Foundation for Survival of Women and Children

Community based Research on understanding of male reproductive health and feasibility of specific interventions

Background: Reproductive and child health (RCH) has received increasing attention in India. The MCH and family planning program were consolidated into child survival and safe motherhood program. A major deficiency in these programs is the relative inattention to male involvement. This is now being increasingly discussed. With the rising rates of sexually transmitted infections (STIs) and increasing threat from HIV/AIDS epidemic it is being increasingly realized that marginalization of men will be harmful to the health of the women as well. Meaningful involvement of men in reproductive and child health requires a deep understanding of sexuality, male sexual behaviour and their determinants like alcohol, drug addiction etc. In addition, understanding of perceptions regarding sexual health problems in males and their care seeking pattern when sick are important in shaping the policy towards male involvement in reproductive health. Keeping these points in mind, a study was conducted with the following objectives

Objectives

- To determine men's perceptions and understanding of their own and their partner's reproductive physiology and sexuality.
- To understand men's pattern of marital and non- marital sexual behavior.
- To assess men's health care seeking with respect to sexual and reproductive behavior.
- To investigate popular health care providers practices in the management of men's reproductive and sexual health problems.
- To improve the treatment practices and prevention advice given by the popular health care providers in dealing with the problems relating to men's reproductive health.
- To strengthen the capacity of the popular health care providers in tackling
- Common concerns and behavioral reproductive health problems of men through interpersonal communication.
- To create awareness in the community regarding male reproductive health problems
- To enable the use of appropriate preventive and health care seeking behaviour.

Methodology

- The study was conducted in one community development block in the district Yamunanagar in Haryana. Social mappings were done in 20 villages in the project area. Homogeneity was ensured by including men of similar age and from the same caste group and religion. In depth interviews were done first with key informants in selected villages with people who were well informed on the subject of sexuality, sexual behaviour and male reproductive health.
- Facilities were audited to capture the range and quality of services they provided.
- KAP Stud was done on 200 men. The protocol comprised of key questions to determine the perceived causation of common sexual health problems and sexually transmitted diseases, the prevention and treatment and awareness about condom use and on AIDS. This was also done on 100 selected popular health care providers.

Key Highlights

Sexual Behavior: Interest in Sex

- The learning about sex and sexuality in rural boys and girls takes place through discussions in-groups in the form of gossips and stories. Most of the times this occurs within the members of the same sex and rarely with other sex.
- Books and magazines are of great interest to them.

- Boys are very keen to procure material with pictures of nude or seminude girls. They look for movie scenes, which show sex directly or indirectly. Blue movies are not commonly watched because they are not freely available.
- Teachers, parents and other responsible persons were either shy to talk about sex or felt that discussion would mislead the youngsters.
- Young men and boys get attracted to the clothes that girls wear especially if they are tight fitting.. They like to look at the bare legs of young girls. Body gestures are another way of attracting them.
- Consequently men and women had poor knowledge and awareness about the risks such as pregnancy, STIs or HIV/AIDS from irresponsible sexual behavior.
- Extramarital and premarital sex in the rural areas is taboo and not permitted.
- Educated men especially beyond high school lead to rational thinking and a better understanding. Educated men understood the role of condoms. However its regular use in risk situations was uncommon.

Masturbation:

- Most men described it as normal although there were some who considered this to be a disease.
- Rarely masturbation was self-induced as a part of exploration of self. Initially it was difficult to ejaculate and evoke sexual satisfaction especially when it was tried at a very young age. After a few experiences it would lead to ejaculation fairly quickly.
- Masturbation was described as a lot of fun. However there were many men who considered masturbation to be a sinful act which is not permitted by the society.
- Some even considered masturbation to be a sexual disease and regarded it as a 'Gupt Rog'. If done too frequently it can lead to impotence (Namardi).
- Others said that excess masturbation leads to thinning of the semen, which then keeps dripping and soils the underwear (Dhat padna).
- Many men were very worried that excessive masturbation can lead to lack of erection of penis or the penis can get deformed.

Nocturnal emissions (swapndosh):

- The rural men considered nocturnal emissions as Gupt Rog.
- Excessive heat in the body leads to excessive heat in the urinary bladder, which manifests as nocturnal emissions.
- Constipation was also regarded as a cause of the problem. Eating spicy foods and sour foods also leads to nocturnal emissions. Consumption of alcohol in excess is also associated with the Problem.
- Most men do not think that nocturnal emissions cause any body harm. It is however a nuisance.

Homosexuality

- The present study did not show many cases of homosexuality amongst rural men.
- Young unmarried boys occasionally are homosexual. The risks of homosexuality are not known.
- The problem is also manifested in the form of attraction amongst some men and they enjoy close physical contact but do not indulge in sex.

Sex with animals

- There was a lot of interest in watching animals do sex.
- This was done for the treatment of sexual problem.
- Some women had interest in pets they kept especially dogs.

First sexual experience- premarital or extramarital

•One half of unmarried males had at least one experience of sexual intercourse with a woman before they were married.
•The age at marriage is advancing and this is also leading to a greater chance of sexual experience since men and women cannot suppress their natural desire for too long.
•Sometimes the CSWs and women with multiple sex partners operated through agents who charge for the service they render in negotiating for sexual intercourse arrangement.
•Sexual intercourse with women in the villages is not forced and rape is rare.
•There was a case where the father in law forced the daughter-in- law to have sex with him.
•Premarital sex in the villages can be broadly categorized in to three groups: - Occasional sexual experience as a chance with a friend or a relative, Sexual contact with a woman from low caste who comes to the field for cutting grass or collecting firewood, with a woman who is a commercial sex worker or with a woman who has multiple sex partnership.
•Initiation comes from the man most of the times but sometimes this can originate from the female also.
•Condom use is unknown when sexual intercourse is not planned.
•Premarital sexual experience is considered more pleasurable than masturbation and nocturnal emission or homosexual experience.
•In the villages there are strong caste barriers and certain restrictions which separate the people from different castes.

Group sex

- Group sex is liked since there is a feeling of togetherness and companionship.
- Group sex is usually organized on a tubewell or a predetermined site like a rest house or a hotel.
- Usually men do sexual intercourse more than once and they keep doing it as many times as they like of course subject to availability of time.
- Condom use was found to be uncommon and in none of the IDIs was the condom use described.
- Several men said that they had developed some symptoms relating to pain while passing urine, swelling and pain in the penis and redness of the penis

Alcohol and sex

- The relationship between alcohol and sex was quite clear.
- Certain religious groups did not use alcohol since this is a taboo.
- Arrangements are made to get a CSW or a woman who indulges in multiple sex partnerships.

Sex and violence

- There was relationship between sex, alcohol and violence.
- Violence was not very common but it was described during many IDIs and key informant interviews.
- The incidence of minor violence was quite common.

Sex and drugs

- Injection drugs users are uncommon in the villages included in the study. Only 0.5% of the young men indulged in injection drug use.
- The use of stimulants and aphrodisiacs came to our attention during the study. The most common drugs used are opium and marijuana.

Sex and societal response

- Premarital and extramarital sex is a taboo in the traditional rural society in which the Study was done. People do not want to discuss it even though they know about it.
- The villagers do not approve of the higher education of the females especially if there is no school or college in the village.
- The widespread belief is that those who go for education have a chance to mix up with boys and will lose their virginity and character.

Sex after marriage

- After the marriage sexual activity with the wife was very common.
- Initially men reported sexual intercourse with the wife for 2-3 times or more in the night.
- Usually after an initial period of heightened sexual activity during the first 2-3 months after marriage sexual activity declines to about 2-3 times per week.
- After marriage there is a substantial decline in masturbation and nocturnal emissions.
- After 3-5 years they get bored of their wife and start looking for other pleasure.
- Men are likely to be involved in extramarital relationship after consuming alcohol.
- The use of condoms was uncommon.

Women involved in **premarital or extramarital sex**

- Commercial sex workers in the villages are very different from those in the cities and in periurban areas.
- There are no red light areas where these women operate. They cannot be identified easily.
- There are no formal agents.
- There is no fixed location where they do their business.

The use of condoms

- The use of condoms in the villages was very uncommon.
- Although men were aware of nirodh and they also said that the government provides them free of cost, there was very little acceptance of nirodh.
- People believed that the use of condoms leads to loss of pleasure during sexual intercourse and many men said that these tear easily and therefore are not effective.
- Some men expressed that we are in a hurry to do sex without being noticed. Therefore where is the time to use condoms? The place where the condoms should be kept and how they should be disposed off was another concern expressed by them.

Local terms for women with multiple sex partners : The terms most frequently used included Taxi, Chaalu aurat (fast woman), Bahut Chaalu aurat (Very fast woman), Maal (good looking woman), Peshawar aurat (A woman in sex business), Vaishya (Prostitute), Chakra (Old car an expression signifying a woman w o has been used many times), Dhanda kame waali (woman in sex business), Awaara aurat (vagabond woman), Randi (prostitute), Badmash aurat (a

woman with a bad character), Badnaam aurat (a woman with a bad reputation)

Sexual Health problems

- Sexual health problems were termed "Gupt Rog" by all the men studied.
- The vocabulary used to describe sexual health problems was very rich, varied and complex. e.g. *Dhat padna* (a local term for phosphaturia it means white discharge), *Muth marna, Hasthmaithun, Hand practice* (masturbation), *Swapndosh* (nocturnal emissions), *Namardi* (Impotence), *Banjhpan* (sterillity), *Sheegrapatan* (early or premature ejaculation), *Kamzori* (weakness this includes in some cases sexual weakness), *Ling tight naaa hona* (floppy penis, lack of erection), *Ling tedha hona* (bent penis) etc.
- Swapndosh, Dhat padna, sheegrapatan, namardi were rated high in the frequency but they were placed low in the severity rating.
- On the other hand diseases like HIV/AIDS were ranked low in frequency but high on the severity ratings.
- The beliefs regarding the causation of Gupt Rog are quite different from the modern theory of causation diseases of the genital tract.
- The men did talk about poor hygiene, not taking bath regularly, not changing the underwear daily or using somebody else's underwear or clothes to the occurrence of some of the sexual health problems.
- The traditional belief was the relationship of many of the Gupt Rog with the diet of excessive heat in the body or a disturbed body balances between hot and cold
- Amongst unmarried males worries about the bad consequences of sexual health problems were common. The maximum concern especially of young men was about the loss of manhood and poor performance.
- The beliefs and practices of the men in the rural areas are quite varied and many times quite irrational.
- Encouraging anal sex for the relief of piles, doing sex with an ass to transfer the body heat into the ass and thus relieve the ulcers on the penis

Popular health care provider profile

- Most men and women who suffer from Gupt Rog do not go to providers of modem system of medicine.
- Common problems that Popular health care provider were seeing included hat panda, namardi, swapandosh, ulcers on penis, banjhpan etc.
- People express their views differently about the popular providers. " *Gaon ke doctor lo loot lete hain unka kaam to paise banana hai"* (village doctors are only interested in making money they will loot you). *"Yeh doctor to parhe /ikhe nahin hain to inka ilaj kaise accha ho sakta hai"* (These doctors are not formally qualified so how can they provide correct treatment).

Tent vendors, mobile providers, self-styled sex specialists

- In addition to the popular health care providers there are a lot of self-styled sex specialists in the villages, townships and cities. Some of these specialists advertise their services through paintings on the walls or hoardings.
- The claims are that they assure a cure for patients who have Namardi, Dhat padna, Sheegrapatan, Nocturnal emissions, marital problems, Piles, Hernia, Hydrocoele and anal fissures.
- The advertisements are more commonly displayed near the cinemas and bus stops.
- The medicines are mostly herbs (and some of them are animals in glass jars). These are displayed around the sitting area. The provider and the client are always males.

- The mobile providers located in the cities and large townships are not very commonly approached by villagers while the mobile providers in the villages do not provide any treatment services.

Study of impact of intervention

KAP of men

- While 57.5% men attributed swapndosh to the consumption of hot foods before the interventions this percentage was reduced to only I3 .5% after the interventions. The decline in this belief relating to masturbation was from 28-3.5%.
- Sheegrapatan was considered to be associated with psychological factors by 20% men. This increased to 43.5% after the interventions.
- The belief that masturbation leads to loss of body and sexual strength declined from 30.5% to 15%. The belief that narnardi is caused by anxiety and worries increased from 8 to 28%.
- There was good understanding on the problems of genital lesions after the IEC.
- The proportion of men who did not know the cause of AIDS declined after the IEC.
- In the prevention of sexual health problems 62.5% men mentioned the recognition of the role of condom in prevention of these problems after IEC as compared to only 38% before the efforts.
- There was an overall well understanding of the high-risk groups after the IEC but specific detailed understanding was inadequate.

KAP of Popular Health Care Providers

- There was a change in the perceptions and beliefs of the popular providers after their training.
- Awareness about the contact sexual health problems increased in general.
- The knowledge of painful urethral discharge increased form 2-70%, about infertility as sexual health problem increased from 11-44%, genital ulcers were recognized as a problem by 44% before the training.
- AIDS was mentioned to be a contact problem by only 18% popular providers before the training and this increased to 90% after the training.
- The association of excess masturbation with psychological factors was increased from 17-51%.
- The adverse consequence of Gupt Rog was better appreciated after the training.

Interventions: Major interventions to improve male reproductive health in the village of the project comprised of training and follow up of popular health care providers, information, education and communication (IEC) activities targeted to different groups, promotion of condom distribution and use and exploratory effort in referral networking.

Training of popular health care providers

- The popular providers could not identify their specific training needs clearly since they were mixed about diseases and psychological problems which affect role reproductive health.
- They wanted training on non-contact problems since they consider them to be disease and because they are commonly seen in the villages. These were fever requests for training on contact sexual problems.
- The diseases they were most worried about were these which cause pain or discomfort or diseases which keep men away from work.
- They wanted symptom/problem based training and not disease centred training.

- Only 6% wanted training on AIDS, this is because of the perception that this is a uniformly fatal diseases and nothing can be done to cure this illness.
- The training material developed was field tested with a number of selected private providers.
- Initially from the list of popular providers, top 211 were chosen. During the course of investigation an additional 43 were identified, thus making a total of 254.
- The location of training was decided in consultation with the popular providers. The training was organized in 3 different sessions, each of about 4-4 ½ hours duration.
- The popular providers were trained in batches of 12-15 with at least 3 facilitators in each training session (one from SWACH, the SMO from PHC and a consultant).
- The session comprised of interactive training for about 2 hours. This was followed by half an hour break and another training session of 2 hours duration.
- In the first session, the participation of private providers was 73.2%. Amongst the 4 PHCs the attendance was only 47.5% in one PHC. Subsequently in the next two training sessions, the attendance improved considerably in this PHC. The attendance came down to 65.9% during the second training session and to 58.7%. Even though, the proportion of PP's participation in attending the training declined, overall the situation was satisfactory.
- The main reasons for this were that they were busy; some of them were out of station. Some of them found training to be boring. Most of them could cope up with training while some found if too complex. An important reason was the loss of income resulting from non-availability in their clinic.
- Another important constraint was the conflict that existed as a result of the indigenous system of medicine and the deep rooted beliefs of the providers.

Sustaining the impact of training

- Forty popular providers were selected for monitoring and follow up (10 each from the four PHCs.). This was done for a period of 4 months.
- The popular providers saw a total of 230 patients with male reproductive health problems.
- The case loads for non contact sexual health problems were three times that for the contact sexual health problems (174 men had non contact sexual health problems while 56 had contact sexual health problems).
- These case loads provide an average of about 1case per practitioner per day.
- Of these 230 patients, only 10 were referred to a doctor m the primary health centre or to a specialist in the city.
- It was found that the doctors were finding the training package to be very useful.
- Most of the popular providers had referred to these guidelines while treating various contact and non-contact sexual health problems of males.
- Another entry point for sustaining the skills of the popular providers after completion of training and maintaining their interest was the use of practitioner's forum.
- There 90 practitioners who are a member of this forum. It is an existing institution and was created to protect the rights and interests of the popular providers.

Community based interventions: The main interventions were education and information on control of sexual health problem, access to condoms, providing information on medical facilities. The main target groups were adolescents and

young men, link to the Traditional Birth Attendants (TBA) Anganwadi Workers (AWWs) and Mahila swasthya Sangh Members, and various high risk groups.

Strategies

- Simplification and adaptation of IEC materials
- Adaptation of IEC materials to suit the different needs of target audience e.g. illiterate TBAs, MSS members, school teachers, and children out of school.
- Organization of orientation separately for boys and girls separately, for married and unmarried persons separately. Even within these subgroups had to be made to include people from different caste groups separately and for different socio economic strata in different groups. The homogeneity of the group participants encouraged free and frank discussions.
- Conducting IEC activities using a focused approach e.g. youth clubs, establishing letter boxes outside the schools, synchronization of IEC work with national events e.g . World AIDS day or with local fairs and festivals.

Description of IEC activities

- An orientation for teachers from 22 schools (13 government and 9 private) was done in which a total of 154 teachers were oriented. The entry point for orientation was discussion on common problems of adolescents which include anemia, Reproductive tract infections in young women, menstruation and hygiene.
- A total of 2200 boys and girls were oriented. Those who were school going and children who were out of school 'were included.
- An innovative peer education strategy was used in the orientation of children out of school. For this purpose a total of 23 youth clubs were included in as many villages. A total of 2500 out of school adolescents (1275 boys and 1225 girls) were oriented though IEC in these 23 villages.
- For sustaining the IEC efforts, letter boxes were put up in 22 locations inside or outside the schools.

IEC activities with young men and women

- A total of 5000 men and women were educated on male sexual health problems. Married and unmarried persons received their orientation separately.
- Education of link workers and volunteers: They are an excellent entry point for discussion of sexual health problems and for solving the common sexual health problems. These link health workers and volunteers include the Mahila swasthya Sangh (MSS) members, Traditional Birth Attendants (TBAs), Anganwadi workers (AWWs), and female multipurpose health workers (FMPWs). A total of 320 MSS members, 129 TBAs, 18 FMPWs and 20 Male multipurpose health workers were involved.

Orientation of NGOs and High risk groups: Out of 12 NGOs for which SWACH Foundation is a mother 3 NGOs were located in project area. The field staff of all these 3 NGOs d oriented on male sexual health problems. Although several high risk groups like CSWs, women with multiple sex partners, truck drivers, taxi drivers, males employed in police and army and males who are employed outside the village were identified.

Special promotional efforts: For advocacy on prevention of HIV/AIDS and Sexually transmitted infections, staff from SWACH Foundation utilised the available entry points to educate the target audience. The examples of these advocacy efforts are the participation in the World AIDS day and organization of a cricket match. On occasion of the world AIDS

day, spot paining competition, debates, slogan competition, were organized in 5 schools in the project villages. In each school 100 students (50 males and 50 females) were involved.

Condom promotion and use: This was a key intervention in risk reduction efforts. The main strategies were for increasing the access to condoms, increasing awareness and demand and removing major concerns from the minds of the target audience. In order to promote increased access to condoms, a total of 250 depot holders were established to stock condoms and promote their use for risk reduction. Criteria were established for selection of depot holders. On an average about 153 condoms were distributed by each depot holder over a 9 month period during which they were monitored.

Direct Observation Study and Exit Interviews

- The direct observation study was conducted on 40 patients with contact sexual health problems, 45 non-contact sexual health problems and 75 patients who had symptoms not related to sexual health. Observations were made by the field workers and then each patient was independently. The quality and completeness of treatment was very good. No laboratory tests were advised and this was according to the training given to the popular providers. The importance of condom was discussed with all the patients, and condoms were given to 0% of the patients. The importance of safe sex was discussed in about 88% of the patients.
- Exit interviews were done by the field workers to assess the extent to which the patients had understood the advice given by the popular providers. Although none of the patients were advised any food restrictions.
- The patients recalled the advice on condoms but were not convinced.
- The quality of counselling can be improved and needs persistent approach to have sustainability. There was a gap between what the popular providers had advised and what the men could recall at the time of follow up.

Conclusions and recommendations

•Sexual health problems and all matters relating to sex are a very sensitive issue. Rapport building, repeated interactions and constant probing were required to get information.

•It is essential to avoid value judgement during case studies and IDIs. Empathy should be shown to the respondent by avoiding leading questions, suggestions and remarks.

•The risks associated with non-marital sex are not learnt and there is temptation to practice aberrant sex behaviour.

•Condom use in the project area is abysmally low. Decrease in pleasure, unplanned sex, and lack of awareness poor quality of condoms and inherent shyness are reasons given for lack of condom use.

•Men do not have clear knowledge about reproductive health problems. There is marked confusion between physiological, psycho-sexual and pathological problems.

•Education of the men and women for responsible sexual behaviour, and provisions of condoms through increased access was the mainstay of successful intervention program.

•Depot holder Strategy provided a boost to the already established system of supply of condoms through government sources.

•Sustainability and influencing the behaviour of large number of people is a major challenge. The change in behaviour requires interpersonal interaction.