

Healing traditions and men's sexual health in Mumbai, India: The realities of practiced medicine in urban poor communities

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Abstract

Men's pre- and extra-marital sexual behavior has been identified as the primary factor in the growing HIV/STI epidemic among both males and females in India. One major barrier to reaching men has been their underutilization of public health services, which has severely limited programs geared to prevention and early case identification. A significant number of men in India have strong culturally-based sexual health concerns, much of which are derived from "semen-loss" and deficiencies in sexual performance. This paper reports on an ongoing Indo-US project that has focused on men's concerns about sexual health problems and assesses the services provided by non-allopaths in three low-income communities in Mumbai. Findings indicate that the primary health resources for these men are private, community-based non-allopaths, who identify themselves as *ayurvedic*, *unani* and homeopathic providers. The paper suggests that the combination of strong culturally-based sexual health concerns and the presence of private non-allopaths who manage these problems present a window of opportunity for intervention programs to address the challenge of HIV/STI prevention and early case identification in India.

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Introduction

Men represent the great majority of the more than five million cases of HIV/AIDS in India (NACO, 2004; UNAIDS, 2004), with a rapidly increasing rate among women that has been primarily accounted for by men's risky sexual behavior and undiagnosed and untreated HIV and other sexually transmitted infections (Gangakhedkar, Bentley,

Divekar, Gadkari, Mehendale, et al., 1997; Maniar, 2000). Despite the presence of this epidemic, a number of studies have shown that males are more concerned about sexual health as it relates to performance than they are about HIV and sexual transmitted infections (STIs). This paper suggests that addressing men's performance priorities may serve as an opportunity for reducing sexual risk and early case identification (Pelto, Joshi, & Verma, 1999).

In India, the concept of *gupt rog* refers to men's perceived sexual health problems, which are

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culturally-defined illnesses that belong to the “secret parts of the body”. *Gupt rog* problems are seen as derived from concerns about excessive semen-loss, through nocturnal emission and masturbation, which cause loss of sexual desire, impotence, and premature ejaculation. *Gupt rog* also includes such symptoms as genital pimples, ulcers, itching, and pus discharge that are mainly seen as derived from sex outside marriage (Lakhani, Gandhi, & Collumbien, 2001; Verma, Khaitan, & Singh, 1998; Verma & Schensul, 2004).

The great majority of men who seek treatment for *gupt rog* problems use practitioners of *ayurveda*, *unani*, *siddha*, homeopathy, naturopathy, yoga and other Indian medical traditions. Unlike allopaths, these practitioners’ cultural and medical knowledge concerning *gupt rog* is consistent with men’s explanatory models and understandings of health and disease (Good, 1994; Kleinman, 1980).

This paper reports on research that examines the knowledge and practices of non-allopathic health providers with regard to men’s sexual health problems in three economically marginal communities in Mumbai (Bombay). The main objectives of this paper are to describe the role of the providers in treating and preventing *gupt rog* and to assess the convergence of the healing disciplines in the treatment of sexual health problems.

Much of the study of traditional medicine in India has been explored through leaders in the field, practitioners with noted reputations and *gurus* practicing a “purer” version of their particular healing tradition. This paper seeks to explore traditional medicine as practiced “on the ground”, or, in Khare’s (1996, p. 846) terms, ‘practiced medicine,’ which: “... deals with patients, their caregivers and medical practitioners for yielding sustained curing and healing practices, skills, and understanding...practiced medicine in India is a product of longstanding cultural negotiations among diverse healing traditions, and their healers... .”

Sexual health problems in the healing traditions in India

The classical texts of *ayurveda* (Charaka Samhita; Sursuta Samhita), *unani* (Al Razi; Ibn Sina) and homeopathy (Hahnemann) explain sexual health concerns and disorders and provide guidelines concerning diagnostic processes and treatment for these problems. The canonical texts emphasise the need to avoid “excessive” sexual activity, especially

during menses, and when there is a significant age difference between partners (Al-Dahbi, 1992; Dash, 1999; Ibn Qayyim al-Jawziyya, 1993; Ranade, 1999). More than any other sexual practice, masturbation is particularly to be avoided because, according to both *ayurvedic* and *unani* traditions, it could lead to sterility, impotency, a reduction in longevity, and other physical and emotional disorders (Ranade, 1999). For Al-Dahbi, a 14th century master of popular *unani* tradition (*al-tibb al-nabawi*): “Physicians have said that to produce a seminal emission by hand causes distress and weakens the sexual appetite and erection of the penis” (translation from Arabic by Elgood, 1962, p. 61). According to the *ayurvedic* tradition, one of the main components of the human body consists of the seven *dhatu*s: one of these, called *sukra*, enters into the formation and cycle of sperm and ovum. When *sukra* is disturbed, it results in reproductive and sexual health problems (Dash, 1999).

In the classical texts, the treatment of reproductive and sexual problems focuses mainly on behavior changes and the use of rejuvenative and invigorating foods and natural (herbal) remedies (Al-Dahbi, 1992; Ranade, 1999). Classical practitioners seek to understand patients’ physical and physiological complaints, and conduct a detailed elicitation of patients’ well-being, social problems, diet, rest and activity patterns, including any risky behavior that may have an impact on patients’ health (Nordstrom, 1988). The underlying medical epistemology of that holistic and ecological approach is that “disease makes sense only in its totality” (Bibeau, 1982). Current healing practices in the study communities have tended to retreat from this classical holism to a more fragmentary and expeditious symptomatic approach.

Methods

The project from which the data for this paper are drawn is a collaboration of the Center for International Community Health Studies (CICHS) at the University of Connecticut School of Medicine, the Institute for Community Research (ICR), Hartford, CT and the International Institute for Population Sciences (IIPS) in Mumbai, the leading demographic institution in India. The project has led to the establishment at IIPS of the program *Research and Intervention in Sexual Health: Theory to Action* (RISHTA, an acronym meaning “relationship” in Hindi and Urdu). The RISHTA project, currently

in the 4th of 5 years, is funded by the National Institute for Mental Health (R01-MH064875).

The project is currently being conducted in three low-income communities in Mumbai and consists of three phases: formative research; development and implementation of a multi-level (community, health provider, patient) intervention; and evaluation (Schensul, Verma, & Nastasi, 2004). The results presented here focus on the formative research utilizing a mix of qualitative and quantitative methods: (1) *In-depth interviews* were conducted with 52 married men that included men's explanatory models of *gupt rog* and health-seeking behaviors, lifestyle, concepts of masculinity, gender-based violence and marital and sexual relationships. (2) *A Rapid Assessment of Providers (RAP)* was administered to all the identified private health providers (245) practicing in the three study communities that included their length of time in the community, their years of practice, their training and degrees, estimates of the number of patients seen daily and monthly, types of patients (men, women and children) and the number of patients with sexual health problems. (3) *In-depth interviews* were conducted with 37 non-allopathic providers that focused on the domains of practitioners' background, their present approaches with patients with sexual health problems (etiology, diagnosis, treatment, counseling, referral), as well as the providers' views on community characteristics. (4) *A Baseline Survey Instrument (BSI)* was administered to a systematic random sample of 2408 married male residents (approximately 800 in each of the three communities) between the ages of 21 and 40. The BSI included current and past history of *gupt rog* problems, consequences of those problems, treatment taken, socio-demographics, household characteristics, marital relationships, lifestyle and personal behavior, sexual behavior and perceptions of masculinity and gender roles.

Results

The study communities are typical of overcrowded Mumbai slums with many lanes and by-lanes, unplanned and ad-hoc structures and many "joints" such as tea and *paan* (betel nut) shops, beer bars, country liquor outlets and illegal gambling establishments. The community demographic profile, as drawn from the BSI, shows an ethno-religious breakdown of primarily Muslims (53%)

and Hindus (43%) of which 66% are migrants from Uttar Pradesh and other poor northern states, rural Maharashtra and Tamil Nadu. Of the sample of men who were not born in Mumbai, 50% came with their natal family at a mean age of 13, while 49% came alone or with friends to seek jobs at a mean age of 18. Only 1% initially came to Mumbai with their wives. Of the total sample, 16% of wives continue to live in the home village, while men live with family or friends. Men have a mean education of 6 years and their average income is Rs. 3272 (US\$70) per month. They are living in households with a mean of 5.6 people per household, with 1.2 rooms or approximately 4 people per room.

Health care resources available to residents present a typical picture for urban poor communities: an allopathic governmental sector that includes large hospitals with indoor and outdoor facilities located at some distance from the communities, "urban health centers" and "health posts" primarily catering to maternal and child health; and a large private sector that consists mainly of traditional healers and a minority of allopaths. In these economically marginal communities, private practices are characterized by small "cabinets" divided into a waiting area and a room for examination, sometimes large enough to fit an examining table.

The Rapid Assessment of Providers (RAP) identified 245 private practitioners in the three study communities. These practitioners reported having completed 33 different degrees, which could be clustered into *ayurvedic* practitioners or *vaidyas* (79, 32.2%), homeopaths (73, 29.8%), *unani* practitioners or *hakims* (67, 27.4%), and allopathic doctors (26, 10.6%). The degrees reported by *vaidyas* are BAMS (Bachelor of Ayurvedic Medicine & Surgery; 59 or 74.7% of the ayurvedic practitioners); homeopaths reported BHMS (Bachelor of Homeopathic Medicine & Surgery; 25, 34.2%) and DHMS (Diploma of Homeopathic Medicine & Surgery; 21, 28.8%); *hakims* reported primarily BUMS (Bachelor of Unani Medicine & Surgery; 58, 86.6%) and DUMS (Diploma of Unani Medicine & Surgery; 5, 7.5%); and the allopathic doctors reported MBBS (Bachelor of Medicine & Bachelor of Surgery, 23, 88.4%) and MD (Doctor of Medicine, 2, 7.6%). We have consciously avoided any attempt to verify degrees or registration with local authorities.

The terminology used for healing practices and practitioners that are outside allopathy has been

a problem in the literature. The terms have included “traditional”, “folk”, “indigenous” or “native” and has been described as “healing”, “medicine”, “treatment”, and “systems” carried out by “curers”, “healers”, “providers”, “practitioners”, and “doctors.” To further add to the terminology confusion, the Indian Ministry of Health, which had used the label “Indian Systems of Medicine and Homeopathy” (ISM&H) for a number of years, has recently shifted to AYUSH (meaning “life” and standing for Ayurveda, Yoga and naturopathy, Unani, Siddha, and Homeopathy). Finally the use of the individual discipline nomenclature is undermined by their merging and overlap. To simplify this issue in this paper, we will adopt the generic term most commonly used by patients in the study communities for “private practitioners” of any discipline, that of *daktar* (an Indianized English term). Since this article focuses on *vaidyas*, *hakims* and homeopaths, the term *daktar* will refer to these individuals, and will be contrasted to allopathic physicians (commonly called “English doctors”) in the study communities.

The private practitioners in our sample reported an average of 17.6 years of education and training. In India, students who want to graduate as *vaidyas*, *hakims* or homeopaths have to study in medical colleges that are officially registered by the Ministry of Health & Family Welfare (2004). Candidates for degrees in these disciplines have to study for 5–6 years on a full-time basis, after they have successfully passed high school exams.

The average age of the *daktars* is 35.8; more than 60% have never practiced in another community. Of the 79 *vaidyas*, 59 (74.7%) are Hindu; of the 73 homeopaths, 48 (65.8%) are Hindu; and of the 67 *hakims*, 65 (97%) are Muslim. Of the 245 private practitioners, 21 (8.6%) are women but are not included in this discussion since they see very few male patients with sexual health problems.

In-depth interviews were conducted with 37 male *daktars* including 18 homeopaths, 13 *vaidyas* and 6 *hakims* (*hakims* were under sampled due to lack of availability in the time period allocated for these interviews). These interviews yielded extensive information on the dynamics of entry into the medical profession, the nature of patient-load, the provider’s environmental perspective, the diagnostic processes and etiologies of sexual health problems, the nature of treatment, counseling, referral and follow-up.

Entry into the healing profession

In-depth interviews indicate that the great majority of *daktars* in the study communities come from relatively poor families in which the costs associated with an allopathic education were out of reach for them (up to Rs. 300,000 [ca. \$6000] to join a MBBS program compared to Rs. 30,000 [ca. US\$600] for a bachelor’s degree in a college of *ayurvedic*, *unani* or homeopathic medicine, according to a respondent). As they entered practice, their choice of location also reflected their limited resources, requiring them to establish small offices in poorer communities in which the rental fee was low.

Entrance into the healing professions was supported by parents and carried significant social prestige through service to the community. The providers expressed a series of reasons that led them to become *daktars* that included: seeking of a respectable profession, which was valued by the society; childhood experiences involving threats to their own health and the health of close relatives that demonstrated the power of their healing discipline; and the wish to serve people in need of health care. One *vaidya* stated that he sought the profession in order to earn “the blessings” of his patients, that is, to earn the spiritual “benefits” resulting from the prayers of those he would successfully treat. These aspirations are both historic and culturally embedded: the classic *vaidya* sought to conform to a threefold ethical and cultural norm in which *artha* is the “material gain by building up a rich practice”; *kama* is the practitioner’s satisfaction resulting from the successful treatment he provided and the subsequent prestige and fame; and *dharma* is the religious merit to be achieved by the practitioner through the healing and relief he provides to his patients (*Charaka Samhita*: i.30.29, in Basham, 1976).

Nature of the patient load

The RAP asked *daktars* to estimate their daily caseload and the gender, locale, and problems of their patients. The 245 private practitioners reported that they saw an estimated total of 6834 patients on a daily basis, an average of 27.9 patients per day (per provider). Of this total, *daktars* saw 84% of the patients who go daily to the private health sector in the three study communities. The private providers reported that their practices

consisted of 44.2% adult men, 34.8% adult women, and 21.0% children. The *daktars* see more men (an estimated 3000 per day across all *daktars*, or 13.7 male patients per day per provider) than any other sector of the health care system in Mumbai, since the local government clinics are almost entirely dominated by maternal and child health care. Adult men who typically underutilize the public health care system are actually the largest component of the patients of the private providers.

In-depth interviews indicate that *daktars* see themselves and are seen by their patients as the “family doctor” and treat multiple members of the same family. Most patients (a mean of 90% from the RAP data) are from the same community, and frequently from the same “lane” where the *daktar* has his office. According to male patients, the providers’ religion, age, degree, governmental registration and other individual provider characteristics have little bearing on their selection; the primary concern for patients is the providers’ reputation in the community, the quality of their care, and their relationship with and their respect for those who seek care.

Environmental perspective

One *vaidya* stated that “poverty is an evil;” a sentiment echoed by half of the 37 *daktars* who indicated that their patients are living in deteriorated environmental conditions. A homeopath reported that “some persons don’t eat or drink for two days... The garbage over here is not cleaned or taken away... there is a creek, which is very dirty, and all its dirt comes here. People breathe such polluted air and get prone to diseases.” Providers complain about their patients’ limited access to healthy nutrition and clean water, people’s illiteracy, as well as about overcrowding in houses and in the community, the lack of environmental cleanliness and poor hygiene, the presence of several acres of garbage dumping areas, heavy air pollution, open drainage and lack of sanitation. *Daktars* view these deteriorating living conditions as the cause and perpetuation of many diseases such as respiratory infections, dysentery, malaria and typhoid. They also see poverty as the main barrier to treatment for men with sexual health problems.

Men’s self-reported symptoms and providers’ diagnosis

Respondents to the BSI were presented with a list of sexual health problems, drawn from in-depth

interviews with men and providers, and were asked to indicate which of the problems they had suffered from in the last 3 months. Overall 1272 (53%) of the 2408 married men reported at least one such problem. Factor analysis of these results confirmed earlier consensus modeling (Verma et al., 1998) that showed three major syndromic clusters: *garmi* (68% reported symptoms such as urethral whitish discharge, itching on the genital organs, burning urination, “hot urine”), *kamjori* (49% reported sexual weakness, including performance problems such as erectile dysfunction and early ejaculation), and *dhat* (27% reported semen-related problems linked to masturbation, nocturnal emission, semen quality, quantity and appearance). Early ejaculation (16%) is the number one reported problem, with itching on the genital organs (14%), burning urination (11%), nocturnal emission (10%) “hot urine” (9%), and loss of sexual desire (7%) also of relatively high frequency (see Table 1).

The providers’ in-depth interviews indicate that of the 37 *daktars*, 33 see patients with all three syndromes. Among the four remaining *daktars*, one *vaidya* does not see any patients with *garmi*, and two homeopaths and one *vaidya* see patients only with either *dhat* or *kamjori* problems. The *daktars* diagnose these sexual health problems by combining three methods: listening to patients’ presenting of problems; using verbal probing to have patients talk about their perceived risk behaviors (sex with sex workers, watching pornographic films and masturbation), and conducting physical examinations.

For the STI-like symptoms classified as *garmi*, most of the *daktars* think more in terms of symptoms rather than in terms of disease entities. For example, the providers talk about patients suffering from pus discharge associated with swelling and blisters on the penis, but none suggested the possibility that these symptoms might represent specific disease entities such as gonorrhea or syphilis. The *daktars* may occasionally refer patients with STI-like symptoms to public and private laboratories and hospitals for analysis of blood using Venereal Disease Research Laboratory (VDRL) and Enzyme-Linked Immunosorbent Assay (ELISA) techniques. They usually do so with no formal referral system, and only when the treatments they provide have failed after a long trial period; putting patients at greater risk of clinical complications and transmission of STIs to wives and other sex partners.

Table 1
Men's reports of sexual health problems and treatment (last 3 months)

Sexual health problem (<i>Gupt rog</i>)	Experienced (% (N))	Treatment taken (% (N))
Early ejaculation ^a	16.1 (388)	19.6 (76)
Itching (<i>cham</i>) on genital organs ^b	13.9 (335)	79.9 (263)
Burning urination ^b	11.5 (276)	37.8 (104)
Nocturnal emission (<i>swapnadosh</i>) ^c	10.5 (178)	5.3 (9)
Hot urine ^b	9.2 (221)	18.6 (39)
Loss of sexual desire ^a	7.7 (185)	15.2 (28)
Thinning of semen ^c	4.3 (104)	16.2 (17)
Masturbation ^c	3.9 (37)	2.6 (1)
White discharge ^b	3.2 (78)	33.8 (26)
Quantity of semen ^c	2.7 (64)	12.3 (8)
Pimples on the genital organs ^b	2.3 (55)	56.4 (31)
Small penis ^a	2.2 (52)	3.9 (2)
Bent penis ^a	2.1 (50)	2.0 (1)
Loss of erection ^a	2.0 (27)	17.0 (8)

Symptoms characteristic of: ^a*Kamjori*; ^b*Garmi*; ^c*Dhat*.

The duration of the diagnostic phase in a patient visit ranges from 5 to 15 minutes, which leaves little time to conduct a detailed elicitation of a patient's general well-being, sexual habits and risky behaviors, and partner's sexual health. Both the practitioner and his patients are required to function within the time constraints of the demanding urban environment of Mumbai. Only two *daktars*, both *hakims*, reported the need to make patients feel relaxed and comfortable in order to have them talk about their risky sex and other stigmatizing STI etiologies.

Etiology of sexual health problems

In-depth interviews indicate that more than half (20) of the 37 providers across the three healing traditions see *dhat* and *kamjori* as being sexual health problems, and directly link them to specific causative factors. According to six *vaidyas* and four homeopaths interviewed, a man suffers from nocturnal emission ("wet dreams") when he also masturbates, reads sexual books, sees "blue films" or "provocative" fashion shows and video-clips on T.V, and when he talks and thinks extensively about sex and women. Nocturnal emission (*swapnadosh*) also happens when a man "sleeps at night with tight underwear," has an inadequate diet, has a lack of sexual activity, or has excessive "heat" in the body, as stated by a homeopath, "Nocturnal emission occurs because of a lot of heat in the body. If a person eats non-vegetarian food, then heat gets generated in

the body. Because of the heat, nocturnal emission occurs... . After marriage nocturnal emission doesn't occur, but if the man is away from his wife for a longer period of time and if he thinks about sex then in the night he will get nocturnal emission." Three *vaidyas* add that nocturnal emission is caused by the habit of watching the sexual activities of others (either in reality or in blue films), and will in turn lead to erection problems and "sexual weakness". In this particular etiological model, a *dhat* problem (in this case nocturnal emission) leads to a *kamjori* problem.

The remaining group of the providers (17 of 37 interviewed) saw semen loss from nocturnal emission and/or masturbation as benign and common to most men. This clear etiological difference, between a more traditional causal agent versus a natural process, is one indicator of greater heterogeneity within the healing disciplines of *ayurveda*, *unani* and homeopathy as practiced in the study communities.

In terms of *garmi*, a *hakim* stated that "people don't get [STIs] by chance." Almost all of the *daktars* linked *garmi* with risky sexual behavior. Half of the providers mentioned three main causes of men's risky sexual behaviors: the impact of media; the influence of friends; and alcohol use. Almost all *daktars* see STIs and STI-like symptoms as caused by extra-marital and risky sex. This explanation is consistent across the three healing disciplines of *ayurveda*, *unani* and homeopathy as practiced in the study communities.

Treatment of sexual health problems

The RAP data indicate that of the monthly average number of men from the three study communities who go to the private health practitioners for sexual health problems ($n = 3133$), 1545 (49.3%) report *dhat* and *kamjori* problems, and 1588 (50.7%) report *garmi* symptoms. These numbers far exceed the use of public allopathic clinics for the number of men seen for sexual health problems. Reasons for the high utilization of *daktars* include: (1) local governmental health facilities are almost exclusively maternal and child health oriented; (2) there is limited availability of private allopaths; and (3) allopaths frequently express a lack respect for *gupt rog* problems. The RAP data suggest that the *daktars*, who represent 90% of the private sector in the study communities, are the major resource for addressing the general health of communities, particularly men's health, and men's sexual health problems.

The Baseline Survey data show that of the 1272 men (53%) who reported sexual health problems, almost half (634; 49.8%) sought some kind of treatment for their problems. Men reported taking a mean of 1.6 treatment actions across all problems. The mean number of actions taken for *garmi* was 1.46, for *kamjori*, 1.73, and for *dhat*, 2.25, reflecting the impact of antibiotics on *garmi* symptoms and the more chronic and difficult to treat *kamjori* and *dhat* problems. Men were more likely to treat problems of *garmi* (58%), which was seen as acute, rather than *kamjori* (23%) or *dhat* (18%), which were seen as not in need of urgent treatment. Consistent with these results, external genital symptoms such as itching and pimples showed the highest rates for seeking treatment (79.9% and 56.4%, respectively; Table 1).

Of the men who sought treatment, over one-quarter (28%) self-treated, primarily securing antibiotics from the "chemist" (local pharmacies, "medicine shops"), while 70% consulted local private providers. Assessing self-treatment by syndromes, we see that men who reported *garmi* utilized self-treatment (34.8%) to a greater extent than those who reported self-treatment of *kamjori* (21.7%) and *dhat* (9.3%). According to men's reports, self-treatment consists primarily of antibiotics (68.4%), which are easily accessible without prescription at the chemist's and are seen by men as "strong" medicine that provides rapid relief.

Daktars use two primary categories of medicines: English medicines consisting of antibiotics and multivitamins and *jaddi-buti* (meaning literally "ancestral plants") consisting of primarily herbal but also mineral preparations in the form of oils, ointments, decoctions and pills. As part of the in-depth interviews, *daktars* were asked to list the medicines they most frequently used for sexual health problems. There was common agreement on the part of the *daktars* from the three disciplines on a series of antibiotics to treat *garmi* symptoms including amoxicillin, ampicillin, azithromycin, ciprofloxacin, doxycycline, and erythromycin among other antibiotics. Only *gandhak malhar* from the *ayurvedic* pharmacopia and *coughitis* from homeopathy were mentioned as treatments for *garmi* symptoms. However, *vaidyas* listed 11 *ayurvedic* preparations (e.g., *shilajeet*, *confido*), for the treatment of *kamjori* and *dhat*, hakims listed 12 *unani* preparations (e.g., *raghanahmur*, *labaobe kabir*, *qurs abyaz*) and homeopaths listed 7 preparations (e.g., selenium, *sac lac*, *straphysajria*).

Results of the in-depth interviews show that *daktars* employ three treatment patterns. The primary and most dominant is for *vaidyas*, homeopaths and *hakims* to treat *garmi* (STI-like symptoms) exclusively with English medicine (antibiotics); and exclusively prescribe *jaddi-buti* medicines for *kamjori* and *dhat* problems. Of the 37 practitioners interviewed, 31 use antibiotics in the form of intravenous injections or pills that patients can buy either at the *daktar's* clinic or at the chemists. A secondary, but still common pattern involves prescribing both English and *jaddi-buti* medicines for the treatment of *garmi*; the primary use of *jaddi-buti* medicines is considered by this subset of providers to be for relieving the patient from pain and discomfort that may result from related STI-like symptoms rather than in addressing the problem itself. The third pattern is characteristic of a small minority of *daktars* who report exclusive use of *jaddi-buti* as effective for the treatment of STI-like symptoms; as stated by a homeopath, "for the STDs, no medicines are better than homeopathic." The dominant *daktars'* treatment pattern for *dhat* and *kamjori* consists of the prescription of *jaddi-buti* medicines. No provider reported the use of English medicines to treat these culturally-defined sexual health concerns, although some providers prescribed multi-vitamin tablets.

The in-depth interview data from providers are not consistent with what men report about medication use in the baseline survey data. Across all types

of treatment (self or provider) the majority of men report using English medicine (mostly antibiotics) for *kamjori* (65.5%), *dhat* (65.9%) and *garmi* (75.5%) problems (Fig. 1). In contrast, *daktars* report prescribing allopathic medicines (primarily antibiotics) to men only for *garmi* problems and *jaddi-buti* for *dhat* and *kamjori*. This contrast between male respondents and *daktars* may be due to the following reasons: (1) in order to treat *dhat* and *kamjori*, male patients may be supplementing the medications from the providers with the easily accessible antibiotics from the chemists in the communities, and (2) *daktars* may be reluctant to share their widespread prescription of antibiotics with project interviewers. Only a few male respondents reported mixing English and traditional medicines for the treatment of *kamjori* (3.3%), *garmi* (4.4%) and *dhat* (9.4%) (Fig. 1); this mix, termed “*masala medicine*” is widely used elsewhere in India (Nichter, 1996).

A homeopath stated, that “*the patients want to see injections [syringes] in the clinic. If there is no injection, no scissors in your [clinic], they don't believe that you are a doctor. That's why I... practice both allopathy and homeopathy.*” Of the 37 *daktars* interviewed, all but one described the use of both *jaddi-buti* and English medicines as a common practice for both general and sexual health problems. Almost all of the 37 *daktars* prescribe allopathic medicines when they diagnose severe and acute health problems. However, depending on the patient's request and the chronicity of the disease (when it does not need “immediate relief”), the providers prefer *jaddi-buti* medicines because they see them as

having fewer side effects and more lasting relief than English medicines. As reported by a *vaidya*: “*Ayurvedic medicines have the least side effects. Patient's disease gets cured from the roots... Allopathic can give immediate relief but later on the illness can relapse. Because of this reason, ayurveda is the best, but only when the patient goes for complete treatment.*” Many of the providers complained that patients are “impatient” and want immediate relief and that as a result they are often “forced” to prescribe antibiotics even though they believe that *jaddi-buti* can be more effective in the long term.

Barriers to adherence

From the *daktars*' perspective, the efficacy of any kind of medicine depends on how the patient adheres to treatment. Providers report that full adherence to treatment is very rare. The major barrier to adherence seems to be the lack of finances; as a homeopath stated, “*because of poverty people are unable to take their proper care.*” *Daktars* report that the cost of a single visit and medicines may range between Rs. 20 and 40 (\$.50 and 1.00), and the full multi-visit treatment between Rs. 200 and 5000 (\$5 and 120). They also report that treatment of *dhat* and *kamjori* problems may cost more (Rs. 500–3000) than treatment of *garmi* (Rs. 200–1000), which can be explained by the fact that *kamjori* and *dhat* problems tend to be more chronic than STI-like symptoms and require a longer duration of treatment. Though *jaddi-buti* medicines are generally cheaper than English medicines for short-term treatment, patients usually

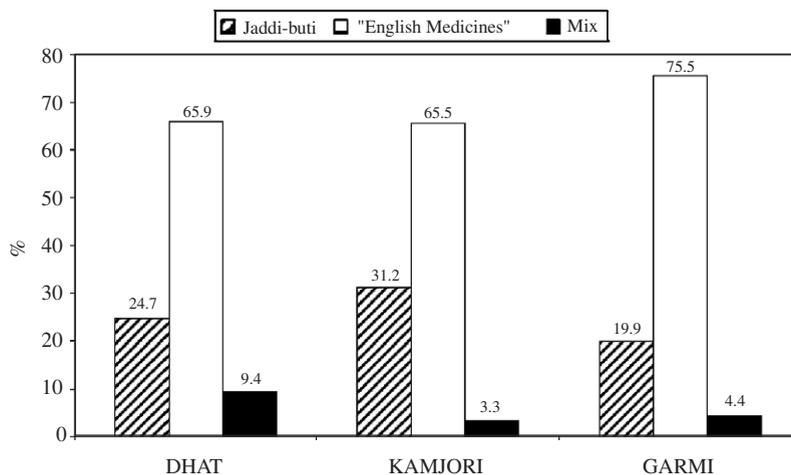


Fig. 1. Men's self-reported use of medicines for the three major syndromes.

request English medicines because they perceive that “it is strong” and provides immediate relief.

The pressure from patients to provide immediate relief stems, in the *daktars*' view, from poverty and the nature of the urban lifestyle in Mumbai. First there is “no time to be sick” because of a heavy work burden and family responsibilities. Second, there is limited money available for treatment. Third, the patients have limited awareness and knowledge of health prevention; and finally there is the urgency of solving sexual health problems. According to several of the practitioners, the need to get immediate relief leads patients to prematurely end a given treatment and start a new one believed to lead to a quicker relief. This behavior results in the use of several treatments and medications over the course of the same disease, despite the advice given by the *daktars*.

Types of advice given to patients with sexual health problems

The in-depth interviews indicate that one-third of the practitioners reported that they inform patients about the direct causes of sexual health problems; four *daktars* provide information to their patients about the physiological (pathogenesis) and psychological (fear, shame, anxiety) aspects of STIs and other sexual health problems. Advice provided consisted of the importance of keeping good personal hygiene, fully complying to treatment prescribed by *daktars*, avoiding blue films due to their impact on masturbation and nocturnal emission as well as their effect of increasing desire for risky sex. Two *daktars* suggest yoga to patients for relief of tension, and another one promotes sexual “self-control” or abstinence. Ten providers use a fear-based approach (“you could die”) or guilt (“you will ruin your life and family”) to motivate their patients to reduce or eliminate sexual involvement outside of marriage. Some *daktars* will refer their patients to other health and related services.

Referrals and follow-up

In-depth interviews indicate that half of the providers refer their patients to allopaths, but there was no evidence that referrals took place to other community *daktars*. There were two main reasons described for referring: either the treatment prescribed had failed or the sexual health problem that was presented was too severe for the *daktars* to

handle. *Daktars* refer to either private or public allopathic facilities depending on patients' economic circumstances because the private sector is seen as providing a better quality of care but at a higher cost. One *hakim* refers his patients only if sexual health problems are chronic. Other *daktars* have particular referral guidelines as in the case of one *hakim* who refers “only if patients ask for it”, and another *hakim* who will wait 3–4 months to assess the success of the treatment before referring the patient to an allopath. Three providers stated that they had no need to refer patients with sexual health problems because they could treat them effectively. Half of the *daktars* ask their patients with sexual health problems to visit them after the first treatment to check on progress, to assess the effects of medications prescribed, and to suggest treatment changes if needed. However, these providers complain that most of the patients do not follow-up due to a lack of time, the cost of a follow-up visit, and lack of knowledge about the importance of follow-up.

Provider identification

Of the men who reported on the baseline survey that they sought treatment, only 25% could correctly identify the discipline of the provider they utilized for a sexual health problem. The great majority misidentified their *daktars* as allopaths. Qualitative analysis of the male in-depth interviews indicated that community residents identify their doctors, not based on their degrees or posted credentials, but on the kinds of medicines they prescribe. Since most of the *vaidyas*, homeopaths and *hakims* utilize English medicines (primarily antibiotics) in their pharmacopia, residents perceived them as English doctors, meaning allopaths. As a result, from the male residents' perspective, the doctors “are what they prescribe.”

On the other hand, most of the *daktars* define themselves as graduated *vaidyas*, *hakims* and homeopaths who have obtained a degree in *ayurveda*, homeopathy or *unani* medicine from accredited colleges. While their degrees are on their cabinet signposts, they are frequently listed by the initials of the degree, providing little opportunity for community residents to know their specific discipline. In a recent study conducted by Guha (2005) in the study communities, it was found that women patients who specifically sought a non-allopathic discipline, by-passed the community

daktars and went to a practitioner outside the study communities who they felt would provide a “purer” form of traditional treatment. Several of the practitioners stated that individual reputation, personal relationship and location were the key elements in attracting patients to their practice. As a result, their specific discipline was not emphasized in their treatment methods.

Discussion

Daktars in these study communities are individuals with limited family and personal financial resources who seek their livelihood dealing with health problems in poor rural and urban communities. They are seen as “family doctors” and depend on serving multiple members of nearby households, utilizing proximity, convenience, accessibility and a personal relationship as their strengths. These practitioners are the major source of treatment for men’s culturally-defined sexual health problems of *gupt rog*.

In general the public allopathic health care system in India has been unresponsive to *gupt rog* (Verma et al., 1998). With only a limited number of private allopaths in low-income urban communities, treatment of *gupt rog* problems is left to the *daktars*. However, while the *daktars* in the study communities fully appreciate *kamjori* and *dhat* problems, they may be failing to effectively address HIV/STI problems effectively. As a result, the service component that sees most men with *gupt rog* problems may be the least competent to deal with HIV/STI, while the service component that is most competent is least used by men in urban poor communities.

The disciplines of *ayurveda*, homeopathy and *unani* as practiced in the study communities show very few differences. Rather than distinct disciplines, they seem to have become three variants of the same healing system and form—as Pugh (2003, p. 417) stated, “a polysynthetic field of ideas and practices...their perspectives show numerous parallels and convergences.” The medical practices of *vaidyas*, *hakims* and homeopaths in the study communities show that there is greater diversity within these healing disciplines than between them. When we add the almost universal use of allopathic medicines, we see a further drift to an amalgamation of healing traditions. For Lambert (1996, pp. 1706–1707), that amalgamation reflects an Indian “medical domain [that] can be character-

ized as an eclectic “non-system” of knowledge and practices deriving from the continuous interplay of indigenous and introduced traditions ...[between which] accommodation and synthesis have occurred conceptually and pragmatically.”

Although the *daktars* expressed commitment to *jaddi-buti* medicines that characterized their disciplines, they felt compelled to meet the demands of their clientele for English medicines. It is now well established that there is widespread misuse of antibiotics in developing countries in general, and in India in particular through the growing Indian pharmaceutical industry (Greenhalgh, 1987; Kamat & Nichter, 1998; Nema, Pemchandani, Asolkar, & Chitis, 1997; Saradamma, Higginbotham, & Nichter, 2000). In a situation with significant competition among providers, with a clientele that rarely distinguishes among the different types of practitioners and their training, and for healers with limited resources, almost all “practiced medicine” requires a significant allopathic component. As an *ayurvedic* practitioner in one of the study communities put it, “...we cannot practice without allopathy.”

Daktars in the study communities describe a practice focused primarily on symptoms and symptom relief. As a result, sexual health problems are seen as symptoms to be relieved rather than indicators of an imbalance in body, mind and emotions, which would be consistent with the holistic perspective so fundamental to the historical traditions of *ayurveda*, homeopathy and *unani* disciplines. However, the power of allopathy (Filc, 2004; Foucault 1978), supported by economic globalization (Janes, 1999), perceptions of the efficacy of Western science (Marshall, 2005), media messages and changing expectations, are altering holistic healing methods—at least at the “ground-level” for poor communities in Mumbai. The retreat from holism to a symptomatic approach is one sign of the required adaptation and survival strategy of non-allopathic health providers in poor communities in the very demanding urban world of Mumbai, where both patients and providers have limited time and resources.

The RISHTA project is based on the principle that male sexual health and STI problems are best addressed within a holistic approach that is more characteristic of the Indian traditional healing systems than allopathic medicine. At the same time the project recognizes the shortcomings of untrained *daktars* prescribing antibiotics and other

English medicines. In an effort to address the realities of “practiced medicine” in urban poor communities, the RISHTA project is currently implementing a training and intervention program for *daktars*. Contrary to most training programs for traditional healers, *daktars* are being trained to utilize an ecological approach, which has been termed the “Narrative Intervention Model (NIM)”, as a means of operationalizing the concept of holism into their practice (Nastasi, Moore, & Varjas, 2004; Schensul et al., 2004). The NIM is intended to assist in this process by providing knowledge, support and skills so that health providers can address the medical, socio-cultural, and psychological components of men’s sexual health problems and HIV/STI risk. This holistic approach is a vital part of addressing HIV/STI risk reduction at a time of the growing epidemic in India. The NIM also uses the methodology of syndromic management (WHO, 1997, 2001) using an algorithm to diagnose and treat STIs. The structure of this intervention suggests that it is necessary not only to train traditional healers in allopathic methods but to strengthen their commitment to their own traditional holistic approaches. The evaluation of the impact of that training is underway in the study communities, and the results of this experiment will be reported in future publications.

The great traditions of healing in India exist at multiple levels—from theory to the realities of day-to-day practice. Much of the published literature has focused on the more theoretical level and has explored the methods of those who have the clientele and resources to practice a more traditional manifestation of their discipline. *Vaidyas*, *hakims* and homeopaths serving in poor urban communities in India have no such luxury as they must meet the needs and expectations of patients who have very limited time and resources. In turn their patients are not looking for a specific discipline but a practitioner who is local, respectful, accommodating, quick and effective in meeting their demands for treatment. The result is that practice models “on the ground” shift and converge to meet these demands. While policymakers, researchers and interventionists may not be happy with this convergence, it is the reality of care in these study communities and, we would suggest, throughout urban poor communities in India. Given that reality, and given that *daktars* represent the main resource for men’s general and sexual health, these results suggest that it is possible to build on the classical epistemological

traditions to generate among *daktars*, a more effective approach to *gupt rog* and as a consequence to the HIV/STI epidemic currently challenging health in India.

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