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Fact Sheet: Male Youth and their Sexual and Reproductive Health and Rights (SRHR) in Bangladesh: A Mixed Methods Nationwide Study

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THE PROJECT

The project report will provide evidence from the nationally representative study, where, both qualitative and quantitative evidence are presented to understand the sexual and reproductive health status (SRH) of male youth (15–24 years). Quantitative and qualitative findings will provide an extensive picture of their knowledge, perceptions, behaviour and experiences around SRH, which includes puberty, social norms, sex & sexuality, masculinity and SRH rights. Successive chapters document existing government and non-government organizational SRH services in Bangladesh, and the implementation challenges that exist through data collected from stakeholders. This is followed by a review of existing SRH policies for male youth; reviewing laws, policies and national curriculum to explore policy gaps in law, service provision and education.

SRHR KNOWLEDGE

Peer networks are the first point of knowledge for SRH issues, followed by schools/teachers. Schools and teachers are one of the primary sources of SRH information for 55% of respondents. However, 64% of respondents go to their friends to discuss these issues, with no significant differences between urban and rural respondents. Peers are the most important source of information in most districts; in Barishal 'Teacher/schools' was the most reported, whereas 'Books/magazines' was the most selected in Rangpur. However, 'friends/peer network' is amongst the top three reported source of information in each division.

"No one discussed these issues (masturbation, wet dream) with us. That is why we discuss it with friends. We do not know where to get correct information. It would be good for us if we know it." (Respondents of FGD 1, Satkhira)

As expected, respondents' recognition of HIV/AIDS increases with each age bracket. Also, respondents with low educational attainment are less likely to have heard about HIV/AIDS (39%) as compared to respondents who have completed secondary school (90%) and more than secondary (94%). These findings indicate that a large proportion of respondents have at least heard about HIV/AIDS. Surprisingly, over half of our respondents (54%) have not heard of Sexually Transmitted Infections (STIs), again with no significant differences between urban and rural respondents. Respondents mostly learn about STIs from their peers (62%), followed by books/magazines (41%), then teachers from school (40%). There is also a demand for more information related to STIs, as one respondent explained:

"Of sexual diseases, I think, these are the most important issues that should be known about- why and to whom it happened, what are the symptoms, where to go, how can we get rid of it. I think, not to have more sex with many girls should be good for it." (A 21 year-old married boy, Sunamganj)

SRHR PRACTICES AND HEALTH SEEKING BEHAVIOUR

It was found that around 17% of unmarried males were sexually active and the average age of first sexual experience is 16.5 years. Overall, for married respondents, the percentage of using condom during the last sexual encounter with anyone other than wife was only 44. For unmarried respondents, 55% used a condom during last sexual encounter with girlfriend, and 56% of those who had sex outside of their relationship used a condom during their last sexual encounter.

The total daily average time spent on the Internet is 4.1 hours. hours. Respondents, on average, spent 1.5 hours on social media per day. Also, pornography could have influenced their sexual practices as 75% respondents have watched pornography at least once. Qualitative interviews reveal many respondents believe that pornography has led them to increase frequency of masturbation, leading to desensitization and addiction in many cases.

"Boys around 19 years old also spread/ get infected by sexual diseases. Technology causes harm to our bodies. Bad pictures are everywhere and in each mobile set. We (boys) watch it...feel excitement. Where to go then? Girls or masturbation." (A 19 year-old married boy, Satkhira)

Only 6% males ever consulted doctor/nurse/health professional at least once. Shyness was a highly reported barrier to seeking health care. As a result, informal health care such as Kobiraj, Homeopaths and local pharmacies became the important sources of consultation for erectile dysfunction, of contact for erectile dysfunction, urethral discharge, testicular swelling, and semen leakage. For some of our respondents, sexual habit and risky behaviour are linked through the use of drugs for sexual stimulation; in the last 6 months, around 1.5 % of the respondents had smoked/consumed Yaba. Among respondents who had sexual experience, around 11% of them used sexual stimulants at least once; 76% used Viagra/local alternatives, 23% used local medication or herbal remedies provided by Kobiraj, and 15% used Yaba.

"After taking Yaba, body becomes hot. If you want to enjoy with a girl and if you can go there after using Yaba, your body will be straight. Then it is more enjoyable to have physical relation." (A 19 year-old unmarried boy, Chattogram)

SRHR PERCEPTIONS, MASCULINITY, AND SEXUAL HARASSMENT

Around 28% of young males agree/strongly agree that sexually transmitted diseases are a result of weak faith/curses/evil eye. Although majority of the respondents are in disagreement, it is important to acknowledge these existing myths and social perceptions, as they have a significant impact on the health seeking practices- whether young men seek licensed professionals or traditional/spiritual healers.

For the male youth, sexuality is a significant part of masculinity, including sexual performance and function. 73% young males reported that they were worried about their sexual performances and that provides an indication that male youth's perception about sexuality propels them into anxiety and worries. Qualitative interviews reveal that the consensus is that a man must be able to provide for his family, be economically established, be physically strong, and have sexual prowess.

"If a man has no income, he is a KAPURUSH (coward). He also needs energy, sexual energy. He needs to be brave. That means, money, energy, and another is bravery- these are needed to be a real man." (19 year-old unmarried boy, Sunamganj)

Negative perceptions regarding the opposite sex was expressed. Some of the male respondents believe that females who smoke or drink are easily available for sex (30%), with 68% of respondents agreeing to the statement, "A woman should obey her husband in all things".

SRH SERVICES IN BANGLADESH

Review of 35 existing interventions reveal that majority of SRH services focus on adolescents (age 10–19), with 8 interventions focusing on the age group between 10–25 years. Males are targeted as a support group in 11 interventions. The existing interventions focus on community awareness building, clinical and non-clinical SRHR services, training for teachers and service providers, Comprehensive Sexuality Education (CSE) (for e.g. Generation Breakthrough) and advocacy. Programme implementers reported demand side and supply side implementation challenges. Demand side challenges include: community resistance during community discussions on SRHR, service accessibility (clashes with school times), access to boys, stigma associated with teaching SRHR topics in the classroom, and lack of information on available services and reluctance to avail SRH services. Supply side challenges are: lack of male focused programmes, program instabilityas a result of insufficient funds and donor dependency, lack of skilled/specialist SRH service providers at health facilities, and lack of specialized service providers and skilled trainers which weakens outreach and application of interventions.

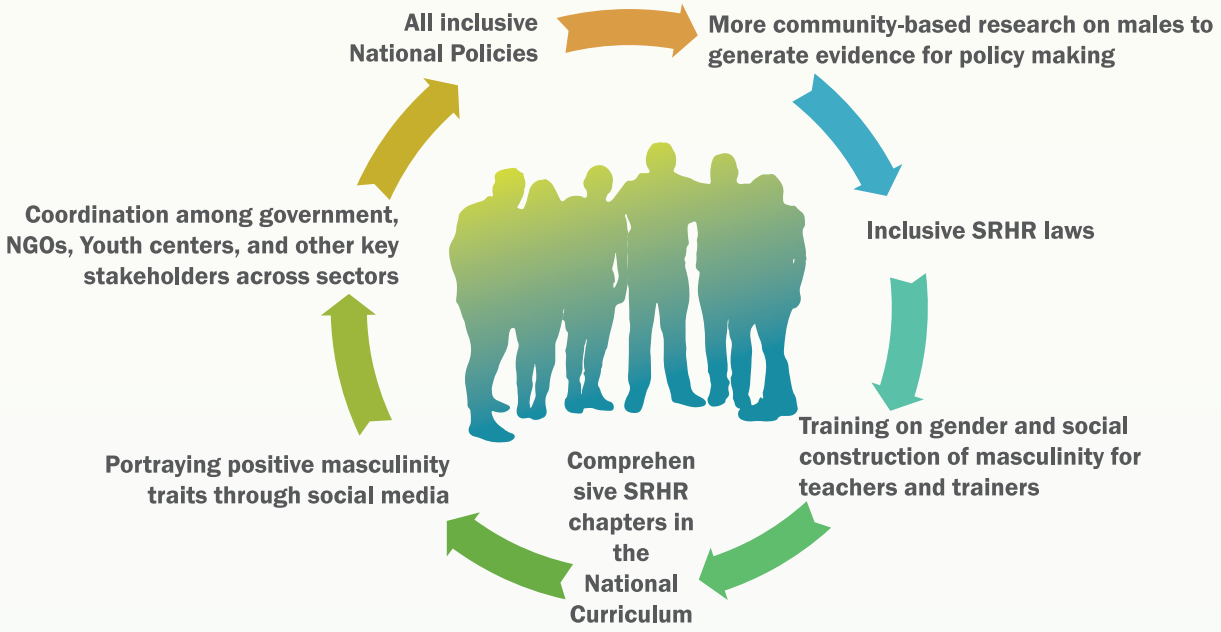
REVIEW OF EXISTING LAWS AND POLICIES

At the policy level, the National Health Policy does not specifically examine the needs of the male youth regarding their sexual health practices and rights. SRHR indicators are exclusively focused on women in the 7th five-year-plan. The fourth Health Population and Nutrition Sector Programme (HPNSP) does not include any guidelines that specifically target male youth.

With regards to the laws of Bangladesh, there is no fixed age range to define 'children'. Male rape victims between the ages of 16–18 years are not addressed under the Women and Children Repression Act (2000). Furthermore, in the Bangladesh Penal Code, section 375 defines males only as rape perpetrators, never as victims. However, a court ruling of, but a court ruling of 2013 stated that male children below 16 years of age could file rape cases if such a crime is committed against them. On the other hand, Section 377 denies forced sexual penetration on males.

Regarding the national education curriculum, there is an imbalance of male and female SRHR issues in textbooks, with topics on female SRHR taking precedence. Despite coverage of some SRHR topics, sexual abuse of male children is ignored in textbooks. In addition, it is reported that majority of, teachers have not been sensitized on SRHR issues for the purpose of teaching. Key Informant Interviews also revealed that senior policy makers do not prioritize SRHR issues. There is a shortage of evidence on male SRHR due to its lowered priority; sexuality and rights components are mostly missing. There is an attitude of denial and discomfort that persists when talking about sexual health of male youth to existing social taboos and stigma which results in results in negligence of such topics. As a consequence, there is lack of planning, specific guidelines, and coordination on working with government bodies and NGOs.

RECOMMENDATIONS



1. **All Inclusive National Policies:**
   National policies should include indicators to measure the development of male SRH. Policies should also ensure the sexual and reproductive health rights of young males; which include access to information and services.
2. **More community-based research on males to generate evidence for policy making:**
   Lack of prioritization has led to gaps in the understanding SRHR of male youth. More reproducible research is required to gain better understanding to inform better policy design and programme development.
3. **Male Inclusive SRHR Laws:**
   The current laws regarding SRHR need to introduce inclusivity, irrespective of gender. They also need to address the notion of consent.
4. **Training on gender and social construction of masculinity for teachers and trainers:**
   There is a need to develop skills of trainers and teachers; programmes should develop interventions addressing the different notions of masculinity.
5. **Comprehensive SRHR chapters in the National Curriculum:**
   The national curriculum should include topics of male sexuality, sexual violence against males, and male sexual and reproductive diseases. Government should incorporate learnings from successful interventions—like Generation Breakthrough—to scale up CSE.
6. **Portraying positive traits through social media:**
   Information technology and social media would be an effective platform to inform the youth about positive aspects of masculinity. This can be through the promotion of contemporary and historical figures in education, science, society and athletics.
7. **Strengthening coordination among Government, NGOs, Youth centres, and other key stakeholders across sectors:**
   SRHR is a social issue, where multiple ministries and agencies are involved in providing SRHR-related information, education and services. Lack of coordination among different government implementing agencies, NGOs, and other key stakeholders across sectors creates setbacks with implementation strategies, which can result in the duplication of programme activities and services. Therefore, a better coordination system of SRHR related programs should be established, with monitoring and evaluation across the programs to establish efficiency and effectiveness.

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