



WHAT ABOUT BOYS?

A Literature Review
on the Health and Development
of Adolescent Boys



Department of Child and
Adolescent Health and Development
World Health Organization



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introduction

Assumptions are often made about the health and development of adolescent boys: that they are faring well, and supposedly have fewer health needs and developmental risks compared to adolescent girls; and that adolescent boys are disruptive, aggressive and “hard to work with.” This second assumption focuses on specific aspects of boys’ behaviour and development – such as violence and delinquency – criticising and sometimes criminalising their behaviour without adequately understanding its context.

These generalisations do not take into account the fact that adolescent boys – like adolescent girls – are a heterogeneous population. Many boys are in school, but too many are out of school; others work; some are fathers; some are partners or husbands of adolescent girls; others are bi- or homosexual; some are involved in armed conflicts as combatants and/or victims; some are sexually or physically abused in their homes; some sexually abuse young women or other young men; some are living or working on the streets; others are involved in survival sex.

Adolescent boys – like adolescent girls – are a heterogeneous population. Some are faring well in their health and development. Other boys face risks and have needs that may not have been considered, or are socialised in ways that lead to violence and discrimination against women.

The majority of adolescent boys are, in fact, faring well in their health and development. They represent positive forces in their societies and are respectful in their relationships with young women and with other young men. However, some young men face risks and have health and developmental needs that may not have been considered, or are socialised in ways that lead to violence and discrimination against women, violence against other young men, and health risks to themselves and their communities.

New research and perspectives call for a more careful and thorough understanding of how adolescent boys are socialised, what they need in terms of healthy development, and what health systems can do to assist them in more appropriate ways, and how we can engage boys to promote greater gender equity for adolescent girls.

The purpose of this document is to review existing and available literature on adolescent boys and their health and development; analyse this research for programme and policy implications; and highlight areas where additional research is needed. This document also seeks to describe what is special about adolescent boys and their developmental and health needs, and to make the case for focusing special attention on meeting the needs of boys and on working with boys to promote greater gender equity for adolescent girls.

Finally, this document is limited by information that was available. Some of the research and information on programmes working with adolescent boys is not in print; in many cases, programme experiences are new and have not yet been evaluated or documented. In many parts of the world, studies on adolescent health focus primarily on adolescent girls (Majali and Salem-Pickartz, 1999).

Applying a Gender Perspective to Adolescent Boys

The “why” of focusing on adolescent boys emerges from a gender perspective. The review of research used a gender perspective from two approaches – **gender equity** and **gender specificity**.

Gender equity refers to the relational aspects of gender and the concept of gender as a power structure that often affords or limits opportunities based on one’s sex. Gender equity applied to adolescent boys implies, among other things, working with young men to improve young women’s health and well-being, and their relative disadvantage in most societies, taking into consideration the power differentials that exist in



many societies between men and women. A common refrain from programmes working in women's and young women's health in many parts of the world is that girls and women are asking for greater involvement of men and adolescent boys in themes that were once defined as "female" – particularly, reproductive health and maternal and child health. Many advocates argue that unless adult and young men are engaged in these issues in appropriate ways, gender equity will not be achieved. Thus, a gender equity perspective for working with adolescent boys suggests that we examine how social constructions of masculinity affect young women and how we can engage adolescent boys in improving the well-being and status of women and girls.

Gender specificity refers to examining specific health risks to women and men because of: 1.) health problems that are specific to each sex for biological reasons (such as testicular cancer or gynecomastia for young men); and 2.) the way that gender norms influence the health of men and women in different ways. The typical approach to gender specificity in health promotion has been to show how each sex faces particular risks or morbidities and then to develop programmes that take into account these specific needs. Applying gender specificity to adolescent males suggests that we focus our attention on those areas where young men have high rates of mortality and morbidity and on those areas in which gender socialisation influences young men's health behaviour and health status (NSW Health, 1998).

A gender equity perspective has long been considered in women's health, examining how unequal power differentials between women and men adversely affect the health and well-being of women. In recent years, however, a number of researchers, theorists and advocates have asked us to reconsider some of our traditional notions about gender power differentials and male dominance. Other researchers have questioned some of our assumptions about men, and how much we really know about the socialisation of boys and men.

Research on adolescent and adult men has suggested that while men were often considered the default gender, they have not been adequately studied or understood.

Emerging research on adolescent and adult men has suggested that while men were often considered the default gender, they have not been adequately studied or understood. Some authors argue that much social science research assumes that men are genderless (Thompson and Pleck, 1995). A review of literature on delinquency and crime – which is overwhelmingly perpetrated by adolescent and young men – concludes that masculinity has been seen as inherently violent and that the impact of gender socialisation on men has largely been ignored in the study of violence (Messerschmidt, 1993). Numerous researchers have argued that men have been treated as absent in the reproductive process, whether in research on fertility or in programme development (Figueroa, 1995; Greene and Biddlecom, 1998). Thus, one of the compelling rationales for applying a gender-specific perspective to adolescent boys is that while we sometimes had statistics on their health conditions and health-related behaviours, we did not have an adequate understanding of their realities, their socialisation and their psychosocial development.

In the last 15 years, a growing body of research on men and masculinities has contributed greatly to our understanding and offered new insights on men's health-related behaviours and their development. Connell's work (1994 and 1996) has been important in introducing the notion of multiple versions of masculinity or manhood, recognising that manhood is not a singular entity. Connell suggests that most cultural contexts have a "hegemonic masculinity," or a prevailing model of masculinity against which males compare themselves, and alternative versions of masculinity. This theoretical framework is useful in identifying men who find ways to be different than the prevailing norms — an important point if we seek to promote more gender-equitable versions of masculinity.



New perspectives suggest that male privilege is not a monolithic structure that distributes an equal slice of advantage to each man. Low-income men, young men, men outside the traditional power structure, men who hold alternative views, homosexual and bisexual men, and other specific groups of men are at times subject to discrimination.

While we must keep in mind that men and boys as a group have privileges and benefits over women and girls, new perspectives suggest that male privilege is not a monolithic structure that distributes an equal slice of advantage to each man. Furthermore, in other cases, it may be that the “costs” of masculinity exceed the benefits and privileges. Low-income men, young men, men outside the traditional power structure, young men in some settings, men who hold alternative views, homosexual and bisexual men, and other specific groups of men are at times subject to discrimination. Connell’s work and that of other authors (for example, Archer, 1994) have called us to examine not only how men and women interact, and the power differentials in such interactions, but also how men interact with other men and the power dynamics and violence that sometimes emerge in such interactions. While we should not portray young men as “victims”, this new field of research on men has also demonstrated that while men and boys may have aggregate privileges over women and girls, manhood generally brings with it a mix of privilege as well as personal costs - costs that are reflected in the mental and other health needs of men. Being socialised not to express emotions, not to have close relationships with one’s children, to use violence to resolve conflicts and maintain “honour,” and to work outside the home at early ages are among the costs of being a man.

Applied to the health and developmental needs of adolescent boys, the field of masculinities is helping us understand how boys are socialised into prevailing norms about what is socially acceptable “masculine” behaviour in a given setting and how boys’ adherence to these prevailing norms can sometimes have negative

consequences for their health and development. Of course, we should be careful not to portray boys as mere puppets to social norms, and to recognise the contextual nature of their behaviour. Nonetheless, it is clear that the versions of masculinity or manhood that young men adhere to or are socialised into have important implications for their health and well-being and that of other young men and women around them.

Finally, however, we should remember that gender is only one variable affecting development and health. Social class, ethnicity, local context and country settings are all important variables that interact with gender to influence health and well-being. By focusing on gender, and specifically masculinity, as the variable, we have to be careful not to lose sight of these other important variables. Some searchers and advocates have questioned whether paying too much attention to gender may draw our attention away from the fundamental social class and income inequalities related to adolescent health and development.

It is also important to keep in mind that looking at what is unique about boys often requires comparing them to girls. In this document, “making the case” for focusing on boys often means highlighting areas where boys have higher rates of morbidities or mortality compared to young women. However, these comparisons are problematic for several reasons. First, comparing relative levels of disease burden by sex is not bias-free. Issues such as women’s victimisation by violence, women’s depression, and chronic pelvic pain related to sexual tract infections (STIs) are sometimes excluded from health statistics. Second, simply comparing relative levels of risk by sex can lead to a polarising and simplistic debate about who “suffers” more or which sex faces greater health risks. Third, by emphasising differences, we may downplay the important similarities between adolescent women and men. Furthermore, by calling attention to the needs and realities of adolescent boys we should not imply that girls’ needs have been adequately considered and included – indeed, in most cases they have not. Finally, we could lose sight of the fact that relationships between boys and girls are important to their development and well-being.



With these caveats, this document approaches the health and developmental needs of adolescent boys via three questions:

- * How do adolescent men and women differ in their health needs, strengths or potentials and risks?
- * What are the implications of gender-specific health needs for health interventions for adolescent boys?
- * Based on what we know about adolescent boys, how can we work with them to promote greater gender equity?

While a certain amount of comparison between the health needs of adolescent males and females is inevitable, the challenge is to examine the specific realities of adolescent boys in a way that allows us both to understand their legitimate needs and to work with boys to promote greater gender equity. From a women's rights perspective, some advocates, researchers and health practitioners have voiced a thoughtful

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concern that calling attention to the health needs of boys and men may draw resources and attention away from women's health concerns – concerns that in some countries have only recently begun to be addressed. However, if we use this dual perspective of gender specificity *and* gender equity, we can potentially avoid a debilitating debate over whose needs are more urgent and instead focus on gender equity for women and young men, and underline this and at the same time incorporating a concept of gender specificity when it is useful to understand the gender-specific health and developmental needs of boys.



adolescent boys, socialization and overall health and development

General Health Status and Health Trends

Like adolescent girls, adolescent boys are generally “healthy,” that is, they show low levels of morbidity and mortality compared to children and adults. However, some adolescent boys face specific morbidities and, on the whole, show higher rates of mortality than adolescent girls. According to international health data, the major difference between adolescent boys and girls is that boys generally show higher rates of mortality, in some places several times higher, while girls in most regions show higher rates of morbidity. Furthermore, there are significant differences in the causes of mortality and morbidity that boys and girls face. Boys world-wide show higher rates of mortality and morbidity from violence, accidents and suicide, while adolescent girls generally have higher rates of morbidity and mortality related to reproductive tract and pregnancy-related causes.

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This chapter reviews general health concerns of adolescent boys and the gender-specific challenges that boys may face as they transition to adulthood. Health and developmental concerns of boys affect their well-being during adolescence and have important implications for their future health and well-being as adults. WHO estimates that 70 percent of premature deaths among adults are due to behavioural patterns that emerge in adolescence, including smoking, violence, and sexual behaviour.

General Morbidity and Mortality

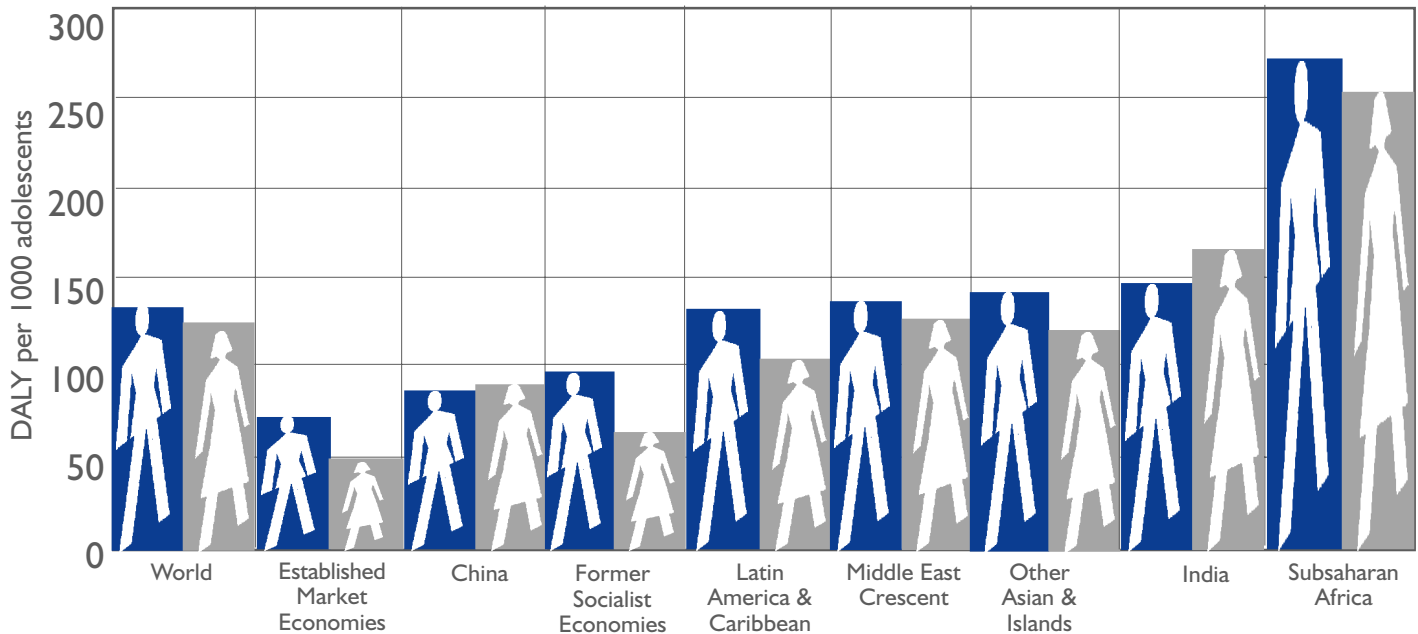
In every region of the world except for India and China (which combined represent about one-third of the world’s population), WHO data shows that Disability Adjusted Life Years (DALYs) lost, which take into account mortality and disability due to morbidity, are higher for men than for women (see Table 1). As we present DALY figures, however, it is important to keep in mind that such broad gender comparisons sometimes downplay other health issues. While there are fewer deaths among adolescent women world-wide, women may suffer from domestic violence, sexual violence and other morbidities that are reflected poorly or not at all in DALY figures.

In most regions of the world, adult men have higher mortality rates from causes not specific to either sex. Men die of heart disease and cancer more frequently than women at all ages, and until old age, men have higher rates of accidents and injuries. Women in most industrialised and many developing countries suffer from a higher incidence of non-fatal conditions and in some settings are more likely to pay attention to their health needs. Overall, in most regions of the world, men have higher rates of fatal conditions, while women have higher rates of acute illness and non-fatal chronic conditions.

According to these DALY figures, gender differences are highest in industrialised countries, in Latin America and the Caribbean, and in the former socialist economies of Europe. One possible explanation for this gender difference in DALYs is that in countries and regions that have made substantial advances in maternal and child health, the morbidities and mortalities of men represent a growing proportion of the public health burden. Overall, in Latin America and the Caribbean, for example, the health burden for men is 26 percent higher than it is for women (World Bank, 1993). Examining regional and country-level statistics on men’s health finds that much of this disease burden is due to health problems associated with the gender socialisation:



Graph I Sex differences in adolescent burden of disease
(DALYs for all causes in 10-19 yr olds, 1990)



traffic accidents (where bravado and alcohol use come into play), injuries (associated with the workplace and with intra-gender violence), homicides (the vast majority as a result of intra-gender violence) and cardiovascular diseases, associated in part with stress and lifestyles. Reviewing data from Mexico, Keijzer (1995) found that mortality rates for males and females are about equal until they reach age 14. At that time, male mortality begins to increase and is twice as high overall for males among young people ages 15-24. The top three causes of death for young men in Mexico – accidents, homicide and cirrhosis – are related to the societal norms on masculinity. These trends are repeated throughout Latin America and in other parts of the world, from the Middle East, to Western Europe, to North America and Australia (Yunes and Rajs, 1994; Commonwealth Department of Health and Family Services, 1997).

Limited studies using official health statistics from some industrialised countries suggest that from birth to age 7, boys have higher rates of health problems than girls. After the perinatal period, boys in Finland had a 64 percent higher cumulative incidence of asthma, a 43 percent higher cumulative incidence of intellectual disability, and 22 percent higher level of mortality. Similar trends have been reported in Australia. Some researchers suggest that there may be some biological propensity for boys' greater rates of

health complications during childhood, some of which may carry over into adolescence (Gissler et al., 1999; NSW Health, 1998).

Infectious Disease Burden

The limited data on sex differences in communicable and infectious diseases provides little evidence for sex differences. A national study of adolescent health in Egypt found that the prevalence of parasitic diseases was 57.4 percent for girls and 55.5 percent for boys, representing no statistical difference (Population Council, 1999). In terms of schistosomiasis, WHO data indicates that in affected regions, infection rates peak between the ages of 10-20 because of the degree of water contact and age-related immunity. Some gender differences are found in rates of schistosomiasis infection in specific contexts, depending on whether boys or girls are more likely to come in contact with infested rivers and lakes (Personal correspondence, Dirk Engels, 1999). The epidemiology of tuberculosis shows a different pattern. Recent WHO data indicates higher TB incidence and death in girls than in boys up to the age of 14. Between 15 and 19 that the pattern is inversed and boys show higher levels. However, for most infectious diseases, large sex differences are unlikely, except when differences in gender socialisation affect boys' or girls' exposure to infectious agents.



Self-Reported Health Status

From existing data on self-reported health status, it is difficult to arrive at any conclusions about whether boys or girls have better general health. Furthermore, when adolescents are asked to report their health status, their responses are likely to be influenced in part by gender norms. In most countries, girls are more likely to be attuned to health problems, whereas boys may be more likely to ignore them, to diminish their importance, not to report them and not to seek health services when they need them. For example, Thai girls were more likely than boys to report a current health problem: 25.2 percent for females compared to 14.9 percent for males. However, nearly equal numbers of males and females reported having purchased medication for themselves in the past month, suggesting that boys and girls face virtually equal rates of health problems, but that girls are more likely to report these problems (Podhisita and Pattaravanich, 1998). A national study on adolescent health in Egypt found that 20.7 percent of adolescents reported having had an illness in the previous month, the most common complaints being common cough and cold followed by gastrointestinal problems. There was virtually no difference in reported rates of illness by gender (Population Council, 1999).

Nutrition, Growth, Puberty and Spermarche

Nutrition

An analysis of existing data questions the long-standing assumption that boys' nutritional status is better than that of girls. In developing countries for which data is available, the nutritional status of boys and girls is about equal, or boys are faring worse. The exception is India, where girls' nutritional status is markedly worse than boys.

In a review of 41 Demographic and Health Surveys for 34 countries examining children from birth to 5 years, 24 surveys show that boys have higher levels of wasting than girls; 19 surveys show that stunting levels are higher for boys, while only five surveys show more stunting among girls. The differences in nutritional status between boys and girls ages 0-5 were relatively small, but the authors

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conclude that, overall, girls in the countries studied seem less likely to be undernourished than boys. Of the 34 developing countries included, the authors did not find any country where girls had a consistent nutritional disadvantage compared with boys (United Nations, 1998). Other researchers have hypothesised that differential treatment for boys and girls, favouring boys in terms of food allocation, should result in lower nutritional status for girls during later childhood and adolescence. However, data has either been inconclusive or has not confirmed this hypothesis, with the important exception of India, noted earlier.

With some exceptions, data on sex differences in stunting during adolescence are similarly inconclusive. Between 27-65 percent of adolescents showed stunting according to data from 11 studies representing nine developing countries. In Benin and Cameroon, boys showed more stunting than girls. The authors suggest that in these two countries, boys may be encouraged to be independent earlier than girls and are thus more likely to have diarrhoeal diseases. In India, stunting was far more prevalent among girls than boys – 45 percent compared to 20 percent – which is consistent with the presumed effects of gender bias in parts of South Asia (Kurz and Johnson-Welch, 1995). In the national adolescent health study in Egypt, boys were more likely to be stunted: 18 percent for boys versus 14 percent for girls (Population Council, 1998). In seven of eight studies presenting data, at least twice as many adolescent boys as girls were undernourished (Kurz and Johnson-Welch, 1995). A note of caution is needed in regard to anthropometric measures underlying stunting and wasting in adolescents. Recent work in this area by WHO shows that both the indicators to identify wasting and stunting in adolescents, as well as the cut-off points for different degrees of these conditions, need more research. It has not been established whether sex differences play any role in the anthropometry of nutritional status in adolescents.



Similarly, a review of data on the nutritional status of adolescents in developing countries found that prevalence of anaemia was 27 percent for adolescents overall, with similar rates among boys and girls (United Nations, 1998). In Egypt, the overall prevalence rate of anaemia was 47 percent, with little difference by gender. Boys had a slightly higher rate of anaemia until age 19, when anaemia for girls increased (Population Council, 1999). Adolescent girls were often presumed to have higher rates of anaemia because of iron lost during menstruation, but boys also have high iron requirements because they are developing muscle mass during the adolescent growth spurt.

The implications of a possible nutritional disadvantage for boys are unclear. Some authors have suggested that the issue is related to boys' delayed and longer growth spurt. In terms of stunting, boys may later catch up with girls. In any case, the existing data suggests paying closer attention to boys' nutritional status and re-examining the longstanding presumption of girls' nutritional disadvantages.

Puberty and Spermarche

Puberty is generally recognised as the beginning of adolescence. With biological changes and sexual maturation, adolescents must incorporate their new body images, reproductive capacity and emerging sexual energies into their identity and learn to cope with their own and others' reactions to their maturing bodies. There are *biologically-based* differences for boys and girls in the timing of puberty and *socially-constructed* gender differences in the meaning of and reactions to puberty for boys and girls.

In terms of biologically-based differences, sexual development among girls generally starts at age 8 with the first stages of breast development. Menarche usually occurs between 10.5 and 15.5 years with the female adolescent growth spurt between 9.5 and 14.5 years. Males are slower to mature sexually, with testicular enlargement generally occurring between 10.5 and 13.5 years and the growth spurt and spermarche about one year later (Population Council, 1999). Compared to growth during childhood, the growth during adolescence is

shorter but more intense. Most boys reach spermarche by age 14, and are about two years older than girls at the height of their maximum growth spurt. The amount of height attained during the growth spurt, however, is about equal for boys and girls.

The social meaning of menarche and spermarche are often quite different. Typically, boys are not encouraged to talk about pubertal changes nor offered spaces to ask questions or seek information about these changes (Pollack, 1998). In contrast, menarche sometimes implies enhanced social status while also bringing with it increased social controls over young women and their movements and activities outside the home. Societies seem to have developed more structures to discuss and prepare girls for menarche than they do boys for spermarche. However, these "structures" in some settings can be repressive for young women, including forced seclusion of girls of reproductive age and even female genital mutilation. Boys on the other hand, may be given more information and guidance related to sexual activity, but not necessarily information about puberty and its procreative implications. In some cases, boys have more information about menarche than ejaculation, given the societal importance attached to female reproduction. Reasonable conclusions are that puberty means intense social pressure for both boys and girls to ascribe to gender norms; that girls generally have their movements and activities restricted to a greater degree than boys after puberty; and that boys in some settings may have less guidance about their reproductive potential.

Puberty means intense social pressure for both boys and girls to ascribe to gender norms.

While there are some studies about adolescent girls and their reactions to puberty and physical changes during adolescence, research is lacking on how adolescent boys feel about their bodies and their ability to procreate. Among Brazilian university students, 50 percent of young men had positive feelings toward their body development and sexuality, 23 percent were indifferent and 17 percent reported being anxious



and uncertain about physical changes during puberty (Lundgren, 1999). Limited research in the U.S. has examined young men's awareness of themselves as procreative beings. Among young men ages 16-30 in the U.S., this awareness is not a major event. In fact, in their desire for sex, some young men even seem to repress notions or concepts of themselves as procreative. This limited research suggests the need to help young men think about themselves as procreative and to offer them spaces where they can discuss what it means to be capable of procreation (Marsiglio, Hutchinson and Cohan, 1999).

Biological Differences in Development

Some research has also examined hormonal differences in boys and girls, particularly the possible role of testosterone both in early childhood and adolescence. This limited research suggests that there may be significant hormonal differences between boys/girls and men/women that are still only partially understood. There may be biologically-based differences in early brain development for boys and girls which affects boys' and girls' styles of communication. Research suggests that early exposure to testosterone in infant boys is associated with boys' greater level of aggression and agitation, a lower attention span than in infant girls, and less visual acuity at early ages (Manstead, 1998). The meaning and extent of these biological differences are ambiguous. Furthermore, existing research suggests that overall differences *within* sexes are often greater than aggregate differences *between* the sexes. In any case, it is important to keep in mind that these biologically-based differences such as the biological tendency toward greater agitation in boys interacts with gendered-patterns of socialisation described below (Manstead, 1998; Pollack, 1998).

Socialisation and Psychosocial Development

Gender-Specific Theories of Adolescent Development

While biologically-based differences and overall growth and nutritional differences between adolescent boys and girls exist, probably the most significant differences, with the greatest implications for programme and policy, are those related to the gender-specific socialisation of young people and the ensuing differences in their psychosocial development before and during adolescence.

There is a growing body of research and theory on the psychosocial development of boys, mainly from industrialised countries, that serves as an important complement to previous work on the psychosocial development of adolescent girls. While there is considerable individual, local and cultural variation, there are similarities across cultures that allow us to begin to construct gender-specific theories of the psychosocial development of adolescent males.

It is important to keep in mind cultural variations in the concept of adolescence. There are major cultural and urban-rural differences in terms of whether the passage from childhood to adulthood is fairly short and direct, or whether it is prolonged (as in many modern, Western societies) and frequently marked by extended formal schooling and conflicting role expectations, among other common characteristics. In spite of cultural and contextual differences, there is a general consensus that adolescence implies, in addition to new reproductive capacities: 1.) an increase in cognitive abilities, and as a consequence, concern over future roles and identity; 2.) greater social expectations that the young person contribute to household income, maintenance and production; and 3.) social expectations of greater economic independence from the family of origin and/or the formation of a new family unit.



Keeping in mind these cultural variations in the concept of adolescence, emerging research on boys' psychosocial development concludes that boys have different potential crisis points during their psychosocial development and their own specific vulnerabilities, even though they sometimes appear and are assumed to be less psychologically vulnerable than girls in adolescence. New, more targeted research on adolescent boys finds that once we get beyond boys' customary silences, their "clowning" and their feigned indifference, boys face their share of challenges during adolescence that have often been ignored or sometimes misdiagnosed. Another common refrain in research on boys' psychosocial development is that men's discussions of identity and roles continue to be limited while 20 years of research and policy development expanded women's options and roles in some areas of the world. Boys world-wide report experiencing the dual pressures to act like "real men" as traditionally defined and to be more respectful and caring in their relationships with young women.

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In looking at the normative pattern of boys' development in Western settings, various researchers argue that boys experience difficult moments at ages 5-7 when they enter the formal primary school and have to learn how to sit still, stay on task and operate in educational systems that in some ways seem more attuned to girls' overall patterns of socialisation (Pollack, 1998; Figueroa, 1997). At the same time, entering the formal school system frequently means greater exposure to male peer groups and the "culture of cruelty" that they can perpetuate. Certain acts and behaviours considered "feminine" can elicit harsh criticisms from the social group, including using stereotypes of homosexuality. One

researcher in the U.S. suggests that both in their introduction to school and in early adolescence, boys are pressured to achieve autonomy and separation from familial support before they are necessarily ready (Pollack, 1998).

In adolescence, boys often face continuing pressure from the male peer group, where sexual experiences may be viewed as achieving or demonstrating competence, rather than achieving intimacy and connection (Marsiglio, 1988). In late adolescence, boys are often encouraged to further distance themselves from their parents. They may, in fact, desire greater connection with their parents or other adults but find themselves unable to express this desire because of social sanctions against boys' expression of emotional need and vulnerability (Paterson, Field and Pryor, 1994; Pollack, 1998).

Boys and Gender Identity Formation

These new perspectives on adolescent males build on previous research and theories on gender identity development and gender socialisation during early childhood. Many developmental psychologists argue that fundamental aspects of gender identity are linked to the earliest experiences of being cared for and to the person giving that care. According to these theories, the fundamental task of early gender identity development for boys is to develop a separate gender identity than the mother's and thus achieve a greater normative separation from the mother than girls generally do. At the stage of separation from the primary attachment figure (generally the mother), a boy must achieve separation and individuation, and publicly define his gender identity (Gilmore, 1990; Chodorow, 1978).

According to this theoretical perspective, boys become non-affective. To create an identity that is different from their mother's – in essence, anti- or not-mother – they frequently reject feminine characteristics, namely emotional displays and affection (Chodorow, 1978; Gilmore, 1990). Furthermore, with the pressure they face to define themselves as masculine in the public arena and because their male role models are often distant, boys may exaggerate their masculinity to make it clear in their social world that they are in fact "real boys" (Pollack, 1995; Chodorow, 1978). In sum,



numerous researchers and theorists argue that girls define themselves more in relationship to others because girls' intense attachment to their mother lasts longer (Gilligan, 1982; Chodorow, 1978). Several researchers assert that the clinical ramifications for men emerging from these early patterns are problems achieving intimacy and expressing emotions (other than anger), and hidden depression resulting from early unmet emotional needs. This depression may be manifested in alcoholism, abuse and anger (Levant and Pollack, 1995; Real, 1997).

Almost universally, cultures and parents promote an achievement- and outward-oriented masculinity for boys and men (Gilmore, 1990). This achievement-oriented manhood is specifically constructed so that boys reach the societal goals of being providers and protectors. Many cultures socialise young boys to be aggressive and competitive – skills useful for being providers and protectors – while socialising girls to be non-violent and sometimes accepting of male violence (Archer, 1984). Boys are also sometimes brought up to adhere to rigid codes of “honour” and “bravado,” or feigned courage, that obligate them to compete, fight and use violence, sometimes over minor altercations, all in the name of proving themselves as “real men” (Archer, 1994).

During late childhood and adolescence, boys may be more likely to accept traditional versions of manhood, displaying “machismo,” or an exaggerated sense of masculinity. Girls, however, are more likely to question traditional gender norms (Erulkar et al., 1998). Thus, the normative challenges in gender identity for girls may be to question the limits that they perceive are placed on them upon reaching puberty, while for boys, the challenge may be to prove oneself as a “man” in the social setting, while searching for ways to create intimacy and connection in private settings. Some researchers suggest a normative pattern of gender identity development in which adolescent boys pass through a period of exaggerated manhood, but then become more progressive or flexible in terms of their gender identities later in adulthood (Archer, 1984). However, other research from a lifespan perspective suggests that unemployment or social changes (for example, women's new roles in many societies) may threaten some men's conceptions

of masculinities and lead to more rigid conceptions of gender roles, and even to domestic violence. Thus, some men may over the lifespan become more flexible in gender roles, while for others, their views about gender roles may be situational. Additional research from a lifespan perspective is needed to offer insights on the tendencies and possible changes in men's views of their roles.

Is it possible to change how boys are socialised? First, it is important to affirm that not all traditional forms of raising boys, and views about manhood, are negative, nor are all boys socialised in the stereotypical ways presented in some research. Research suggests the important role of fathers and other male family members in raising boys who are more flexible in their views of masculinity. But all family members have an important role in socialising boys. Mothers and other female family members may inadvertently reinforce traditional views about masculinity by not involving boys in domestic tasks, or encouraging them to repress emotions or not to complain about health needs. Mothers, fathers, other family members, teachers and other adults who interact with young people may worry more about girls during puberty, believing that boys can manage without guidance. Research finds that when boys interact with adults and peers who reinforce alternative views about gender – for example, men involved in caring for children or in domestic tasks, or women involved in leadership positions – boys are more likely to be flexible in their views about gender roles (Pollack, 1998; Barker and Loewenstein, 1997).

Socialisation Outside the Home and the Male Peer Group

Studies from many parts of the world conclude that boys generally spend more unsupervised time on the street or outside the home than do girls. This time outside the home represents both benefits and risks for adolescent boys.

Studies from many parts of the world conclude that from an early age, boys generally spend more unsupervised time on the street or



outside the home than do girls, and participate in more economic activities outside the home (Evans, 1997; Bursik and Grasmick, 1995; Emler and Reicher, 1995). During adolescence, the amount of time adolescent boys spend outside the home increases further. In Latin America, for example, an important share of the economically active population is between ages 15-19. While labour force participation is increasing among females and decreasing for males, it continues to be substantially higher for males. In Ecuador, for example, 44 percent of boys and 19 percent of girls from low-income families studied were engaged in wage-earning activities. In five developing country studies reviewed, girls were more likely to do work in the home while boys were far more likely to work outside the home (Kurz and Johnson-Welch, 1995). In Egypt, one-third of adolescents work, with one out of every two boys involved in economic activities outside the home compared to one in every six girls. Also, 48 percent of boys went out with friends the day prior to the interview compared to 12 percent of girls (Population Council, 1999).

This time spent outside the home represents both benefits and risks for adolescent boys. While freedom of movement is generally a benefit, and provides boys with opportunities to learn social and vocational skills useful for their development, it also brings risks and costs. The primary risk is related to the kinds of behaviour and socialisation promoted by the male peer group. These peers may encourage health-compromising behaviours such as substance use or may promote traditional, restrictive male behaviours such as the repression of emotions.

Because of the time they spend outside the home, in many cultural settings, girls' role models (mothers, sisters, aunts, other adult women) are physically closer and perhaps more apparent for girls, while boys' same-sex role models may be physically and emotionally distant. Accordingly, some researchers have suggested that the male peer group is the place where young men "try out and rehearse macho roles," and that the male street-based peer group judges which acts and behaviours are worthy of being called "manly" (Mosher and Tomkins, 1988). However, the versions of manhood that are sometimes promoted by the male peer group can be

homophobic, callous in their attitudes toward women, and supportive of violence as a way to prove one's manhood and resolve conflicts.

While the male peer group is not the cause of males' aggressive attitudes or of macho attitudes, greater association with an oppositional, street-based peer group is correlated with academic difficulties, substance abuse, risk-taking behaviour in general, delinquency and violence (Archer, 1994; Earls, 1991; Elliott, 1994). Furthermore, while the male peer group is often studied for its negative influences on boys, there are also examples of male peer groups that have positive, prosocial influences on boys. A positive male peer group can serve several important functions: 1.) it provides a sense of belonging as boys seek or are encouraged to seek independence, 2.) it provides a buffer against a sense of failure that some low-income boys may experience in the school setting, and 3.) it provides boys with models for male identity, which may be missing in some homes.

It is interesting to note that some research suggests that this differential socialisation – girls closer to home and female role models, and boys outside the home – also leads to different kinds of cognitive development or "intelligences" for boys and girls. Consistently, women have a greater ability to read emotions and a greater ability to decode non-verbal messages (Manstead, 1998). Some researchers suggest that girls develop more "emotional empathy" – the ability to "read" and understand human emotions – while boys develop "action empathy" – the ability to "read" and interpret action and movement (Pollack, 1998).

Boys and School Performance

Emerging data on school performance and enrolment suggest that boys face special challenges in completing their formal education. In a 1994 UNICEF meeting, researchers from the Caribbean, North America, parts of South Asia and some urban areas in Latin America reported that in secondary schools in several countries in the region, young men currently comprise fewer than 50 percent of students in secondary schools (Engle, 1994). While female disadvantage in the education sector is still prevalent in many regions – particularly South Asia, Africa and some rural parts of Latin America – in other areas, girls'



disadvantage has diminished substantially and educational inequality based on socio-economic status is more prevalent than gender imbalances in education enrolment and attainment (Knodel and Jones, 1996). Where the structural barriers to girls' access to formal education have been overcome, there is increasing evidence that boys face gender-specific educational challenges.

Data on school performance in Western Europe, Australia, North America, parts of Latin America and the Caribbean suggests that where the structural barriers to girls' access to formal education have been overcome, boys face gender-specific educational challenges.

Throughout Western Europe (with the exceptions of Austria and Switzerland) girls currently outperform boys on standardised tests, graduate from secondary school in higher numbers and are more likely to attend university (Economist, 1996; Pedersen, 1996). In the U.S., national figures show that boys score higher on standardised tests in math and science, but girls score higher on writing and reading, arguably the most important skills for academic success (Ravitch, 1996). In low-income, urban areas in many industrialised countries, the differences between girls' and boys' academic performance are even more accentuated. In Brazil, as of 1995, 95.3 percent of young women ages 15-24 were literate compared to 90.6 percent of boys. In addition, 42.8 percent of girls in this age range were enrolled in school compared to 38.9 percent of boys. Boys are also more likely to repeat a grade (Saboia, 1998). The most frequent explanation for boys' lower school enrolment and achievement is that boys begin working outside the home at earlier ages and their work outside the home may interfere with school.

Similarly, by age 19, girls in the Philippines had on average 10 years of education compared to 8 years for boys. Girls also spend more time each week in school. As in Brazil, researchers hypothesised that boys were being taken out of school to work, but respondents felt that boys'

higher rates of school drop-out were related to gender issues within the school environment, namely that girls' behaviour patterns were more in tune with school norms (Kurz and Johnson-Welch, 1995). It is important to note that boys dropping out of school in order to work is not always perceived as negative. In certain parts of Nigeria, cultural practice requires boys to end their schooling around age 13 to become highly valued apprentices with trading masters. Women, therefore, are the majority at universities.

Researchers in parts of North America, the Caribbean, Australia and Western Europe are beginning to ask what specific factors impede boys' – and particularly low-income boys' – academic achievement. This research has focused on several issues, including the possibility that socialisation in the home for girls encourages positive study habits, and that the school environment is more conducive to “female” ways of thinking and interacting. In Jamaica, where girls are outperforming boys at the secondary and tertiary levels, boys are generally socialised to run free while girls are confined to the home. As a result, girls may learn to concentrate on tasks, sit still for longer periods of time and interact with greater ease with female authority figures. Research from North America and the Caribbean on low-income boys suggests that teachers (the majority of whom are women at the primary level) sometimes possess stereotypical images of boys, creating self-fulfilling prophecies – i.e. they think that boys will act out and, in turn, boys act out (Figueroa, 1997; Taylor, 1991). Qualitative research is also examining the dynamics of gender relations in low-income, urban settings where male peer groups may be ambivalent to school completion, and where school systems expel those children and youth who do not conform to its modes of authority and interaction – in most instances, these are more likely to be boys.

In Western Europe, Australia, North America, Caribbean and parts of Latin America, researchers are also examining learning disabilities that may impede boys' academic performance, including attention deficit hypertensive disorder (ADHD) – also known as hyperactivity or attention deficit disorder – which is more prevalent among boys than girls (Pollack, 1998). Boys also have higher reported rates of conduct disorder in school,



a factor associated with lower educational performance (Stormont-Spurgin and Zentall, 1995; Pollack, 1998). Boys who rated high on stereotypical “masculine” behaviours had the highest rates of externalising behaviour and conduct disorder, which in turn are associated with higher rates of school difficulties (Silvern and Katz, 1986).

While this research on boys’ experiences in the school system is far from definitive, a number of compelling questions arise. One is the cost of boys’ oppositional and aggressive behaviour in terms of their early educational achievement. At the primary school level, the control mechanisms that educational systems have over disobedient, troublesome or aggressive boys or those who are not performing at academic levels are various: placing boys in slower track groups, retention, or labelling them as having some specific problem, the most common being ADHD. While some boys have a neurological predisposition that warrants both the term and treatment associated with ADHD, some researchers and commentators have questioned the sometimes overzealous tendency to use this diagnosis in some Western settings (Mariani, 1995; Pollack, 1998). Researchers have confirmed a connection between early conduct disorder and ADHD and later involvement in delinquency and problems in the school setting (Moffitt, 1990; Cairns and Cairns, 1994). What is not clear is whether these boys have biologically-based temperamental traits that predispose them to ADHD and aggressive behaviour, or whether being labelled as “troublesome” or delinquent *leads* boys to become delinquent and have difficulties in school.

Boys’ school performance has important implications in terms of individual development and health. Research from North America has found that school performance as well as the degree of “connection” to the school are protective factors against health-risk behaviours. Youth who do better academically and who feel connected to their school display fewer risk behaviours, including substance use, early and unprotected sexual activity, and suicidal thoughts. (Resnick et al., 1997).

Boys and Health-Seeking and Help-Seeking Behaviour

The pressure to adhere to traditional and stereotypical norms of masculinity has direct consequences for men’s mental and other health, and for their health-seeking, help-seeking and risk-related behaviour. A national survey of adolescent males ages 15-19 in the U.S. found that beliefs about manhood emerged as the strongest predictor of risk-taking behaviours; young men who adhered to traditional views of manhood were more likely to report substance use, violence and delinquency, and unsafe sexual practices (Courtenay, 1998). Pleck (1995) asserts that violating gender norms has significant mental health consequences for men – ridicule, family pressure and social sanctions – and that a significant proportion of males feel stress as a result of not being able to live up to the norms of “true manhood.” O’Neill, Good and Holmes (1995) suggest that the version of manhood promoted in many societies leads to six characteristics frequently found in men: restrictive emotionality; socialised control, power and competition; homophobia; restrictive sexual and affectionate behaviour; obsession with achievement and success; and health problems. In settings where they feel comfortable expressing such emotions – generally outside of the traditional male peer group – some young men are able to express frustration at these rigid gender socialisation patterns just as girls have expressed frustration about their gender normative patterns (Pollack, 1998; Barker and Loewenstein, 1997; Gilligan, 1982).

Research confirms that boys are less likely than girls to seek health services when they need them and less likely to be attuned to their health needs. A study in Thailand found that adolescent girls in urban areas were more likely than boys to report having sought medical attention in the last month. However, nearly equal numbers of adolescents reported having purchased medications for themselves in the past month, suggesting nearly equal rates of illnesses for boys and girls (Podhisita and Pattaravanich, 1998). In a Kenyan study, girls were slightly more likely than boys to have used health facilities (52 percent versus 47 percent) (Erulkar et al., 1998). In Jamaica, a national survey of young people ages 15-24 found that young women were more than



twice as likely (29.8 percent versus 13 percent) to talk to health personnel about family life education topics than were young men (National Family Planning Board, 1999). A nation-wide survey of boys ages 11-18 in the U.S. found that by the time they entered high school, more than one in five boys said there had been at least one occasion when they did not seek needed health care. The primary reason cited was not wanting to tell anyone about their problem (28 percent), followed by cost and lack of health insurance (25 percent) (Schoen et al., 1998). Other anecdotal information finds that young men sometimes encounter hostile attitudes in clinics, that they perceive maternal and child health clinics and reproductive health clinics as “female” spaces, and that they are even turned away from clinics (Armstrong, 1998; Green, 1997). Young men in a Ghana study said they were sometimes turned away from reproductive health clinics because of their age; others said they were uncomfortable with female staff (Koster, 1998). Indeed, while there are health professionals who specialise in working with girls and women, such as a gynaecologist, there is no such professional for adolescent and adult men.

How might boys be encouraged to make greater use of existing health services? When asked, boys often say that they want many of the same things in health services that young women want: high quality service at an accessible price; privacy; staff who are open to their needs; confidentiality; the ability to ask questions; and a short waiting time (Webb, 1997; Site visit to CISTAC, Santa Cruz, Bolivia, 1998).

Research also suggests that gender socialisation is related to boys’ limited help-seeking behaviour. Boys are generally socialised to be self-reliant and independent, not to show emotions, not to be concerned with or complain about their physical health, and not to seek assistance during times of stress. Research in Germany with boys ages 14-16 found that in times of trouble, 36 percent would prefer to be alone and 11 percent said they needed no comfort; 50 percent of boys turned to their mothers, and fewer than 2 percent said they turned to their fathers (Lindau-Bank, 1996). Among low-income youth in the U.S., girls more frequently learn how to and are allowed to process pain and emotions

brought on by the frustrations of living in a low-income and violent setting (Nightingale, 1993). Researchers have concluded that the ability to process and express emotional stress in non-violent ways protects against a number of developmental and health problems. Thus, boys are at a disadvantage if they have fewer opportunities and feel constrained to express emotions associated with adverse circumstances and stressful life events (Cohler, 1987; Barker, 1998).

Boys’ difficulties in seeking help and expressing emotions have important consequences for their mental health and development. Where boys are working in large numbers or spend their time outside the home and school settings, boys may also be less likely than girls to be connected to informal and formal support networks. While male kinship and peer groups may provide a space for socialisation and companionship, they may provide limited opportunities for discussions of personal needs and health concerns.

The literature suggests that the biological differences that clearly exist between boys and girls affect their health and development in a more limited way than differences due to gender socialisation.

Implications

Summing up, the literature suggests that the biological differences that exist between boys and girls affect their health and development in a more limited way than differences due to gender socialisation. The literature identifies two key trends in the socialisation of adolescent boys with direct implications for their health and well-being: 1.) a too-early push toward autonomy and a repression of desires for emotional connection; and 2.) social pressure to achieve rigidly defined male roles. In some low-income areas – where access to other sources of masculine identity, such as school success or stable employment, are harder to achieve – young men may be more inclined to adopt exaggerated masculine postures that involve risk-taking behaviour, violence or sexist attitudes toward women, and violence against other men as a way to prove their manhood.



The implications of this research include:

Programme Implications

- * The need to sensitise health personnel and others who work with young people on the realities and perspectives of boys, and how to encourage boys to seek health services and help when they need it. This may also include engaging health personnel and other youth-serving staff in discussions about their own possible stereotypes about boys.
- * There is a need for health educators and other youth-serving staff consider alternative spaces for boys to discuss normative developmental milestones such as spermarche and puberty, and other issues.
- * There is a need to sensitise teachers and education personnel on the possible gender-specific challenges that boys, particularly low income boys, may encounter in school .
- * There is need for creative approaches in health service delivery for adolescent boys, taking into account their expressed desires for confidentiality, staff who are sensitive to their needs, waiting areas that are welcoming, and accessible hours.
- * There is a need to engage boys, parents, communities, health and educational personnel and youth-serving personnel in open discussions about longstanding ideas about manhood, recognising both the positive and negative aspects of traditional aspects of gender socialisation.

Research Implications

- * There is a need for additional information on young men's attitudes toward existing health services to find ways to confront challenges to access and encourage young men to utilise existing health services.
- * There is a need for additional research on gender socialisation and boys' school performance, and the implications of boys' apparent school difficulties and mental health and well-being.
- * The need for additional research on how boys are socialised in various settings, and additional qualitative explorations that incorporate boys' voices and their interpretations of gender, equity, masculinity, roles and responsibilities.
- * There is a need for additional research on the changing nature of masculinities and gender roles and boys' perceptions of these changes. More must be understood about how boys are responding to changes in women's roles and changes in gender roles generally.
- * There is a need for additional research on where boys "hang out," the meaning of their time use in different settings, their social networks and implications for their development and socialisation. These studies should also examine more adequately the meaning and impact of boys' greater socialisation outside the home.



mental health, coping, suicide and substance use

The previous chapter highlights a number of mental health issues related to gender socialisation, particularly the lack of perceived and real opportunities for young men to seek assistance during stressful moments; boys' tendencies not to talk about emotions and personal problems; difficulties admitting mental health needs; and rigid pressures to adhere to traditional gender roles and norms. Substance use should be added to this constellation of young men's common reactions to stressful situations, and viewed as a risk-taking behaviour sometimes used as a way to prove one's "manhood" or fit in with the peer group. Similarly, there are gender-related patterns in suicide that emerge from patterns of male socialisation.

There are clear gender patterns in the way that young people respond to stressful and traumatic life events. Some researchers argue that men typically respond less well, face greater risks and are less likely than women to seek social support during stressful life events, such as a death in the family or divorce (Manstead, 1998). While women's external expressions of emotion and grief during traumatic life events were traditionally considered a sign of mental weakness or even precursors of mental health disorders, the mental health field has come to see these outward expressions of emotion as a sign of positive mental health (Manstead, 1998).

In times of stress or trauma, boys are more likely to respond to stress with aggression (either against others or against themselves), to use physical exertion or recreation strategies, and to deny or ignore stress and problems.

Various studies have found that in times of stress or trauma, boys are more likely than girls to respond to stress with aggression (either against others or against themselves), to use physical exertion or recreation strategies, and to deny or ignore stress and problems. Some researchers

even suggest that young men's greater denial of stress and problems, and their propensity not to talk about problems, may be related to men's greater rates of substance use (Frydenberg, 1997).

On the other hand, adolescent girls more frequently turn to friends and pay attention to health needs resulting from stress. Boys are less likely to admit that they could not cope during stressful moments, while girls are more likely to be able to express their difficulties in coping, probably because they are more willing to express helplessness and fear (Frydenberg, 1997). However, it is important to point out that while girls may sometimes be more likely than boys to verbally express their stress, they may also internalize such feelings in the form of eating disorders and general aches and pains – issues seldom reported by or observed in boys. Thus, in suggesting that boys and girls show different patterns in responding to stress, we should not imply which sex actually is subject to greater stress.

Suicide

These gendered patterns of coping with stress can also be seen in gender differences in suicide. Suicide is among the three leading causes of death for adolescents, and suicide rates among adolescents are rising faster than among any other age group. World-wide, between 100,000 and 200,000 young people commit suicide annually, while possibly 40 times as many attempt suicide (WHO Adolescent Health and Development Programme, 1998). In terms of sex-disaggregation, three times more women than men *attempt* suicide but three times as many men *commit* suicide (WHO, 1998). (There are some exceptions, such as China and India, where suicide rates among women are higher. It should also be mentioned that suicide rates world-wide are underreported because suicides are often classified as accidents or simply not classified.)

In the U.S., where suicide is currently the third leading cause of death among young people ages 15-24, boys are four times as likely to commit suicide as girls, although girls try more often



(Goldberg, 1998; National Center for Injury Prevention and Control, 1998). In addition, suicide rates for girls and boys, until age 9, are identical. From ages 10-14, boys commit suicide at twice the rate of girls; from ages 15-19 at rates four times as high; and from age 20-24, at rates six times as high as girls (U.S. Bureau of Health and Human Services, 1991).

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Girls are more likely to attempt suicide but less likely to complete the act. Because suicide attempts for some women are sometimes used to get attention, women may choose methods that are deliberately ineffective (Personal correspondence, Benno de Keijzer, 1999). Men, on the other hand, may choose effective and terminal suicide because prevailing gender norms do not allow them to seek help for personal stress. For young men, therefore, suicide may not be a call for help, but an effective and final end to suffering.

However, the issue of suicide and gender must be considered with caution. Research on suicide is insufficiently clear to determine whether girls' suicide attempts and the methods they choose generally are not intended to be final. It may be that both adolescent boys and girls want to end pain when they attempt suicide, but that boys have greater access to effective and immediate means such as firearms, or that boys have a greater propensity for aggression and risk-taking, and can more directly act out their suicidal thoughts.

In some countries, bisexual or homosexual youth – both male and female – constitute a significant risk group for suicidal behaviour. Studies have found that between 20-42 percent of homosexual youth attempt suicide, with most attempts occurring between 15-17 years of age.

Although it is difficult to assess whether such surveys are truly representative, evidence indicates that youth who identify themselves as homosexual probably engage in higher rates of suicidal behaviour but may not necessarily complete suicide. Comparison studies with hetero- and homosexual youth in Australia found no significant differences in rates of depression, but homosexual youth more frequently reported suicidal thoughts. A quarter of homosexual youth who had attempted suicide identified sexual orientation as at least part of the reason they had attempted. Overall, 28.1 percent of homosexual youth had attempted suicide compared to 7.4 percent of heterosexual youth (Nicholas and Howard, 1998). Similarly, 30 percent of all homosexual and bisexual males interviewed in the U.S. report having attempted suicide at least once (American Academy of Pediatrics, 1993).

It is also important to note that in Australia, the U.S. and New Zealand, suicide was once more common among adolescent males of European descent, but is becoming equally or more prevalent among minority and indigenous populations (African-Americans and Native Americans in the U.S., Aboriginal and Torres Strait Islanders in Australia and Maori, and Pacific Islanders in New Zealand). There is evidence of an increasing number of older adolescent males in the South Pacific committing suicides by hanging, jumping, or using firearms (Personal correspondence, John Howard, 1998).

Substance Use

Gender also influences rates of substance use. While statistics often are not disaggregated by sex, boys are more likely than girls to smoke, drink and use drugs. Currently, about 300 million youth are smokers and 150 million will die of smoking-related causes later in life. In most developing countries, boys smoke at higher rates than girls, although rates in girls are increasing faster (WHO Adolescent Health and Development Programme, 1998).

Similar trends are seen with other substances. In Ecuador, 80 percent of narcotics users are men, the majority are in the late teen years to early 20s (UNDCP and CONSEP, 1996). In Jamaica, lifetime and current use of marijuana



for young and adult men is two to three times greater than usage rates for young women (Wallace and Reid, 1994). In Jordan, 17 percent of adolescent males ages 15-19 smoke regularly, 16 percent occasionally use tranquilisers and 3 percent occasionally use stimulants (UNICEF, 1998). A national survey of adolescents in the U.S. found that 20.1 percent of males compared to 15.6 percent of females report using alcohol two days or more per month (Blum and Rinehart, 1997). Upon reaching high school age, boys and girls were smoking, drinking and using drugs at similar rates, but younger boys (ages 11-14) were twice as likely as girls to drink (6 percent of boys versus 3 percent of girls) and more likely to use illegal drugs (9 percent of younger boys versus 6 percent of girls in the same age range). Boys are also more likely than girls to say that they use drugs to be “cool” (Schoen et al., 1998). Surveys in the U.S. find that boys and girls around age 13 engaged in nearly equal rates of “binge” drinking (defined in the study as five or more drinks in a row). By age 18, 40 percent of boys are engaging in such behaviour compared to fewer than 25 percent of girls (Kantowitz and Kalb, 1998). Similarly, in Kenya, boys are more likely to have tried cigarettes, alcohol and marijuana than girls (38 percent versus 6 percent for cigarettes; 38 percent versus 14 percent for alcohol; and 7 percent versus 1 percent for marijuana) (Erulkar, et al., 1998). In Egypt, 11.2 percent of boys smoke compared to 0.3 percent for girls (Population Council, 1999).

In many parts of the world, boys are more likely than girls to smoke, drink and use drugs. Substance use, particularly alcohol use, is frequently part of a constellation of male risk-taking behaviours, including violence and unprotected sexual activity.

Substance use, particularly alcohol use, is frequently part of a constellation of male risk-taking behaviours, including violence and unprotected sexual activity. In Brazil, substance abuse among young men was associated with having the “courage” to propose sexual relations, and was likely to impair sexual decision-making (Childhope, 1997). In a study of adolescent males using family planning clinics in the U.S., 31 percent

said they “are always or sometimes high on alcohol or drugs during sex” (Brindis et al., 1998). In the U.K., one in three 15-year-old boys compared to one-in-five 15-year-old girls reported being involved in fights or arguments after drinking (Gulbenkian Foundation, 1995).

World-wide, substance use is correlated with a range of problems that are more frequently associated with adolescent boys: violence, accidents and injuries (Senderowitz, 1995). Various studies suggest that substance use is related to lack of parental support, unconventional goals, negative peer group influences, exposure to violence in the home, personal frustration, lack of future orientation, and having been victims of abuse or violence at home. Reporting substance use rates by sex is an important first step toward understanding how substance abuse differs in rates, meaning, context and sequelae for boys and girls.

Mental Health Problems and Needs

Do boys and girls or men and women have different rates of mental health disorders or different mental health needs? Evidence for sex differences in rates of mental disorders are limited, and those studies that do exist must be interpreted with caution. Women are more likely to be diagnosed for psychoneuroses and depression, but these higher rates may not reflect true sex differences. Instead, they may reflect the willingness of women to admit that they are experiencing these problems. Other studies have confirmed biases by mental health professionals in terms of diagnosing psychological disorders; that is, mental health professionals may be more likely to label the externalising behaviour of women, rather than the internalising behaviour of men, as a mental disorder (Manstead, 1998). Adolescent boys, on the other hand, are more likely than adolescent girls to be diagnosed with conduct disorders and aggressive disorders. Again these differences may reflect biologically-based sex differences, or may reflect gender biases in the diagnoses of mental health professionals.

The timing of mental health disorders and the possible underdiagnosis of young men’s mental health problems may be the most important issues regarding adolescent boys and



The timing of mental health disorders and the possible underdiagnosis of young men's mental health problems may be the most important issues regarding the mental health of adolescent boys. Late adolescence is a time when some serious mental disorders such as schizophrenia and bipolar mood disorders may initially present, especially for young men.

their mental health. Late adolescence is a time when some serious mental disorders such as schizophrenia and bipolar mood disorders may initially present, especially for young men (Burke et al., 1990; Christie et al., 1988). Thus, while the overall rates of mental illness may be more or less equal for males and females, there may be sex differences in the timing of the onset of mental illnesses, in the sequelae of mental disorders, and in the rates of young people who seek help for mental health needs and illnesses.

As previously discussed, the general patterns of male socialisation suggest that young men may have specific mental health needs, but frequently do not seek such services, or that in times of stress, they do not discuss their concerns with others. Information on young men's preferences for, use of and attitudes toward mental health and counselling services is extremely limited, but there are some indications that young men would like additional services in this area. Research in Australia, Germany and the U.S. finds that boys are less likely to have someone to turn to in times of stress or depression, and that boys seem to be less willing or able to talk about problems (Keys Young, 1997). A study of adolescent males using U.S. family planning clinics found that 46 percent reported psychosocial issues for which they wanted counselling, the most common being unemployment, followed by problems talking to family or friends, alcohol use, the death of someone close to them and drug use (Brindis et al., 1998). In the U.S., four boys to every girl are diagnosed with an emotional disturbance (Goldberg, 1998). Girls reported feeling more stress, but 21 percent of boys compared to 13 percent of girls said they had "no one" to talk to at such times (Schoen et al., 1998). Boys who

showed signs of depression were particularly at risk of lacking social support; 40 percent of boys with depressive symptoms compared to 18 percent without these symptoms reported that they had "no one" to talk to when they felt stressed.

Whether boys or girls have higher rates of mental health problems and counselling needs is unclear. A 16-country study (including North America, Europe, Asia and Latin America) found that income level or social class and developmental status were more important variables than gender in determining counselling needs. Youth from impoverished backgrounds in poorer countries reported higher rates of personal problems. Males reported a higher percentage of problems related to school than did girls, but rates of reporting of problems were virtually equal for boys and girls (Gibson et al., 1992).

It is likely that boys frequently feel less comfortable than girls in seeking out such help and that institutions where boys are socialised – the workplace, the school, vocational training programmes, the military, sports clubs – are less likely to be sensitive to the mental health needs of boys because of prevailing gender norms. Furthermore, adolescent males may be at higher risk of early onset of serious mental disorders.

Implications

Summing up, there are clear patterns of sex differences in substance use and suicide rates, with boys in developing countries generally reporting higher rates of substance use and boys completing suicide at much higher rates than young women. In recent years, the trend in industrialised countries has been toward nearly equal rates of substance use by adolescent boys and girls. Greater gender equality in those regions may imply that substance use is equally a problem for men and women. There is inconclusive evidence for sex differences in rates of serious mental health problems. The following are implications for programmes and research on mental health of adolescent boys:

**Programme Implications:**

- * There is a need to sensitise and educate health personnel about boys' common styles of reacting to stress, and their higher rates of suicide and substance use. Mental health professionals and other social service professionals may be less likely to believe that boys have mental health needs.
- * There is a need for special programme attention to the issue of boys who may be away from home due to migration for work. In many parts of the world, counselling with professionals or paraprofessionals is not commonly used, and young men rely on kinship networks, family, traditional healers or elders for advice about personal problems. However, in many parts of the world, as young people and particularly young men migrate to urban areas, they are often physically separated from these traditional sources of support.
- * There is a need for substance use prevention and treatment programmes, including harm reduction programmes to pay greater attention to the role of gender socialization in substance use, working with boys to question stereotypical views of masculinity that may be related to boys' higher rates of substance use.

Research Implications:

- * Additional research is needed to determine specific mental health needs of boys, and to understand their help-seeking behaviour, both through new studies and through reviews of existing data, analysed through a gender perspective.
- * Research is needed to develop strategies for earlier identification, assessment, treatment and care for boys' mental health needs, especially for conditions that may have greater incidence and prevalence among late adolescent males (e.g. schizophrenia and bipolar disorder) and those with no greater prevalence with boys but which are also associated with significant morbidity and mortality (e.g. depression and its relationship to suicide).





sexuality, reproductive health and fatherhood

Two underlying principles about adolescent boys increasingly shape the work of those in the field of sexual and reproductive health: that young men are frequently more willing than adult men to consider alternative views about their roles in reproductive health; and that adolescence is a critical time when young men begin forming values that may shape lifelong patterns.

Often, young men are more likely than adult men to have time and to be open to participating in group sessions and educational activities. There is also compelling reason to believe that styles of interaction in intimate relationships are “rehearsed” during adolescence, providing a strong argument for working with young men on reproductive health issues (Archer, 1984; Kindler, 1995; Erikson, 1968; Ross, 1994). Qualitative research with adolescent males in Latin America, Asia, North America and Sub-Saharan Africa suggests that patterns of viewing women as sexual objects, viewing sex as performance-oriented, and using coercion to obtain sex often begin in adolescence and continue into adulthood. This too provides a strong rationale for working with adolescent men when attitudes toward women and styles of interactions in intimate relationships are forming (Shepard, 1996; Bledsoe and Cohen, 1993). Adolescent males in the U.S. who used condoms during their first sexual relations were more likely to use condoms consistently thereafter, providing additional evidence on the importance of early patterns in sexual relationships (Sonenstein, Pleck and Ku, 1995).

Research suggests that patterns of viewing women as sexual objects, viewing sex as performance-oriented and using coercion to obtain sex often begin in adolescence and continue into adulthood.

In the last 20 years, there has been increasing attention to male involvement in reproductive health. For example, promoting

greater male involvement in reproductive health and greater gender equity in child care and domestic tasks were endorsed at the International Conference on Population and Development (ICPD) in Cairo in 1994. This increased attention has led to new research on the sexual and reproductive health of adolescent males. However, this information has had a heterosexual bias. Information on the attitudes and behaviours of young men who define themselves as homosexual or bisexual is often lacking. Homosexual and bisexual young men are often the subject of discrimination or, in other cases, simply ignored.

Adolescent Boys, Sexuality and “Sexual Scripts”

The increased research on male reproductive and sexual health has allowed us to describe and better understand what is often called the “sexual script” of adolescent boys – the common patterns of sexual activity, including sexual initiation, found in given venues. While such “scripts” vary tremendously by individual, social class and culture, there are a number of similarities in the sexual relations, activity and attitudes of adolescent boys world-wide.

Sexual Initiation and Sexual Activity as Male Competence

Young men often believe that sexual initiation affirms their identity as men and provides them status in the male peer group (Sielert, 1995). For many young men world-wide, heterosexual sexual experience is seen as a rite of passage to manhood and an accomplishment or achievement, rather than an opportunity for intimacy. Heterosexual “conquests” are frequently shared with pride within the male peer group, while doubts or inexperience are frequently hidden from the group. Hence, boys “effectively curtail their opportunities to discuss their sexuality openly and honestly with their friends” (Marsiglio, 1988). Marsiglio concludes that boys view “sex as a valuable commodity in its own right, regardless of the relationship context in which it might occur,



that sexual activity is desirable as early in a relationship as possible, that more sex is better, and that opportunities to have heterosexual relations should generally not be squandered.” The status that a young man achieves in his peer group when he is involved in a sexual relationship can be equally or more important than the intimacy he experiences in the relationship (Lundgren, 1999).

For many young men world-wide, heterosexual sexual experience is seen as a rite of passage to manhood and an accomplishment or achievement rather than an opportunity for intimacy.

In most of the world, boys report having their first sexual experience at earlier ages than do young women. Furthermore, Demographic and Health Survey data finds that boys’ ages at sexual initiation are generally decreasing in nearly all countries for which DHS data is available, while young women’s ages at first sexual experience had decreased in only about one-fifth of those countries. Adolescent women more frequently report having sexual intercourse (including premarital sex) within the context of a relationship, while young men more frequently report having sex with multiple partners (before and after marriage) and in more occasional relationships (Green, 1997).

Young men and young women sometimes give different interpretations of the same sexual experiences. In some areas of the world, young women have sexual experiences nearly as frequently as young men but young women portray their relationships as more stable and intimate, while young men may portray the same sexual relationship as casual or occasional. For example, research with young people ages 15-24 in Nigeria found that the prevalence of “casual sex” for males in the preceding 12 months was 35 percent, compared to 6 percent for females. Young women were more likely to report having a regular sexual partner (80 percent) compared to 44 percent of sexually experienced males (Amazigo et al., 1997).

In some cases, these more “casual” sexual relationships for adolescent boys may include having their first sexual encounter (and subsequent sexual encounters) with a sex worker. For example, in urban and rural areas of Thailand, 61 percent of currently single men and 81 percent of ever-married men had sex with sex workers (Im-em, 1998). In regions of India, between 19 percent and 78 percent of males reported having sexual relations with a sex worker (Jejeebhoy, 1996).

In Argentina, 42 percent of boys in secondary schools said their first sexual experience was with a sex worker, while 27 percent reported a first sexual experience with a girlfriend. For girls, 89 percent said their first sexual experience was with their boyfriend (Necchi and Schufer, 1998). Boys more frequently mentioned “sexual desire and physical necessity” (45 percent) as the motivation for their sexual encounter, while girls more frequently mentioned the desire for a deeper intimate relationship (68 percent). Boys in Guinea (West Africa) said they frequently used false promises of long-term commitment to convince girls to have sex. These boys also said they frequently worried that if they did not have sex with a girl, their reputation would suffer among their male peers (Gorgen et al., 1998).

The pattern of viewing sex as an achievement to present to the male peer group emerges in adolescence, and often continues into adulthood. In rural India, for example, men report that they frequently have sex with sex workers in their early years of marriage to present a facade of male prowess to their male peers (Khan, Khan and Mukerjee, 1998). This pressure to recount one’s sexual conquests to the male peer group has led some researchers to question whether young men have had all the sexual relations they report. In Brazil, one young man told staff from an NGO that “we lie so much (about our sexual conquests to our friends) that we end up believing it” (Site visit to ECOS, Sao Paulo, Brazil, 1998).

The common sexual script of boys around the world supports the myths that the masculine sexual appetite is insatiable, that boys’ need for sex is biologically uncontrollable, and that sex is something to be done, not talked about.



The common sexual script of boys around the world also encourages the myths that the masculine sexual appetite is insatiable, that boys' need for sex is biologically uncontrollable, and that sex is something to be done, not talked about – except to talk about exploits and conquests (Barker and Loewenstein, 1997; Khan, Khan and Mukerjee, 1998). In Mexico and Brazil, young men say that once aroused, men cannot turn down a sexual opportunity because such a refusal would be non-masculine (Aramburu and Rodriguez, 1995; Barker and Loewenstein, 1997). Boys frequently feign the possession of vast amounts of information about sex and the reproductive process. This posture frequently masks the fact that boys lack information on their bodies and reproductive health.

Another aspect of the performance-oriented adolescent male sexual script is the focus on genitally-oriented sexual pleasure. One Mexican researcher concludes that male sexuality in the context of *machismo* is “mutilated” or “distorted” because the male is not allowed to enjoy any part of his body apart from his penis (Meijueiro, 1995). Prevailing sexual and gender scripts for young men sometime give the impression that their body is a tool or machine, whether to be “used” in sports, work or sex (Personal correspondence, Benno de Keijzer, 1999). Young men's perceptions of their bodies, coupled with their lack of information on reproductive and sexual physiology, can have ramifications for their health. In India, young men callers to a hotline on reproductive and sexual health did not consider STIs as a risk because they perceived themselves as the “givers” during sexual intercourse (Singh, 1997).

Substance Use and Sexual Activity

Alcohol and other substance use often accompany the early (and later) sexual experiences of young men. In one study, Thai men reported that their sexual initiation frequently took place as a male peer group-influenced activity accompanied by social drinking (Im-em, 1998). In rural Thailand, 49 percent of young men ages 15-24 said they were sexually experienced. Of that group, 77 percent said they had sex at some time with a sex worker, 94 percent said they were persuaded to visit a sex worker by male friends, and 58 percent said they were drunk before visiting

a sex worker the first time (WHO, 1997). In Latin America, young men report that using alcohol or other substances helps them have the “courage” to attempt a sexual conquest (Childhope, 1997; Keijzer, 1995). Substance use is also frequently associated with incidents of sexual abuse and coercion.

Denial of Sexual Rights to Women and Delegation of Reproductive Health Concerns

Another common feature of the male sexual script is denying sexual rights to girls or women, and categorising women. Moroccan adolescents of both sexes in a semi-rural town considered female virginity at marriage as important, although few females and almost no males were without some premarital erotic experience. Males in this setting typically had their first sexual intercourse with a sex worker or a girlfriend. Male youth typically had two roles: “lustful suitor” of a neighbourhood girl, and “jealous guardian” of his sisters' “virtue.” Some young men viewed the world of unmarried females as divided into “marriageable virgins” and “unmarriageable whores” (Davis and Davis, 1989). Similarly, young men in Latin America frequently value their own sexual activity regardless of relationship context, but categorise those girls who have sex in casual relationships as “loose” (Figueroa, 1995; Childhope, 1997). Adolescents in Peru concluded that girls are identified as “good” or “bad” based on whether they are sexually experienced. Boys on the other hand have to constantly prove their manhood through sexual activity, or risk being seen as “not men” (Yon, Jimenez and Valverde, 1998).

Another common refrain in the sexual scripts of young men is the delegation of reproductive health concerns to women, and the lack of concern for their own health, reproductive and otherwise.

Another common refrain in research on the sexual scripts of young men is young men's delegation of reproductive health concerns to women, and the lack of concern for their own health, reproductive and otherwise. For urban,



working class men ages 20-44 in Brazil, reproductive health was seen as a woman's responsibility. The concept of "responsibility" applied to taking responsibility for a child or, in some cases, for helping a woman acquire an abortion (Arihla, 1998). In Bolivia, university students confirmed that having an STI could be seen as a badge of honour both before one's male family members (fathers in particular) and among peers (Site visit to CISTAC, Santa Cruz, Bolivia, 1998). Boys also frequently mention their low use of health services and their reliance on self-treatment or home remedies in the case of an STI. Among men ages 15-62 in Bihar, India, more than half of the group had suffered an STI. Of this group, more than half either used a local "quack" or went untreated (Bang et al., 1997). Focus group discussions with college students in Bolivia found self-treatment to be the overwhelming medical treatment "of choice". One of the young men said, "When it comes to getting sick ...we're all doctors" (Site visit to CISTAC, Santa Cruz, Bolivia, 1998).

Not all young men in a given group adhere to every aspect of the prevailing sexual script, nor do even the most traditional young men always behave in accordance with such scripts.

Exceptions to Prevailing "Sexual Scripts"

Not all young men in a given group adhere to every aspect of the prevailing sexual script, nor do even the most traditional young men always behave in accordance with such scripts. While the research reports general tendencies, there are young men who report different patterns in their sexual and intimate relationships. Three categories of young men were identified in a study in Argentina: 1.) 40 percent of young men interviewed fell into the category of "impulsive," meaning they sought sexual experience at early ages primarily for physical desire and worried only about AIDS; 2.) 32 percent were categorised as "occasional," meaning that they had a sexual relationship mainly out of curiosity, without necessarily pursuing it or planning it; and 3.) 27 percent were categorised as "integrated,"

meaning that they had their first sexual encounter within a relationship context, with the intention of establishing a deeper relationship with a partner, and with negotiation over contraceptive use. As the authors state: "Belonging to this category ('integrated') may imply a search for integration of sexuality with affectivity and a greater democratisation of sexual roles in this generation of young people" (Necchi and Schufer, 1998). In Peru, young women characterised some boys as being "sincere," "quiet" or "respectable" – the types of boys with whom girls felt they could have a relationship and express feelings "without being forced to have sexual relations with them" (Yon, Jimenez and Valverde, 1998). Similarly, in qualitative research with low-income young men in Brazil, the authors found that approximately one or two out of every 10 young men interviewed in focus group discussions displayed a set of values that were characterised as "progressive," that is repudiating violence toward women, advocating for men's roles in reproductive health, advocating negotiation in relationships and generally desiring sexual activity in the context of a relationship (Barker and Loewenstein, 1997).

Same-Sex Sexual Activity and Homophobia

For many young men – regardless of whether they identify themselves as heterosexual or as homosexual or bisexual – have sex with another man or boy is a common part of sexual experimentation and/or of their ongoing sexual activity. In Peru and Brazil, 10-13 percent of adolescent males and young adult males report having had both heterosexual and homosexual experiences. In Latin America, 28 percent of young men reported having had sex with another male, but did not necessarily identify themselves as homosexual. Indeed, homosexual activity, while often repressed or considered inappropriate in many instances, may be considered a normal part of sexual development. However, because it is frequently repressed or denied in many cultures, this stigma attached to homosexual activity often creates anxiety, leading some young men to question the "normality" of such activity and leaving them with few opportunities to express doubts or ask questions about their sexuality (Caceres et al., 1997; Lundgren, 1999).



And while same-sex sexual activity seems to be a fairly common aspect of sexual experimentation and development for many young men, another frequently cited aspect of the male sexual script – both for men who have sex with men (MSM) and heterosexual young men – is homophobia. Homophobia serves both to keep homosexual behaviour and young men of homosexual or bisexual orientation “in the closet,” and, in effect, to keep heterosexual men “in line.” Parker (1991 and 1998) has extensively documented the meaning of various pejorative terms used to refer to homosexual men in Brazil, and the ways such language is used to pressure young men and boys to adhere to specific heterosexual sexual scripts. At the same time, though, boys are permitted same-sex sexual play as long as these “sexual games” are temporary diversions on the way to a final identity as a heterosexual male. In some areas of the Middle East, same-sex sexual play between boys is common (although seldom acknowledged) around the time of puberty, while adult homosexual activity is widely condemned (Davis and Davis, 1989).

Heterosexual young men often share their “conquests” with pride with the peer group, while homosexual young men often have to hide their sexual experiences.

While there is much less research on the sexual scripts and sexual experiences of young men who self-identify as homosexual or bisexual, emerging research (largely from the AIDS prevention field) has provided some insights on the challenges that homosexual young men face. Homosexual or bisexual adolescent males face a number of commonalities, including rejection or lack of understanding on the part of their parents and family, an early awareness of being “different,” and the lack of individuals they could confide in or seek advice from about their same-sex sexual feelings or experiences (American Academy of Pediatrics, 1993).

The stress associated with this familial rejection, societal homophobia and the lack of outlets for expression of their sexuality are reflected in the apparently higher rates of suicide among homosexual males as reported earlier. The development of a homosexual identity may leave young people feeling isolated from their peers; heterosexual young men often share their “conquests” with pride with the peer group, while homosexual young men often have to hide their sexual experiences. Because of the social stigma associated with homosexual behaviour, these young men sometimes have their first sexual experiences in furtive or anonymous situations and may feel unsure of the normality of these experiences (Nicholas and Howard, 1998).

Adolescent Boys and Reproductive and Sexual Health

Boys and Sources of Information about Sexuality and Reproduction

The sexual script of many adolescent males would suggest that they are well-informed about issues of sexuality and reproduction, but survey research contradicts this. A survey of secondary students in Nigeria found that young women were more likely than young men to understand the timing of conception (fertility) (Amazigo et al., 1997). Various surveys in Latin America have found that many men, adult and young, think they possess adequate information about sexuality and reproduction, when in reality they have little information. In surveys with adolescents and young adults in 15 cities in Latin America and the Caribbean, fewer than a quarter of males ages 15-24 could identify the female fertile period (Morris, 1993). While young women were only slightly better informed, the issue is perhaps more striking for young men who frequently claim that they know such things.

World-wide, adolescent boys say they largely rely on the media and on their self-taught peers for information about sexuality and reproductive health. Young men ages 15-24 in Jamaica were more likely to get information on reproductive health and sexuality from peers than were girls; young women were more likely to talk to parents (32.2 percent) and to health personnel (29.8 percent) (National Family Planning Board,



1999). In Kenya, girls were more likely to discuss sex with parents than were boys (27 percent versus 16 percent), although friends were the primary source of information for both males and females (Erulkar et al., 1998).

Even in countries where frank discussions about sexuality with adolescents are encouraged, such as Denmark, nearly half of adolescent males ages 16-20 say they never talk to their parents about sexuality (Rix, 1996). Boys may view sex education as irrelevant to them because it has traditionally focused on reproductive health and contraception, which they see as issues for girls.

The sexual script of many adolescent males would suggest that they are well-informed about issues of sexuality and reproduction, but research contradicts this.

Other barriers toward communication between adolescent males and health educators include negative attitudes that some sex educators may have in terms of adolescent males, and the social pressure that boys feel to act as if they already know everything about sex. A programme in Mexico that sought to increase parent-adolescent communication on STIs and HIV/AIDS found that such an intervention was successful and useful for parents and adolescent daughters, but that fathers and mothers had difficulty engaging their sons in a discussion on such matters (Givaudan, Pick and Proctor, 1997). In general, we have few in-depth studies on how adolescent males acquire their knowledge about sexuality and reproductive health, the context of that knowledge acquisition and its meaning to them (Greene and Biddlecom, 1998). Even when sex education is offered to boys, it often focuses on bodily functions with little attention to the issue of enjoying a healthy sex life and the full range of human sexual and intimate expression.

Adolescent Boys and Contraceptive and Condom Use

Studies from various parts of the world show that condom use among adolescent and young adult males has increased in recent years

Studies from various parts of the world have shown that condom use among adolescent and young adult males has increased in recent years but is still inconsistent, and often varies according to the “category” of the sexual partner.

but is still inconsistent and often varies according to the “category” of the sexual partner. Sixty-nine percent of sexually active males in Jamaica, 40 percent in Guatemala City and 53 percent in Costa Rica reported using condoms in the last month in their sexual relations (Morris, 1993). In the U.S., reported condom use among young males more than doubled from about one-fifth in 1979 to more than half in 1998. However, only 35 percent of U.S. males said they had used a condom every time they had sex (Sonenstein and Pleck, 1994).

Young men’s motivation for using condoms frequently varies with their partner: with a stable partner or girlfriend, condoms are used for contraception; with a “casual” partner, condoms are used for STI and HIV prevention. Most often, condom use is associated with a casual partner. A survey with young adult factory workers in Thailand found that 54 percent of young men who had their first sexual experience with a sex worker reported using a condom on that occasion, compared to only 20 percent who said they used condoms on their first sexual experience when the partner was not a sex worker (WHO, 1997).

Condom use may be higher when there is more communication or negotiation among the sexual partners. A study of males using family planning clinics in the U.S. found that contraceptive use was higher when couples agreed on use, suggesting the importance of discussion among couples and young men’s involvement in contraceptive selection and decision-making even if a female contraceptive method is used (Brindis et al., 1998). Although the effectiveness of condoms for contraception and STI prevention is widely acknowledged, there are still areas where awareness is low, such as rural areas in Africa and Asia (Sharma and Sharma, 1997).

Barriers to young men’s use of condoms include availability, cost, the sporadic nature of their sexual activity, lack of information on correct



use, reported discomfort, social norms that inhibit communication between partners and rigid sexual scripts or norms about whose responsibility it is to propose condom use. Young men's sexual scripts often suggest that because reproductive health is a "female" concern, the woman must suggest condom use or other contraceptive methods. At the same time, the sexual script frequently holds that it is the male's responsibility to acquire condoms, since for a female to carry condoms would suggest that she "planned" to have sex and is "promiscuous" (Webb, 1997; Childhope, 1997). If a young man responds to a woman's request that he use a condom, this may imply that he is allowing her to have "control" of the relationship. Condom use also requires a young man to place less emphasis on his sexual pleasure, and thus requires him to control his sexuality and consider his health. However, as previously mentioned, male sexuality is often defined by its uncontrolled nature and by not worrying about health and body concerns. The sexual activity of unmarried adolescent males and females tends to be sporadic, a factor probably related to inconsistent contraceptive use. Urban youth in Brazil did not always identify themselves as "sexually active" because their sexual activity was infrequent (Childhope, 1997).

Research and programme development on adolescent men's use of contraceptives has often focused on condom use, but it is important to consider adolescent male attitudes and practices related to other contraceptive methods. Young men in many countries report withdrawal as a common, traditional contraceptive method. While withdrawal is considered an ineffective contraceptive method, and has often been ignored or even condemned by many organisations working in the reproductive and sexual health field, some researchers have suggested that withdrawal can be a reasonably effective method for pregnancy prevention (and more effective than commonly presented), could be promoted to boys in stable relationships when more widely as a backup method when condoms are not available (Rogow, 1998). Indeed, more research is needed on young men's attitudes about other contraceptive methods; about their attitudes toward young women's use of contraceptive methods, including the female condom; and about non-penetrative sex.

STIs and HIV/AIDS

Adolescent boys and young men often have high rates of STIs, but young men frequently ignore such infections or rely on home remedies or self-treatment. In rural India, 80.7 percent of the men ages 15-44 were found to have some reproductive-related morbidity, 22.3 percent of which were STIs. The rates of reproductive health morbidities for men were nearly identical to rates found among women in research carried out by the same authors (Bang et al., 1997). In the same rural region of India, 83 percent of men reported some reproductive health-related complaint in the last 30 days; 98 percent said they were open to talk about reproductive health, but said that such problems are generally "embarrassing" to talk about and reported that public health service clinics and doctors tended to focus on family planning for women (Bang, Bang and Phirke, 1997). Some adolescent boys – perhaps because of their earlier sexual activity, or their sexual activity with sex workers – have higher reported rates of STIs than do adolescent girls. In one study, 3 percent of Thai adolescent males have had an STI compared to only 0.3 percent for young women.

WHO-sponsored research on STIs has found an increasing number of young men are contracting chlamydial urethritis, which is asymptomatic in up to 80 percent of cases. Prevalence studies on chlamydial urethritis in Chile with 154 asymptomatic adolescent males found that 3 percent of sexually active males tested positive. Adolescents may also comprise more than 50 percent of new cases of gonorrhoea and syphilis (WHO, 1995). Research with male industrial workers and students in South Korea found that 3-17 percent said they have had an STI. In Kenya, 44 percent of STI patients are 15-25 years old (Senderowitz, 1995). Studies in the U.S. have found that 10-29 percent of sexually active adolescent women and 10 percent of boys tested for STIs had chlamydia (Alan Guttmacher Institute, 1998). In Brazil, nearly 30 percent of sexually active adolescent males in low-income areas said they have had an STI at least once; of those, about a third said they resorted to self-medication for treatment (Childhope, 1997). In Zambia, young people said that when they had an STI, they used home remedies first and formal health services "as a last resort" (Webb, 1997).



Research in various parts of the world confirms that adolescent boys and young men often have high rates of STIs, and that young men frequently ignore such infections or rely on home remedies or self-treatment.

There has been limited discussion of the role of young and adult men in the transmission of human papilloma virus, which can be transmitted even with condom use. An estimated 10 million women, the majority in their late teens and early 20s, have active HPV infections. In parts of Africa and Asia, where regular Pap testing is less common than in industrialised countries, cervical cancer from HPV is the most common cause of cancer-related mortality. HPV is implicated in 95 percent of cervical cancer. In men, HPV is frequently asymptomatic, meaning that young men can and do infect young women without knowing it. HPV is associated with precancerous lesions of the penis and with penile cancer, although at extremely low rates. Because heterosexual men seldom suffer consequences from HPV, there is an issue of gender equity for young men to consider how their sexual activity places women at risk. Limited research also finds a growing incidence of HPV in MSM; studies in the U.S. have found that 95 percent of HIV-positive men have HPV, which is associated with anal cancer. Some health professionals working with MSM recommend anal pap tests as a routine screening procedure (Groopman, 1999).

These relatively high rates of STIs among adolescent boys are linked to the increased risk of HIV infection. Presently an estimated one in four of all persons infected by HIV/AIDS in the world is a young man under age 25 (Green, 1997). In Zimbabwe, 26 percent of all pregnant women age 15-19 were HIV positive. In Botswana, the figure was 31 percent. Adolescent boys in these countries, however, are much less affected than girls, who are four times more likely to be HIV positive. Besides having a higher physiological risk of infection, girls seem to be infected by older men. Adult men's behaviours and attitudes – including their higher number of sexual partners on average than women, their higher use of alcohol and other substances, and their generally greater control over sexual relations

than women – are directly related to the spread of HIV/AIDS. Encouraging boys to engage in safer sexual behaviour has an important potential for reducing their own risk of HIV, but also can lead to lasting changes in adult men's sexual behaviour (Meekers and Wekwete, 1997).

Research from the HIV/AIDS prevention field has provided many insights on the sexual scripts and behaviours of young men reported previously, as well as on couples' patterns of negotiation, or lack thereof, and on the identity formation and behaviour of men who have sex with other men. Many individuals and organisations in the reproductive and sexual health field have called for greater co-ordination between adolescent reproductive health and HIV/AIDS prevention initiatives, including those for adolescent men. It is also important to mention the association of HIV and Hepatitis B and C with increased injectable drug use and unprotected sex among men who have sex with men, an issue that has emerged in the U.S., Australia and other regions (Personal correspondence, John Howard, 1998).

Other Sexual and Reproductive Health Concerns and Needs of Young Men

Discussions of the sexual and reproductive health needs of adolescent boys have often focused on contraception, condom use and STIs. However, boys also express other concerns and face other needs related to their sexual and reproductive health. When offered the chance to discuss sexuality and reproductive health, boys are sometimes more interested in issues such as penis size, maintaining erections, anxiety about meeting the expectations of sexual partners, getting erections at inappropriate times, fertility, potency and premature ejaculation (Population Council, 1998). Existing research on boys and sexuality often focuses on indicators such as age at first sexual experience, sexual partners, condom use and frequency of sexual activity, but doesn't adequately examine the quality of and feelings associated with young men's early sexual experiences. What worries or concerns do they have? Who do they talk to about these worries? Who would they have liked to have talked to before having their first sexual experience? Are they satisfied with their sexual experiences? Boys' concerns during their first sexual experience may



be similar to those of young women. When asked about their first sexual experience, young men in Argentina frequently said that it was pleasurable/satisfying (62 percent); however, 48 percent of young men also reported anxiety or nervousness, 15 percent reported confusion and 12 percent reported fear (Necchi and Schufer, 1998). Boys frequently lack opportunities to discuss doubts or anxieties associated with their first sexual experiences or to discuss fully their own sexual desire. In some parts of the world, many adolescent males are married, yet their specific concerns have rarely been discussed in sexual health programming.

When discussing reproductive health, boys are sometimes more interested in issues such as penis size, maintaining erections, anxiety about meeting the expectations of sexual partners, getting erections at inappropriate times, fertility, potency and premature ejaculation.

Other sexual health issues for young men include the issue of circumcision. There is an unresolved debate about whether male circumcision promotes greater genital hygiene and reduces the risk of some STIs including HIV, or whether it inflicts unnecessary pain on young boys. WHO currently has no official position on male circumcision.

The question of penis size and adolescent boys' use of condoms is also unresolved. Some public health sectors have introduced a smaller condom (49 mm diameter versus the 52 mm) with the assumption that adolescent boys require smaller condoms, but existing research has not confirmed whether this an appropriate response. Unpublished research from Brazil on adolescent boys using the 49 mm condom finds that some boys report discomfort in using the smaller condoms, but the results are unclear (Instituto PROMUNDO and NESAs, 1999).

The issue of declining sperm counts also needs greater discussion. Exposure to various toxins could be related to male infertility (Lundgren, 1999). Declining sperm counts have been noted in parts of Europe, but the implications

are unclear, as is the issue of whether this manifests itself in adolescence or adulthood. In some parts of the world, boys face possible negative side effects from potency medicines, or may not be aware of the risks of some such medicines.

Access to Reproductive and Sexual Health Services

The general tendency for young men to view reproductive health as a "female" concern means that even when specific services exist for youth, the majority of clients of such services are young women. In turn, public health workers may perceive that young men are disinterested in reproductive health issues and target their efforts to young women. Research from Sub-Saharan Africa, Latin America and North America confirms a pattern of low male attendance at adolescent clinics, including adolescent sexual and reproductive health clinics. Young women represented 76-89 percent of all adolescent health clinic users in Ghana (Glover, Erulkar and Nerquaye-Tetteh, 1998). In addition to perceiving reproductive health as "female concerns," young men often perceive clinics as "female" spaces, given that most clients and service providers are women. Clinic staff may also have difficulty reacting in positive ways to the styles of interaction and the sometimes aggressive energy that young men bring to the clinic setting.

The Needs of Boys Involved in Sex Work and in Other High Risk Settings

While young women's exploitation involvement in and exploitation in sex work has received increased attention in recent years, there is little attention given to young men involved in sex work or exploited through sex work. Limited research from Sub-Saharan Africa, Asia and Latin America found that it is difficult to estimate the number of young men involved in such activity, that such activity is typically covert, and that young men involved in sex work may lack power to negotiate condom use and other forms of self-protection – all issues similar to those faced by young women who are exploited through sex work. Depending on the region and setting, young men involved in sex work may be more or less visible than young women engaged in the same



activities, and the sexual activity may have different implications in terms of self image and mental health.

Some young men interviewed in parts of sub-Saharan Africa also report that the phenomenon of “Sugar Daddies” (older men who pay or exchange favours with young women or girls for sex) also works in reverse with adult women (“Sugar Mommies”) sometimes paying adolescent males for sex (Barker and Rich, 1992; Mbogori and Barker, 1993). Some “Sugar Daddies” prefer boys as sexual partners. A handful of studies in Brazil have focused on adolescent males who are sexually exploited. Some of the young men involved in such sexual exploitation ended up on the streets because they were rejected or expelled from their homes because of homosexual activity (Larvie, 1992). Overall, there is a need for more attention to the special needs of young men involved in sex work, including a need for research that seeks to identify the scope of the issue.

There is also a need for greater attention to the sexual health needs of boys and young men in high-risk settings, including boys detained in juvenile (and adult) detention facilities, boys who work away from home and young men in the military. Young men who migrate for work, or live away from home, including those in the military, may engage in higher rates of sexual activity with sex workers and use substances, including alcohol, as a way to cope with the stress of living away from home – both behaviors that increase their risk of STIs, including HIV. Studies with young men in the military, for example, consistently find higher rates of HIV prevalence than the overall population (PANOS, 1997). Boys in same-sex institutions, including juvenile detention facilities, may engage in both forced and consensual sex with few options for STI or HIV prevention.

Adolescent Fatherhood

Researchers, programme planners and policymakers, including UNICEF and WHO, have begun to call attention to fathers’ roles in child development and child rearing, including the roles of young fathers. Part of this attention is driven by women’s increasing participation in the formal

workplace – and a greater demand on men to take responsibility for child-rearing-, but has also been spurred by research showing that an increasing percentage of fathers around the world are not living with their children. Numerous studies have underscored the increase in men’s migration for work, the instability of men’s employment and the impact of these trends on men’s roles and participation in the family (Bruce, Lloyd and Leonard, 1995; Barroso, 1996). These trends have led to increased discussions of men’s child support obligations in various countries, and in some cases to insightful research on the dynamics of men’s lack of involvement with their children, particularly as it relates to their inability to find stable employment and achieve the socially proscribed role of provider.

While interest in adolescent fathers is limited, there have been some important programme models developed in the Americas region, North America and Western Europe and discussion of the issue at seminars in various parts of the world, including India (Lyra, 1998; Personal correspondence, John Howard, 1998). Various reproductive health surveys have asked young men whether they have ever impregnated a partner, but research on young men’s attitudes toward fatherhood, their involvement as fathers, or their desire for involvement as fathers, is lacking.

Adolescent fathers face some of the same issues that young mothers face: too-early role transition from adolescent to parent; social isolation; unstable relationships; and social and family opposition to their involvement as fathers.

With the stigma associated with adolescent pregnancy, unplanned pregnancy or pregnancy outside of formal unions, young men may be reluctant to establish legal paternity or to acknowledge having fathered a child. Some young men may not be aware they have fathered a child. Adolescent fathers, like adolescent mothers, may face social pressures to drop out of school to support their children and are less likely to complete secondary school than their non-parenting peers (WHO, 1993). Young men may deny responsibility and paternity in large part because of the financial burden associated with caring for a child (Barker



and Rich, 1992). In Mexico, adolescent fathers' employment and financial situation were important factors in determining how they viewed the pregnancy and whether they were actively involved as fathers (Atkin and Alatorre-Rico, 1991). Still another issue related to adolescent pregnancy is young men's involvement in abortion decision-making. Various qualitative and quantitative studies have found that young men often play a key role in the abortion decision-making process and that male attitudes toward a pregnancy are important in whether a young woman decides to seek an induced abortion.

In some parts of the world, boys have benefited from and continue to benefit from social norms that allow them to stay in school after fathering a child, while teenage mothers were and in some settings still are expelled from school. Many adolescent fathers do not participate in providing for or caring for their children. At the same, however, research in some settings (the U.S. for example) finds that adolescent fathers frequently provide some support and seek to maintain relationships with their children even if they are not living with the mother and the child (Barret and Robinson, 1982). As in the case of adolescent mothers, adolescent fathers, compared to their non-parenting male peers, are more likely to have had mothers who were themselves adolescent mothers, and to have had unsatisfactory relationships with their fathers (Gohel, Diamond and Chambers, 1997).

An adolescent father's parents, the parents of the child's mother, the mother of the child and service providers frequently hold numerous deep-rooted stereotypes about adolescent fatherhood. There are widespread beliefs, for example, that a adolescent father who does not marry the mother is "irresponsible," when, in fact, his motivations are often complex. Some adolescent fathers may in fact be avoiding responsibilities, while others may want to be involved with their child but are not allowed to by the child's mother, or do not feel they have the right to interact with the child if they cannot provide financial support. Such nuances have not been studied adequately and are often neglected in discussions about adolescent fathers (Lyra, 1998). Adolescent fathers, albeit in different ways and to different degrees, face some of the same issues that young mothers face: too-

early role transition from adolescent to parent; social isolation; unstable relationships; and social and family opposition to their involvement as fathers (Elster, 1986).

A few programmes and researchers in Latin America and elsewhere call attention to the need for more positive and less deficit-driven approaches to adolescent fathers (Lyra, 1998). Researchers argue that, for some young men, the act of fathering can be a powerful maturational process, a strong source of positive identity and an opportunity to organise one's life and priorities. These researchers have subsequently argued for the role of programmes, families and schools to assist adolescent fathers in being more involved and supportive of their children (Rhoden and Robinson, 1997).

Implications

Summing up, research on the sexual behaviour of adolescent boys provides insights on how boys are socialised and pressured to adhere to prevailing sexual scripts. As highlighted here, young men often describe pressure from their male peers to have sexual relations at a relatively young age as a form of sexual coercion. In some countries, young men describe being taken to sex workers by male relatives when these male relatives determined that the time was appropriate. This subtle and not-so-subtle peer and societal pressure on young men to prove their sexual competency has important and often negative consequences to how young men construct their sexual identity and styles of interaction in intimate relationships.

The research presented in this chapter also provides a strong rationale for engaging adolescent boys on these issues as a way to affect the behaviour of men when they are adults. Viewing women as objects, viewing sex as a competency rather than an opportunity for intimacy, feeling that they are "owed" sex by girls and women, and disregarding their sexual health are patterns that often emerge in adolescence and continue into adulthood. Adolescent boys are also likely to internalise the styles of male-female interaction they see around them. Young men who were disrespectful in relationships with young women often have experienced similar relationships in



their homes or had negative relationship experiences in their families. Where male-female relationships are characterised by conflicts over resources, many young men lack internalised models of positive, mutually supporting male-female relationships. These examples confirm that promoting greater gender equity in male-female relationships must include working with adolescent boys.

The review of literature presented in this chapter highlights a number of areas where additional information and programme and policy development are required, and yields important implications for current and future work:

Programme Implications:

- * Programmes need to offer boys more information on sexuality and reproductive health. This information should take into account their concerns and realities and should be provided in open, non-judgmental settings
- * Given the prevailing views about sexual activity as a competency rather than an opportunity for intimacy, there is a need for programmes to engage adolescent boys in wide-ranging discussions about sexuality, including sexual health and safer sex, but also including boys' other sexual health concerns (e.g. concerns over satisfying their partner, penis size, etc.), and working with boys to question some of the "myths" about male sexuality.
- * There is a need for greater programme attention to the concerns of adolescent boys who identify themselves as homosexual, and to confront widespread homophobia, which has negative implications for men having sex with men and for heterosexual boys and young men.

- * Given the increasing rates of HIV in some regions of the world, and the important role of men and adolescent boys in the spread of HIV, there is an urgent need to engage adolescent boys in discussions about safer sex, particularly condom use and use their participation in the design of safer sex programmes for boys.
- * There is a need for increased voluntary and confidential testing and counseling for STIs, including HIV, for adolescent boys, given the high rates of STIs, including HIV, among adolescent boys, and the asymptomatic nature of many STIs.
- * There is a need for greater programme attention to the realities of adolescent fathers, and to engage all adolescent boys in discussions about their potential roles as fathers. Boys are generally not socialised to nurture or care for young children; engaging boys in discussions in these issues while they are adolescents provides an important opportunity to encourage greater male participation in caring for children.

Research Implications:

- * There is a need for research to consider the full range of sexual expression for young and to work on several fronts to broaden our definitions of sexual expression and intimacy in research on adolescent sexuality.
- * There is a need for more research on the concerns and unmet health needs of adolescent boys who self-identify as homosexual or bisexual who have few spaces to discuss their sexual identities and experiences, and face considerable social and familial prejudice in nearly all parts of the world.
- * There is a need for more research on the realities of adolescent fathers, and boys' attitudes about fathering.
- * There is a need for additional research on which interventions are most effective in encouraging boys to be more gender equitable and sensitive to their partners' needs in terms of their sexual behaviour



accidents, injuries and violence

Accidents, injuries and violence are the leading causes of death and morbidities in adolescent boys world-wide. Boys' behaviour and socialisation often put them at high risk of being victimised by violence and injuries, and boys are also perpetrators of violence and traffic-related injuries and deaths. Yet, despite these two facts, most reports of violence have not considered the issue of gender. There is a great need to understand and address how gender socialisation – how boys are socialised to be boys – influences boys' victimisation by violence, injuries and accidents, and their perpetration of violence.

Accidents, Injuries and Occupational Health

Road Traffic Accidents

Road accidents are the main cause of death of young men world-wide; many of these accidents are related to drug and alcohol use (WHO Adolescent Health and Development Programme, 1998). For every young person killed in traffic accidents, another 10 are seriously injured or maimed for life. Traffic safety conditions are more precarious in developing countries, where there has also been an increase in number of vehicles. Road traffic mortality increased more than 200 percent in Africa and 150 percent in Asia between 1968 and 1983. In Thailand, nearly twice as many boys as girls have been involved in a traffic accident and 48.5 percent of urban-based boys report having been in an accident in the last three years (Podhisita and Pattaravanich, 1998). In the United Arab Emirates, 70 percent of emergency room visits involved boys, with the most common causes of trauma being road traffic accidents, injuries from sharp objects, fights and sporting accidents (Bener, Al-Salman and Pugh, 1998).

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Boys are at higher risk of road traffic accidents than girls for a number of reasons. As previously noted, boys often spend a larger proportion of their time outside of the home, and spend more time in or around streets and public thoroughfares. Use of alcohol or other substances combined with reckless use of motor vehicles are behaviours that the male peer group often condone.

Injuries and Occupational Health

In developing countries in particular, a large number of adolescents work outside the home to contribute to their own and their family's income. In these countries, boys are more likely than girls to work outside the home. While additional information is needed, limited data suggests that many boys in resource-poor countries work in occupations or tasks that present risks to their health, work on the streets where they are exposed to environmental hazards and traffic-related accidents, or work with hazardous materials. As previously noted, in some parts of the world, adolescent boys and young men work in transient settings away from their families and may be exposed to higher risk of STIs, including HIV. Substance use in the workplace, or substance use to endure difficult work conditions, is another occupational-related health hazard that young men sometimes face.

While sex-disaggregated data on occupational health hazards is limited, a few studies suggest that boys may be more likely to face work-related accidents, injuries or occupational health problems. In Thailand, nearly twice as many males as females reported work-related accidents: 13.9 percent for urban males and 17.5 percent for rural males, compared to 5.7 percent for both urban and rural females (Podhisita and Pattaravanich, 1998). Similarly, in Italy, 90 percent of the work-related injuries to children and youth were among males (Pianosi and Zocchetti, 1995).



Violence

Boys as Perpetrators of Violence

Boys are far more likely than girls to be perpetrators of violence according to numerous reports from various countries. Studies on bullying behaviour in the United Kingdom find that one in eight primary school students and one in 14 secondary school students said they took part in bullying activities; boys are disproportionately represented both as victims and perpetrators (Utting, 1997). A survey of youth in a low-income community in Brazil found that 30 percent had been involved in fights, the vast majority of those boys (Ruzany et al., 1996). In the U.S., 14.9 percent of males compared to 5.8 percent of females reported engaging in at least one form of delinquent behaviour in the last year, including less violent forms, such as vandalism (U.S. Department of Justice, 1997). The U.S. National Longitudinal Study of Adolescent Health found that more than 10 percent of males compared to 5 percent of females reported having committed a violent act in the past year (Resnick et al, 1997). Boys in the U.S. are four times more likely than girls to have been involved in fights (Centers for Disease Control and Prevention, 1992).

While there may be some evidence for a male biological and temperamental link to aggressive and risk-taking behaviour, the majority of boys' violent behaviour is explained by social and environmental factors during childhood and adolescence.

What are the reasons for boys' higher rates of violent behaviour? Specific traits in boys' temperaments — higher rates of lack of impulse control, ADHD and other traits such as sensation-seeking, reactivity and irritability — may be precursors to aggression (Miedzian, 1991; Earls, 1991). As early as four months of age, temperamental differences can be detected between boys and girls. Boys show higher levels of irritability and manageability, factors that are associated with later hyperactivity and aggression (Stormont-Spurgin and Zentall, 1995). All of these precursors may dispose some males to become

aggressive, violent or risk-seeking. However, these factors are not conclusive explanations. Other researchers have looked at the role of testosterone in aggression, but existing evidence suggests that the effect of sex hormones on levels of aggression is limited; this issue is further complicated by the fact that violent and aggressive behaviour can cause serum testosterone levels to rise, thus confusing cause and effect (Miedzian, 1991). While there may be some evidence for a biological or temperamental link to aggressive and risk-taking behaviour, most researchers conclude that the majority of boys' violent behaviour is explained by social and environmental factors during childhood and adolescence (Sampson and Laub, 1993).

It is important to note that aggression and violence are not merely male domains. Comparative studies with boys and girls around the world find that boys are more likely to use physical aggression, while girls are more likely to be indirectly aggressive — telling lies, ignoring someone or ostracising others from the social group. Furthermore, some of the supposed biological bases for boys' aggressive behaviour — ADHD and personality disorder, for example — may themselves be subject to gender bias. ADHD, personality disorder and conduct behaviour disorder are all diagnoses based on behavioural assessments. It may be that some of the sex differences found in reported rates of such disorders are due to the tendency of researchers and clinicians to measure and note the physical aggression of boys but not the indirect aggression of girls. Some researchers have suggested that female aggression in the U.S. may have increased as social stereotypes for gender roles there have changed, allowing and even encouraging girls to act in more “masculine” and “violent” ways, but not the other way around (Renfrew, 1997).

The emerging consensus is that socialisation of boys in the home — for example, encouraging more rough and tumble play with boys than with girls — interacts with genetic factors to produce higher rates of aggressive behaviour in boys (Boulton, 1994). For some boys, aggressive behaviour can lead to acts of violence against others depending on environmental factors, such as the nature of the relationship with parents or other important adults and exposure to violence



in the home or community. Having been a victim of violence is strongly associated with being violent. Research in a number of countries finds that boys are more likely than girls to have been victims of physical (non-sexual) abuse in their homes and physical violence outside the home (Blum et al., 1997; UNICEF, 1998).

While witnessing violence is stressful for both boys and girls, they may manifest this stress in different ways. For boys, the trauma related to witnessing violence is more likely to be externalised as violence (U.S. Department of Justice, 1997). Some researchers suggest that most boys are socialised to believe that it is inappropriate for them to express fear and sadness but appropriate for them to express anger and aggression. Indeed, depression and psychological pain are common precursors to both violence committed against other young men and violence committed by men against women (Personal correspondence, Benno de Keijzer, 1998).

Overall, early childhood anti-social, biologically-based tendencies (temperament, aggressiveness, and hyperactivity) are weak predictors of future violent behaviour for most adolescent boys. While there may be some evidence for the early biologically-based propensity of violent behaviour, researchers believe the majority of violent behaviour is explained by social factors during adolescence and childhood. For example, poverty and structural disadvantage influence delinquency by reducing the capacity of families to achieve effective informal social controls. Distressed parents are more likely to use coercive discipline against boys, thereby contributing to antisocial behaviour as boys rebel against this authoritarian parenting. Early conduct disorder and ADHD or hyperactivity in some boys may be linked to later violent behaviour, but it is unclear if these early traits "cause" violent behaviour per se. Parents and teachers might label these behaviours as troublesome, as we have previously seen, and react in authoritarian ways that create a chain of expectations and reactions that indeed lead to delinquency (Sampson and Laub, 1993). Boys' higher rates of victimisation by physical abuse in the home, and the documented connection between having been a victim of abuse in the home and subsequent participation in

delinquency and violence, lends additional support to this argument.

Violence has a survival and status function for young men in some low-income communities in some cultures. For many low-income males, with the absence of clear social roles, violence is way to maintain status in the male peer group and to prevent violence against oneself (Majors and Billson, 1993; Anderson, 1990; Archer, 1994; Schwartz, 1987; Zaluar, 1994). Emler and Reicher (1995) conclude that for some low-income young men in the United Kingdom and the U.S., delinquency and violence against other males and against females become ways to affirm their identity.

Various studies also provide a compelling rationale for working with boys at early age to prevent violence. Some boys, after committing a few delinquent acts in early adolescence, are subsequently labelled as delinquent and eventually accept the label and identity of delinquent. Delinquent behaviour for many boys starts early in childhood and is strongly related to the peer group (Elliott, 1994). In addition, the earlier the onset of violent behaviour, the greater the probability of continued violent behaviour into adulthood.

Boys as Victims and Witnesses of Violence

Young men are more frequently studied as perpetrators rather than as victims of violence. However, some researchers and programme personnel have begun to emphasise that young men are also victims and that, when allowed to express it, young men are often fearful of the potential for violence within themselves and of the violence inflicted or threatened by other young men.

Health statistics from many parts of world confirm that injuries resulting from violence are among the chief causes of mortality and morbidity for adolescent males. Available statistics indicate that the most violent region in the world is the Americas region, with a regional homicide rate of about 20 per 100,000 inhabitants (World Bank, 1997). In some Latin American countries, public and private costs associated with violence represent up to 10 percent of gross domestic



products (Fontes, May and Santos, 1999). Throughout the region, the highest rates of homicides are among young men ages 15-24 (PAHO, 1993). In Colombia, between 1991 and 1995, there were 112,000 homicides. Young people accounted for 41,000 deaths – the vast majority males (World Bank, 1997). Homicide is the third leading cause of death in adolescents age 10-19 in the U.S. and accounted for 42 percent of deaths among young black males in the last 10 years (U.S. Department of Health and Human Services, 1991). In Brazil, between 1988 and 1990, Federal Police confirmed that 4,611 children and youth were victims of homicide; the majority of these were male and 70 percent were between the ages of 15-17 (CEAP, 1993; Rizzini, 1994).

Injuries resulting from violence are among the chief causes of mortality and morbidity for adolescent males.

Because they spend more time outside the home in most cultures, boys are more likely to be exposed to or to witness physical violence outside the home. In a number of regions, public health officials are concerned about the psychological impact of exposure to violence, both in low-income urban areas, and also in countries where children and youth have been involved as combatants in civil wars or exposed to ongoing armed conflicts. In the Gaza Strip, for example, 21.5 percent of children and adolescents (ages 9-13) reported anxiety as a result of witnessing violence and experienced stress associated with socio-economic conditions (Thabet and Vostanis, 1998). In the U.S., 27 percent of children and youth in a low-income, violent urban environment met the diagnostic criteria for post-traumatic stress disorder (American Academy of Pediatrics, 1996). Of course, not all children or adolescents exposed to violence manifest these psychological sequelae, but research from various war zones and low-income, violent urban areas has found that several disturbances are often associated with exposure to violence, including substance use, sleep disorders, psychic numbing, avoidance behaviours, depression and suicidal behaviour.

More than 100 million young people are currently affected by armed conflict, either as soldiers, civilians or refugees. Young men are more likely than young women to be involved as combatants – some voluntarily, others against their will, often encouraged by political leaders (WHO Adolescent Health and Development Programme, 1998).

Boys as Perpetrators and Victims of Dating or Courtship Violence

Studies with high school and college students in New Zealand and the U.S. have found that between 20 and 59 percent of both males and females say they have experienced physical aggression during a dating relationship (Jezl, Molidor and Wright, 1996; Magdol et al., 1997). While nearly equal numbers of males and females report having been victims of dating violence, male dating violence against women tends to be more severe and males tend to initiate this violence. Concern over dating violence or courtship violence in North America, Western Europe and Australia has led to the creation of educational campaigns targeted largely at young men.

In response to men's violence against women, including violence by young men against young women, some researchers and programme personnel have begun to ask: What are we doing directly with men, including young men, to prevent them from being violent to women? Many industrialised countries have long used court-mandated therapy for men, including adolescent men, accused or convicted of domestic violence or sexual assault. In North America, Australia and Western Europe, and to a limited extent in some parts of Latin America, there are now discussion groups working on date rape awareness and domestic or courtship violence. Some of these group activities have taken place with military recruits, in sports locker rooms or in the school with the goal of increasing men's awareness about such issues, or with the idea of creating positive peer pressure so that young men themselves convince their male peers that such behaviour is unacceptable. In a few countries in Latin America, NGOs have started voluntary discussion groups with men, including young men, who want to work in a group setting to discuss their past acts of violence against women and their desire to prevent such acts in the future.



For the most part, though, research has not adequately informed us about the settings in which young men's violence against young women occurs and young men's perspectives on this violence, nor offered ideas for prevention. Limited research from Africa and Latin America confirms that many men, adult and adolescent, see domestic or courtship violence as part of an informal marriage or cohabitation contract (Ali, 1995; Brown et al., 1995, Barker and Loewenstein, 1997; Njovana and Watts, 1996). Other young men may also condone this courtship or dating violence, providing mutual support for each other. Models of intervention and research on how to work with young men to prevent domestic violence, dating or courtship violence, and sexual coercion are still lacking.

Boys as Victims of Physical and Sexual Abuse and Sexual Coercion

A number of studies have provided information on the extent that adolescent boys are victimised by physical and sexual abuse. Most studies confirm that girls are more likely to be victims of sexual abuse or sexual coercion than are boys, but numerous studies confirm that large numbers of boys also suffer from sexual abuse. In Brazil, 20 percent of sexually active youth said they had been forced to have sex against their will at least once, with girls reporting about twice the rate of boys (Childhope, 1997). In the U.S., 3.4 percent of males and 13 percent of females had experienced sexual assault defined as "unwanted but actual sexual contact" (U.S. Department of Justice, 1997). In the Caribbean, 16 percent of boys ages 16-18 reported being physically abused and 7.5 percent reported being sexually abused (Lundgren, 1999). In Canada, one-third of men surveyed reported having experienced some kind of sexual abuse (Stewart, 1996, in Lundgren, 1999).

In Kenya, a national survey of youth found that 28 percent of boys and 22 percent of girls reported that forced sex was attempted with them. In addition, 31 percent of boys and 27 percent of girls reported having been pressured to have sex. For both males and females, that pressure comes largely from adolescent and adult males. In this study, the authors state the idea of "force" in sexual relationships is likely to be experienced differently

by boys than girls. In this same study, when asked about their most recent sexual activity, 66 percent of boys and 51 percent of girls reported that they had actually wanted to have sex, suggesting that "desire" and consensus for sexual activity are complex issues for boys and girls (Erulkar et al., 1998).

In Nicaragua, 27 percent of women and 19 percent of men reported sexual abuse in childhood or adolescence. In Sri Lanka, 7.4 percent of young men surveyed reported having been coerced into sex by an older male when they were young. In Zimbabwe, 30 percent of secondary study students interviewed reported that they had been sexually abused; half were boys being abused by female perpetrators (FOCUS, 1998).

A national survey in the U.S. found that 13 percent of high school-age boys reported physical or sexual abuse (including abuse in the home and in intimate relationships), compared to 21 percent of high school girls. Abused boys were more than three times as likely to report mental health problems than were non-abused boys; fewer than half of abused boys told someone about the abuse (Schoen et al., 1998). This same U.S. study found that abused boys reported nearly twice as many suicidal thoughts as did abused girls. Indeed, from various parts of the world, there is evidence from clinical mental health settings that boys physically or sexually abused in early childhood have difficulty talking about the abuse later on. While young women often face similar difficulties in talking about past victimisation, there is evidence from Australia and North America that boys have even more difficulty expressing this victimisation and finding persons in whom to confide about abuse, or even finding adults who will acknowledge that they experienced abuse (Keys Young, 1997).

Other health consequences of sexual abuse include physical injury, STIs and unwanted pregnancy for girls. Some studies also find that sexual abuse is linked to subsequent high-risk sexual activity for both boys and girls. Victims of sexual abuse are generally less likely to use self-protective behaviour and less likely to feel they have power in sexual relationships. An ongoing comparative study of sexual violence during adolescence in South Africa, Brazil and the U.S.



has found that sexual coercion and violence in adolescent intimate relationships are associated with lower condom use (Personal correspondence, Maria Helena Ruzany).

While girls are more likely than boys to be victims of sexual abuse, a number of studies suggest that boys are more likely than girls to be victims of other forms of physical abuse in their homes.

While girls are more likely than boys to be victims of sexual abuse, a number of studies suggest that boys are more likely than girls to be victims of other forms of physical abuse in their homes. In Jordan, boys were more likely to be physically abused in the home and more likely to be victims of violence resulting in injuries, while girls were more likely to be victims of verbal abuse (UNICEF, 1998). Of officially reported cases of child abuse in Jordan, males under age 19 were seven times more likely to be victims of physical abuse resulting in injuries than were girls (UNICEF, 1997). In Brazil, 61 percent of boys ages 11-17 reported having been victims of physical violence from their parents, compared to 47 percent of girls (Goncalves de Assis, 1997).

Boys as Perpetrators of Sexual Coercion

A 1992 national survey of U.S. adolescents ages 15-18 found that 4.8 percent of males, as compared to 1.3 percent of females, reported having forced someone into a sexual act at least once. Sexually aggressive adolescents were themselves more likely to have been sexually abused, to have witnessed abuse of a family member, and to have used drugs or alcohol (American Academy of Pediatrics, 1997). Several studies from Western Europe and North America find a strong link between a young man having been a victim of abuse in the home, including sexual abuse, and his subsequently carrying out sexual assault or dating violence. This evidence supports the need for services for young men who have been victims of physical and sexual abuse as a form of treatment, but also as an important element in preventing potential sexual or dating violence against others.

There are difficulties in documenting boys' acts of sexual assault and dating violence. Because of societal norms in some regions, sexual coercion may be seen as part of boys' "normal" sexual script. For example, after a widely publicised event in Kenya in 1991 in which 71 young women were raped and 19 died from a group attack from their male classmates, school officials treated the event as "boys will be boys" behaviour (Senderowitz, 1995). A few studies have looked at the social setting in which domestic violence, dating violence or sexual coercion takes place, seeking to understand how dating violence and sexual coercion may be reinforced in the male peer group (Katz, 1995; Barker and Loewenstein, 1997). This limited research suggests that there is a strong connection between boys' socialisation and the coercive or aggressive behavior of some boys toward girls. In many settings, some boys feel themselves entitled to young women's sexual favours, however defined, and thus feel empowered to use pressure, coercion and direct and indirect violence to obtain these sexual favours. In many settings, this behaviour is tolerated on the part of boys, as suggested above, while girls who dare protest sexual violence are often accused of having provoked boys.

Implications

Summing up, in most regions of the world, violence and traffic-related injuries account for the majority of mortality of adolescent males. Research and interventions related to violence often focus on boys as perpetrators of violence. However, young men are also victims of violence. Having been a victim of or witness to violence, either in or outside the home, is a factor associated with carrying out violence. The research presented in this chapter also provides a compelling case that the causes of boys' higher rates of some forms of violent behaviour are found in the ways and conditions in which boys are socialised. Examining and considering the ways that boys' violence is embedded in gender socialisation is an important starting point in designing more effective violence prevention strategies.

The research presented here also suggests that we should keep in mind that violence is not merely associated with low-income adolescent boys, although much research on violence has



focused on low-income young men. Poverty is itself a form of social violence, but poverty should not be considered a cause of violence. Middle class adolescent boys are also involved in violence, and are also socialised to use violence to express emotions and resolve conflicts, just as many boys in low-income areas are not perpetrators of violence. In studying and responding to violence, it is imperative not to stigmatise or label low-income boys, or boys in general, as inherently violent, and to recognise that most boys are not perpetrators of violence.

The following are other implications of the existing research on violence and adolescent boys:

Programme Implications:

- * There is a need for youth-serving programmes to offer young men alternative ways of resolving conflicts, developing their identities and expressing emotions. Limited interventions along these lines have confirmed that young men respond well when offered opportunities to discuss their victimisation by violence and their fear of violence and to reflect about the ways that violence is often part of male socialisation.
- * There is a need for more programme attention to the issue of relationship or dating violence. A few programme experiences cited here have sought to engage boys in discussions about these issues, but more programme development is needed in this area.
- * There is a need for more programmatic attention to boys as victims and witnesses of violence by offering formal and informal opportunities to discuss the violence boys witness and to reduce the stress associated with victimisation.
- * There is a need to establish programmes in settings where violent and delinquent behaviour by boys is prevalent and these should target boys at an early age. Interventions working with boys in violence prevention should not assume that boys are potentially violent or label them as

delinquent, but instead should seek to engage them in positive ways with their community, family, pro-social peers and non-violent male role models.

- * There is a need for programmes to sensitise and educate parents, teachers, health personnel and other youth-serving professionals about the possible roots of some boys' violent behaviour, helping them to effectively engage boys rather than responding in mainly punitive ways.
- * There is a need for additional and expanded campaigns to raise awareness about road traffic accidents, occupational health hazards and injuries among adolescent boys.

Research Implications:

- * There is a need for additional research to examine how the socialisation of boys is linked to sexual coercion and other forms of violence against women, and on the factors that may prevent this violence.
- * There is a need to examine more explicitly the role of gender socialisation in reinforcing male violence. Young men are often socialised to see anger and aggression as the only appropriate "male" emotions. Or to see violence as a way to define their identities.
- * There is a need for additional research on how the media influences violent behaviour by boys. This might offer insights on how to work with young people to develop critical attitudes toward the media.
- * More research is needed on alternative, non-punitive approaches to violence prevention, including effective conflict resolution training methodologies. The literature reviewed here makes a strong case for taking a human development and human ecology approach to violence prevention, exploring sources of social and family support, the subjective experiences of youth and the role of gender socialisation in violence.





final considerations

Research on adolescent boys, as for adolescents of both sexes, tends to focus on problems and risks. In examining the research reviewed here, we may be left with the impression that adolescent boys are “walking problems.” The challenge is to recognise and understand the problems and risks that boys face – and the harm they sometimes do to themselves and others – without merely seeing boys in deficit terms. We must also look at the positive ways that boys contribute to their families and societies, and identify the potentials they represent.

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The field of child development offers us some ideas on how to do this. For example, some child development theories suggest that all adolescents – boys and girls – have the ability to nurture and care for another human being if they themselves were adequately nurtured. In studying adolescent boys and men, we sometimes assume that boys and men lack the ability to care for others. Child development theories suggest that instead of seeing boys as inherently lacking such caregiving skills, it is more appropriate to see boys as being socialised to repress their inherent abilities to emotionally bond to other human beings. In this perspective, the challenge becomes helping boys regain or reappropriate caregiving and nurturing skills that were, in effect, “socialised out of them” (Pollack, 1998).

The research presented here argues that the ways boys are socialised strongly influences their behaviours and determines their health risks. Changing how societies and families raise boys

will be not be easy, but it is possible, necessary and in some places already happening. We have strong evidence of changing behaviours and roles related to views about women’s roles in society in the last 20 to 30 years. There is also some evidence that boys’ and men’s attitudes are in fact changing, and that young men are more flexible than the previous generation with regard to gender roles. Even in areas of the world characterised by traditional patriarchal values, there is some evidence of changes in gender roles and men’s attitudes, driven perhaps by changes in women’s roles in society. While young women have had some spaces and opportunities to construct new roles for themselves, boys and young men have few spaces in which to react to changing expectations and in which to discuss new identities and ways of being young men, but urgently need such opportunities.

Experiences in Engaging Boys

Rather than sounding utopian, it is important to point out that there are already programme experiences from around the world that have engaged boys in these kinds of discussions. As mentioned at the beginning of this document, one of the assumptions often made about adolescent boys is that they are “hard to work with” and difficult to engage in health promotion. However, the experiences in working with adolescent boys already offer lessons about how to engage and attract adolescent boys into existing health services and health promotion activities:

- * Boys are more likely to use existing health services when such services are made attractive to them. Some programmes report that having male staff to work with young men is important, while others report that the sex of the staff is not important if they are sensitive to boys’ needs. Some clinics have used sports activities and peer outreach workers to invite boys into existing health facilities.



- * Program staff also report that boys, like girls, prefer integrated services and activities that take into account their full range of interests and needs, such as the need for vocational training or responses to community violence.
- * Boys often request or appreciate having the chance to discuss their concerns in boy-only groups, but most programmes also find it important to have boys and girls subsequently discuss their concerns together. Boys generally report a lack of spaces where they can discuss – in a non-judgmental manner – questions about masculinity, personal issues or health-related matters.
- * In parts of the world where households are headed by females, or where adult men and fathers may be physically distant, boys often report the importance of interaction with positive male role models, such as teachers, older male family members, health educators or peer promoters.
- * Boys may require counselling and mental health services, but are reluctant to seek such services. Often, teachers and other social service staff may not recognise signs and symptoms of boys' needs for such attention. When staff are adequately sensitive and sensitised to boys' ways of expressing stress, trauma and psychological pain, and staff approach boys in ways that respect their silences, results have shown that boys will make use of mental health and counselling services in greater numbers.
- * When exposed to fathers, adult men or important role models who are caring, flexible, and involved in child rearing, boys are more likely to grow up to be caring, to negotiate in their intimate relationships and to be more involved fathers, if they have children. Similarly, programmes working in violence prevention have found the importance of exposing adolescent boys to non-violent ways of expressing emotions, including frustration and anger.
- * Experiences in conflict resolution, violence prevention, sexuality education and family life education have found that the school is an important setting for carrying out such activities because large numbers of young people attend school. However, because some adolescent boys with the most urgent needs may be outside the school setting, they must be reached in those settings where they "hang out" – the street, sporting activities, the community, in military barracks, at transportation hubs, and, in some cases, at facilities for juvenile offenders.
- * There is a strong rationale for reaching adolescent boys at an early age and to keep reaching them. Young men have been found to have high levels of participation in organised sports and youth groups. This provides an opportunity to reach these young men with preventive messages related to sexual health before they start their sexual activity. Boys change their attitudes over time, and behaviours vary as situations, partners and peer groups change. Thus, programmes cannot assume that a young man, once engaged in a programme, does not need to be engaged again. Furthermore, programme experiences suggest that interventions should have flexible age limits. Some programmes end when a young person turns 18. Experience suggests that programmes must meet the varied and changing needs of young men over time, and not use mandatory age cut-offs that may not follow developmental needs of young people.



The research cited here confirms that adolescent boys have gender-specific potentials and risks, just as adolescent girls do. In virtually every culture we examine, being a boy brings with it advantages and disadvantages.

Final Comments

Summing up, there are important programme experiences that offer us ideas on how to engage boys in ways that promote their health and development. Similarly, the body of literature analysed here provides a strong basis for designing more effective policies and programmes related to adolescent boys. Taken together this information helps us confront and overturn some of the assumptions about boys. First, boys can

be engaged when we listen to their needs and concerns and approach them in positive ways. Secondly, instead of assuming that boys do not have problems, the research cited here confirms that adolescent boys have gender-specific potentials and risks, just as adolescent girls do. In virtually every culture we examine, being a boy brings with it advantages and disadvantages. Even in regions of the world where structural biases against women continue to be strong and where men, on aggregate, benefit from gender inequities, masculinity nonetheless implies both benefits and costs for adolescent boys and adult men. The challenge before us is to offer young men opportunities to explore their past and current roles and expectations as men, and to engage them in ways that promote healthy development and well-being for them, their partners and their communities.





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