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RETHINKING GENDER AND HEALTH: HELP-SEEKING AND HEALTH-SEEKING PRACTICES AMONG THREE GENERATIONS OF MEN IN BANGLADESH

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ABSTRACT

Help-seeking and health-seeking are social practices influenced by ethnicity, class, race, age, and gender, among other factors. Globally, research suggests that ideas about masculinity influence men's health-seeking practices. However, only a modest body of literature has considered masculinity in relation to men's health problems in South Asia. To address this research gap, a qualitative study was conducted to gather the narratives of three distinct social generations of men in Bangladesh concerning the understandings of gender and masculinity, and men's help-seeking and health-seeking practices. Drawing on evidence from men's accounts, we suggest some of the ways in which specific forms of social generational masculinity influence men's help-seeking and sexual health-seeking practices. Findings carry implications for future health policy and health promotion practices. Generational masculinities and generation-specific health-seeking practices need to be taken into account in health policy and practice.

Keywords: *Help-seeking; health-seeking; sexual health; masculinity; gender; social generation; Bangladesh; South Asia.*

Internationally, while a growing body of research on men's health has focused on Euro-American contexts, until very recently, little research has examined relevant issues in South Asian settings.[1] Since the 2000s, however, a few important studies have been undertaken.[2–11] Several of these investigations signal the legacy of culture and history, as well as processes of social and economic transformation, as factors influencing men's health.

Likewise, while there exists a considerable body of literature on men's sexual and reproductive health (SRH) in Euro-American[12,13] and some African[14,15] contexts, relatively few studies have focused on men's sexual and reproductive health in South Asian settings. Instead, much of the SRH literature in South Asia seems to engage with questions of gender and health, with gender being narrowly understood in terms of a focus on women's health concerns.[16] Among the issues explored, research has looked at the influence of gender on health care utilization,[17] issues of sex-selective abortion in India,[18], and the general neglect of girls.[19] Also of interest have been the unusual life expectancy rates which have tended to favour men in several South Asian countries.[20]

In contrast to the findings of international research, which tend to show that gender norms hinder men's health-seeking, research in South Asia reveals that women encounter gender-specific barriers to seeking health care. For example, women tend to report a disadvantage in relation to seeking treatment for illnesses in rural India[21]. Similarly, research in Bangladesh indicates that women are less likely to seek health

care than men.[22] In several studies, men have appeared as 'barriers' to women's health in the countries of South Asia.[23–25] This particular positioning of men, together with a general lack of focus on men's health itself, underscores the need to further study men's health-seeking practices, consid-ering men as gendered subjects[26] whose experiences matter, being shaped historically and culturally by notions of masculinity and the social generation of which they are a part.[27]

Throughout this paper, a distinction is made be-tween help-seeking and health-seeking. While the term 'help-seeking' has been used to refer to the use of formal or informal supports in general from sources such as health facilities, media, family networks, friends, traditional healers, professional care provid-ers, religious leaders, health workers, counsellors, and schools, 'health-seeking' more narrowly refers to the seeking services or remedies for a specific ailment, illness or disease.[28] Both of these aspects are focused on here, with special reference to the sexual health of men of differing social generations in Bangladesh.

This paper is based on findings from a qualita-tive study conducted in Bangladesh which sought to examine the implications of social generational masculinities for men's health in general and sexual health in particular. Among other issues, the study explored the help-seeking and health-seeking practices of different generations of men and examined how these practices might be linked to generation-specific masculinities. In what follows we explore three con-trasting social generations of men's understandings of sexual health, including sources and types of sexual health information and health services sought. Of particular interest are participants' understandings of safe sexual practices, patterns of media use, and knowledge of sexually transmitted infections (STIs) including ideas about HIV and AIDS. Special attention is paid to the men's health and help-seeking practices and the socio-economic and cultural forces that were seen as shaping these.

METHODS

As part of a broader study on masculinity and sexual health, men's narratives were gathered to examine the relationships between men's enactment of gender and their help-seeking and health-seeking practices. Participants belonged to three distinct social generations and lived in three cities at the time of the interview. The three cities – Dhaka, Chittagong and Gazipur – were purposively selected as centres of com-merce, industry and education, and important sites for understanding social change and social generations. While Dhaka and Gazipur are located in the Dhaka division, Chittagong is in the Chittagong division. The three generations focused upon included men from an older social generation growing up in the 1950s and 1960s, a middle social generation growing up in the 1980s, and a younger social generation growing up in the 2000s. Men in each of these generations were purposefully selected to help identify commonalities and variations in masculinity, in sexual practices and help-seeking practices.

After obtaining ethics approval from the UNSW Human Research Ethics Committee, qualitative interviews were conducted with men in each of the study sites mentioned above. Local higher educational institutions and several non-government organizations assisted in recruiting participants. The first author conducted the interviews face-to-face with each man. In all, accounts from 34 Bangladeshi men were elicited through semi-structured interviews and analyzed using a broadly abductive research strategy. Of the men, 10 men belonged to the older social generation, 11 to the middle social generation, and the remaining 13 belonged to the younger social generation. A semi-structured interview guide, consisting of a set of open-ended questions, was utilized to guide the research conversations. In line with a semi-structured interview method, each participant was invited to explore and discuss any points and issues relating to the research problem – namely, the relationship be-tween notions and practices of masculinity, and men's help- and health-seeking in relation to sexual health.

All men's narratives were audio-recorded and were translated from Bengali into English prior to being uploaded into NVivo (version 10), a data analysis software, for analysis. Using NVivo, the first author coded the transcripts and analyzed them to identify recurrent themes within men's narratives. All transcripts were subjected to multiple readings. Analytic notes were prepared when reading through the transcripts.

Men's understandings and their enactments of masculinity, their sexual practices, their help-seeking, and health-seeking practices were compared and contrasted across the social generations. Generational similarities and differences in the men's help-seeking practices and health-seeking practices are discussed in the following sections.

OLDER SOCIAL GENERATION MEN'S SEXUAL HEALTH AND HELP-SEEKING PRACTICES

Help-Seeking Practices

Older social generation men's accounts suggested that they rarely sought help for health problems linked to personal circumstances, mental health issues, and/or financial hardship which influenced their help-seeking practices as well as sexual health. Bazlul's (about 70-75 years, retired, Gazipur) had been suffering from multiple health issues, including *durbalata* (weakness), insomnia, and breathing problems. He was no longer able to work. He complained that his adult sons had not been providing him enough money and food. Overall, he said that his life was miserable and he wished he was dead. A few other older generation men, like Bazlul, displayed misery and fatalistic attitude, although they did not attempt suicide. Bazlul recalled that he had twice planned suicide to end his suffering:

> I've *durbalata* [weakness], my knees and legs become numb after I walk for a while. I also have headaches. I went to kill myself two times by going under vehicles [train]. The *buri* [meaning the old woman, his wife] lives with me. Not seeing me at home, she asked my sons to find me. I'd walked towards the railway tracks. My sons brought me back home.

Bazlul attempted to kill himself by throwing himself under a train but was unsuccessful because his adult children caught him before he could reach the railway track. In Bazlul's case, not seeking help was influenced by his old age, poverty, lack of support, and a general sense of despair. Men reasoned that their adult sons did not take care of them in their old age and they received limited or no assistance from the government which explained their general sense of despair. Similarly, Halim (70 years, security guard, Chittagong) had a life full of sorrow but did not seek help from others. Instead, he found consolation in the fact that Allah (God) would come to his aid. He said that he had often cried out and prayed to Allah, adding that he had disclosed these experiences for the first time during the interview.

When men of this older social generation were asked to reflect on how they had first learned about sex and relationships, they offered a variety of responses. Whilst some men felt that there was no need for explicit education about sexual matters, others described how they had learned about sex from religious leaders and from people who were older than themselves. Those who had not felt the need to seek out information concerning sex believed that sex was something that occurred naturally.

Adil (about 75 years, retired, Gazipur), for example, said that sexuality had never been talked about when he was younger. He said, 'Everything else was discussed except this thing'. He added that it was Allah who had helped him learn about sex: 'Allah made me know about this. Since childhood, nobody had been telling us about it [sex]. It happened automatically. Nobody teaches it to others.' Adil's words signal something of the taboo attached to the discussion of sexual matters when he was young, although he later stated that he had heard that pregnancy could occur through sexual intercourse and that babies could be born as a result.

Based on their accounts, several explanations can be given for older social generation men's reliance on their own resources or on these traditional sources of information. First, many men reported believing that religion held the answer to everything in life. Several older social generation men were of the view that there was no need to learn about sex because it took place according to the will of God. Second, because many older generation men had only attended school for a couple of years and had lived in villages without the use of modern technology, they had had to rely on more traditional sources of knowledge and information with respect to sex and other related matters.

Older social generation men's narratives also suggest that they did not have much awareness of what nowadays might be regarded as safer sexual practices with respect to sexually transmissible infections (STIs). Almost all reported that they had not heard about condoms, STIs, HIV and AIDS. One likely reason

was that they did not have access to mass media and education; almost none of them, when growing up, had had access to modern technology such as television and computers, and some viewed watching television as an 'un-Islamic' practice. Although HIV and AIDS had been emerging as an issue of concern when men of this social generation were younger, their lack of literacy and poor access to the media prevented them from knowing much about these issues.

Health-Seeking Practices

With respect to health-seeking for specific health issues, there were reported to be few medical doctors in the villages where men of the older social generation had grown up. Adil (75 years, retired, Gazipur) said, 'In our times, there were *kabiraj* [traditional healers] only'. Because of this, men had had to rely on herbal medicine, traditional healers, or religious leaders for advice about or treatment for health problems. Adil, for instance, remembered having sought help from *kabiraj* and taken herbal medicines when he had a fever. He also believed that modern medicines held little power. He belonged to the local *Tabligh Jamat* which is a non-violent and non-aggressive movement of Muslim men that emerged in South Asian countries.[29] Adherents of *Tabligh Jamat* are often described as feminized Muslim men as they learned how to cook and share food with others, while on *chilla* (religious missionary tour).[30] When he was ill, Adil only saw a doctor or a *kabiraj* because he believed it was his *sunnat* (the duty of a Muslim as a follower of the Prophet Muhammad) to do so:

> Yes, I did. I'd fever or cough, I went and they prescribed medicines. Medicines don't have any power. Power lies with Allah. The Prophet used medicines and so we've to take medicines as *sunnat* [actions done to emulate the Prophet]. We've to remember this. [But] if we say, 'I'll get cured if I take medicines', that will be a sin. … If we take medicines as *sunnat*, Allah will bless us.

Like Adil, Mobin (62 years, rickshaw puller, Gazipur) had rarely sought professional help for health problems. When he had once done so for fever by buying tablets from a pharmacy, he had been cured 'by the grace of Allah'.

Older social generation men reported a number of sexual health problems that are well-documented in the South Asian literature, including *swapnodosh* (nocturnal emissions), sexual impotence, erection problems and premature ejaculation.[4,31–32] For Amir (56 years, security guard, Gazipur), sexual health problems also included problems with the quality of *birjo* (semen), thickness being an important criterion. Overall, however, the majority of older social generation men described their sex lives as having once been satisfactory, especially when they were younger. They felt that it was only natural to encounter sexual health problems in old age. Demonstrating with his finger, Mozammel (about 72 years, retired, Gazipur) explained: 'My *lingo* [penis] is now like this. It doesn't stand [erect]. Previously it was like this [it used to be erect].'

Taken together, the narratives of older social generation men suggest that health care seeking for sexual health problems was the exception rather than the norm. Most of the men interviewed said that they had never sought professional or other types of help for sexual health problems. The main reason for not seeking health care was the fact that most men of this older social generation saw themselves as sexually healthy and believed that they did not have problems requiring help. Such a perspective was in line with their accounts of being sexually potent when young but experiencing what was understood to be a 'natural' decline as they aged.

Only a very few older social generation men interviewed reported having sought health care for sexual health matters. Mozammel said that he had once sought advice from a *maulana* or religious leader concerning *swapnodosh*. In Mozammel's eyes, these emissions were robbing him of his strength, which in turn made him weak and gave him headaches. He said: 'It [semen] came out and it kept on coming out, then you've headache and then you get weak. That's why, I said this to the *maulana*. I got well'. The *maulana* had taught him a *mantra* to recite six times before going to bed. This, he believed, eventually cured him and the *swapnodosh* ceased.

In summary, older social generation men's adherence to Islamic values and traditional Bangladeshi cultural norms strongly influenced their understandings of sexual relationships and sexuality, affecting their sexual health information-seeking. In the absence of access to modern information technologies and lack

of formal education, older generation men tended to rely on mainly traditional channels, such as religious teaching and the family for information about health-related issues. In addition, older social generation men's cultural and religious beliefs and their low incomes tended to shape their health-related help-seeking practices. Of all three social generations in this study, men of this social generation were the least likely to seek (or to have sought) help for sexual matters. When they did take medicine, they did so largely because they thought it was their duty to emulate the Prophet's lifestyle or for the specific kinds of health issues described above.

MIDDLE SOCIAL GENERATION MEN'S SEXUAL HEALTH AND HELP-SEEKING PRACTICES

Help-Seeking Practices

Like their older social generation counterparts, most men of the middle social generation said that they had not sought support for sexual health either because they saw themselves as not needing to do so or, because as some reported, they felt *lojja* (shame) in doing so. Men of this social generation also described how low income and prioritizing their wives' and children's needs over their own were reasons for not seeking help themselves.

Mazid (35 years, garment factory worker, Gazipur) lived in a state of financial hardship and experienced relationship problems. His wife, a garments worker, used to give her wages to her parents. She did not contribute to the family financially. Mazid said that his wife also complained about his *osukh* (sickness) or *jauno somossa* (sexual health problem) which took the form of impotence. News of his *jauno somossa* had spread among his family, relatives, and friends. His wife gave him one year to improve his relationship with her, but things did not work out and the marriage had ended in divorce. Mazid did not seek any help for his relationship problem but continued to look after others, finding it difficult to borrow money from friends when he needed money for his child's health care.

Similarly, Khairul (35 years, vendor, Gazipur), as a household head, prioritized the care needs of his wife, children, and his old mother above his own. He believed that Allah (God) was there to take care of him. When asked whether he ever went to see a doctor, Khairul said,

> No, I don't. I take my wife and child and mother. But I don't go for myself. For me, Allah is there. One gets diseases if one does a sin.

This finding is significant because, contrary to the stereotypical representation of men as lacking care about others, it signals the importance of the provider role as an aspect of hegemonic masculinity causing men of this social generation to prioritize the health needs of other family members over their personal well-being. That said, being a breadwinner was also a means of asserting masculinity and power for men of this generation.

Unlike their older counterparts, middle social generation men described obtaining sexual health information from a more diverse range of sources. These included television, older people, schools, and Bangladeshi and Indian movies. Several men described watching 'naked' or 'blue' films (meaning pornography) with their male friends. The two men from this social generation who had university degrees mentioned that they often read newspapers but observed that the newspapers did not contain much information about sex or sexuality. Apart from the sources mentioned above, men of this middle social generation tended to learn about sex and relationships from other male friends.

> We discuss it among friends. One says, 'I've done two times'. Another says, 'I've done three times.' Someone else would say, 'I've *mere disi* (have had sex) this morning after coming back from night-shift work. I couldn't do at night, so *maira disi* [have had sex] in the morning'. This is how it works. (Dulal, 46 years, office assistant, Chittagong).

All-male groups chatting near tea stalls, in shopping centres, at universities, in cafes, and in parks were valued sources of information about sex, sexuality, and relationships. Through such means, Dulal, for example, had learned there were medicines that could increase his sexual prowess. Masud (37 years, van driver, Gazipur) said that he had first learned how to massage his *lingo* (penis) (i.e., masturbation) from his male *dosto* (friends) after going with them to a place where 'naked' movies were shown to low-income

men in exchange for a nominal fee. He said that his friends had encouraged him to massage his *lingo* in the darkness while watching these films.

While many middle social generation men had heard about AIDS and could identify several modes of HIV transmission, almost none had heard about other STIs. Even though they were aware of HIV, some held misconceptions regarding modes of HIV transmission believing, for example, that washing the genitals after sex could protect against HIV if condoms were not used. Other men were of the view that people only got HIV through *kharap kaaj* (bad work), by which they meant extra-marital or pre-marital sex (usually with female sex workers).

In common with their older social generational counterparts, middle generation men stressed the importance of not having sex during a woman's menstruation. Both groups of men believed that to do so could cause harm to the man and was prohibited by Islam. Shahit (35 years, rickshaw puller, Gazipur) had received 10 years of schooling at a *madrassa* (an Islamic religious school) where he remembered having been taught about issues like menstruation and masturbation. He explained that he had learned that women have a periodic *osukh* (literally sickness) during which, he believed, a man and his wife should sleep separately. He added that he had also learned from one of the books at the *madrassa* that masturbation could be harmful and was 'bad for the health'.

Health-Seeking Practices

While most middle social generation men saw themselves as sexually healthy, they described others with sexual health problems including *swapnodosh* (see earlier), the thinning of the semen, and/or the loss of too much semen. They also believed that *beshi kora*, or indulgence in what they saw as 'too much' sex, could weaken their sexual performance. Shahit (34-35 years, garments factory worker, Gazipur), for example, said that his grandmother had advised him to have sex no more than 12 times per month. He recalled a Bengali proverb she had told him: *Mashe baro, joto komate paro* (12 times a month, the fewer, the better). Similarly, Shahit's grandfather had advised him never to waste his semen.

> When I was younger, my grandfather said, 'Do not write with your own ink on someone else's notebook. If the ink of a pen is used up, it can be refilled, but if a man's ink is wasted, it can't be refilled'. I still remember his advice. I think it's very true. If once lost, will you be able to bring it [semen] back even if you try a hundred times?

Implicit here is the traditional belief that semen provides a source of bodily energy associated with masculinity[2]. Since the wastage or loss of too much semen was viewed as causing weakness, men felt that once they became weak, they would not be able to have sex for a long time. Alim (30 years, van driver, Gazipur) described his experience of semen-loss as follows:

> Once when my semen became *patla* [thin, meaning too liquid]. Do you know what I mean? It falls in drops [discharge keeps coming out] … The semen wasn't thick at all. It had a water-like texture. This can happen after men have erections. A man becomes weak if he experiences this.

Middle social generation men who had had sex with multiple partners (including sex workers) stated that they had experienced some sexual health problems but delayed seeking help because they hoped that the problem would resolve itself with time, or because of *lojja* or shame. Alim (30 years, driver, Gazipur) found it difficult to seek health care when his semen became *patla* (thin, i.e., too liquid). When he experienced blood in his urine, Islam (35 years, office assistant, Chittagong) became very worried, but could not tell anyone about it. He secretly visited a doctor early in the morning so that no family member would know about the situation.

Khairul described how *lojja* had caused him to delay seeking health care after an incident of sex between himself and a male friend when both were younger. Neither Khairul nor his male friend had felt able to seek any professional help in a context where sex between men was sanctioned both legally and socially; so instead, they had instead gone to a local pharmacy to purchase medicines. He found himself in a difficult situation, first because he had had pre-marital sex and second because the sex had taken place with a male friend.

> When I first *disi* [inserted] the whole thing [anus] got broken [fractured]. He was crying. I asked, 'Why do you cry'? The situation was bad. Later from a shop… there's an ointment … It's called *Millat balm* … It cost only 4, 5 taka, or maybe 3 taka. […] If parents knew about it, we would have to leave the area. We could get into lots of trouble.

Khairul's quotation reflects his fear of stigmatization and rejection because he had violated the codes of hegemonic masculinity. His experience, reflected in the quotation above, signals how local culture, heteronormative gender norms and dominant understandings of what it means to be a *sottikarer purush* (real man) act to prevent men in Bangladesh from seeking help for sexual health issues arising from male-to-male sexual encounters.

By way of contrast, a few middle social generation men described seeking care for sexual health issues in order to strengthen a sense of masculinity. For example, Salam (35 years, van driver, Gazipur) had sought medical help after realizing that if his wife complained about his sexual performance, his masculinity would be threatened. Similarly, Masud (37 years, van driver, Gazipur) sought help from a doctor to deal with erection and premature ejaculation problems. In his view, a wife could create problems if she was not sexually satisfied.

> If she suddenly says something [relating to sexual impotence], all my *maan-izzat* [honour] will be ruined. So I saw a doctor after four, five days of the problems. Later after taking the medicines, I found it useful.

Three important insights emerge from the narratives presented above. First, many men of the middle social generation did not seek professional help because of the need to prioritize other people's health care needs over their own as heads of households. This finding challenges the stereotypical representation of men as non-caring towards others, and violent towards women, in the South Asian context. Second, *lojja* relating to sex outside of marriage (and other forms of social transgression) limited men's ability to seek health care. Third, the findings point to occasions when middle social generation men might seek health care in order to maintain and display valued aspects of masculinity (such as sexual prowess) that align to what norms of manliness should be like.

YOUNGER SOCIAL GENERATION MEN'S SEXUAL HEALTH HEALTH-SEEKING PRACTICES

Help-Seeking Practices

Younger social generation men's accounts suggested that like their older counterparts they had sought relatively little help for sexual health issues and problems. Although several were unsure what the term *jauno shaisto* (sexual health) meant, men from Dhaka in particular, and especially those with college education or from a higher socio-economic background, displayed a greater awareness of STIs, HIV and AIDS than other younger and their older social generational counterparts. Much of what they knew had been learned from the television and other media. Foysal (25 years, private university student, Dhaka) for example said:

> I came to know from TV and also from some promotional activities. I also use the Internet and so I see a lot of information regarding sexual health … In Bangladesh, most of the ads are about AIDS, HIV; but in other countries, there are ads about other diseases like genital diseases like gonorrhoea, syphilis etc.

Other younger social generation men mentioned obtaining information about sex, sexuality and sexual health from books, social media and sometimes pornographic videos.

In contrast, those younger social generation men who came from a lower socio-economic background or who lived outside the capital city tended to have much less information about sexual health and relationships. Roshid (27 years, electrician, Gazipur), Babor (22 years, van driver, Gazipur) and Nurul (19 years, office assistant, Chittagong) did not know what *jauno shaisto* meant. All three had dropped out early from school, unlike their other younger social generational counterparts. Nurul thought that married people were supposed to have a better knowledge about sexual matters. He added that older people would brief him about sex at the time of his marriage. He said: 'What sexual health means ... those who got married, they'd understand it well ... I ain't married yet, am I? … Had

I been married, I would've known something about this. I haven't got married'.

In contrast to men of the two older social generations, problems relating to relationship break-ups figured more frequently in younger generation men's narratives. Several men of this social generation reported finding it difficult to sustain a romantic or sexual relationship with their partners, and few had sought help given they found themselves in society that is generally not accepting of pre-marital sexual/romantic relationships. Foysal (25 years, university student, Dhaka) had formed a relationship with a young woman he met through Facebook. After their break-up, however, he was very upset. His distress was compounded by the fact that he could not concentrate on his studies, while most of his friends had already earned their degrees and were working full-time. He described performing *namaz* (prayers) regularly to try to deal with his distress, but did not seek help from others, believing like many of his older social generational counterparts that a *sottikarer purush* (real man) had to be independent.

Living in a sexually conservative country while simultaneously being exposed to a global popular culture in which sexual content is readily available, the majority of younger social generation men expressed dissatisfaction with the ways sexual matters were currently dealt within Bangladesh. Karim (22 years, university student, Chittagong) stressed that not enough information about sexual matters was disseminated and that there was a need for more research on sex education. Students from both public (Karim, for example) and private universities (Foysal, for example) expressed dissatisfaction with the taboo about sex in Bangladeshi society and felt society should be more open about sexual matters. They reported discussion about sex and sexuality at school as either absent or cursory, perhaps because of cultural taboos or the framing of pre-marital sex as a 'bad thing'. Karim, for instance, said that his school teachers had not discussed sexual issues at any length. He described a biology teacher, for example, who had tried to avoid teaching about these topics.

Other younger social generation men concerned said that sexual matters were not discussed at all, even at the secondary school level. Without access to information about sex and relationships through the family or educational institutions, men had to rely instead on the Internet, friends and television to learn about sex. Rahul said:

> These things [sexuality issues] aren't discussed in our country. To know about this ... those of us who are young, we've the Internet. We can see and know everything here. We can learn. I learned these things from there. Another important source are friends. These topics aren't discussed with family members. So we discuss these with friends. And we ultimately know from them.

Health-Seeking Practices

Although younger social generation men reported that they had encountered sexual health problems, like the men of the two older generations few of them had sought help for these difficulties and many delayed seeking professional health care. Roshid, for example, described having a *bota* (rash) on his penis. Because of shame, he delayed seeking help for a week hoping the problem would simply go away. Babor (22 years, van driver, Gazipur) reported having suffered from *durbalata* (weakness) in his knees after visiting a hotel in Dhaka where he paid for sex. Due to *shorom* (shame), he too had not sought health care. Karim and Fahim (22 years, college student, Dhaka) described never having sought help. Karim mentioned that he had a sore in his genital area at the time of the interview, but *lojja* delayed him seeking help with the problem. Instead, he had consulted a friend. He said, 'I don't know much about these diseases. I've been suffering from one. I was too shy to talk about this. He [a friend] recommended to take some medications without seeing [genitals]. He advised over the phone'.

In comparison to their heterosexual counterparts, the health-seeking experiences of three same-sex-attracted men in the younger social generation sample were somewhat different. Unlike other participants, each reported having been tested for HIV, perhaps because HIV prevention programs in Bangladesh have specifically targeted men who have sex with men. They were relatively aware of sexual health risks and based on their own experience all expressed an interest in sexual activism and sexual rights, advocating for greater respect for and awareness of gender and sexual minorities in Bangladesh.

Two of the same-sex attracted men (Fahim, 22 years, college student and Helal, 24 years, university student, both from Dhaka) recalled how badly they had been treated by health professionals when they had sought help for mental health problems arising from the verbal abuse they had received from others. The doctors they had visited simply advised them to mix more with girls and prescribed medicines which did not help. When he had bled following his first experience of anal sex, Helal had been too afraid to seek help because of fear of his doctor's likely homophobic response. He felt that it would be difficult to make doctors and other health care workers understand male-to-male sex because they would likely share the heteronormative assumptions prevalent in mainstream Bangladeshi society.[3]

In contrast to these three same-sex attracted men, it was noticeable how many heterosexual men from the younger social generation had engaged in unprotected sex but had never been tested for STIs or HIV because they did not perceive themselves to be at risk. Pial (23 years, university student, Gazipur), who had engaged in multi-partner heterosexual sex, reported having never been tested for STIs. He said that although he had condoms with him, he did not always use them. Because he believed his body was strong he felt reluctant to see a doctor, indicating how for members of this social generation masculine notions of strength may be linked to not seeking health care.

Growing up in a sexualized global culture with greater access to education and communication technology, many younger social generation men in the study sample were better informed than their older social generation counterparts about sexual health issues. Issues such as semen-loss, menstruation, and the need to avoid sex after childbirth rarely came up in interviews with younger social generation men, most likely because of changing beliefs and ideologies or perhaps because most men of this social generation were yet to marry or start a family. Despite these differences, however, men of the younger social generation also found it difficult to seek help for sexual health problems – through shame, because of the belief that they were physically strong, and (in the case of the same-sex attracted men) because of the fact that the Bangladeshi health system lacks sensitivity to younger men's diverse sexual health needs.

DISCUSSION

Norms of masculinity have been shown to be associated with men's reluctance to seek health services and help, especially in Western countries.[12,13,26] Research suggests that men adopt beliefs and practices that are in line with their notions of manhood.[33] Findings from this study highlight the relevance of generation-specific health beliefs and practices among men in Bangladesh. Men from the older social generation displayed more traditional beliefs that were in line with expressions of masculinity shaped largely by adherence to Islam. Furthermore, despite social generational differences, some of these traditional beliefs and practices continue to shape aspects of masculinity and help-seeking practices among men belonging to other social generations in the study.

Much previous research in Bangladesh has focused on women's health-seeking behaviours, highlighting gender barriers within the patriarchal cultures of Bangladesh and South Asia more broadly.[23–25,31] Men remain largely as figures in the background of this body of research, being seen as 'barriers' to women's health, 'gatekeepers' to women's access to health services, and 'risk-takers' endangering women's health.[16] Our findings fill an important gap in the literature in that they shed light on men's help-seeking and health-seeking practices within this patriarchal setting, demonstrating how expressions of masculinity within patriarchy carry implications for *both* men's and women's help- and health-seeking practices.

Findings highlight similarities and differences across the generations in help- and health-seeking practices. Men adopted culturally and generationally specific beliefs and practices aligned with their notions and norms of manhood. Cultural beliefs about good health, belief in Allah, and the need to be a good Muslim influenced both older and several middle social generation men's health information-seeking, health care, and help-seeking practices. Men also tended to adopt health beliefs and practices from a culture that reflected their representation and enactment of gender.[34] The association of shame with pre-marital and extra-marital sex, and cultural taboos around sex

more generally, discouraged help-seeking among middle and some younger social generation men. Yet middle social generation men displayed a degree of versatility in negotiating the hegemonic masculine codes that prevented them from help-seeking when they felt it necessary to protect the more important aspects of hegemonic masculinity, such as the display of sexual prowess. A few middle social generation men were found to prioritize their wives' and children's health needs over their own, thereby enacting a caring masculinity[35] with positive health consequences for their families, but negative health outcomes for men themselves when they did not seek help for their own health problems.

In contrast to men of the older and middle social generation, younger social generation men had been provided with new opportunities for learning about STIs, condoms, HIV and AIDS, through education as well as via modern information technology. This influenced their health understandings and health-related help-seeking. Men of the younger social generation also appeared to be better connected to a more sexualized global culture, enabling them to utilize more diverse sources of information. They felt that the information and services they received at school, from the Bangladesh-based mass media, and from families were inadequate. In contrast, they found the Internet and friendship networks to be more realistic providers of information. This finding suggests that in Bangladesh, in the absence of good quality adequate sex and relationships education in schools, information and communication technologies may come to play an even more important educational role in the near future as sources of sexual health information and advice for young people.

CONCLUDING REMARKS: REIMAGINING GENDER AND HEALTH

It should be clear from the foregoing discussion that men's help-seeking and information-gathering relating to sexual health is a gendered process mediated by complex religious, cultural, social, economic, and technological factors.

Under the influence of patriarchal and religious ideologies, older and middle social generation men, as well as several younger social generation men in this study sought little help for hardships in general, and for sexual health issues in particular. Most older social generation men had not even felt the need to seek help and information, believing themselves to be protected by Allah or God. Cultural notions of *lojja* and men's belief in having a 'healthy' body (again rooted in cultural notions of 'good' health) also discouraged them – and indeed men from other social generations as well – from seeking help. Successfully performing the hegemonic responsibilities associated with being a good family provider and a good Muslim prevented middle social generation men in particular from seeking help and health care. Growing up in an 'information age' and a 'network society'[36-37] enabled younger social generation men to access a more diverse range of sources of information. The health system too was viewed as offering limited support, with the Internet and friendship networks perceived as being more reliable in times of need.

Despite these differences, running throughout the findings from this study there is clear evidence of the relevance of *masculinity* to men's help- and health-care seeking for sexual health. In this study, men of each of three social generations displayed health beliefs and practices that reflected their representation and enactments of gender, a finding little documented in the South Asian literature to date where gender and health remain largely understood as being a women's issue[16, 20-25]. Moving beyond this narrow conceptualization to recognize the diverse ways in which both men and women construct themselves in relation to health, is essential if the sexual health of all people is to be promoted in a country such as Bangladesh.

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