Sexual & Reproductive Health Concerns of Married Men and Their Access to Health Service Providers in a Rural Area of Bangladesh

Research Summary

The research highlights the huge implications for poor and vulnerable men who spend a major source of their income on treatment for sexual and reproductive health concerns. As sexual and reproductive health issues remain neglected, this research is specifically targeted to future policy and interventions, including acknowledgement of the need to engage with the role of informal providers who provide a large percentage of the services. This is one of the few studies that has also noted the link between men's sexual health concerns and domestic violence. Given the power relationship between men and women in Bangladesh if a woman refuses sexual contact with her husband for any reason, the husband's reaction varies from anger to violence including forced sex. This suggests that if men's sexual health needs were more adequately met, this might have an impact on relations between husbands and wives, decreasing the likelihood of violence related to sexual dysfunction as well as decreasing the incidence of sexually transmitted infection (STI) transmission.

Key messages

Poor rural men are very worried about their sexual and reproductive health and these concerns are both psychosocial and biomedical. Formal services do not cater to men's needs and they therefore spend a lot of money to obtain services in the thriving informal sector, which may not be of appropriate type and quality.

The efficacy of women's sexual and reproductive programmes and interventions will be enhanced through the inclusion of men in services.

Description of the project and main findings

The study explored men's sexual and reproductive health concerns and access to different types of provider in a poor rural district of Bangladesh. 693 randomly selected married men were interviewed and 60% stated that they had sexual and reproductive health concerns both biomedical (including RTIs, STIs, HIV/AIDS, infertility) and psychosocial. The leading causes of concern were psychosocial, focusing on failure to 'perform', worries about penis size and sexual weakness or loss of power; with worries about infidelity and abandonment by wives, being ridiculed and marital discord. It was also found that men explore multiple options for care ranging from self-care to folk and western biomedicine and spend substantial amounts of money on treatments. Formal services which provide very little support not surprisingly remain underutilized and men usually resort to the formal and informal private sector.

66% received treatment from different types of providers, mainly in the informal sector, including herbalists (45%); untrained "village" doctors (39%), unregistered pharmacists (19%), homeopaths (25%); and street vendors (13%). While formally qualified doctors were acknowledged by many informants to provide the most appropriate treatment, most could not afford to consult them. But informal providers were also favoured for their convenience and sympathetic approach. Informal providers themselves claimed expertise in specific sexual and reproductive health conditions and had built clienteles through local reputation.

This indicates that there is a serious gap in formal service delivery for sexual and reproductive health, especially for poor men, and that men's health is not taken seriously, exposing them to financial and quality risks.

What is the actual or potential impact of the research?

There is an increasing realisation in the global health arena that sexual and reproductive health programmes and interventions must be more inclusive of men and their sexual and reproductive health needs. These findings show the need to critically reassess comprehensive sexual and reproductive health services, which continue to neglect men's health. They point to the potential links with intimate partner related violence.

This research addresses the universal access to SRH services target of MDG5. It will inform an emerging debate at both national and international level about the neglect of men's sexual and reproductive health in primary health care services and the need to rethink service provision. It will provide the evidence base for developing interventions to address these concerns.

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It contributes to evidence on the impact of men's health and well being on women. It also contributes to an increasing national debate about the role of informal providers and how to improve quality of services for first line care.

Why is this research novel?

It examines a very neglected and often stigmatised area of health which has particularly salient effects for poor people as it contributes to health inequities. It is part of a larger study which looked at the concerns of both men and women, rather than focusing wholly or mainly on women, as in much SRH research. It also examined where they sought services from and followed up with the informal providers who are most usually consulted, rather than limiting its scope to the formal sector.

What made this research successful?

It was done in an area where there is a respected demographic surveillance site and people are more familiar with being asked questions. It was able to use existing sampling frames from related research. The interviewers were local men trained especially for the project who managed to get good rapport with respondents, both service users and providers. There was a feedback mechanism to the community in the form of a workshop for local providers, and dissemination of key findings in Bangla to key stakeholders in the District.

Case Study

Majid's Story: 38 years old Majid (pseudonym) was married for 7 years. His wife was 26 years old. He completed grade 8. They had three children aged between 6 and 3 years.

Majid experienced several sexual and reproductive health concerns. Firstly, he suffered from *shopnodosh* (nocturnal emission) for 5 years. He was worried as he became physically weak. He sought treatment from multiple providers for his problem. He went to a *Hujur* (faith healer) for enchanted water, to a *Kabiraj* (herbalist) for herbal medicines. But neither the enchanted water nor the herbal medicines could resolve this.
His other problems were *gota* (bump) on the penis and unsatisfied sexual intercourse. Although in the beginning he neglected the bump on his penis, later he found it growing. He went to a medical doctor and received treatment. About 3 years after marriage Majid started to experience sexual dissatisfaction for which he was very worried; as he said, *"without (sexual) satisfaction nothing feels good enough… The duration of intercourse is long but I do not get satisfaction. Sometimes I ejaculate regardless of my awareness..."* He went to a local doctor for treatment. Majid did not share this problem with his wife being scared that his wife might look down upon him. But he was concerned whether she was satisfied or not. Majid said, *"Now I want to have another child, but I cannot have any. I am not sure if this problem is the reason."*

Follow-on project

Research- further studies are taking place in Sylhet (high fertility zone), Rangpur (north, rural) and Chittagong (urban).
Intervention- possibility of pilot intervention in Chakaria based on earlier findings by ICDDR,B colleagues in the Future Health Systems RPC on training of formal and informal providers.
Partners- There is potential to use BRAC infrastructure in future interventions.
Publications- Monographs and journal articles.

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