Chapter V
Impact of gender on men's health: sexual risk and sexual dysfunction

KEY STEPS TOWARDS FORMATIVE RESEARCH TO BETTER UNDERSTAND MEN'S SEXUAL RISK AND SEXUAL DYSFUNCTION	
Determine characteristics (e.g., gender, educational level, age range, location, income level, professional level) of population that will participate in the baseline survey	Choose target audience to survey based on national or local demographic data for project area (e.g., men and women, age rate, employed/unemployed, rural/urban, married/unmarried).
Research national and local demographic data on issues the study addresses (e.g., drug abuse, alcoholism, violence)	Study the demographics of populations who tend to exhibit risky behaviors (e.g., employment status, age range, literacy rate, geographical location, religion). If data are available, study the rates of alcoholism and drug abuse in light of STI and HIV/AIDS infection rates and prevalence. Inquire about the source of distribution of alcohol and illegal drugs.
Segment target audience into subpopulations of interest. Develop qualitative and/or quantitative instruments for focus group discussions, surveys, and individual interviews targeted at specific audiences	Address life styles, behaviors and attitudes, for example: • Alcohol consumption (frequency, location, feelings about drinking, attitudes towards consuming alcohol and sexual performance/enjoyment) • Nature of marriage (age of man and partner at marriage, length of marriage, was marriage arranged) • Nature of extramarital relations, if reported (frequency of condom use, use of condom during last sex, alcohol consumption during sex) • HIV/AIDS (experience with HIV testing, awareness of HIV serostatus, knowledge about HIV transmission and ways to protect self and partner from infection, communication with partner about HIV/AIDS) • Gender-based violence (justification, if any, of violence, past instances of hitting a woman, nature of alcohol consumption--if relevant--during such occasions, reasons for hitting a woman).
Train staff in research methodology and assessing research results	Determine capacity needs among staff. Inquire about professional organizations and

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	universities familiar with conducting such research and/or training staff in research methodology. Decide if staff will be trained or if survey will be conducted by technical experts. Provide supportive supervision for research staff. Include ethics and informed consent training if staff will implement research.
Use research findings to evaluate project success	Develop post-test assessments based on baseline survey and compare changes.

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Becoming a man and living up to the traditional or hegemonic model of masculinity is challenge that takes a toll on men's health and impacts women's well being when the traditional norms associated with manhood encourage behaviors that put men and women at risk. Socially reinforced assumptions that men know everything and that masculinity is synonymous with virility pose significant challenges for men, especially regarding their sexual performance. Such assumptions contribute to sexual dysfunctions and misinformation about what constitutes normal biological functions. For example, a study on sexual health problems among men in India found that Indian men spend large amounts of money seeking treatment "for symptoms such as wet dreams and masturbation. One estimate is that one out of every 10 Indian men is impotent and that almost two-thirds of cases of impotence stem from psychological causes" (Raju, 2000).

Assumptions about traditional models of masculinities also may lead to stigma and discrimination against men who do not conform to such models. Challenges remain in reaching boys who live on the street, men who migrate for work, and men who have sex with men. These men are often marginalized because of their lower socioeconomic status or non-traditional behaviors, and may engage in behaviors that confer a high risk of contracting STIs and HIV.

The project **Reaching Marginalized Populations: a Project on HIV/AIDS Prevention Among Men who have Sex with Men in the City of Lahore, Pakistan** describes a population alienated because of the sexual orientation of its members, which conflicts with rigidly upheld cultural norms. Through in-depth research that attempts to characterize the community, this project provides a wealth of information about the *Zenana* (men who identify themselves as women and wear mostly women's clothing) community in Bangladesh, India, and Pakistan. It exposes the violence *Zenana* suffer and the conditions under which they are willing to live rather than seek health care and

thereby risk revealing their sexual orientation. These men are powerless, a reminder that women do not have a monopoly in the struggle for equal power.

The **lessons learned** from this project are that:

- HIV/AIDS prevention in marginalized communities can never be effective in isolation;
- marginalized communities have inherent strengths as they learn to survive under adverse circumstance and these strengths can serve as guidelines and frameworks for designing holistic interventions
- a complete knowledge of the dynamics of the community is essential before undertaking a program intervention.

The three other intervention studies presented here summarize research that explores how drugs and alcohol affect men's and women's health, highlight the need to recognize marital sex as a dyadic event in HIV prevention programs, and look at the symptoms for which men seek health care. These three studies represent sub-sections of a larger Population Council-New Delhi study on sexual risk.

The research interventions described in this chapter were the only papers submitted on sexual dysfunctions, thus the Guide does not include examples of how this issue is addressed in other countries.

Research and Training Program on Alcohol and Sex Risk Behavior among Male Migrants to Mumbai summarizes aspects of the study that links the use of alcohol and drug use to sexually risky behaviors. Its goals and objectives were to:

- provide faculty and students of the International Institute of Population Services (IPPS) with background on migration, drug, and alcohol use and HIV in India;
- accumulate literature on this topic;
- train faculty and students in ethnographic research methods to identify patterns and processes of alcohol and drug use related to sexual risk taking;
- present results to interested public and private sector institutions and plan for community interventions.

To achieve these objectives, researchers used three approaches. They trained faculty and students in ethnographic research methods for assessing young men's attitudes about alcohol, their beliefs about sexuality, and expectations and behaviors. They conducted community-based research and assessments through pilot studies and disseminated their findings nationally in fora where they discussed the implications for research, practice, interventions, and policies.

Some research results that pertain to men and their health found that alcohol is associated with physical abuse and forced sex and that men believe alcohol and opiate use enhances their sexual performance. Furthermore, men who participated in the study reported that alcohol justifies the need for immediate sexual satisfaction. Such findings highlight the need for health professionals working with men to address the issue of substance use and abuse with their clientele. They should talk to men about men's and women's rights and

provide them with alternative means for enhancing their sexual performance. This includes developing meaningful and trusting relationships with their partners and communicating with their partners to find out what they enjoy. Discussions about alcohol and drug abuse are opportunities to talk to men about why they drink and what pleasures alcohol and drugs provide, and to explore how they can achieve these pleasures while being sober.

The **Gender Concepts, Marital Relationships, and Sexual Risk Behavior in Mumbai, India** intervention study worked with couples to reduce risky behaviors that contribute to spreading STIs including HIV.

The **goals and objectives** of this study were to:

- Describe sexual risk from the perspective of both married women and men in slum communities in Mumbai;
- Assess the risk of HIV/STI for married, monogamous women;
- Delineate the dynamics of the marital relationship that increase or reduce risk for HIV/STI transmission;
- Assess the potential of the husband-wife dyad as a unit for intervention for sexual risk reduction through a pilot intervention;
- Conduct community health education focused on risk reduction for the marital dyad;
- Determine the feasibility of developing a marital intervention resource network.

The study, which relied on in-depth interviews and surveys, found that even in the poorest communities, couples' intervention can be a viable approach to risk reduction. Although further research is necessary to identify the key factors that contribute to reproductive and sexual risk for wives and husbands, study results indicated that the marital relationship in both sexual and non-sexual manifestations has a significant impact on the reproductive health of women and men.

Men's Secret Illnesses (*Gupt Rog*) and its Relationship to Sexual Risk: A Case from India

Based on a paper submitted by Ravi K. Verma et al, *Men's Secret Illnesses (Gupt Rog) and its Relationship to Sexual Risk: A Case from India*, September 2003.

Implementing agencies: Population Council, New Delhi; Institute of Community Research, Hartford, CT; International Institute for Population Sciences, Mumbai (Bombay), India.

Background: India, with a population of 1.07 billion, has about 4 million adults living with HIV. According to the data of the National AIDS Control Surveillance, 83 % of the cases are transmitted sexually. More significantly, the epidemic is quickly reaching the general population. The sentinel data from the antenatal clinics suggest HIV prevalence rate among pregnant mothers is well over 3%. Yet another feature of the epidemic is that

the sex-ratio among AIDS cases is rapidly changing to favor women. The current sex-ratio is 3:1 in favor of men which about a year ago was 5:1.

It is evident that any effort to arrest the growth of the epidemic has to rely primarily upon changing men's risky sexual behavior. However, reaching men is a major challenge given the fact that India is predominantly a patriarchal society where men are not as easily accessible to interventions as women. They are the bread winners and therefore spend a significant portion of their time outside and away from home. Men enjoy greater freedom in terms of mobility and have access to resources; these two factors provide them with greater opportunities to engage in risky behaviors. Yet another important feature of the Indian society is that men mature and develop within a male dominated context, with little contact in the post-pubertal period with female peers and virtually no sex education. Under these circumstances, it is not surprising that most growing boys develop a misdirected sense of masculinity characterized by male sexual dominance, and unequal gender attitudes and behavior. It is not uncommon to find young men seeking to prove their manhood through visits to sex workers and other willing partners in the community.

A closely linked feature of this sense of masculinity among your men is the widespread presence of sexual health anxieties popularly known as '*gupt rog*' in India (DCT, 1999; Verma et al 2000, Pelto, Joshi and Verma 1999). Independent surveys completed by men and their women partners revealed a widespread presence of sexual health problems among men in the community. The survey forms submitted by men (44.3%) and by women (49.4%) reported on at least one of 12 symptoms of male sexual health problems (Verma et al 2003).

Pelto (1999) and later Verma and his colleagues (2001, 2003) classified various '*gupt rog*s' into two broad categories:

1) 'Non-contact' (e.g., involuntary loss of semen while urinating, lessening or thining of semen, nocturnal emission, premature ejaculation, masturbation, and problems with erections);

2) 'Contact' problems (e.g., STIs-like problems such as pus discharge, burning urination, gonorrhea, and syphilis).

These studies provided initial empirical evidence on the conceptual link between non-contact problems, contact problems, and sexually risky behaviors.

The results of these studies showed that men who are single or not living with their wives are close to two and a half times more likely to have non-contact problems than married men or those men who have had first sex with a women other than their wife. These studies also revealed that a large proportion of those who reported non-contact problems also sought treatment from various care providers. Among respondents reporting at least one non-contact problem, 25.5% said they had sought treatment. Of the 65 respondents that reported at least one contact problem, 61.5% sought treatment.

The present intervention research finds its rationale in these initial studies and outlines a study design that uses *gupt rog*--and sexual health providers who treat the *gupt rog*--as entry points to change risky sexual behaviors among men and reduce the incidence of STIs. The present intervention research is a collaborative effort among various agencies. The International Institute for Population Sciences (IIPS), Deonar, Mumbai, India, an apex demography research and training institution is carrying out the implementation of the intervention and related research. The other collaborators include: the Center for International Community Health Studies (CICHS) of the University of Connecticut School of Medicine, Farmington, CT USA; The Institute for Community Research (ICR), Hartford, CT; Population Council, New Delhi, India; The Department of Community Medicine, Nair Medical College, Mumbai; Committee of Resource Organizations (CORO), a community based NGO; National AIDS Research Institute (NARI), India; and OSB Diagnostics, Mumbai, India. The study has been carried out in different phases and funds were raised from various sources. Preliminary research (1999-2001) was supported by the Ford Foundation, New Delhi. The National Institute of Mental Health (NIMH), USA is supporting the current intervention research on men (RISHTA acronym for Research and Intervention in Sexual Health: Theory to Action 2002-2006) and on women; Population Council, New Delhi is supporting a nested study on youth risk behavior in the same communities.

Goals and objectives: The study aims to achieve the following major goals and objectives:

- Test the proposition that *gupt rog* is associated with higher rates of HIV/STI;
- Develop an intervention utilizing culturally based sexual health concerns that can attract men into HIV/STI education, sexual risk reduction and early identification of HIV/STIs;
- Further develop, test, and evaluate a culturally-based therapeutic approach to male sexual health problems termed “Narrative Intervention Model" (NIM) that can result in positive social, psychological, and health outcomes;
- Assess the relative efficacy of developing the NIM with the allopathic providers versus the Indian System of Medicine (ISM) doctors serving men with sexual health problems.

The Study Community: The present intervention research is set up in three large slum pockets in the north-eastern part of Mumbai. These slum pockets are also characterized by the presence of a large number of untrained health providers including sexual health providers. One can easily locate hoardings/wall-paintings and a range of advertisements claiming treatment for a variety of *gupt rog* in these communities.

Intervention approach: This approach involves implementing a treatment process called a ‘narrative intervention model’ by the sexual health providers, allopaths, and non-allopaths. Initial findings suggest that allopaths and non-allopaths use the practices listed in the table below while providing care to men suffering from sexual health problems (SHP).

Focus/component of care

	Allopaths	Non-Allopaths
Use patient "language"	No	**Yes**
Assess sexual health problem	No	**Yes**
Cultural aspects of SHPs	No	**Yes**
Psychological aspects of SHPs	No	No
Relationships aspects of SHPs	No	No
Syndromic recognition of symptoms	**Yes**	No
Referral-STI testing, medical treatment	**Yes**	No
Referral-psychological/social services	No	No
Education and risk reduction	No	No

Given the cultural underpinning of sexual health problems, this intervention proposes to shift the practices among allopaths and non-allopaths by converting all 'no's to 'yes'es in the table above.

The hypothesis is that changing the practices of health providers will lead to a greater change in risk behavior and thus reduce the incidence of STI among men in the community.

The study uses a three-arm intervention design as described below:

1. Establishment of an allopathic "male health clinic" in the public health facility in one experimental community plus positive sexual health messages to be disseminated through multi-media approaches;
2. Train Indian System of Medicine (ISM) providers on the use of Narrative Intervention Model in the other experimental community plus positive sexual health messages to be disseminated through multi-media approaches,
3. Control community with only positive sexual health messages to be disseminated through multi-media approaches.

Research design: The research design is characterized by the following major stages:

- Formative research that involved in-depth interviews with men in the community and providers and assessing the capacity of community-based organizations;
- Quantitative survey that involved conducting a baseline survey of 2,400 randomly selected men in the three study communities on KAP and STI testing for syphilis, HSV-2 (using blood samples) and chlamydia and gonorrhea (using urine and PCR analysis) for a subset of 640 men;
- Intervention phase that involved training providers, establishing referral networks, community based educational programs and pre-post treatment and six-month follow-up survey and STI testing for 640 patients drawn randomly from the male health clinic, the trained ISM providers and the untrained allopathic and ISM providers in the control community; observation and interviews with providers and patient exit interviews to establish integrity and acceptability of provider

approaches; data on men treated, service statistics; focus group and interviews with key informants on community health education;
- End-line KAP survey of 2,400 randomly selected men in the three study communities and STI testing of a sub-sample.

Indicators: Researchers used the following set of indicators:
- Reduction in the prevalence of STIs;
- Reduction in HIV/STI risk behaviors including an increase in condom use;
- Increased capacity (efficacy of treatment, referral, perceived skills) on the part of providers to treat sexual health problems;
- Increase in treatment-seeking among men with sexual health problems;
- Reduction in the consequences of sexual health problems including domestic violence, coercive sex, and marital discord;
- Increased utilization of available referral resources by providers and men in the community.

Preliminary results on the prevalence of sexual health problems and treatment-seeking from the men in community: The baseline survey of 2,400 married men inquired about their sexual health concerns, treatment seeking behaviors, and presence of STIs. Researchers also undertook a situational assessment of 245 providers in the community on the practices that they follow while treating sexual health problems. Reiterating earlier results, the preliminary results from the baseline survey revealed a significantly large presence of sexual health problems in the community with a considerably larger proportion of men reporting non-contact problems. About 69% reported having experienced wet-dreams as a problem and 18% said they had experienced involuntary loss of semen. There were distinct treatment seeking behaviors for the contact and the non-contact problems. About 53% of those who had non-contact problems went to allopathic doctors, 25.9 % to ayurvedic specialists, 18 % to chemists, and 2.8% to homeopathic doctors. While more than one-third of the respondents received zadibutty (local herbs and plants) as the medication for treatment, almost 59% of the respondents received English medicine. A much larger proportion of those who received zadibutti reported complete relief from the non-contact problems than those who received English medicine.

Among those who reported contact problems about 55% went to the allopathic doctors, 9.8% to ayurvedic specialists, 33.5% to chemists, and 1.4% to homeopathic doctors. While more than four-fifths of the respondents received English medication, one-fifths received other medicines or zadibutti.

Preliminary results reported by providers: A total of 245 providers belonging to various types of treatment systems (allopathic, ayurvedic, homeopathic, and unani) were interviewed to assess the patient load for sexual health problems, treatment practices, and willingness to participate in the intervention. Allopaths and non-allopaths saw on an average 13 (10 by allopaths, 7 by non-allopaths) patients with sexual health problems per month.

Practices used by the non-allopaths in treating patients with sexual health problems

- Non-allopathic providers use lab tests for diagnosis and allopathic medicines for treatment; however, these providers are not necessarily using the test and treatment in the correct contexts.
- The non-allopathic providers do not pay as much attention as originally thought to counseling and psychological/emotional issues.
- They usually refer clients for treatment after the treatment they are providing is failing.
- The most common non-contact problems were nocturnal emission, premature ejaculation, and masturbation. Masturbation is seen as an expression of losing sexual control and if not treated on time may lead to compulsive behavior and cause perpetual loss of semen which is considered a vital source of energy and strength. Men seek treatment for masturbation if they think that they are masturbating compulsively. In qualitative interviews, men mentioned different range of the frequency of masturbation that they considered as normal or abnormal. For some, anything more than three times a week was a problematic behavior and needed treatment. They also believe that excessive masturbation leads to the thinning of semen.
- The most common contact problems were gonorrhea, syphilis, HIV/AIDS, and cancroids.

Practices used by allopath providers in treating patients with sexual health problems

- The allopath providers saw the same problems as non-allopathic providers.
- They did not do much counseling (as with non-allopathic providers).
- They used primarily allopathic treatment for contact and non-contact problems and appeared to be using a lot of lab tests.

Activities undertaken: On the basis of the treatment practices, results researchers carried out the following activities:

- Developed a training module on treating contact and non-contact sexual health problems and on sexual risk behavior change;
- Developed a male health clinic and trained staff in association with Nair Medical College;
- Trained providers from the Indian System of Medicine (ISM) providers (on-going);
- Trained literacy staff from the Community of Resource Organization (CORO) in community education;
- Developed a referral network of service resources;
- Distributed condoms through male health clinics and ISM providers.

Stakeholders and their roles:

- As part of the Indian Council of Medical Research (ICMR) Committee, The National AIDS Control Organization (NACO) provided the approval for the study. The state level societies of NACO were kept informed about the progress.

- As a parent body of the institute, The Ministry of Health and Family Welfare approved the study.
- The Mumbai Municipal Corporation (BMC), Health Division was extremely helpful in providing community-based services. Its health outreach workers, working as key informants collected important clues about the community. In addition, its medical school, Nair Madical College, provided services to the male health clinic.
- The International Institute of Population Sciences (IIPS) provided infrastructure, manpower, and technical resources.
- The National Institute for Mental Health (NIMH) provided financial support.
- Community-based providers acted as key informants and helped enroll clients.
- Community-based organizations were key informants and provided the local infrastructure to carry out the study.

Obstacles and how they were addressed: The novelty of sexuality research and intervention at the Indian organizational base could have been problematic, but researchers addressed this by holding a series of preparatory meetings where they talked with all the stakeholders about the programmatic implications of the research. They also made sure that the rigor of the research and ethical considerations were highlighted in all the discussions. In addition, the participatory approach used in these meetings reduced apprehensions and encouraged constructive inputs.

Research conducted by an international group of researchers is difficult to undertake as they are likely to face skepticism while working on a local issue. Partner research organizations (ICMR, IIPS, and NIMH) had to be convinced that this study was a worthwhile undertaking.

The informed consent and ethical review process also had to be addressed. Major obstacles came from groups of researchers who were apprehensive in that by imposing the process of informed consent they would not get the cooperation from respondents; they also feared that most participants would avoid talking about personal issues. Rigorous training and field testing of the informed consent and relevant ethical processes removed all apprehensions, however, and the study was carried out with full ethical protocols.

Attracting men to complete the baseline survey was another challenge which researchers overcame by adjusting the timing of interviews according to times that were convenient to men. Hence, to reduce the refusal rate, the baseline survey had to be monitored and followed very carefully.

Drawing blood and urine for STI testing was addressed by first holding community meetings and talking with community leaders who in turn advocated for the need to participate in the study. Samples were collected in the communit, often in places of worship (Masjid or temples) or community centers. This increased the accessibility and also removed apprehensions.

Opportunities

- The current male focus of the HIV epidemic in India;
- The opportunity to link *gupt rog* concerns with HIV/STI;
- The concern that public health services do not address men's needs and need to be restructured;
- The importance of ISM providers in addressing men's health;
- The emphasis on HIV/STI prevention in Indian public policy sectors.

Lessons Learned

1. Launching such a study requires several steps to inform the community and its leaders and to train researchers from local institutions to undertake the research. Leaders of this study held a series of meetings with health officials from Mumbai Municipal Corporation (BMC) and opinion leaders at the local community level. Community surveys that preceded the intervention study made it visible and prepared the community to accept the intervention. A careful selection of sensitive and experienced field investigators and their thorough training also formed part of the ground work.
2. Complete transparency and strict adherence of ethical protocols enhances credibility. These principles were an integral component of the training extended to local researchers.
3. Apprehensions about sexuality research are not necessarily based on experiences, and if the research is carried out with sensitivity, people are willing to share their personal lives.
4. Providing feedback on research findings to important stakeholders at regular interval fosters their support and builds good rapport.

Chapter V
References

Raju, S., and Leonard, A. 2000. *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality.* New York: Population Council.