the boys, a boy who is not at ease in life, who is unemployed, if you don’t have money, she accepts everything. She pays for car, she will build you a villa, everything that you have a need of, so many things, the woman wants you. All that you have to do is satisfy her sexually. They are numerous. There is a lot of that, they are everywhere.” Both men and women engage in sexual activities for economic benefits, but as men are often the ones spending money, it is necessary during their playtime to engage in at least small money earning activities to maintain their current lifestyle. Eventually, as the interview subjects suggested, most men become more serious both in terms of economics and establishing a family. But
before we explore why men end this period in their lives, it is first necessary to discuss
the protection (or lack thereof) young men employ in their sexual relationships. As
HIV/AIDS and other sexually transmitted infections are common subjects of discussion
in the North region of Cameroon, there are also many attitudes, beliefs, and stigmas
surrounding condoms, which is the focus of the next section.

Condoms are fairly available in the North region of Cameroon, though much more so in
urban areas compared to rural. Halimatou described their presence “Now it is in all the
boutiques so they can buy them for 100 francs. It is easy now.” However, just because
condoms are now more easily available than in the past does not mean that individuals
want to use them. A major determinant of condom use was relationship with partner (as
also found in the quantitative analysis in the first chapter). Robert explained the
partnerships where condom use was necessary: “if it is not your wife, if it is a woman
who is outside, that you don’t know, you haven’t been in contact for a long time, and you
haven’t been to the hospital, then it is an obligation to use condoms.” The reason for this
is that condoms were almost exclusively thought of as protection against sexually
transmitted infections. David said this explicitly, “men use condoms to control AIDS,
but not to control the prohibition of children.” Therefore, using a condom with your
main partner would signal either infidelity on your behalf or mistrust of your partner.
The reality of disease was apparent, as Pierre described the mindset of many young men:
“Without a condom, he is going to think ’Oh my god, I had sex without a condom. I am
already dead.’”

To learn more about the sale of condoms, I visited a shop owner in a small town. In her
boutique, Mireille sold a variety of products, from cleaning supplies to cookies. On the
door of her shop was a large poster featuring a panther, an advertisement for a popular condom brand. Mireille sold condoms in packs of three or by the box, the larger generally bought by women who would return to their much more rural villages and sell the condoms there. Mireille was open and forthcoming about her business and clientele. When I asked her who bought condoms, she responded “Everyone. All the men who already understand the problem of condoms come to buy them…Even the grandfathers, even the mborrorro (the nomadic herdsman), they buy condoms. They already understand that with the condoms they can dodge illness, as well as many things.” Here, she explained to me that while people were able to access condoms, there was still a major barrier: embarrassment. Asking if young people bought condoms, she replied, “in fact, you know that those condoms, there are people who are ashamed and they send children, so it depends. When they buy you don’t know directly for who it’s for.” It was common, she said, for men to be embarrassed to be seen buying condoms, so they would have little children come and purchase their condoms. Mireille tried her best to put her customers at ease, and show them that buying condoms should not be embarrassing. She explained a common scenario: “there are people who are ashamed, but as I am a business woman, when they come and they are ashamed to buy, they tell me what I should do to give them to them so that the people don’t see. So he says to hide them to give them to him. When you say to him ‘Why do you hide?’ He says: ‘No, no.’ When certain people see, they are ashamed. They have old thoughts.” In my discussion with Mireille, she offered prime examples of the heterogeneity and changing social norms surrounding condoms. While more and more people understood the importance of protection against disease (Calves’ (1999) work in Cameroon in the 1990s speaks of individuals who do not
believe in the existence of HIV/AIDS) there are still major social barriers in accessing and using condoms.

This feeling was echoed in numerous other interviews. Ali described what young men might do when attempting to buy condoms: “For example, when a boy comes to a boutique, he can find four people, if he wants to buy condoms he will say that he wants cookies. So he feels a little bothered, because for them the fact the one knows that he buys condoms, for example to protect himself, it is the shame for them, that makes them ashamed. So it is often not easy because condoms, they are available, but arriving at buying them leads to shame.” This shame is brought about because of the small community aspect of life, where even in the city people know each other and each other’s business. Purchasing condoms can lead to a bad reputation, Issa described it as such: “it incites the image that you are someone perverted, someone who has a disordered sexual life or what you do is not good.” Though many, such as Mireille, are attempting to change this view. François, the trainer of peer educators gave a personal example of this effort. He said, “when I was with him [my friend], we passed by the boutique, and someone said ‘please I want a condom’ … My friend, behind me, he laughed, and I said ‘why do you laugh?’ and I said that if he asked for condoms, that’s good, at least he knows to ask for a condom.” Shame was often cited as the main problem with young men accessing condoms, though it should be noted that many respondents said that this shame is much less for men than women. Peter believed, in fact that “it is shame that can be the only obstacle. The availability of condoms is enough for everyone to have access to them.”
Previous work does not identify monetary constraints as an obstacle to purchasing condoms (Agah et al. 2002 look at eight countries in sub-Saharan Africa, including Cameroon). However, the data used contain an urban bias, and may not capture the limited pecuniary means of those in extremely rural areas, where many activities are focused on agricultural production for personal consumption. Issa explained this situation: “They are poor. A condom is 50 francs, there are people who look for 50 francs to eat beignets and can’t find it. If you can’t find 100 francs, he is not going to buy condoms and he is going to go have sexual relations.” Pierre also echoed this sentiment: “it is difficult for a poor man to have 100 francs and go buy a condom instead of buying salt for the house. It is very difficult. It is rather the villagers who are more menaced by AIDS compared to those who are in cities. A person in the village might only have 100 francs a day. He doesn’t have activities that gain him money. But he has a woman. He is obligated to have sex without a condom.” During interviews conducted at a weekly market, where many people came from “en brousse," several interviewees explained the lengths those without money went to to protect themselves from disease and pregnancy. Georges explained, “when there isn’t money to buy condoms they use the traditional products.” Patricia answered in a similar manner: “he can use traditional products.” While the small amount of money necessary to purchase condoms may not be an obstacle for those in the city or village, those living mostly outside of the monetized society still expressed problems in accessing condoms and resorting to traditional practices with unknown effectiveness.

37 The bush, very rural area
From these interviews, it is apparent that most people in the region know about AIDS and have access to condoms. But the cultural taboos surrounding sex intrude into the world of protection, and cause shame to be a major obstacle in condom purchasing, especially since condoms are not seen as a contraceptive, which limits their use among serious partners. Young men in this community understand the importance of condoms, and it will be interesting to see in the future if the taboo surrounding discussing sexuality declines, if shame in purchasing condoms will also diminish.

Moving from young men’s sexual lives prior to marriage, the next section explores men’s entry into marriage, the determinants, the delays, and the idea that the marriage market never ends for those who approve of or desire polygamous unions, still common in the North region of Cameroon.

**Determinants of timing of marriage**

Men in the North region of Cameroon, in general, do not continue with youthful pastimes indefinitely. Most men marry, in the 2011 DHS, only 6% of 35-39 year old men had never married, and every man over 40 had married. However, there are several requirements necessary for men to move from the unmarried to married state, including being psychologically and financially ready for marriage. Issa discussed the age range this readiness generally occurs in, and how men feel at this stage. He said, “he wants to have his house, because he wants to have security for his family. So to have all of that, and finish with playing, that takes 25 years. Sometimes 30 years. And it is between 25 years and 35 years the people marry, because they think that now they are responsible, they are conscientious, they know what they want to do with their lives. And they are also socially and physically, and sometimes materially ready to marry.” The idea that
men have their lives on a path is important. However, it is not always solely the individual; social and familial ties that can influence the shift towards stability. Issa also explained the pressure on young men to end their playtime and start a family. He said, “at 25 years he already starts to think, he sees that some of his friends, they are already married. He already starts to feel lonely. So he says ‘Ok, I also think that I should start now to reflect on getting married.’ There is social pressure, there is family pressure, that says that ‘You still haven’t found a fiancée?’ When your aunt comes to your house, she says, ‘Where is my daughter in law? I want to eat the food of you wife. What are you waiting for?’” Because men are expected to marry, there is much pressure put on them to eventually become more mature and find a wife.

One major theme in the interviews, when discussing timing of marriage, which also involved maturity and stability, was education. Schooling, while seen as making individuals more mature, also delays their entry into the marriage market. When I asked David, who at the time was studying for an advanced degree, when men want to marry, he replied “Here is it .. if they want to continue with their education. My little brother has a wife, he is 28… But I want to continue my school and that is why I don’t have a wife. It depends on what you are looking for in life.” Eriksson et al. (2013) find in their interviews from South Africa that boys describe girlfriends as a distraction during school, something that should be avoided so that more time can be spent focused on studies. Marriage at a young age means leaving school. François described his personal experience and what often happens with others who do not continue schooling. He said, “it depends on the environment. If a boy does nothing, he is going to get married in the village. A boy that doesn’t go to school, he is going to marry. Me, I was married at 31
years. Because I had my professor who told us that if you have not yet started to work, you must not marry. And that stayed in my head. But in village, when a boy is 17, 18, 19, when he doesn’t do anything, one gives him a wife.” The distinction here is that boys in the villages can start working, but those attending school cannot. As the next section will show, there are major economic difference between urban and rural areas, which lead to a divergence in age at marriage patterns between these communities: in the North region during the 2011 DHS, the median age at first marriage or cohabitation for men was over 3 years higher in urban areas compared to rural areas (28.9 compared to 25.6).

A core question in the interviews was at what age men want to marry, to understand end chapter of men’s unmarried, sexually active lives. The responses rarely included a universal age at which all men wish to marry; instead, I was presented with many caveats. While the interview subjects suggested that economics determined timing of marriage, there existed a major distinction between those who live in rural and urban areas and the economic abilities they must possess in order to marry. Bernard described it, “when one lives in a village, one starts activities starting from 14, 15 years. That means the youth can already go to the fields, farm, have some money. He is not too dependent on his parents. Once he has some means he can get married- 16, 17, 18 years, 20 years… While when one is in a city, it is necessary first to have work. It is necessary to have a certain social security. It is all that and you will see that people are already to 30, 35, 40 years without being married.” While it is necessary to have means in the long run to support a family, what also is necessary is the payment of bride price, a practice common in the North region of Cameroon.
Bride price is the transfer of wealth (cattle, money, cloth, etc.) from the groom’s family to the bride’s family in return for the woman’s reproductive and household labor (Anderson 2007). Traditionally, extended families would help with bride price, but as Peter said “Cameroonian are becoming more and more individualistic” and men must save. In rural areas, families may still help with marriage payments in order to guarantee descendants. Pierre told me of such a scenario: “Imagine that you have a parent who has certain means, and finds out they are going to die, since he wants to have a grandson, he is going to tell his child to marry a wife so that he can see his grandchild before he dies. I have seen that, I have seen boys who were married because their fathers decided that their children should marry. Because he doesn’t want to die without seeing his grandson.” This can be the case even when death is not imminent. Aboubakary explained how parents can have different influences depending on location. He said, “if you are the first son of your parents, if you are the only son of your parents, your parents say that you must marry quickly so you can give us other children. One pushes you often to quickly marry, at 17 or 18 years even you marry so that you can give them children. In the city that argument doesn’t work, because one doesn’t only see the children, but the cost.” As Aboubakary’s quote illustrates, in the rural areas, the major expense in marriage is the bride price, while in urban areas the costs after marriage are also great, as children are more expensive in the city. Because of the high cost of city life, parents (and extended family) have less influence on the timing of their children’s marriages, where the costs of family is less about bride price and more about the long term costs of children.

In the interviews, people talked about the accumulation of wealth not just for a wife, but multiple wives. Polygamy is still common in the North region of Cameroon, both among
Muslims (28% of married Muslim men had more than one wife in the 2011 DHS) and Christians (18% of Christian married men had more than one wife in the 2011 DHS). Peter explained the connection between wealth accumulation and marriage. He said, “what actually pushed those men to get married is … when they feel they have arrived for it, when they have the means. They know that marriage comes with responsibility. They need to take care of the woman, they need to take care of the children. So you have many people that do not marry at an early age because they are looking for the means, especially here in the north. Most of them go in for late marriages because they are still looking for the means. ‘I am not yet ready, I do not have the money.’ ‘I am looking for the money, when I am ready I will go in.’ And truly, when you see them get the money, they go in. And not only for one, or two, or three… as the money increases… polygamy.” Therefore, for men who approve of polygamy, they never really leave the marriage market. Additionally, many interviewees discussed married men’s sexual relationships with outside partners, so again, even though they are not practicing traditional polygamy, they are not completely removed from the realm of non-marital sexual relations.

Many of the people interviewed felt that it was becoming harder for men to support multiple wives with the increasing monetization of society. François explained Muslim men’s apprehension: “the religion allows them to take four wives, but these days even so they say that to have four wives is to have four problems.” While more men are turning away from the ways of their fathers (several men interviewed discussed the poverty they experienced growing up in a polygamous household and how it influenced them to only take one wife), others are unsatisfied with the four wife limit. Issa gave an example: “So
as polygamy is also authorized, there are people who have four wives. They are 30 years old and they have 4 wives. And when he sees a girl who interests him outside, who is called Kristin, or I don’t know who, he says ‘Ah! I will marry that girl.’ He goes to the house, he looks at his four wives, who is he going to expel because he can’t have more than four wives in the Muslim religion. Who is he going to get rid of to marry the other woman? He looks and says like that the marriage is over. There is not a reason… But people always do gymnastics to find what interests them and say that they are going to create little reasons to divorce a wife.” And so, even at four wives, men may not exit the marriage market. However, this portion of the population is small (only 1% of men in the North of Cameroon in the 2011 DHS reported four or more wives), and many men, especially in urban areas, find it economically difficult to find one wife, let alone four. The cost associated with marriage in Cameroon is one cause of men’s long periods of non-marital sexual activity, as seen in many other countries in sub-Saharan Africa and around the world.

Men’s desired family size

As this dissertation has shown, many countries have seen a decline in men’s desired family size over the previous 35 years (since DHS began interviewing all men about the subject). This decline has not been among all men, but rather, as the interviews also illustrate, some men now have defined ideal family sizes (even approaching replacement level) while others still subscribe to an “up to God” concept of reproduction. A common indicator, brought up by many interview subjects, of how many children a man desires, is education. David said, “the men who don’t go to school, they say that they are going to have as many children as god gives them. The others agree to use contraception. I, for
example, do not want to have more than four or five children.” Nicole gave a similar comment, “a civilized man, a man who has frequented [school], who has an objective, wants to have a certain number of children. But he who walks without an objective, even if it’s ten, he doesn’t keep [a number in his head].” The ideal can depend on how much the man believes he will have to invest in his children, and as many said, those who want a large number of children do not think of the costs of education for their children. Issa explained, “there are some who say that they are even going to give birth to 100, it is not a problem. Their education and all that is not a worry. They say that they are going to handle their life like that. But there are some who think that if they have four or five or ten, it is good.” The average ideal number of children among men in the North Region of Cameroon is still much higher than replacement (8.5 children, calculated from the 2011 DHS), and some interview answers pointed to the remaining uncertainty surrounding child survival as a reason for the high number. Phillippe said, “At least four, because one says that if the epidemic comes, that would take everybody. So maybe that makes them afraid.” While child mortality has declined in Cameroon (from 144 (in 1991) to 128 (in 2011) deaths under age 5 per 1000 live births), this is still a consideration for many people and influences their desired number of children.

Many changes are occurring in the North of Cameroon, and elsewhere throughout sub-Saharan Africa, which have shifted the view of children as potential wealth to great cost. Peter explained, “in the past the idea was that a man who has many children, it was very expected, because children are considered to be wealth. And especially female children. If you had many more female children, ten female children, or seven and two boys, or nine and one boy, most of them are very happy because there are an inflow of men,
rushing in to knock at their door for many of them into marriage. And they receive gifts from these who got married to their children. But now the train is not that way, the train has changed. You see, there are lots of financial difficulties, economic crisis has come, has led everyone to understand that if you have many children you will not be able to take care of them. So now the general tendency is many are talking about three, two, it’s not even four. Some think that four is too much.” As mentioned earlier, Cameroon is becoming more individualistic, and as Peter continued “now, people are looking at their immediate families. So if you are giving birth to many children now and thinking of the fact that you have an uncle that is very rich, no one is coming to your assistance.” People may not be able to depend on extended family as they used to, and at the same time the costs of children are rising in the increasingly monetized society, especially as the government no longer provides the social services it once did. Aboubakary explained the changes that have come around since his childhood: “school is very expensive. Care as well. Medical care was free, or practically free, you went to the hospital and they cured you.” People interviewed, and those around them, internalize the new expenses, and how those multiply with children. François discussed it as such: “If one teaches that life is expensive, life is difficult, to limit problems, it is necessary to have fewer children to take care of; that limits the cost of life for you.” Aside from monetary costs, time costs of raising children were also a subject of discussion. Étienne, 19 and male, and still a student, told me that people, especially successful people, just did not want large families because of their limited free time. He said, “I would say that people who are well off don’t have enough time to be responsible for those children. And when they have time it’s only a little so they prefer to have the least amount of children and work a lot.” In
sum, many changes are occurring in Cameroonian society which lead individuals, on average, to a smaller desired family size. Whether it is financial constraints or individualism, fewer and fewer people are leaving their families “up to God.”

With all these changes, conflicts arise, often within couples. Several people told me of divorces resulting from differing ideas around family size. I asked people, when marriages do stay intact, who achieves their desired goal? Many people spoke, with force, that it would be the man. Halimatou said, “the man wins, always! He is the master of the family.” And Bernard explained that men still have control over their wives. He said, “there are religious barriers, cultural barriers, which make it so the woman does not always have the possibility to make decisions. You see that here the women are in the compound, that means that to leave it is necessary to ask permission from her husband. And if her husband refuses, she can’t go; she can’t enter into the possession of family planning services and contraceptive methods.” While pronatalist men may be able to block their wives’ access to contraception, interview subjects also described how women are really in charge of contraception (many men expressed the idea that contraception was a women’s business), and if a wife wants more children than her husband, she will achieve her goal. Robert said, “if the woman decides that she wants 10 children, even if the man says he wants five, the woman decides. She will go to ten children because all the things come by her.” This idea, that women really controlled family planning, was repeated in many interviews. In one, Aboubakary explained his own spousal disagreement, “in my case, I told her that I wanted two, now I am displaced\textsuperscript{38}, she lied about her cycle and then a child came. She made up stories, for three months I was

\textsuperscript{38} He is a government worker, living in a different region than his wife
angry, you see that that creates anger like that.” In Aboubakary’s situation, he wanted two children while his wife wanted four. The story he is telling actually happened twice, and now Aboubakary has four children. He was very upset with his wife, but there was little he could do, as he expressed displeasure in condom use and believed that the responsibility of preventing pregnancy relied on his wife knowing her ovulation cycle. This discussion shows that in an area where contraception is available, but not easily or discretely accessible, the more pronatalist individual in the couple often comes away with their desired family size.

This section has illustrated the heterogeneity in men’s ideal family size. Yes, some men may still want as many children from as many wives as they can, but more and more men have a numeric desired family size and should therefore be included, with their partners, in discussions of family planning so that they may find the means to achieve their goals.

**Discussion**

As the results from the interviews have shown, there are societal changes occurring which affect the lives of young men. In this section I will highlight four: the HIV/AIDS epidemic, increased educational attainment, urbanization, and westernization. Many aspects of these concepts overlap, and changes are unable to be neatly separated into these categories.
HIV/AIDS Epidemic

In Cameroon, the presence of the HIV/AIDS epidemic has grown in the last two and a half decades, from less than 0.6% in 1990 to 5.1% in 2010 (National AIDS Control Group 2010). For more detailed estimates of HIV prevalence in Cameroon, we turn to the Demographic and Health Survey, which in 2011 estimated the proportion of 15-49’s infected to be 4.3%. The North region has the country’s second lowest regional prevalence, with only 2.4% of individuals aged 15-49 infected. There is also a large disparity between the prevalence of women (3.5% regionally, 5.6% nationally) and men (1.5% regionally, 2.9% nationally). What is interesting, is that even though the prevalence is relatively low in the north of Cameroon compared with the rest of the country, there is still much discussion surrounding HIV/AIDS. As I mentioned in the results section, the epidemic has forced the subject of sex and sexuality to move from a taboo subject to a public health concern. There is an inflow of money into the region (and Cameroon in general) as seen by the presence of non-governmental organizations (such as Population Services International which partners with ACMS, who hosts the weekly radio show discussed earlier) and international government donors (including USAID and PEPFAR) focusing on HIV education.

Discussing HIV prevention brings men directly into the discussion of family planning, as the primary users of condoms (female condoms were often referenced in interviews, but were available on a much more limited scale). Because of the differential of HIV prevalence between genders, men, as with pregnancy, bear fewer costs than women in unsafe sexual intercourse. However, unlike pregnancy, men do not have the ability to escape responsibility.
The North region of Cameroon has experienced an increase in conversation about HIV/AIDS and sex in general, while being spared the high prevalence of other regions and countries on the continent.

**Increased educational attainment**

A positive societal change occurring in the North (and elsewhere), is the steady increase in years of schooling for both genders, though the male median education, nationally, was still a year greater than female in 2011. Looking at the educational attainment of men in the North region in 2011, major changes can be seen. Men age 20-24 had over twice as much education, on average, compared to those 50-54 (6.1 years versus 2.6). When looking at the proportion with at least some secondary education, the difference is even more dramatic, with less than 8% of 50-54 year old men falling into this category compared to 43% of 20-24 year olds.

The increasing levels of education among men in the North of Cameroon is delaying their initiation into adulthood, as the interviews repeatedly reported education as a key determinant of later marriage and sexual initiation. Additionally, increased education is associated with a smaller desired family size. Thus, as educational attainment continues to grow, we may see a decline in fertility and a further increase in the age at marriage resulting from the improved access to and attainment of education.

**Urbanization**

The proportion urban has increased in Cameroon from 37% in 1991 to 51% in 2011. With this rise comes an increase in the proportion of people dependent on wages to support themselves and their families. As discussed by Silberschimdt (2001) in her work
in Dar es Salaam, inability to accrue a living can leave men with a feeling of inadequacy. My interviews suggested that living in urban areas may lead men to delay marriage because they do not have the means, but there are still opportunities to earn small amounts of money to cover the expenses of less formal relationships.

Urbanization can also separate young men from their parents, and as Aboubakary implied in his interview, this separation can decrease parental influence over their children’s actions. If parents are not giving their children the land necessary for supporting a family, they have less power to push their children into marriage or bear children.

Living in urban areas, as Bongaarts et al. 1984 point out, also leads to more education for women, which lead to a delay in marriage. Many aspects of urbanization, including wage earning, lack of familial influence, and increased education combine to make an ideal environment for “playtime” prior to marriage. In urban areas, disparities exists in wage earning, especially between the formal and informal work forces, which lead to the inequality ideal for multiple partnerships (Becker (1974) states that polygamy can occur either in areas with skewed sex ratios in the marriage market or inequality among men). As found in other qualitative work (Calves et al. 1996), young men without the means to show women a good time are jealous of the men with more resources, and therefore more partners. So, while urbanization can create an ideal playground for some, it also leaves others with limited economic or romantic opportunities.

**Westernization**

Finally, in connection with the above highlighted societal changes, is the increasing westernization of the north of Cameroon. Media access has become prevalent in the
region, with the percent watching television increasing from 26% in 2004 to 40% in 2011. The North has lower viewership than the country as a whole, where the percent watching television rose from 45% in 1998 to 64% in 2011. Television is much more common in urban than rural areas (86% versus 37% for the whole country in 2011), but even in rural areas, over half of the people interviewed by the DHS in 2011 reported listening to the radio weekly. While there is Cameroonian programming, satellite television has brought in programs from around the world. French television shows (especially news programs and music videos) were commonly mentioned in my interviews as popular entertainment. As interviews said, the media introduces children (and adults) to many new ideas, some of which may be unwelcome. Still, the media is able to spread information quickly across the region.

Increasing westernization can also be seen in the decline of polygamy in Cameroon. In 1991, 26% of married men in the country had more than one wife. By 2011, this number declined to 16%. There are many things which can account for the decline in polygamy, including the increased status of women and the economic difficulty of obtaining multiple wives.

On a similar note, the desired number of children has also declined dramatically among men in Cameroon, from 12.3 in 1998 to 6.7 in 2011. While this number is far above replacement, it has almost halved in 13 years. This decline is a perfect illustration of a change in men’s sexual and reproductive lives which should prompt their inclusion in the realm of sexual and reproductive health.
Many societal changes have been and will continue to occur in the North region of Cameroon which will affect young men’s lives. While the HIV/AIDS prevalence is optimistically expected to plateau (according to estimates from the Health Policy Initiative), educational attainment, urbanization, and westernization should continue to increase and impact young men, as well as the rest, of Cameroonian society.

Conclusion

This chapter has provided an in-depth investigation of young men’s sexual lives. Relying on interviews conducted in the North region of Cameroon, means by which boys learn about sex and contraception have been identified, including peers, family, media, self-discovery, and formal sexual education both in and out of school. Given the long period of sexual activity prior to marriage, interviews focused on what men did during this time, and how this activity affected their sexual health. Additionally, what determines the timing of the end of this period was investigated, with notable differences emerging between urban and rural residents. Finally, since men have influence on their partner’s fertility, this chapter explored men’s changing ideal number of children, and the heterogeneity in desires among men in the region. Many changes are taking place in the North region of Cameroon, as well as throughout sub-Saharan Africa. The understanding of young men’s sexual desires and actions provides us with key insight into sexual and reproductive health as young men’s sex lives affect their partners, their future wives, and themselves.
References


—. 2011b. "Risky Sexual Behaviour among Unmarried Young People in Cameroon:


Magadi, MA. 2011. "Understanding the Gender Disparity in HIV Infection across Countries in Sub-Saharan Africa: Evidence from the Demographic and Health
Social Marketing to Promote Adolescent and Young Adult Reproductive Health in Cameroon." *AIDS Education and Prevention* 12(5):383-404.


**Tables and Figures**

Table 1: Interview Subjects Information

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<td>Peter</td>
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<td>48</td>
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<tr>
<td>Philippe</td>
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<td>22</td>
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<tr>
<td>Pierre</td>
<td>Male</td>
<td>30</td>
<td>Teacher</td>
</tr>
<tr>
<td>Robert</td>
<td>Male</td>
<td>36</td>
<td>Preacher</td>
</tr>
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</table>
Conclusion

This dissertation has highlighted the heterogeneity of men’s need for, attitudes towards, and use of contraception in sub-Saharan Africa. The first two chapters examined how we can use available data to increase our understanding of men’s sexual and reproductive lives. What these chapters have shown is an overwhelming demand among men for access to family planning for themselves and their partners (with limited use achieved) and a great support for contraception in general. The final chapter gave a detailed view of men’s sexual lives on a small portion of the continent, from the means in which men learn about sex to determining what is necessary for men to enter into marriage.

The continued focus of this dissertation is the complicated nature of men’s sexual experiences. Compared to women, men have a higher rate of multiple partnerships before marriage, a higher likelihood of engaging in an extramarital partnership while married, and the ability to be the key node in long-term polygamous unions, studying men’s fertility and sexual behaviors is a challenge. But we as demographers have the ability to enhance our understanding. The data currently available may be limited, but its analysis provides a jumping off point to a greater understanding of men’s role in fertility, reproduction, sex, and even the spread of HIV/AIDS.

In the future, more data is needed; surveys must take into account the complex nature of sexuality and reproduction. There were several questions I wished to explore in my dissertation, which I was unable to because of data availability. I would like to address them here, in the hope that someday they may be answerable.
Currently, the Demographic Health Surveys ask men questions about their fertility desires in general, not conditional on partner. While the DHS asks about contraceptive use with each partner (in a limited number of surveys), there is nothing like this for fertility intention. This speaks to a biased belief that men’s role in sex is limited to wearing condoms to limit the spread of HIV/AIDS. What we should understand more is men’s roles as fathers, and this begins with fertility intentions. This understanding is especially important in polygamous unions, where little is known about desired fertility with individual wives. Understanding men’s fertility intentions with each partner acknowledges the complicated nature of polygamy, and would allow us to better serve the family planning needs of individuals in these relationships.

On a similar note, very little information is collected by the Demographic and Health Surveys concerning men’s roles as fathers of children once they are born. Several years ago, when this dissertation was just a seed starting to take shape, my intention had been to include a chapter on the role of men as fathers in sub-Saharan Africa. Data exploration showed this to be almost impossible. Aside from a question about treating a child’s diarrhea, most questions asked to men focus on pregnancy, childbirth, and contraception. Asking more questions to men would, at the minimum, provide us with a baseline understanding of men’s roles in families. So many changes are taking place in sub-Saharan Africa with urbanization and westernization, as Chapter 3 illustrated, that the nature of family may also be undergoing a transition. However, if we do not have the data, we cannot speak firmly on this topic.

Understanding men’s role in sex, contraceptive use, disease transmission, and reproduction may be complicated, but it is an integral piece of the sexual and
reproductive health framework that can no longer be ignored. This dissertation presents examples of ways in which we can go about research, and I hope that as this dissertation becomes a long ago memory in my mind, that discussion about men and fertility extends beyond its one sparsely attended section at the Population Association of America’s annual meeting, and instead finds itself part of the everyday language of fertility and reproductive health research and interventions.