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# A study of male sexual health problems in a Mumbai slum population

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Conducted in a Mumbai slum population, this study examines the vocabulary men use to describe sexual health problems, cultural views about categorization, and the views of local health practitioners. Structured qualitative methods including free-listing, pile sorting and ratings were used. In addition to sexually transmitted infections, men are equally or more concerned about the quality and quantity of semen and 'impotence', which includes erectile deficiencies and premature ejaculation. A number of problems that may be indicative of the presence of STIs are thought to be transmitted through both sexual contact and other means subsumed under the category *garmi*. Men, as well as untrained non-allopathic sexual health practitioners, perceived the indiscreet wastage of semen through excessive masturbation, wet dreams or excessive sexual desire to be a major cause of these problems. A comprehensive reproductive health programme should address these male sexual health problems in order to motivate men to play more active and positive roles in reproductive health and family planning.

## Introduction

The reproductive health programme set forth in the International Conference on Population and Development (ICPD) in 1994, stressed the need to encourage and enable men to take responsibility for sexual and reproductive behaviour, and social and family roles (United Nations 1994). The behavioural and psycho-social aspects of reproductive health include (i) involving men in reproductive health programmes; (ii) promoting responsible and healthy sexual behaviour; (iii) enhancing greater responsibility and participation in all matters related to conjugal relations; and (iv) ensuring the effective treatment of sexual health problems.

Family planning programmes in India have largely ignored issues of sexuality and gender relations, which are the underlying causes of most of the behaviours and conditions addressed in reproductive health. Lack of male involvement in family planning and other family matters, sexual violence within marriage, and irresponsible sexual behaviour on the part of men are all closely linked to traditional gender role identities in Indian culture. It is in fact the tremendous pressure of traditional gender role ideologies which generates many of the behaviours by which men seek to assert their individual sexual identities (Amuchastegui 1996).

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In India, men, unlike women, mature slowly when it comes to sexual matters. With the initiation of menarche, a girl is informed (though reluctantly) by mothers and female kinfolk that she has entered a new level of adult sexual maturity. Among men, signs of maturation are not so clear cut. Physiological changes may not be marked and literature concerning this transition is limited. Boys' sources of information on sexuality are generally limited to films and television and information from peers.

As boys mature, however, they experience increased sexual urges. These generate interest in contact with sexual partners, but also lead to the 'discovery' of self-stimulation and other sexual experiences. For a minority of men, adolescent experiences of sexual arousal lead to sexual contact with women, including sex workers. Nocturnal emissions and masturbation, however, constitute the main sources of 'sexual release' in the years before marriage among the majority of males (Collumbien *et al.* 1998). At the same time, masturbation and nocturnal emissions are major causes of anxiety among unmarried young men in South Asia (Bashayak and Thapa 1985), Watsa 1993, Bhende 1994, Collumbien *et al.* 1998).

For a minority of adolescents and young unmarried men, sexual intercourse with various types of available partners become one of the expressions of their sexuality. Estimates of premarital sexual experiences in different populations of men range from 10 to 40% (Nag 1996, Rangaiyan 1996, Pelto, Joshi and Verma 2000). Premarital sexual contact usually takes place without condoms and may lead to STIs, which in turn can be transmitted to their partners, and can damage the quality of future conjugal relations. Other sexual health problems may lead to sexual dysfunctions that can have deep psychological effects, and can greatly influence the quality of married life, sexual behaviour and family planning (Pandian 1996). Clearly, there is a need to pay greater attention to a wide range of male sexual health problems.

Growing public and government awareness of AIDS has also focused attention on male sexual health problems, in part because of the role of sexually transmitted infections in the increased risk of HIV infection. In India and elsewhere, programmes aimed at reducing the spread of HIV typically consist of provision of STD services, counselling, and behavioural change interventions. Rising rates of STI and HIV infection have signalled that male involvement in all aspects of reproductive health is essential, as marginalizing them would be harmful to women's health as well. Specifically, programmes to reduce rates of STIs need to reach both partners if they are to have real impact (Hira 1999, The Population Council 1998).

Very few community-based studies exist on the prevalence of sexually transmitted infections among men, and very little is known about their health seeking behaviours. A study by Narayana (1996) reported that among men interviewed in Uttar Pradesh, 13% had at least one perceived symptom of genital infection. The study reported that the proportion of men who reported symptoms was close to the proportion of men who had premarital sexual contacts. It is likely that a large number of those men who had experienced risky sexual contacts also reported symptoms of sexually transmitted infection. Difficulty urinating, pain with urination, frequent urination, and swelling of the testes or groin were the major symptoms reported. On the other hand, there is increasing evidence that symptoms such as pain in

urination and swelling of testes are often reported by men who have no sexually transmitted infection (Hawkes 1998).

Another study of men's perceptions of illnesses in the genital area ('illnesses of the nether region' in local terminology), found that men in rural Gujarat operate with a relatively coherent explanatory model to describe this domain and, more significantly, that this perceived domain is not synonymous with the biomedical domain of 'sexually transmitted disease' (Grenon *et al.* 1996). In particular, illnesses of the nether area include illnesses with multiple causes, as well as problems that are distinctly not caused by sexual contact (including itching, heat rash, and others).

Research on the sexual health of men is needed to examine local terminology of these illnesses, perceived severity, symptoms, explanation about the causes, consequences, treatment seeking behaviours and modes of prevention. Such information will prove useful in implementing effective interventions because understanding peoples' perceptions of disease will enable programme planners to ensure that interventions make sense to the individuals concerned (Grenon *et al.* 1996).

This paper presents data on cultural perceptions and categorization of sexual health problems of men in a slum population in Mumbai, India. A number of inter-related questions are addressed. In addition to the vocabulary of sexual health problems, we explored the cultural views of the men in terms of their categorization or grouping together of sexual problems. We also sought the views of local health practitioners on the causes of these sexual health problems. In this study we use the term, 'sexual health problems' rather than sexually transmitted infections because the term STI connotes a bio-medical understanding which does not correspond to the ways in which people in the Mumbai slum community categorize illnesses and symptoms.

Published and unpublished data from studies of gynaecological health, and unpublished data from some recent studies of males indicate, that the vocabularies used to describe sexual health problems are complex (Pelto 1999). The emerging picture suggests that both men and women recognize the concept of sexual transmission, but the same health problems that may be transmitted sexually are also thought to be caused by other factors, especially those associated with *Garmi*. *Garmi* is a generic term used to imply inner body heat, which manifests itself in the form of boils, sores, small-fistulas and so on around genital areas. The concept of *garmi* is also believed to be main cause of women's reproductive health problems (Joshi and Dhapola 1999).

The cultural domain of sexual health problems among Mumbai slum men can be encompassed by the general cover term *gupt rog* (secret illness), which is the most common term to describe sexual health problems in the Hindi speaking part of India. The term *gupt rog* implies that the illness belongs to the 'secret' parts of the human body. It also suggests that the illnesses are associated with something shameful. It is however important to remember that many sexual health problems are not necessarily thought to be transmitted through interpersonal contacts. For example, excessive masturbation, thinning of the semen, wet dreams and penile abnormalities are clearly not transmitted through personal contact. In that sense they are

not 'diseases' but problems which have a very different etiology than that is expected bio-medically. Pelto (1996) has used the concepts of 'contact' and 'non-contact' illnesses to indicate these two broad categories of sexual problems.

## Contact and non-contact sexual health problems

Non-contact concerns about semen loss, including masturbation and nocturnal emission, are pervasive among young men in South Asia. They are also related to fears of impotence (Pelto 1996, Grenon *et al.* 1996). Contact or infectious problems are those that may indicate STIs. There are some problems, however, which might not be due to infections and yet may be perceived as sexually transmitted. For example, burning urination might not be due to infection, but may still be perceived by men as sexually transmitted (Hawkes 1998). Similarly, itching and some sores, pimples or other conditions in the genital areas are often due to fungal infections rather than sexually transmitted infections. In some areas of India, Filariasis and Hydrocele occur quite frequently, and are often reported as sexual health problems (*gupt rog*) by many people (Bang and Bang 1997, Collumbien *et al.* 1998).

In view of the above, the major objectives of the present study were (i) to explore the domain of male sexual health problems in a slum community in Mumbai, including perceived severity and categorization; and (ii) to understand the causes of various sexual health problems as perceived by untrained/unqualified sexual health practitioners, whose explanations are closely related to the explanations offered by popular (male) culture.

## Study area and methodology

The data presented here derive from a study in progress in a slum community of about 70,000 people located in the northeast of Mumbai.[1] The population was relocated from the central part of the Mumbai in the late 1970s. Over a period of about two decades, the slum population has grown enormously, with a large number of illegal and unauthorized buildings being added by migrants from various parts of the country. A large proportion of the population is Muslim from the Konkan area of Maharashtra, Kerala and the eastern Uttar Pradesh. It is a typical overcrowded Mumbai slum with many lanes and by-lanes, unplanned *ad hoc* structures and many small enterprises—including tea and *paan* shops, beer bars, country liquor outlets and illegal gambling joints. Transecting the entire area, we counted 53 local health practitioners, only a few of who had formal training in allopathic medicine.[2] A large number of them did not possess any recognized degree.

Initial contacts were made by the principal investigator and a senior level female researcher with practitioners who were willing to help. Initial discussion with practitioners took the form of informal conversations about the kind of patients who visit them. These discussions provided some insights into the sexual behaviours of the men in the community. Subsequently, practitioners introduced us to informants, who also happened to be their clients.

Three male researchers carried out main data collection. Initial confidence building among the practitioners was the most crucial part of the initial phase of fieldwork, repeated contact being made. This, coupled with the fact that IIPS is located nearby, and is fairly well known locally, helped the research process.

Techniques used to collect information on sexual problems included free-listing, pile sorting and rating alongside in-depth interviews. All interviews were conducted on a one-on-one basis, usually over two to three sessions. In the first session, questions were asked about the individual's background, living and occupational pattern and health problems in general. In this same session, free-lists were obtained of sexual health problems. Second and third sessions included pile sorting and illness severity ratings. Information on treatment seeking and perceived causes of the sexual problems including their sexual behaviour was also included. Interviews were conducted in the evenings or in the afternoons away from respondents' residences. A sample of 56 community men was contacted in the initial qualitative phase of data collection.

## Findings

### *Free-listing of sexual health problems*

According to Weller and Romney (1988), the first step in a study of cultural perceptions is to obtain a clear understanding of, and the boundaries to, the domain being studied. Free-listing is one technique that is particularly useful in accessing culturally relevant items (vocabulary) and in delineating the boundaries of a semantic or cultural domain. Free-listing can also be used to draw inferences about an informant's cognitive structure from the order and frequency of recall. Responses are tabulated by counting the number of respondents who mention each item, and items are then ordered in terms of frequency of response. Frequencies or percentages can then be used as estimates of how salient or important each item is within the sample of informants.

In the present study, each respondent was asked: what are all the sexual health problems (*gupt rog*) faced by men in this community? The answer to this question generated a large number of sexual health problems from both men and practitioners. In referring to these problems a variety of synonyms were used.

Obvious synonyms were grouped together thus in local language: (1) Masturbation: *hasthmaithun*, *muth marna*, *paani nikalana*, and hand practice; (2) Bent penis problems: *tedhapan*, *ling ka mud jaana*, *dahine ya baayi* or muda ling; (3) Sores on the penis: *jhakham*, *phori*, *phunsi* or *foda*; (4) White discharge: *dhat girna*, *apne ap dhatu girna*, *money ka girna* or *safeda*; (5) Loss of sexual desire: *sambhog ki eichha na hona* or *sambhog na kar pana*. Data were analysed and tabulated using ANTHROPAC.[3]

Table 1 presents the frequency, percentage response, average rank, salience and severity of the various types of sexual health problems listed by men in the community. *Kamjori* (sexual weakness), *khujli* (itching around

**Table 1.** Freelisting of male sexual problems ($n = 56$).

| *No.* | *Sexual problems and local terms* | *Freq.* | *Resp. pct.* | *Avg. rank* | *Salience* |
|---|---|---|---|---|---|
| 1 | *Kamjori* (weakness) | 35 | 63 | 3.914 | 0.285 |
| 2 | *Khujli* (itching) | 31 | 55 | 3.484 | 0.271 |
| 3 | *Peshab main jalan* (burning urine) | 30 | 54 | 3.467 | 0.294 |
| 4 | *Jaldi girna* (early ejaculation) | 28 | 50 | 4.464 | 0.212 |
| 5 | *Jakham hona/fori/foda* (sores) | 28 | 50 | 3.786 | 0.251 |
| 6 | *Dhat girna* (white discharge) | 27 | 48 | 3.370 | 0.312 |
| 7 | *Echcha na hona* (lack of desire) | 17 | 30 | 4.765 | 0.155 |
| 8 | *Tedhapan* (bent penis) | 17 | 30 | 4.706 | 0.135 |
| 9 | Khada na hona (lack of erection) | 15 | 27 | 4.867 | 0.111 |
| 10 | *Hasthmaithun* (masturbation) | 15 | 27 | 3.800 | 0.149 |
| 11 | *Dane nikalna* (boils, sores) | 14 | 25 | 4.071 | 0.113 |
| 12 | *Dhat patla hona* (thinning of semen) | 13 | 23 | 5.308 | 0.084 |
| 13 | *Ling main dard/sujan/sujak* (pain) | 11 | 20 | 4.636 | 0.085 |
| 14 | *Swapnadosh* (wet dream) | 11 | 20 | 4.455 | 0.108 |
| 15 | *Garmi* (heat) | 10 | 18 | 2.700 | 0.120 |
| 16 | AIDS | 9 | 16 | 3.778 | 0.094 |
| 17 | *Pus nikalna* (pus discharge) | 9 | 16 | 3.778 | 0.094 |
| 18 | *Ling se khoon/chamdi* (bleeding) | 8 | 14 | 5.875 | 0.058 |
| 19 | Hydrocele | 7 | 13 | 5.714 | 0.041 |
| 20 | Syphilis | 5 | 9 | 2.800 | 0.039 |
| 21 | Gonorrhoea | 2 | 4 | 1.000 | 0.036 |

genital areas), *peshab main jalan* (burning sensation during urination), *jaldi girna* (early ejaculation), *jakham/phori* (sores on the genitals), and *dhat girna* (semen discharge) are among the most frequently mentioned sexual problems. Of the first 10 items in our list, only number 5 (sores on penis) is a clear indicator of a sexually transmitted infection. Burning urination (number 3) could indicate infection, but is often unrelated to sexual contact. Our lists also illustrate the extent to which an awareness of AIDS, gonorrhoea, and other medical terminology has to some extent entered local vocabulary.

It is interesting to note that although *kamjori* and *khujli* were the most frequently mentioned items, *dhat girna* (involuntary loss of semen) was also very much on the minds of men as revealed by the measure of salience,[4] which is a configuration of the frequency of mention and the average rank of a particular item. Men apparently express greater awareness of semen loss issues, sexual performance (items 4, 7, 9) and itching problems, and place less emphasis on symptoms and conditions indicating STIs.

### *Severity of sexual health problems*

We also asked respondents to rate the severity of these problems. We asked them to rate severity on a four-point scale ranging from 'not at all severe' to 'very severe', with 'somewhat severe' and 'severe' in between. Findings are presented in table 2. AIDS was uniformly rated as very severe, followed by syphilis and gonorrhoea. Pus discharge (*pus-nikalna*) was also seen as severe. Standard deviations are in the moderate range, indicating that there is a good level of agreement among the men with regard to the severity

estimates. The lowest severity ratings are for masturbation (*hasthmaithun*), wet dreams (*ssapnadosh*) and bent penis (*tedhapan*). On the other hand, concerns about semen and sexual performance are mainly found in the intermediate range of scores (2.0–2.4). There is an apparent paradox here. Conditions such as *kamjori* are very much on peoples' minds, but they are not seen as 'severe'. In part, this reflects their perceptions of their likelihood of explaining the condition. It is also a reflection of relative *chronicity*. Men see *kamjori*, semen loss and related conditions as something they have experienced, or are very likely to experience. Syphilis and AIDS are much more life-threatening if they occur, but are not seen as likely.

### *Grouping of sexual health problems*

From the list of the sexual problems, we chose 23 of the more salient items for pile sorting. The items were written on a set of cards (each item on separate card) and 49 male respondents were asked to group these items according to their similarity, without reference to any specific criteria. The combined results of the pile sorting were analysed using the multidimensional scaling program (MDS).

Figure 1 presents the results of the men's groupings as revealed by pile sorting in a multidimensional scaling (MDS) analysis. These data show that the men divide or sort sexual health problems into four basic groups of symptoms/problems: (i) symptoms and events relating to loss or thinning of semen; (ii) performance related concerns such as impotence, premature ejaculation, etc.; (iii) sexually transmitted infections (as

**Table 2.** Perceived severity of male sexual problems ($n = 56$).

| *No.* | *Sexual problems and local terms* | *Mean* | *(SD)* |
|---|---|---|---|
| 1 | *Kamjori* (weakness) | 2.10 | (0.61) |
| 2 | *Khujli* (itching) | 2.14 | (0.86) |
| 3 | *Peshab main jalan* (burning urine) | 2.29 | (0.73) |
| 4 | *Jaldi girna* (early ejaculation) | 2.02 | (0.80) |
| 5 | *Jakham hona/fori/foda* (sores) | 2.37 | (0.72) |
| 6 | *Dhat girna* (white discharge) | 2.27 | (0.75) |
| 7 | *Echcha na hona* (lack of desire) | 1.98 | (0.80) |
| 8 | *Tedhapan* (bent penis) | 1.86 | (0.83) |
| 9 | *Khada na hona* (lack of erection) | 2.27 | (0.80) |
| 10 | *Hasthmaithun* (masturbation) | 1.55 | (0.83) |
| 11 | *Dane nikalna* (boils, sores) | 2.24 | (0.80) |
| 12 | *Dhat patla hona* (thinning of semen) | 2.43 | (0.81) |
| 13 | *Ling main dard/sujan/sujak* (pain) | 2.31 | (0.61) |
| 14 | *Swapnadosh* (wet dream) | 1.37 | (0.63) |
| 15 | *Garmi* (heat) | 2.33 | (0.96) |
| 16 | AIDS | 3.94 | (0.42) |
| 17 | *Pus nikalna* (pus discharge) | 2.78 | (0.74) |
| 18 | *Ling se khoon/chamdi* (bleeding) | 2.39 | (0.60) |
| 19 | Hydrocele | 2.02 | (0.59) |
| 20 | Syphilis | 3.00 | (0.61) |
| 21 | Gonorrhoea | 3.20 | (0.59) |

**Figure 1.** Cognitive map of sexual problems ($n = 56$).

identified in bio-medical terminology as syphilis, gonorrhoea); and (iv) infections or sores around the genital area that might or might not be sexually transmitted, and which reflect vernacular terminology.

### *Consensus analysis*

Men's responses in pile sorting and severity rating were subjected to consensus analysis using ANTHROPAC (Borgatti 1993). The results showed a very high degree of cultural consensus regarding these sexual health problems (Weller and Romney 1988).

### *Perceived causes of sexual health problems*

In order to understand the perceived aetiology of several of these problems, we conducted in-depth interviews with health providers who reported they were treating the sexual health problems in the community. As mentioned earlier, a large number of practitioners did not possess any recognized degree or diploma and yet prescribed all kinds of health care treatment. Although the majority of them were not qualified, local people consider them to be doctors and we will refer to them by this label. Many of these unqualified practitioners prescribe antibiotics and other allopathic treatments, sometimes along with ayurvedic and other medicines. During in-depth interviews, we asked practitioners about the causes for several of these sexual health problems and possible treatments.

**Kamjori** ***(Sexual weakness)***. According to local practitioners, *kamjori* is a general concept that appears to be salient for both practitioners and lay persons. *Kamjori* refers to a wide range of symptoms, including impotence,

inadequate quantity and quality of semen, and infertility among men (table 2). According to one doctor, it begins with early masturbation. Boys start 'hand practice' (another local term for masturbation) at a very young age, and gradually begin losing large quantities of semen. As a result, they feel weak and, over a period, become impotent or *kamjori*.

The quantity and quality of semen appears to be at the root of *kamjori*. Most doctors clearly stated that with frequent masturbation, the quantity of semen reduces and semen becomes thin. Thinning of semen was also attributed to food habits. For example, according to one doctor,

> Hot foods, including spices, onions, liquor and even 'English medicines' (allopathic medicines), produce excessive (sexual) heat in the body, and result in involuntary loss and thinning of semen.

Early ejaculation and lack of erection were also attributed to excessive masturbation (once or twice a day) and the poor quality of semen. The high and sacrosanct value which is attached to semen can be gauged from the fact that semen or *veerya* or *dhat* was also often referred to in pecuniary terms. One doctor summed up the importance of semen by drawing similarities between a poor man who has no money and a sexually weak person who has no semen. 'One hundred drops of blood produce one drop of semen' was the common statement of doctors, who believed that masturbation and excessive sexual desire lead to their loss.

Men in the community consider *kamjori* to be one of the more worrisome male sexual health problems. They identify loss of sexual desire; early ejaculation, white discharge, thinning, and loss of semen; burning urination and dark circle around eyes as the main symptoms of *kamjori*. It is believed that men can suffer from *kamjori* because of sexual intercourse with sex workers, excessive masturbation, frequent intercourse, sex with multiple partners, and other causes.

Some of the important sexual problems, their local terms, and their perceived causes as reported by practitioners are summarized in table 3.

Masturbation or 'excessive masturbation', was thought to be caused by 'bad company' (peer pressure etc.), exposure to sex magazines and films (including popular Hindi films) and the suppression of sexual desires. Practitioners clearly thought that masturbation is a kind of illness, which in turn is a cause of several other problems.

**Garmi *(heat)*.** *Garmi* is a problem that may indicate the prevalence of STIs among men. Sores and various forms of pus discharges and the appearance of boils and pimples are thought to represent *garmi*. Practitioners perceive its etiology as different from what is conceptualized bio-medically. According to doctors, excessive sexual desire results in the involuntary loss of semen and may be manifested in the forms of boils, sores, or ulcers around the penis and genital area. Public toilets, sex without condoms, oral and anal sex, and sex with 'cheap' women were considered important reasons for *garmi* which is generally considered a serious illness.

Men strongly believe that pimples around the genital area are a major sign of *garmi*. Other signs and symptoms of *garmi* are sores and itching around the genitals, burning urination, pus discharge, swelling and pain in penis. Intercourse with sex workers is again considered an important cause of

**Table 3.** Male sexual problems, local terms and perceived causes as reported by doctors.

| *Male sexual problems* | *Local terms* | *Perceived causes* |
|---|---|---|
| 1. Boils, sores, pus or blood in the urine, ulcers around genital areas | *Garmi; sujak; foda/ phunsi* | Intercourse without condoms; use of public toilets; anal sex/homosex/oral sex; sex with 'cheap' women |
| 2. White discharge | *Dhat girna;* loss of money; *beej girna* | Excessive sexual desire; excessive masturbation; watching 'blue' films; sexual excitement; stomach problems (gastric) |
| 3. Thinning of semen/ reduction in semen quantity | *Dhat patla hona; dhat ka abhav* | *Swapnadosh*; excessive masturbation; eating 'hot foods'/liquor; garmi inside body |
| 4. Masturbation | *Muth marna;* hand practice; *Hasthmaithun* | Wrong company; exposure to sex magazines and films; suppression of sexual desire; an illness to satisfy one's own sexual desire |
| 5. Wet dream | *Swapnadosh* | Excessive masturbation; exposure to sex magazines and films; unsatisfied sexual desire |
| 6. Early ejaculation | *Jaldi girna*, money *girna* | Ignorance about sex; excessive masturbation; mental problem; thinning of semen |
| 7. Lack of erection | *Ling ka khada na hona; ling ka kamjor hona* | Thinning of semen; excessive masturbation; excessive swapnadosh; weak muscles of penis; excessive sexual intercourse |

*garmi*. Spicy food, frequent intercourse and sex with multiple partners are also causes. Along with *kamjori*, *garmi* is also perceived as one of the most salient sexual health problems that men generally suffer from.

## Conclusions

The data presented here show that in the domain of 'sexual health problems' men identify several groups of problems. In addition to sexually transmitted infections, men are equally or more concerned about the quality and quantity of semen and impotence, which also includes erectile deficiencies and premature ejaculation. Men as well as untrained non-allopathic practitioners (who are found in large numbers in the study area and claimed to treat several of these sexual problems), perceived the indiscreet wastage of semen to be a major cause of these problems, and both men and practitioners use same explanatory models for the sexual health problems.

According to Indian tradition (writings in 'Upanishads'), the term *virya* connotes both 'vigour' and 'semen' (Nag 1996), being a source of physical and spiritual strength. The loss of *virya* through sexual acts or imagery (including masturbation, *swapnadosh*, etc.) is considered harmful both physically and spiritually. According to metaphysical physiology, food is converted into semen and there numerous beliefs and practices are prescribed to preserve and enhance the quality and quantity of semen. Given this background it is not surprising that semen loss in some form seems to be a major health concern among the men in Mumbai slum area.

Another major area of concern for men is the possibility of impotence. Erectile deficiencies and early ejaculation are manifestations of impotence. Numerous anecdotes and clinical observations seem to suggest that the increasing number of men of all age groups and social classes reportedly suffered from erectile deficiency or premature ejaculation, or both, and may spend large amounts of money for its treatment. In fact, one estimate goes on to claim that one out of every 10 men in India is impotent (Jain, Menon and Vinayak 1998). An important feature of impotence is that most cases of impotence stem from psychological causes, the most damaging aspect of which is that it creates a vicious cycle of anxiety and depression, which in turn aggravates the problems (Shah 1998).

What implications do the categorizations of sexual health problems and views and beliefs surrounding them have for understanding reproductive health issues? From the point of view of research, we need empirical evidence to relate sexual health problems, their perceived causes, and consequences to the quality of conjugal relations, family violence, sexual behaviour within the outside marriage and use of male methods of family planning. Given the importance of sexual prowess in defining male identity, it is reasonable to assume that perceived sexual inadequacy on the part of men will not only adversely influence the quality of family life, but may also be manifested in the form of domestic and sexual violence. These problems may also discourage men from taking an active part in use of family planning methods. The non-acceptability of vasectomy, for example, is largely a product of widespread fears that vasectomy causes erectile dysfunction, along with diminishing the quantity and quality of semen.

The wide range of male sexual health concerns identified in our study suggests that any comprehensive programme in reproductive health should address these concerns in order to encourage men to seek adequate health care and counselling for both contact and non-contact problems. If men can be convinced that health care professionals understand their problems, they may be drawn into more active roles in relation to women's reproductive health as well.

There are significant differences between lay models of 'sexual illness' and the images of sexually transmitted infections (STIs) promoted by the Indian health service. The terminology and concepts discussed here may therefore be particularly useful in the training and orientation of health providers. Such training will of course require careful adaptation for use in other areas of India where concepts and vocabulary may be different from those observed in Mumbai.

In addition to further research on these topics in other areas of India, there is need for work to explore the causal linkages among various demographic factors, sexual experiences, and individual instances of *kamjori*, *garmi* and other ailments. Finally, relationships between men's perceptions of infections need to be correlated with the results of biomedical tests.

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## Notes

1. The study is part of a Ford Foundation funded capacity building project (Grant No 950-1006) in the area of reproductive health at the International Institute of Population Sciences, Mumbai. This paper presents qualitative data from a larger study which addresses the issue of men's sexual health as it relates to their sexual behaviour, conjugal relations and family planning acceptance. The opinions expressed here are that of authors alone and do not necessarily reflect the opinions of neither the Ford Foundation nor the International Institute for Population Sciences.
2. A formally trained medical graduate in India is conferred with MBBS (Bachelor in Medicine and Bachelor in Surgery) degree.
3. ANTHROPAC is a software package, which allows data analysis for the structured data collected through systematic methods.
4. Salience is calculated by combining the frequency of an item with its average rank in individual lists. Salience can thus be thought of as 'how much is this (problem) on peoples' minds?'

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**Résumé**

Réalisée auprès des habitants d'un bidonville de Mumbai, cette étude examine le vocabulaire utilisé par les hommes pour décrire leurs problèmes de santé sexuelle, leurs modes culturels de catégorisation et l'opinion des praticiens de santé locaux. Des méthodes qualitatives structurées telles que l'énumération libre, le tri par regroupement et le classement ont été employées. Si les hommes interrogés se disent préoccupés par les infections sexuellement transmissibles, ils le sont autant, voire davantage, par la qualité et la quantité de leur sperme, ainsi que par « l'impuissance » qui comprend aussi bien les problèms d'érection que l'éjaculation précoce. Certains problèmes qui évoquent la présence d'infections sexuellement transmissibles, sont perçus comme pouvant se transmettre à la fois par contact sexuel et par d'autres biais que la catégorie *garmi* englobe. Aussi bien les hommes interrogés que les praticiens non-allopathes et sans formation à la santé sexuelle, considèrent que le gaspillage inconséquent de sperme (causé par les excès de masturbation, les pollutions nocturnes ou le désir sexuel excessif) est la cause principale de ces problèmes. Une politique sanitaire globale de la reproduction doit prendre en considération ces problèmes de santé sexuelle masculine afin de mieux convaincre les hommes à s'engager activement et positivement dans la santé de la reproduction et dans la planification familiale.

**Resumen**

Este estudio, realizado en una barriada de Mumbai, examina el vocabulario que los hombres utilizan para describir sus problemas de salud sexual, las

visiones culturales sobre su categorización y las opiniones de los profesionales locales de la salud. Se utilizaron métodos cualitativos estructurados, entre ellos el listado libre, la clasificación por grupos y el ''rating''. Además de las infecciones de transmisión sexual, a los hombres también les preocupaba igual o más la calidad y cantidad del semen y la 'impotencia', incluyendo deficiencias de erección y eyaculación precoz. Varios de los problemas que pueden indicar la presencia de infecciones de transmisión sexual se creía que se transmitían por el contacto sexual y por otros medios incluidos bajo la categoría *garmi*. Los hombres, al igual que los profesionales de la salud sexual no alopática y sin formación, consideraban como principal problema el indiscreto desperdicio de semen por masturbación, eyaculaciones estando dormido o excesivo deseo sexual. Un programa abarcatio de salud reproductive debería abordar estos problemas de salud sexual de la población masculina para motivar a los hombres a desempeñar un papel más activo y positivo en la salud reproductiva y la planificación familiar.