Men's Sexual Health and Traditional Healing Systems in Urban Slum Communities of Mumbai, India

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INTRODUCTION

The India subcontinent has been a crossroad of language, religion, culture, trade and movement over many centuries and the size and social complexity of current boundaries of the nation of India, as carved out by colonial independence, make it no less a crossroad in this new millennium. Of the many aspects that have intrigued scholars in this dynamic mix of humanity, medicine and healing has received a significant amount of attention. India was and is a laboratory for the exploration of a variety of theories and approaches to humankind's physical and emotional ills. The ancient traditions of *ayurveda* and the closely related *siddha*, which made its way to many countries in the region with the Indian Diaspora; *yunani*, brought by conquering Muslims from the Middle East, allopathy brought and established by the English Raj through its military, missionaries, and colonial rule; homeopathy, brought by German physicians; and the current increasingly popularity of yoga derived from eastern Buddhist religion and culture, and many other more localized medical and spiritual traditions characterized by itinerant healers, village *dokturs*, and family practices. All these traditions and practices constitute the medical and healing "pluralism" of India (Leslie 1992, 1976; Trawick 1992).

A central question for those who have studied Indian health care systems is how these alternatives exist side-by-side and how are they utilized, in general and in terms of specific health problems. One term that is used extensively in describing health care in Indian is "pluralism" (Khare 1996; Lambert 1992; Leslie 1976; Nichter 1996). Typically, this term is meant to imply the diversity of traditions and the availability of alternative explanations, methods, treatments, and medications associated with the named "pathys" or healing systems. However, it stands to reason that a cultural and now global crossroad such as India would present a far more complex situation than simply the co-existence of these traditions without considerable effect on one another. This paper will seek to explore the mutuality of impact that may result in a greater amount of "pluralism" within a given 'pathy' than between them.

The focus on "traditional medical systems" has meant that there has been less emphasis on the study of allopathy and allopathic impact on non-allopathic systems. A number of authors have demonstrated the link between colonial domination and the perceived power of allopathy (Fanon 1967a, 1967b; Ibn Lkhayat 1989; Jabrane 1987; Lidam 1987). The growing Indian pharmaceutical industry, the easy access to antibiotics through chemists and providers and the growing level of self-medication with western-derived pharmaceuticals suggest there must be significant allopathic penetration into the traditional 'pathys.' As one *ayurvedic* practitioner in a Mumbai slum put it, "…*we cannot practice without allopathy*." However, Janes (1999:1805) points out that, "there is a distinct tension between the theoretical and applied…The crisis of traditional

medicine…is…that these alternative systems may become so much like biomedicine, so rationalized and 'sanitized' of their alternative epistemological tenants that they may not be able to meet the human and social needs of the rapidly approaching health crises produced by structural adjustment and demographic transition." We will explore the degree to which these non-allopathic systems are merging with, and losing their identity to allopathic medicine; and the implications of the penetration of allopathy for the practice of those trained in the non-allopathic systems. In this complex and highly communicative world, the dichotomy between "traditional" and "western" (cosmopolitan) medicine seems no longer useful (Khare 1996).

The central focus of our research is on male sexual health problems, also called *gupt rog* ("secret illnesses" in Hindi). In fact, we examinee the link between STIs and the culturally defined sexual health concerns of "semen loss" and "sexual weakness". The culturally defined sexual health concerns are sexual dysfunctions that are not sexually transmitted. While the issue of culturally defined sexual health *gupt rog* presents problems and obstacles for reproductive health, it also presents opportunities for intervention. Data analysis indicates that a large number of men report having these problems in the last three months and that a significant number of men seek treatment for these problems. Health care services that seek to impact on men's health must first address the culturally-defined sexual health *gupt rog* concerns, and through these concerns can address issues of STI symptom identification, treatment and prevention. For this goal to be properly achieved there is also an urgent need to focus on traditional medicine as daily practiced at the local level. Much of traditional medicine has been explored through leaders in the field, practitioners with noted reputations and *gurus* practicing a "purer" version of their particular "pathy". In this paper, we seek to learn the nature of Indian healing system at the local level; in this case in slum communities of Mumbai. The approach that will be explored in this paper builds on a concept put forth by Khare (1996:846), which he terms 'practiced medicine.' He proposes that "*Practiced medicine* 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, whether Hindu, Muslim, Christian, Sikh or any other."

INDIAN MEDICAL HISTORY

There are several medical traditions in India including those derived from within the Indian civilization(s), and those that find their origins in other cultures. The most popular of the endogeneous medical traditons are ayurveda and siddha, although there are many other practices including yoga, magico-religious and supernatural healing, bone-setting and midwivery. The exogenous or "imported" medical traditions consist of yunani medicine (14^{th} century), homeopathy, naturopathy and allopathy (all introduced in India by the 19^{th} century). The focus of this paper is on ayureveda, yunani medicine and homeopathy as the dominant disciplines of our Mumbai study communities.

In Sanskrit, *ayurveda* means "science of life" and ayurvedic medicine stems from ancient Indian culture through the veda tradition. According to ayurveda, the human body is a microcosmic replica of the universe, both constituted of and classified into five elements (earth/solidity; water/fluidity; fire/heat; air/movement; ether/space). These five elements

translate into the body and organs as three humors (air, bile, and phlegm). The third main component of the human body is seven *dhatus*: one of which, called *sukra*, enters into the formation and cycle of sperm and ovum. When sukra is disturbed, it results in reproductive and sexual health problems; in the same way any disturbance in the equilibrum of the elements, humors and dhatus results in disease. The main principle of treatment is thus to maintain or restore equilibrium. Ayurvedic medicine promotes a preventive and positive health approach, and when treatment is needed, it is aimed at avoiding causative factors such as risky behaviors, unbalanced diet and excessive regimens. Ayurvedic medicine is considered holistic in its focus on a balanced state of the body, mind, and emotions as well as environmental, social, moral and spiritual welfare (Basham, 1976; Dash, 1999; Lad, 1990; Ministry of Health and Family Welfare, 2004; Obeyesekere, 1976; Sharma, 1996; Zysk, 1993, 1996).

In Arabic, the term *yunani* means "Greek" and unani medicine is also called Islamic, Arab, Greco-Islamic, or humoral medicine. It stems mainly from the Greco-Hellenic and Islamic civilizations. According to unani medicine, all beings are made up of basic elements (earth, air, water, fire), temperaments and qualities (cold, hot, wet, dry), humors (blood, phlegm, yellow and black bile) and forces (natural, vital, and psychic). In this system, health is a state of the body in which there is equilibrium of these components, and when this equilibrium is disturbed, disease occurs. The main goal of unani medicine is to achieve an optimal balance (*eukrasia*) for each person. Unani treatment is based on the *contraria contraris* principle, "to treat a disease by its opposite" (e.g. a "hot" disease is cured with a "cold" medicine). Unani medicine is also considered holistic in its consideration of physical and mental activity, environment, and diet, which contribute to the preservation of health (Brain, 1986; Bürgel, 1976; Dols, 1984; Leslie, 1976; Ministry of Health and Family Welfare, 2004; Temkin, 1973).

The term homeopathy derives from the Greek *homois* (similar) and *pathos* (disease/suffering). Homeopathy was developed in Germany and appeared discreetly in the midst of the political and medical effervescence of modern India in the 19th century. According to homeopathy, "miasm" (from the Greek to pollute) is the main cause of all diseases. The human body contains an innate vital force that, is weakened during illness. Treatment is based on similia similibus principle (Latin, "like are cured by like"); a remedy, which by its "nature" is most similar to the symptom, is prescribed in the minimum dose and administered to the patient. This remedy stimulates the "vital force" or existing defense mechanism of the body, which is failing when disease occurs. Homeopathy, like ayurvea and yunani, is also considered holistic in its concern with environmental, social and emotional determinants upon which action is taken for better treatment (Gala, 2000; Jacobs and Moscowitz, 1996; Leslie, 1976; Ministry of Health and Family Welfare, 2004).

The *vaidya*, the *hakim* and the homeopath

Ayurvedic healers (*vaidyas*), yunani providers (*hakims*) and homeopaths have played a medical as well as a cultural and politcal roles in the modern history of India. The vaidya is an ambivalent figure in medieval India and remains so. He is seen as a person of wisdom, trustfull and skilled and as such respectfully treated by the people of his community, but he also was and still is perceived as a quack whose only ambitioin is to

take as much money as he possibly can from his patients (Basham, 1976). This ambivalence is rendered more complexe by the existence of several types of vaidyas within the ayurvedic medical system (Nordstrom, 1988; Leslie, 1976) among whom are the "purists" and the "integrationists". The "purist" is the traditional vaidya who had been educated for several years by a *guru* to whom he is professionally, socially, supernaturally and eternally linked by the Lord Siva (Basham, 1976). The student is taught the tenants of ayurvedic medicine from the Sanskrit canonical texts and becomes a purist but not officially registered by the government, because he did not attend any of the non-allopathic medical colleges licensed by the Ministry of Health and Family Welfare. The purist uses only traditional medicines (*zadi buti*) and classical diagnostic methods; he asks his patients about his/her physical and physiological complaints, and conducts a detailed elicitation of patient's well-being, social problems, diet, rest and activity patterns, including any risky behavior that may have an impact on patient's health (Nordstrom, 1988). In fact, the traditional vaidya "keeps alive" the Sanskrit classical texts of ayurvedic medicine, and adopts a holistic perspective, an ecological approach that takes into account the multidimensionality of health and illness, and where "disease makes sense only in its totality" (Bibeau, 1982).

The Muslim yunani hakims also brought with them a holistic medical epistemology in the 14th century. The main differences between the classical ayurveda and the classical yunani medical models are more practical than theoretical; which means that although the two traditions refer to different types of drugs, diagnostic methods, and therapeutical actions, they nevertheless both rely on the humoral theory that makes holism at the center of medical knowledge, meaning and action In fact, the theoretical frameworks of the three non-allopathic medical systems under study are based on holistic perspectives and approaches. The canonical texts of ayurveda (*Caraka Samhita*; *Sursuta Samhita*), homeopathy (Hahnemann's work) and yunani medicine (Galen; Al Razi; Ibn Sina) all focus on a harmony between physical and mental activity, environment, and diet, which contribute to the preservation of health; their emphais is on the maintenance of health and a balanced state of the body, mind, and emotions as well as social, moral and spiritual welfare. In this paper, we will see if the non-allopaths practicing in the three study communities are still translating into their daily practice the holistic medical perspective so fundamental to the classical ayurvedic, yunani and homeopathic epistemologies.

In the first half of the 19th century, British Orientalists on one side and Indian leaders of the Independance Movement on the other side started to organize medical associations and colleges where was taught both allopathy and non-allopathic medical systems. Ayurveda, yunani and allopathic classical texts were available in Hindi, Marathi, Urdu and other vernacular languages, and students could become specialized in a given non-allopathic discipline in addition to be taught basic allopathic knowledge. Many students attended medical classes emerging with degrees or diplomas, and hence became "professionalized" vaidyas or hakims (Leslie 1976) who integrated both non-allopathy and allopathy into their medical practice.

In the 1950s, the Ministry of Health and Family Welfare (MOH&FW) started to officially recognize the medical colleges born during the fight for Indian independence. The new type of graduates that are the "integrationist" vaidyas and hakims, are registered in the

MOH&FW. We are far from the traditional "purist" type of healer: the "professionalized integrationist" is graduated from a medical institution licensed by the government, and combines allopathy with non-allopathy. As we will see later in this paper, our data suggest that the "integrationit" does no longer transform into his daily medical practice the holistic perspective so fundamental to the canonical and to the purist vaidyas and hakims; he uses more the sthetoscope than the classical diagnostic method of pulse-taking; he provides *zadi buti* medicines as well as heavy antibiotics; he spends about 15 minutes with each patient, which leaves no time to conduct a detailed elicitation of patient's general well-being, family problems, habits and risky behaviors. Both he and his patients are under the pressure of the huge and demanding urban environement of Mumbai. Although the integrationist healer respects and have some knowledge of the classical texts of ayurevda, yunani and/or homeopathy, his present daily practice diverges however from these texts.

In 1995, the Ministry of Health and Family Welfare officially gave a separate identity to the non-allopathic systems of medicine. This identity was made concrete by a new name and the creation of a new department with multiple ongoing and new projects as well as a complex organization within the MOH&FW: "The Department of Indian System of Medicine and Homoeopathy (ISM&H)" is born, but shortly after (november 2003) renamed: "Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy " (AYUSH). The department is responsible for regulating, developing and propagating officially recognized systems, namely, ayurveda, siddha, unani, yoga, naturopathy and homoeopathy. The department facilitates research in traditional pharmacopea and regulates ISM&H education and practice in all officially recognized indigenous streams of medicine.

In 2001-02, there were more than 400 officially recognized AYUSH medical colleges in India, as well as 3,000 AYUSH hospitals (with a total of 60,000 beds); and 23,000 AYUSH dispensaries. Ayurveda, as the historically indigenous system, dominates this infrastructure; but homeopathic and yunani facilities are well represented. Also, a new type of AYUSH medical institution has been coming to light: In February 2004, the President and the Vice-President of India, respectively Singh Shekahawat and Bihari Vajpayee, along with the Federal and State Ministers of Health and Family Welfare laid the foundation stone of the "All India Institute of Ayurveda". The Institute is presented as "state of art multispeciality hospital" where will be provided a quality patient care as well as a post graduate teaching and research centre; which may lead to an additional and new type of professionalized vaidyas.

Presently, India has over 600,000 registereed AYUSH practitioners including ayurvedic doctors (60%), homeopaths (30%), and yunani providers (6%); and probably much more non-registered AYUSH healers, including most of the gurus and other purist traditional healers. There are nationwide about 70 registered AYUSH providers and 50 allopaths per 100,000 population (Ministry of Health and Family Welfare, 2004; World Health Organization, 2004). Just for a quick comparative glance with the three study community where approximately 700,000 people live, there are about 30 AYUSH providers and 4

allopaths per 100,000 population. This paper explores the role of AYUSH healers in the management of male sexual helath problems in Mumbai, India.

SEXUAL HEALTH PROBLEMS IN INDIA

The concern about male sexual health, and concomitantly the health of their sexual partners, is set in the context of the rapid spread of HIV/AIDS and increasing rates of STIs in India. As in most developing countries, estimates of disease burden rest on surveillance in limited sites or stand-alone studies. However UNAIDS (2000) places the current figure of individuals with HIV/AIDS in India at close to four million, with a rate of 0.7%. An estimate of the actual burden of HIV-infected population in India suggests that 1.5% of the 1 billion Indian population, or 11.5 million individuals were already infected with HIV, making it the country with the largest numerical burden in the world (Kumar 1999). The State of Maharashtra and the city of Mumbai have been severely impacted by the spread of STIs and HIV/AIDS. In Mumbai, surveillance data indicates there has been a steady progression of HIV positive individuals among patients attending STI clinics rising from a low of 1.6% in 1987 to the most recent estimate of 64.4% in 1999, with HIV prevalence increasing in the city from 1% in 1993 to 3% in 1999 (UNAIDS 2000). A screening of female sex workers and their clients attending a STI clinic in Mumbai shows that 42% were seropositive for HIV, 72% for herpes simplex virus II, 79% for cytomegalovirus, 38% for syphilis and 26% for gonorrhoea. Findings also indicate that members of high-risk cohorts suffer from multiple STIs, which increases the risk of subsequent HIV infection (Das et al. 1998; Hawkes and Hart 2000).

The predominance of HIV/STI infected individuals in India are men; estimates in 1994 indicated a male to female ration of 5:1, with female cases being mainly sex workers (Pais 1996). More recent estimates indicate a 3:1 ratio; of the 3.5 million adults (age 15-49) living with HIV/AIDS in India, 2.2 million are male (UNAIDS 2000). Heterosexual contact with commercial sex workers, both before and during marriage, has been considered the major source of infection in men. At the same time the increasing proportion of women is a result of men having risky sex and then having sex with their wives (Bentley et al 1998; Jacob et al 1995; Jain et al. 1994). In Mumbai, 2-4% of pregnant women have tested positive for HIV in public hospitals (Maniar 2000) while recent data from Pune in Maharasthra has shown a relatively high prevalence rate among "low risk", married, monogamous women whose only risk factor was sexual contact with a husband who had experienced an STI (Gangakhedkar et al. 1997).

At this point in the epidemic in India the disproportionate gender ratio indicates that the primary burden for infection and transmission is on men. However, reproductive health services in India have not as yet found effective approaches for consistent involvement of males in utilization of HIV/STI services and in engagement in reproductive health information, education and communication programs. When males do go to primary care or STI clinics they frequently find an insensitive, judgmental staff with little understanding or appreciation for male reproductive health problems.

Research conducted over the last decade in India has shown that men living in both urban and rural areas of India have widespread anxieties associated with sexual matters (Lakhani et al. 2001; Pelto et al. 1999; Kulhara and Avasthi 1995). Men in India are

dealing with many of the universal male sexual health problems including premature ejaculation, impotence, infertility, nocturnal emission (wet dreams), feelings of guilt associated with masturbation, and concerns about penis size (Verma et al. 1998). What makes these issues even more problematic in India is that sex is often associated with matters of pollution and purity (Savara 1993). Many of the sexual health problems reported by men in India are described in terms of "semen impurity" and are viewed as caused by excessive sexual intercourse, wrong types of food, excessive exercise, grief, and loveless sexual intercourse (Bhugra and de Silva 1994). According to Indian tradition (writings in Upanishids) semen is known as *virya*, derived from a Sanskrit word which means bravery, power or greatness (ARCH 1999; Verma et al. 1998; Nag 1996) and is considered the source of physical and spiritual strength. The loss of virya through sexual acts or imagery (including masturbation and nocturnal emission) is considered harmful both physically and spiritually. The focus on semen-loss makes premature ejaculation, nocturnal emission, and masturbation special concerns among Indian men (Verma et al. 1998).

A number of studies have indicated that men are also more concerned about performance issues related to semen loss than they are about sexually transmitted infections (Pelto et al. 1999). A study in Pune reported that young men had sex with sex workers only a few days before marriage, either due to peer pressure or performance anxiety (Raju and Leonard 2000). Also, there is a widespread belief among Indian men that the loss of semen during sex with partners is less, and therefore not as "dangerous" as the loss of semen in masturbation (DCT 2000; Dewaraga and Sasaki 1991).

Men throughout the world have concerns associated with such issues as masturbation, penile size, and sexual performance. South Asian and Indian culture amplifies these concerns through the concept of *gupt rog* ("secret illness" in Hindi), which refers to the culturally defined illnesses that belong to the secret parts of the body. STIs are also "secret illnesses" and are hence included in the *gupt rog* cultural category. Most of the *gupt rog* problems reported by men in India are however derived from concerns about excessive semen-loss and sexual performance problems. This paper explores how culturally-defined sexual health *gupt rog* could influence the issues of STI symptom identification, treatment and prevention in the traditional healing practices.

METHODS

The project within which the data for this paper was generated is a joint Indo-US research team involving the RISHTA project (RISHTA for Research and Intervention in Sexual Health: Theory to Action. RISHTA also means "relationships) of the International Institute for Population Sciences (Mumbai) in collaboration with the Center for International Community Health Studies of the University of Connecticut School of Medicine (Farmington, CT) and the Institute for Community Research (Hartford, CT). The focus of the five year NIMH research and intervention project (2001-2006) is men's sexual health, and the collaboration brings together a multidisciplinary and international team that includes anthropologists, demographers, psychologists and physicians

The project is being conducted in three low-income communities with a total population of approximately 700,000 in northeast Mumbai. Over a period of about two decades the

slum population has grown rapidly, with a large number of illegal and unauthorized structures added by migrants coming from various parts of the country. The population is mixed Hindu and Muslim coming from Maharashtra, eastern Uttar Pradesh and Tamil Nadu. These 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 (bettle nut) shops, beer bars, country liquor outlets and illegal gambling establishments. These communities, located at least ten kilometers from each other, are served by five public health services, and 245 private providers of which 26 (10%) are physicians (allopaths) and the remaining 90% are traditional healers from the three major traditional medical systems in India (ayurveda, unani and homeopathy).

The mixed methodology of qualitative and quantitative data in the three study communities includes: a) In-depth interviews with 45 allopaths and traditional healers. During these individual interviews that were conducted over several meetings, we covered the domains of providers background (training, experience, practice principles, medical ethics), their present practice with sexual health patients (etiology, diagnostic process, types of SHPs seen, treatment, counseling, referral), as well as the providers' views on patients and general community characteristics. We have collected health practitioners' perspectives and explanatory models that both shape the medical practice and impact on male sexual health in the study communities. The health providers interviewed were also included in b) A rapid assessment of providers (RAP), utilizing a short, structured interview form administered to all the 245 providers from the three study communities. The goal was twofold and consisted on one hand of the first census ever conducted among private allopaths and traditional healers of Baganwadi, Cheetah Camp and Mankhurd, which represent the most easily accessible health resources for the 700,000 people of these communities. On the other hand, the RAP was aimed at collecting information on providers' gender, religion, training, experience, number of hours and days of service per week, as well as information on number and types of general and sexual health problems (SHPs) seen per month in present practice, and number of sessions and average time spent with patients. In addition to interviewing heath providers, we also conducted c) In-depth interviews with 52 married men between the ages of 21-40. Each interview was conducted in several meetings in order to be able to cover as much as possible of the domains of contact and non-contact *gupt rog* (symptoms, etiology, treatment, consequences) in relation to lifestyle (sociodemographics, media exposure, friends, substance use, religiosity), and marital relationships (household characteristics, marital formation, violence, children, extended family), and sexual behavior (marital sex, self sex, non-marital sex). We also conducted d) A structured baseline survey instrument (BSI) that we have built from the variables we have first qualitatively identified. We have then piloted the instrument among 100 men, and validated it before we have selected a systematic random sample of 2408 married men, ages 21-40 in the three study communities for administration of the validated BSI. Data collection was on various issues including sociodemographics, household characteristics, marital relationships, lifestyle and personal behavior, sexual behavior, masculinity, sexual health problems, treatment seeking behavior and consequences of sexual health problems.

RESULTS

The average age of men in the sample is 31 years, with a mean education at 6th standard. The sample is 53% Muslim, 43% Hindu and 4% other. The majority of the sample was born outside of Mumbai (66%). Men migrated to Mumbai with their natal family (50%) at an average age of 13, alone (28%) at an average age of 18, with friends (21%), at an average age of 18 or with a spouse (1%), with an average age of 18. Men's average income is Rs. 3272 ($70) per month; they are currently living in households with a mean of 3.6 people per household, with 1.2 rooms or approximately 3 people per room.

Sexual health problems

The ten most common sexual health problems men report as "have ever had" are as follows: Wet dream (70.8%), Itching on the genital organs (43 %), Masturbation (39.8%), Burning during urination (34.4%), Early ejaculation of semen (31%), Hot urine (27.9%), Sexual weakness (23.7%), "Dhat" (16.9%), Pain in lower abdomen (14%) and Loss of sexual desire (12.1%). In all, 53 % of the men in the sample reported at least one problem in the last three months.

The data on male sexual health problems was subjected to "maximum likelihood" PCA. The results showed seven factors or clusters of symptoms including: (1) Semen loss problems (masturbation and nocturnal emission), (2) The nature of semen (thinning, quantity and color), (3) Fertility problems (infertility and lack of a male child), (4) Performance problems (sexual weakness, early ejaculation, loss of erection and loss of sexual desire), (5) Penile characteristics (penile size, swelling of genitals and "bent penis"), (6) External STI-like symptoms (sores on the penis, itching on the genital organs, pain in the penis, nodules –pimples- on the genital organs, redness of penis, syphilis, and pus discharge) and (7) Internal STI-like symptoms (burning during urination, white discharge, and "hot urine"). Factors 1-5 are culturally-defined problems that do not result from sexual contact (**"non-contact problems"**). Factors 6 and 7 are men's reports about classic STI-like symptoms (**"contact problems"**). These seven factors constitute the three categories called *dhat*, *kamjori* and *garmi*. *Dhat* regroups all the semen-related problems (factors 1, 2, 3); *kamjori* refers to performance-related problems (factors 4, 5); and *garmi* represents the STIs and STI-like symptoms (factors 6, 7). More than half (1272) of the male sample (2408) reports having suffered from at least one problem in the "last three months". From the total sample of 2408 men, 36% reported having a *garmi* problem, 26% reported *kamjori* and 14% *dhat*. From the 1272 men with SHPs, *garmi* problems represent 70%, *kamjori* 50%, and *dhat* 27%.

Our data actually highlight three main *gupt rog* syndromes that are *garmi*, *dhat*, and *kamjori*. The first *gupt rog* syndrome of *garmi* refers mainly to STI-like symptoms of *phora/phori* on penis (boils, pimples, sores), *sujan* (swelling of penis; inflammation), *khaj/ghujali* (itching; cutaneous eruption), *jalan* (burning), burning urination and pus discharge. The *garmi* syndrome also refers to disease entities such as gonorrhea, syphilis and chancroid, although very rarely do male residents use these terms, while traditional healers use them more but not systematically as we will see in this paper. *Garmi* is a

contact sexual health problem because its main perceived cause is extramarital risky sex. In the Indian context, *garmi* also refers to "excessive heat in the body", where "heat" is linked to the theoretical notion of "hot/cold" stemming from the humoral systems of medicine such as ayurveda and unani traditions. In addition to *garmi*, the second *gupt rog* syndrome of *dhat* is frequently mentioned by male residents and healers in reference to semen-related problems (color, quality, quantity), and excessive "semen-loss" that is either voluntary (sex with partner; self sex) or involuntary (nocturnal emission). Excessive semen-loss leads to semen-related problems that are themselves linked to infertility. *Dhat* problems also lead to *kamjori* ("weakness") problems that constitute the third *gupt rog* syndrome. *Kamjori* consists of erection problems, impotency, early ejaculation, loss of desire for sex, and size and shape of the penis. While *garmi* problems are mainly acute SHPs that are usually rapidly treated with heavy antibiotics; both the *dhat* and *kamjori* syndromes often represent chronic non-contact sexual health concerns, the etiology and diagnosis of which are outside the biomedical or allopathic tradition. They as such have generally been ignored, demeaned and seen as a relic of the cultural past by cosmopolitan health services. However, any reproductive health service in India that hopes to improve men's reproductive health and to increase safer sex practices must start by addressing these male sexual health concerns.

Treatment-seeking behavior

The primary resources men are using in the study communities are self treatment and the 245 private providers. The RAP data analysis shows that the traditional healers provide for 85% of the 5400 patients seen daily in the three communities, of which 44% are adult men. Twelve percent of the men presented with sexual health problems, of which majority were culture-bound sexual dysfunction problems (*dhat* & *kamjori*: factors 1 to 5) seen by the traditional healers, while STI symptoms (factors 6 & 7) were presented primarily to private allopaths. The BSI data analysis indicated that men with sexual health problems take 1.6165 of treatment-seeking action (mean number of actions across all problems). They take significantly more actions (1.8270) to treat non-sexually transmitted and culturally-defined problems (factors 1 to 5) than for STI-like problems (mean: 1.4641 action). Regarding each syndrome, men take more treatment actions for *dhat* (1.92) and *kamjori* (1.58) than for *garmi* (1.51). They also report seeing a health provider more often when they suffer from *dhat* (90%) and *kamjori* (76%) than for *garmi* (62%). They prefer self-treatment (traditional home remedies; allopathic medicines over the counter at chemists) more for STIs and STI-like problems (34%) than for *kamjori* (21%) and *dhat* (9%).

Across all the types of SHPs and treatment actions taken, men report going either to providers (69%) or getting self-treatment (28%) or mixing both (2%). Men with SHPs show a consistency in health seeking-behavior. In other words, when starting with self-treatment for a SHP, 93% will again take self-treatment as the second action; and if they start by seeing a provider, 96% of the respondent's second action will again also be seeing a provider. The percentage of those who first use self-treatment before switching to a health care provider (6%) is higher than those who start with a provider and then switch to self-treatment (3%).

Syndromes, etiology and treatment from the men's perspective

Fifty-two community men in the study communities were interviewed,utilizing a semi-structured interview guide and for those that had SHP, they reported their perceived causes of *dhat*, *kamjori* and *garmi* syndromes, and the modes of treatment that helped them overcoming these problems. In terms of etiology, men saw *dhat* problems as mainly caused by seeing blue films, and by thinking about sex and having a strong desire for it. When they take "English" medicines to treat *dhat* problems, it is usually in the form of multivitamin tablets; they prefer, however, using the three kinds of AYUSH medicines (ayurvedic, unani, homeopathic) which they get either directly from a chemist, a friend, a neighbor, a relative (self-treatment) or when visiting an AYUSH provider. For both *dhat* and *kamjori*, AYUSH medicines usually consist of oils and ointments for massage, perfume spray for the penis, and various herbal tonics taken either as self treatment or prepared, supplied and prescribed by healers. In some cases, men go to "spiritual healers" (*ojha-soka*; *jadu-mantra*; *maulana*) who perform divination, soothsaying, incantation, and prescribe prayers, religious instruction and charms. A 31 year old married man from one of the study communities, who has completed eight years of schooling and is presently working in a garage, reports:

> "…When I was wet dreaming much…I became very weak. But I had not taken any treatment from any doctor. I just paid Rs. 100 [$2] to one *maulana*, a religious person. He had given me a *Tabij* [bracelet] he tightened on my hand. Because of this, frequency of my wet dreams had reduced and my health is now fine. Since then I never had any serious problems."

Men report that *kamjori* is mainly caused by *dhat* (excessive semen-loss through masturbation and wet dreams), as well as by extramarital sex, improper diet, anxiety related to sexual performance, and lack of communication between sex partners. Men treat *kamjori* problems with exclusively AYUSH medicines they purchase directly from the chemists or they get from friends and relatives (self-treatment). When they go to a health provider, they prefer AYUSH healers who sometimes prepare their own medicines. A 30 year old married man who is living in Baganwadi and has completed four years of schooling, says:

> "Firstly, if water [semen] doesn't come out from my penis then I could not do anything [I worry a lot] because I would come to know that my time has come [death]. If the semen …comes before time [early ejaculation] then I would take the treatment from the doctor and go for homeopathy or some *zadi butti* medicines. And according to me, Homeopathy is good… Homeopathy is a medicine made from some tree. "English" medicines are made from the animal's bones. Homeopathy means natural medicine [because of which] 100% of the disease gets cured."

Regarding *garmi* problems, the first main perceived cause is what many respondents call "wrong illicit relationships" that consist of extramarital sex with sex workers, having sex with males, and sex during menses. The second main perceived cause of *garmi* is lack of personal and environmental hygiene. Another less often mentioned cause is the "excessive heat in the body", where heat refers to the theoretical concept of "hot/cold" in

the humoral epistemology. Men indicated that, when suffering from *garmi*, they use AYUSH medicines that consist of oil, ointment and herbs; however the main medicines utilized against *garmi* are "English" medicines that respondents call "tablets", "capsules", injections" and "antibiotics".

Other modes of treatment, regardless of types of SHPs, consist of returning to the home village to see a known healer; or seek help outside the community from providers who are "famous" for treating SHPs and with whom friends suffering from similar problems found relief. A 28 year old married man who has completed eight years of schooling and is working as a hawker reports that:

> "After doing sex outside [with a sex worker], I get burning urination, pain in penis and I get pimples around penis…My friend (X) has more problems for which he takes treatment [and] he also gives us [me and other friends] the same medicines, by which we get relief. We go all together to the doctor but only him [my friend X] shows his problem to the doctor. Whatever medicines he prescribes, we all purchase and take…He is an ayurvedic doctor, he prepares a lotion that we all use."

PRIVATE PROVIDERS IN THE STUDY COMMUNITIES

The 245 private providers that men with *dhat*, *kamjori* and STIs usually visit in the three study communities are vaidyas (79, 32.2%), homeopaths (73, 29.8%), unanis (67, 27.3%) and allopaths (26, 10.6%). The average age of the providers is 36.6, with 17.6 years of education and training. In general, the providers are an established group; they had an average of 9.3 years of practice, and an average of 7.2 years of practice in the study community. More than 60% have never practiced in another location and almost 90% of their patients come from the same community where they have their practice. The private providers see an average of 28 patients per day of which 44.2% are adult men, 34.8% are adult women, and 21% are children. Allopaths are significantly older (mean age of 44.1) than traditional providers (33-37, $F = 7.9$, $p < .001$), they have been in practice almost twice as long (16.7 years) than the traditional providers (7.7 to 9.2, $F = 11.1$, $p < .001$) and see significantly more patients per day (42) than the traditional healers (23-29, $F = 7.0$, $p < .001$).

Of the 67 unani providers, 65 (97%) are Muslim and 2 (4.5%) are women; of the 26 allopaths, 21(81%) are Hindu and 5 (19.2%) are women; of the 73 homeopaths, 48 (65.8%) are Hindu and 10 (13.7%) are women, and of the 79 ayurvedics, 59 (74.7%) are Hindu and 5 (6.3%) are women. Allopaths see the largest average percentage of women patients (39.4%) and unani see the least (28.9%) with homeopaths (37.7%) and ayurvedics are in between (37.7, $df = 3$, $F = 4.1$, $p = .007$). The 245 providers see 12.6 patients with sexual SHPs per month (mean). Also, men rarely go to public health facilities, although these services are available in the communities and cost less than the private health sector. Public facilities are exclusively allopathic, and no AYUSH public health services are available in the study communities. All the 219 AYUSH providers with whom we conducted the RAP and the semi-structured interviews are from the private sector.

The Perspectives of the AYUSH Providers

We conducted semi-structured interviews with 45 health care providers from the three study communities. In the present analysis, however, we excluded interviews with five female providers because their patients are mainly women; and three interviews with allopaths because of their small and non-representative number. The 37 remaining interviews consist of male AYUSH providers from the three study communities (table 1). We have compared the perspectives of the *vaidyas*, *hakims* and homeopaths.

The comparative qualitative analysis presented here was organized into nine selected domains that emerged from the provider's narratives. Two of these domains relate to general information like the main reasons that lead them to become AYUSH providers; and the main characteristics of both the patients seen by these practitioners, and their community of residence. Six other domains cover the types of SHPs, their etiologies, diagnostic processes, treatment, consequences, counseling and referrals provided by the interviewed AYUSH healers to their male patients suffering from contact and non-contact sexual health problems.

The present analysis shows that the providers from the three medical traditions exhibit several similarities in regards to most of the eight dimensions. As such, this section is mainly about these similarities, however the details of any significant differences that emerged will be mentioned as well.

1. Reasons: Why a Medical Profession?

Providers expressed a series of reasons that led them to become AYUSH practitioners, which included seeking of a respectable profession, prestige, fame; as well as disease episodes that occurred during their childhood and made them feel helpless; and the wish to serve people in need of health care assistance (13 providers). To achieve their goal the providers (11 out of 37) counted on the financial help, encouragement and the positive influence of their parents as well as relatives who are in a medical profession

One provider stated that he also sought the medical 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:

> "When they [my uncles and my cousins who are doctors] would say that they have cured a chronic case and got the blessings from the patient's family, I used to think that it is so nice to have others blessings. So, I decided to become a doctor like them" (P25: Ayurveda)

Seven providers become ayurvedas, unanis or homeopaths because they failed to enter the MBBS program, either because their high school marks were too low or the university fees were too high (up to Rs. 300,000 [$6,000] to join a MBBS program compared to Rs. 30,000 [$600] for a BUMS according to a respondent).

As mentioned by a 30 year old homeopath who has been practicing for four years in Mankhurd, some providers can even get free admission to non-allopathic education:

> "I did not go into MBBS because its fees were Rs. 3 lakhs [Rs. 300,000]. I belonged to the open category ["wealthy"] and even didn't want to spend more money on my education. I easily got admission in DHMS in free seat [Diploma in homeopathy]. So I joined it."

In sum, the providers from the three medical traditions entered their profession under the influence of parents who provided encouragement and financial support and becoming a vaidya or hakim was a childhood aspiration. This dream was also about achieving wealth, prestige and respectability, as well as to serve the ill and the poor. This pattern is in fact culturally embedded and reminiscent of medieval India, well before the introduction of unani medicine and homeopathy. The vaidya, in this case the "purist" vaidya, whose father was often himself a vaidya, was seeking to conform to a threefold ethical and cultural norm in which *artha* is the "material gain [a vaidya achieves] by building up a rich practice"; and where *kama* is the vaidya's satisfaction resulting from the successful treatment he provides and the subsequent prestige and fame; and *dharma* is the religious merit to be achieved by the vaidya through the healing and relief he provides to his patients (*Caraka Samhita*: i.30.29, in Basham, 1976).

2. Patients and Community Characteristics

In terms of the socio-demographic characteristics of patient's, as reported by the providers, such as age, gender, marital status, religion, and locality of residence, qualitative data show no significant differences between the three medical traditions. These patients have been living in deteriorating conditions, and half of the providers are very much concerned about this issue. We will first briefly examine the patients' characteristics, before commenting on their living conditions as reported by the providers.

The providers see both males and females, mainly males both married and unmarried. Patients are also from the same community where the doctor is practicing, indicating that patients do not leave their community of residence to seek treatment for their SHPs. They are from all ages ("pediatrics to geriatrics"), and those who have SHPs are in the age range of 15-55, and are from all castes and religions. In fact, eight providers from the three medical traditions see either mainly Muslim patients or mainly Hindus. On one hand, four of them (two vaidyas, one homeopath and one hakim) of whom the only Muslim is the hakim, see mainly Hindu patients. On the other hand, four other doctors (two homeopaths, one ayurveda and one unani) see mainly Muslim patients, but we know only the religion of the homeopaths who are "non-Muslims". Our initial hypothesis was that Hindus would tend to visit Hindu doctors, and Muslims patients would go to Muslim providers. However, available qualitative data do not support the religious similitude between providers and patients, which indicates that providers' religion is less important for patients than the providers' reputation and the perceived quality of their relationship with patients.

<u>Environmental Perspective</u>

These patients have been living in deteriorating environmental conditions, particularly in Mankhurd and Baganwadi, according to about half of the AYUSH providers from the three medical traditions. According to a 32 year old vaidya who has been practicing in Mankhurd for ten years:

> "I would say that poverty is an evil. People don't have money to have proper food/diet and take care of the children properly. It is been seen that children take anything from the road and eat it. And as they play in dirt and mud, they do eat mud, which gives rise to diseases…Along with this, here water is also 50% cause. As drinking water pipe is leaking, the rubbish goes inside the pipe and people drink contaminated water only"

Another doctor, also from Mankhurd where he has been practicing for ten years, is a 37 year old homeopath who described the poor living conditions of his patients:

> "Some persons don't eat or drink for two days… The garbage over here is not cleaned or taken away and on the other hand there is a creek, which is very dirty, and all its dirt comes here. People breathe such polluted air and get prone to diseases. This is nothing, if you have to come here during rainy season then you won't be able to come because this area is full of water and so it is very dirty….Because of poverty over here people are not able to eat and drink properly."

In sum, 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 dumping areas, heavy air pollution, open drainage and lack of sanitation. Providers view these deteriorating living conditions as the cause and perpetuation of many diseases such as respiratory infections, dysentery, malaria and typhoid. Moreover, the situation is worsened by the SHPs of which half of the men residing in the three study communities are suffering from (53% of the 2408 men of our sample suffered from at least one SHP in the three months preceding the interview).

3. Types of sexual health problems (SHPs)

Qualitative data show that AYUSH providers see patients with both contact SHPs (*garmi*) and non-contact SHPs (*dhat*, *kamjori*). AYUSH providers split however in two groups who disagree on the status of masturbation and nocturnal emission: one group perceives them as SHPs and the other group sees them as natural processes.

<u>*Garmi* or STIs and STI-like symptoms</u>

All the AYUSH providers see STI patients suffering from gonorrhea, chancroid, syphilis, and herpes; although syphilis and herpes seem to be rare. The providers, however, seem to think more in term of symptoms rather than in terms of diseases. For example, vaidyas and homeopaths talk about patients suffering from pus discharge associated with swelling and blisters on the penis, but none of them mentioned specific disease entities such as gonorrhea or syphilis. One hypothesis is that the AYUSH providers see each symptom as a disease in itself, but this hypothesis is so far supported by only one practitioner. Hi is a vaidya graduated from Podar medical College and practicing in Mankhurd; he states that "itching" is actually a disease in itself and as such, it has a name, *cham*: "*Cham* is a type of burning sensation of the skin of the penis". This provider is the only one who identifies

so precisely the localization of a given SHP on the body ("on the skin of the penis" instead of the much more general and common description of "on the genital area"). Also, another vaidya says he was "used to getting itching patients". Actually, the term "itching" is also mentioned by three homeopaths in the same list as gonorrhea, syphilis and chancroid, as if "itching" was more a disease than a symptom. But only one ayurveda gave it a specific Hindi name: *Cham.* Other providers also mentioned the term "itching", but in association to other STI-like symptoms (burning urination, pus discharge, blisters) and not to STIs per se (gonorrhea, syphilis). We believe that when listed among symptoms by providers, "itching" also refers to a symptom, while when listed with STIs it refers to a "culturally-embedded STI" named *cham*. In all cases, we know that the "itching-symptom" and the "itching-disease" are seen as primarily caused by extra-marital risky sex and are hence contact-SHPs. What we do not know, however, is whether *cham* is a disease defined by only one symptom (itching) or by a cluster of symptoms. We also do not know if other STI-like symptoms have the same status as "itching"/*cham*. For example, we do not know if symptoms like "burning urination" (also called "hot urine" *[no Hindi name available so far]*) and "boils/blisters" (*phoda-phunsi* in Hindi) or other STI-like symptoms, are viewed as sexually transmitted diseases per se by AYUSH providers.. So far, six homeopaths and five vaidyas discuss STI-like symptoms as if these symptoms were diseases by themselves. All the AYUSH healers identify STI-like symptoms and know the disease entities, but they hardly can either link them or know whether given STI-like symptoms are signs of gonorrhea, syphilis or other STIs. In fact, they conduct a symptomatic approach in which knowing the disease entity does not seem to be a priority.

<u>*Dhat* and *kamjori*</u>

Regarding non-contact SHPs, thirty-three of the 37 providers report seeing patients with *dhat* (masturbation, nocturnal emission, rare infertility) and *kamjori* problems ("sexual weakness", erection problems, early ejaculation, penile characteristic– mainly bent penis). However, as far as the *dhat* syndrome is concerned, about half of the providers (ten hoemopaths, four ayurvedas, and two unanis) see nocturnal emission and/or masturbation as not SHPs but as natural processes common to most of men, or at worse as signs or symptoms of psychological problems. Nevertheless, both masturbation (voluntary semen-loss) and nocturnal emission (involuntary semen-loss) are seen as main etiological factors of other SHPs such as *kamjori* (see etiology section below). Also, the other half of the AYUSH providers did say masturbation and nocturnal emission are SHPs (table 2)

When compared, these two groups (half of the AYUSH providers who say *swapnadosh* or masturbation are SHPs, and the other half who disagree) show no significant differences in terms of experience (number of years of practice) and type of medical practice (ayurveda, unani, homeopathy, allopathy). One variable that may explain why there are two such opposite explanatory models, is the history of community-based intervention and training programs that providers from the three study communities may have attended. In other words, it may be that the group who says *swapnadosh* and masturbation are not SHPs attended training/intervention prior to the RISHTA project, while the converse group did not; an alternative hypothesis would be that, when the

providers were medical students the content of their education *curricula* varied on that matter from college to college.

In sum, the dominant pattern is that providers from the three AYUSH medical traditions see patients with *garmi*, *dhat* and *kamjori* problems. Also, half of the providers from the three medical systems perceive masturbation and nocturnal emission as natural behavior and processes common to most of men; while the other half sees them as SHPs linked to the *dhat* syndrome.

4. Diagnosis of SHPs

The majority of providers from the three medical systems diagnose SHPs by combining four methods: Listening to their patients' presenting of problems; using much probing to have patients tell them about their actual risk behaviors (sex with sex workers, watching blue films, masturbation); undergoing physical examinations; and when after using these three methods, the provider fails to diagnose the problem, he then refers patients to public and private laboratories and hospitals for urine or sperm analyses. The main tests for STIs consist of urine analyses with VDRL and ELISA techniques; and for non-contact SHPs, the main laboratory tests are performed on sperm samples when patients complain of infertility[1]. Laboratory tests are also requested when the treatment provided by the healers fails, which means that there is no systematic testing for the identification of specific STIs.

A less utilized diagnostic "technique" consists of taking down the patient's history. Although all providers ask their patients about the causes of their presenting problems, fifteen AYUSH doctors occasionally ask some of their patients about the past and present history that includes information on marriage, children, work, substance use, sexual habits, medication taken, self medication, doctors seen, previous chronic problems, and whether the same problem occurs or not in the family (eight homeopaths, six ayurvedas and one unani). The majority of these fifteen AYUSH providers also use most of the other above-mentioned diagnostic techniques. Only two practitioners, both unanis, reported the need to make patients feel comfortable in order to have them talk about their risky sex and other stigmatizing STI etiologies. These fifteen practitioners illustrate that they occasionally utilize a type of ecological model our team intends to reinforce and systemize by co-building with the providers a more holistic and culture-sensitive model. We have presented this model to 40 AYUSH healers from Mankhurd during a training we delivered in September 2003. Also, whether the patients present STIs or non-contact *gupt-rog*, the main diagnostic pattern consists of patients' presenting of problem, physical examinations and the use of probing to elicit the etiology of sexual health problems.

5. Etiology of sexual health problems

"People don't get STDs by chance" (P18: Unani)

Providers talked about the catalysts of risky sexual behavior, and mentioned their perspectives on the causative factors of *garmi*, *dhat* and *kamjori* syndromes. So far, we

[1] Seven providers mentioned patients with fertility problems (four homeopaths, one ayurveda, and one unani).

have no strong evidence suggesting that there is one dominant etiological model for each AYUSH tradition (table3).

Catalysts of risky sexual behavior

AYUSH providers have a definition of "risky sexual behavior" that includes both extramarital sex and masturbation. Half of the providers mentioned three main causes of men's risky sexual behaviors, which are: the influence of media; friends' influence; and alcohol use. These providers define "media" in term of the numerous music and fashion T.V. channels, blue films, video parlors, sex books and magazines. One 32 old vaidya who has been practicing for nine years in Mankhurd, blames the media stating that in their effort to help men who engage in risky sex, they inevitably provoke the opposite effect:

> "…Media exposure is also another cause of sexual health problems. What happens, when an advertisement is shown on T.V., such as if Kamasutra advertisement is shown, then it is to spread the awareness about condoms but actually instead of understanding the real meaning of the advertisement, they get interested in doing sex. And in this way they go and have sex with any women either a prostitute or a call girl. Actually such advertisements, which projects condom promotion in such a sensuous and vulgar way, should be banned."

In fact, about half of the providers from the three AYUSH traditions see the media and friends as catalysts to both masturbation and extramarital sex. They also see masturbation as a major cause of *dhat* and *kamjori* problems, and extramarital sex as the leading cause of STIs. AYUSH providers see the media as leading to sexual behaviors (extra-marital sex, masturbation) that in turn lead to both contact and non-contact SHPs

Causes of *garmi*

STI cases are linked to specific causes by fifteen providers from the three AYUSH traditions, and mainly consist of "STI-like symptoms". Occasionally, these providers also mentioned gonorrhea, syphilis, herpes[2]. AYUSH healers link all STIs and STI-like symptoms to sex with sex workers. Five of these fifteen providers link syphilis patients to sex with sex workers after drinking alcohol with friends (two vaidyas, two homeopaths, one unani). In fact, AYUSH healers see all STIs and STI-like symptoms as caused by extra-marital risky sex and very rarely by additional causes such as heredity and sex during menses. Only two vaidyas see gonorrhea and syphilis as both caused by either risky sex or sex during menses; and one homeopath sees syphilis as hereditary.

Causes of *dhat* and *kamjori*

Regarding the causes of non-contact SHPs, 20 of the 37 AYUSH healers see *dhat* problems (nocturnal emission, masturbation) and *kamjori* problems (early ejaculation, "erection problems", "bent penis") as SHPs, and directly link them to specific causative factors (the 17 remaining healers made only general etiological statements, that is without linking SHPs to specific causative factors). According to six vaidyas from our sample, a man suffers from nocturnal emission when he masturbates, when he reads sexual books

[2] - Herpes was reported by one provider only, a vaidya.

or sees blue films or fashion shows and video-clips on T.V, and when he talks and thinks much about sex and women. The same etiological model is mentioned by four homeopaths. Nocturnal emission also happens either when a man "sleeps at night with tight underwear" (P2: ayurveda) or eats an inadequate diet, and lack of sexual activity, or excessive "heat" that is also called *garmi* as the STIs are considered to be "hot" diseases in the humoral theory of medicine:

> "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." (P10: Homeopath)

It is worth noting that this statement is made by a homeopath although the concept of "hot/cold" does not appear in the classical texts of homeopathy; it is rather a humoral concept of ayurvedic and uani epistemologies. This observation illustrates how the AYUSH providers of the study communities could integrate different medical models in not only their practice but also in their theoretical framework: the integration happens at both the practical and epistemological levels.

Three ayurvedas add that nocturnal emission, caused by masturbation and watching sexual activities of others (either in real or in blue films), will in turn be the cause of erection problems and "sexual weakness")[3]. A *dhat* problem (in this case nocturnal emission) leads to a *kamjori* problem: The involuntary loss of semen leads here to the loss of strength, energy and sexual power. The voluntary loss of semen through masturbation is also seen as a problem, although more a major cause of SHPs than a SHP per se:

> "Some doctors say that by doing masturbation no problem arises, but actually many problems take place due to masturbation, such as the nerves of the penis becomes loose (*ling ki nase dhile hona*). Before or after the marriage while having intercourse with a woman, the penis doesn't erect properly." (P14: Homeopath)

6. Consequences of SHPs

As reported by only three providers, the most direct consequence of non-contact SHPs such as *kamjori* and its related unsatisfying marital sex, seems to be the deterioration of marital relationships, which in turn lead to extra-marital sex.

Only three AYUSH healers linked SHPs to marital relationships. Two homeopaths and one unani doctor mentioned the lack of understanding between husband and wife, and the husband not caring for wife, as well as the wife either too busy with household activities or being at her native place and hence unavailable for sex, which leads husbands to extramarital risky sex. One 32 year old unani doctor who has studied in Hari Singh Gaur Sagar University in Mahya Pradesh, and has been practicing for 8 years in Cheetah Camp, stated that:

[3] - "Sexual weakness" is a vague category that includes the *kamjori* problems of early ejaculation and erection difficulties.

> "The patient thinks that his wife is very busy in household works and is not able to give time to him as well as in the night time she doesn't get excited about sex. In such a situation she is unable to satisfy him in the night. This is the reason why people love having sex with other woman instead of his wife. Whereas the patient should think and take care of his wife. Wife is not a sexual commodity. If they both don't have proper understanding then many problems would arise"

A 29 year old homeopath who has been practicing in Mankhurd for five years, also adds that:

> "Some married men are also there who are either unsatisfied with their wives or had quarrel with wives … So also people get helpless [they can't control] to go outside and have sex. Some get misguided after drinking alcohol.

The same point of view is reported by another homeopath who is aged 31 and has been practicing in Cheetah Camp for about three years:

> "Such bad economic conditions are there. Normally, small houses have big families. So if sometimes a person gets stress because of the fight in the family, he goes and have sex outside with an infected woman and then comes home and have sex with his wife- by this way the disease spreads." (P3: Homeopath)

Providers (three of 37 interviewed), sensitive to these kinds of issues, are not representative of the majority who do not take into account the links between marital relationships and sexual health problems. The majority of providers do not attempt to explore how social and marital problems could be either the causes or consequences of sexual health problems, and yet this seems to be part of the holistic perspective so fundamental in the classical texts of ayurveda (*Caraka Samhita*; *Sursuta Samhita*), homeopathy (Hahnemann's work) and unani medicine (Galen; Al Razi; Ibn Sina). The three classical AYUSH epistemologies present etiology as multidimensional, and disease as making sense only in its totality, and as such, treatment approaches have to be holistic.

7. Treatment of SHPs

"Now, no practice is purely allopathy, ayurveda, homeopathy or unani…" (P38: Ayurveda)

The main pattern shared by practitioners from the three AYUSH traditions is that healers prescribe both allopathic and AYUSH medicines in their general and daily medical practice. In the more restricted field of SHPs, they prescribe only antibiotics for the treatment of STIs; and only AYUSH medicines against non-contact sexual health problems. Another alternative pattern consists of giving both AYUSH and allopathic medicines for the treatment of STIs; however, AYUSH medicines that consist of oils, ointments and herbs (*zadi bhuti*) are intended only to relieve the patient from pain and discomfort that may result from some symptoms of veneral diseases. There is also an alternative used by a minority of providers that treat STIs with AYUSH medicines exclusively. The last possibility used by another minority is to prescribe no medicines at all, be it for contact or non-contact SHPs (table 4)

.

The mixing of AYUSH and "English medicines" is a common practice and concern both general and sexual health problems. All the AYUSH providers, but one, combine "English" medicines with medicines from their own medical field (that is, either ayurveda, homeopathy or unani). A 28 year old homeopath who has been practicing for five years in Mankhurd, specifies that there is a rule, however, in prescribing both AYUSH and allopathic medicines:

> "Actually if a patient is taking homeopathic treatment then I don't give allopathic treatment at the same time because it doesn't have any effect…In front of high power medicines [allopathic], low power [homeopathic] medicine's effect stops immediately. And the medicines won't react properly."

This homeopath actually tells us that patients should not take both "English" and homeopathic medicines at the same time, because the "high power" of the former makes the homeopathic medicines inefficient. In other words, a patient who takes allopathic medicines should first end these medicines before starting the homeopathic treatment, and *vice versa*. There is another rule in the prescribing of allopathic medicines in addition to AYUSH medicines, but this one is more linked to a marketing strategy than to treatment-providing, as stated a 26 year old homeopath who has been practicing in Mankhurd for three years:

> "The patients want to see injections 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 use to practice both allopathic and homeopathic."

The main pattern is the mixing of "English" medicines with medicines from a single AYUSH tradition. There is however a minority of four homeopaths and one unani who use ayurvedic forms of treatment as a third resource in their daily medical practice.

Treatment of *garmi*

Almost all the practitioners (31 of 37) do provide antibiotics in the form of intravenous injection or pills that patients can buy either at the healer's clinic or over the counter at most of the numerous pharmacies and medicine shops ("chemists") available in the three study communities.

A minority of six providers from the three AYUSH traditions do however not prescribe antibiotics against STIs. Rather, three of them give their STI patients AYUSH medicines exclusively; and the three others prescribe no medicines at all. Among these, one homeopath out of the 37 providers uses only homeopathic techniques and prescribes exclusively homeopathic medicines in his general practice. He is aged 43 and had graduated from Bihar University:

> "From the beginning I practice only in homeopathy. I prepare medicines myself and give to the patients…In my clinic you won't get any other medicines of any other pathy [any other medical field/practice] because the patients who come to me themselves like homeopathic medicines. So other than homeopathic medicines there is no question to give any other medicine."

Although this provider has a diploma in homeopathic medicine and surgery (DHMS) from an Indian university, he is using one single AYUSH tradition and as such reminds us of the "traditional purist" vaidyas. He represents one exception in our sample of "professionalized integrationist". This healer prescribes exclusively AYUSH medicines for the treatment of STIs. Two other healers (one homeopath and one vaidya) also provide exclusively AYUSH medicines against STIs although they also use "English medicines" in their general practice. These healers feel very confident in treating STIs with either ayurvedic or homeopathic medicines. The vaidya who graduated from Podar medical College and practices in Mankhurd, says:

> "These patients [with STIs] are treated by ayurvedic…medicines that I am preparing here. I give them for one month, two months or depending on the type of disease…These medicines are in the form of either small tablets or in the form of powder or in the form of ointment to apply or in the form of oil to apply. Normally what is happening, the patients with STD problems are coming to me after trying treatments at various people and then they are coming to me and I am here to solve their problems completely…In some cases it might happen that there is a very late recovery for any particular kind of problem of STDs. However I am very sure that they would be cured with my treatment."

A similar statement is expressed by one of the two homeopaths who is aged 26 and has been practicing for 3 of years in Mankhurd:

> "For the STDs, no medicines are better than homeopathic…for the problems like gonorrhea and other types of STDs, homeopathy has very good treatment"

In addition to these three providers who prescribe exclusively AYUSH medicines to treat STIs, three other providers (one vaidya, one unani and one homeopath) do not prescribe any medicines to patients with STIs, they rather counsel and refer STI patients to specialists such as dermatologists (allopaths) in either private or public facilities. Apart from this minority subgroup of six healers, the main STI treatment pattern followed by thirty one practitioners remains the prescribing of "English" antibiotics. The large majority prescribe both antibiotics and AYUSH medicines to STI patients, however the latter are intended solely for patients' relief from the discomfort associated with some STI-like symptoms like itching and burning near genitals, while the antibiotics are intended to fight the STIs.

Treatment of *dhat* and *kamjori*

The dominant treatment pattern for *dhat* and *kamjori* consists of the prescription of AYUSH medicines. No provider prescribes "English medicines" to fight non-contact SHPs, although they may suggest some multi-vitamins tablets. Also, only three providers report prescribing no medicines for non-contact SHPs. One of them is a unani healer who has been practicing for 14 years and prescribes no medicines for non-contact gupt rog:

> "[Early ejaculation is a] psychological problem and…can be cured only by giving the patients proper education and training" (P18: Unani)

Treatment of chronic and acute general health problems

In addition to prescribing antibiotics for the treatment of STIs, AYUSH providers prescribe allopathic medicines to treat acute general health problems such as injuries, fever, cold, or other more severe and acute health problems. However, when the disease does not need "immediate relief", AYUSH doctors prefer AYUSH medicines because they see them as having less side effects than allopathic medicines. AYUSH medicines are seen as better for chronic problems and more efficient when other long lasting treatments are needed. Although allopathic medicines provide quick relief, the disease can relapse, as put it a 52 year old homeopath who graduated from Mumbai University and has been practicing in Cheetah Camp for 23 years:

> "Because to get immediate relief, allopathic medicines are better. But if they [patients] are comfortable with long-term treatment then homeopathy is helpful. In homeopathy the diseases get cured from the roots and do not relapse again, because of which I put greater emphasis on homeopathy. Homeopathic medicines also suit many." (P37: Homeopath)

Ayurvedic doctors also see ayurvedic medicines as much more efficient than "English medicines" and prescribe them depending on the patient's request and the chronicity of their disease. One ayurvedic provider who is aged 30 and has been practicing for 11 years in Mankhurd, says:

> "Ayurved [ayurvedic medicines] have the least side effects. Patient's disease gets cured from the roots. The patient asks for medicines, which would give him immediate relief. So in this condition for immediate relief, I give allopathic medicines. Ayurvedic is a little expensive but the disease gets cured completely. But it is only possible when the patient takes regular treatment, because until and unless the patient won't take regular treatment, till that time the disease won't get cured. I give allopathic medicines to such patient and also asked him to come and show me again. After 5 days that patient came back and told me, till the time he was having the medicines, he felt better. But after that again the problem increased. So, I want to say that 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. Ayurveda can treat any chronic disease."

Compliance and barriers to treatment

From the perception of the providers, the efficacy of any kind of medicine taken depends on how the patient complies to the treatment, but full compliance to the treatment is very rare according to four vaidyas and four homeopaths, and is generally attributed to poverty:

> "Because of poverty people are unable to take their proper care. If they fall ill, then also they don't have enough money for the treatment and so they get scared to go to the doctor. They think that if doctor tells to bring some medicines then from where are they going to bring medicines." (P36: Homeopath)

According to vaidyas and homeopaths, the cost of treatment ranges from Rs. 200 to Rs. 5,000 while the range is Rs. 300 – 3,000 for unanis[4]. But the cost of treatment can be

[4] - The range is Rs. 200 – 1,500 for three allopaths we have also interviewed.

unlimited, as said a 30 year old homeopath who who graduated from Mumbai University and has been practicing for five years in Mankhurd:

> "There is no limit at all. Patients are worried about their health, so they don't mind spending any amount of money"

Also, treatment of non-contact problems (Rs 500 - 3,000) seems to cost more than STIs (Rs. 200 - 1,000): One possible explanation is that non-contact SHPs are usually more chronic than STIs and require longer duration of treatment, as it is the case for most non-contact *gupt rog* such as infertility, impotency or other performance related problems. However, although non-allopathic medicines are generally cheaper than the allopathic for very short term treatment, patients usually request the latter because "it is strong" and provides immediate relief. This seem convenient to patients because "in Mumbai, people are in hurry", particularly the younger patients, while the older have more time available and prefer non-allopathic medicines "which can break the mountains of death" as a homeopath put it, that is which can provide longevity and cure for even the most serious and chronic disease.

The cost of treatment, as well as the "patients' impatience" influences compliance to treatment. This impatience can involve four non-mutually exclusive factors: first is the limited time available because of a heavy work burden and "no time to be sick", second is the limited money available for treatment, third is the limited awareness and education of patients, and last but not least is the urgency to get rid of SHP symptoms in general and STI-like symptoms in particular to avoid having wife being aware of it and hence impacting on marital relationship. According to a vaidya, the impatience of SHPs patients to get immediate relief leads them to prematurely end a given treatment and start a new one believed to lead to a quicker relief. This behavior, according to that same vaidya, leads to the use of several treatments and medications over the course of the same disease without having the patients fully complying to any, hence worsening the health condition instead of improving it. He

> "Medicines I give or the treatment I do, has a course and until the course is not completed, medicines has to be taken. People get scared very fast. The problem with the patients is that if they take treatment from one doctor, then its fine but if his health doesn't improve [quickly] then he will run to different people and will take different treatment to cure the disease. In this the patient gets experimented which is not good. So, I always say that the patient should take medicines as per the prescriptions and should keep patience." (P34: Ayurveda)

According to this provider, the impatient health-seeking behavior seems particularly true for patients suffering from SHPs that usually make men more anxious than when suffering from general health problems

The general and most dominant pattern is that providers use both AYUSH and "English" medicines in their daily medical practice. STI patients are prescribed antibiotics as the main treatment, in addition to AYUSH medicines for relieving them from pain and discomfort associated with STI-symptoms such as itching or burning urination. It is also

worth noting that a minority of three healers prescribes exclusively AYUSH medicines against STIs. Another minority of three give no medicines for neither STIs nor *dhat* or *kamjori*. Their rather refer STI patients to allopaths; and provide some counseling to non-contact SHP patients. The main treatment pattern for the treatment of *dhat* and *kamjori* consists however of AYUSH medicines. Also, the providers see AYUSH medicines as much more efficient for chronic diseases, while "English" medicine are seen better for any acute problem in need of a quick cure, including STIs.

8. Types of advice given to patients with SHPs

The advice given to patients can be organized into ten categories related to risky sex, condom use, diet, hygiene, compliance to treatment, the media exposure, substance use, sex desire, non-medicinal treatment, and etiology of SHPs. The two most common advice are given by all providers and consist of asking the patents with STIs to 1) avoid non-marital sex and 2) to use condoms.[5] The third most common advice is given by ten providers and consists in encouraging patients to have a balanced diet as preventive measure. According to a 28 year old homeopath who practices in Mankhurd since 1998, diet is actually direct part of treatment as it impacts on the effects of medicines taken:

> "If the problem is very severe then I tell the patient to avoid sexual intercourse. Till the time he is not cured I tell him to take precautions, avoid oily and spicy food, then only the disease would get cured, because the medicines would have good result."

If the patients do not comply to dietary advice-giving, a 50 year old vaidya who has been practicing for 26 years in Baganawadi, has his own strategy:

> "Ayurveda gives importance to eating habits like eat green vegetables and fruits. But nowadays very few people eat such fruits and vegetables. … People are great believer of God. If I want a patient to control his diet, if I tell them directly to avoid non-veg food, or fatty products, they won't listen. But if I tell them to keep fast on Monday for Lord Shankar, then they will surely keep it. By keeping fast some organs in the body gets rest."

Apart from diet, thirteen providers inform patients about causes of SHPs, among whom four do inform their patients about the physiological (pathogenesis) and psychological (fear, shame, anxiety) aspects of both contact and non-contact SHPs. Other types of advice are about the importance of keeping a good personal hygienel (four homeopaths, three ayurvedas, one unani) and fully complying to treatment prescribed by doctors (three homeopaths, one ayurveda, one unani). Seven providers advise patients to avoid blue films (three homeopaths, two ayurvedas, one unani). Only one unani and one homeopath suggest yoga to patients for tension relief, and another one promotes sexual "self-control" or abstinence. Five homeopaths, four ayurvedas and one unani use lecturing and fear ("you could die") or guilt ("you will ruin your life family") to put patients of risky sexual behavior.

[5] Only one provider, an ayurveda who is aged 30 and has been practicing for 11 years in Mankhurd, is against the use of condoms: "So, I don't pressurize the patients to use condoms because I feel that it is important to tell them to avoid sex instead of asking them to use condoms. It is not fair, because if we ask them to use condoms then it is like motivating them to have as many relations as they want." (P34: Ayurveda)

9. Referrals and follow-ups.

There are two main reasons for which providers refer their patients to another health professional: Either the treatment they suggested has failed or the SHP presented is too severe for them to handle. This was reported by eighteen providers (seven homeopaths, six ayurvedas, five unanis). Five of them refer to either private or public health facilities depending on patients' economic condition, because private sector is seen as providing a better quality of care but at a higher cost. A 29 year old homeopath who has studied in a medical college in Mumbai, and has been practicing for five years in Mankhurd, describes in his own way the difference for patients between the public and private health sectors:

> "To reduce the patient's expenses I refer them to government hospital…But the patients do not prefer going to government because they face difficulties. Government people don't check properly. Legal formalities …. Those who don't have money, they will only go to government hospital because they are helpless…Doctor's don't behave properly. They see the patient and tell in front of the other staff that this patient had sex outside. Because of which patients morale reduces. So patients prefer private clinics or hospitals. At least the patients have his privacy, means no one else should come to know about his disease. We give a note in writing, but this also depends on patient's interest."

In addition to this homeopath, one unani and two vaidyas report giving the referred patients a stamped and hand written note indicating to the specialist the nature and onset of the diagnosed problem, the treatment given and tests done if any. Nine providers report getting feedback from patients or specialists about the patients' health status during and after the referral process. Also, one unani doctor refers his patients only if SHPs are chronic. Other doctors have particular referral determinants as it is the case of one unani who refers "only if patients ask for it", and another unani who will wait three to four months of unsuccessful treatment before referring the patient to a specialist. Two homeopaths and one ayurveda usually feel no need of referring sexual health problem patients because they can treat them effectively:

> "I am able to solve sexual health problems with my own capacity…No I don't refer such type of patients to anybody normally. I take consultation from…my guru and then I treat" (P17: Ayurevda)

Half of the providers ask their SHP patients for follow-ups as a way to continuously check the effects of medications prescribed, and change it if needed. However, these providers complain about their many patients not complying to follow-ups.

DISCUSSION

This paper has explored the ways in which the three AYUSH medical traditions have adapted to the circumstances of current life in a Mumbai slum. We have seen that they have significantly merged, and that further they are taking on many methods and treatments characteristic of allopathy.

The merging of AYUSH traditions

On one hand, the ancient and classical texts of ayurvedic, unani and homeopathic medicine show considerable practical differences in term of diagnosis, treatment, surgery, and medical education. However, there is an overarching theoretical commitment to a holistic perspective that blends spiritual and physiological, individual and environmental, social and psychological. On the other hand, unlike the classical traditions, the three "practiced" AYUSH medicine as observable today at the local level of Mumbai slum communities, show no considerable differences in the realm of practice; and only occasionally and partially do few practitioners translate the classical holistic perspective into their daily practice.

Also, in terms of "practiced medicne" (Khare 1996) there are numerous interconnections, convergences, parallels and similarities between the three AYUSH traditions, which do not allow us to consider them as three distinct healing traditions. Rather, they seem to be three "Indian" variants of the same healing system. Pugh (2003:417) states that "Together Unani and Ayurveda constitute the heart of India's humoral medical heritage…[they constitute] a broader unit of study [that] more fully represents the region's humoral construction of…illnesses…Ayurveda and Unani [form] a polysynthetic field of ideas and practices…their perspectives show numerous parallels and convergences". The analyses derived from the data in our project suggest that this is also true for the daily medical practice of vaidyas and hakims in the study communities. Moreover, our analysis shows that homeopathy is also part of that "polysynthetic field of ideas and practices". And yet, homeopathy that is based on the *Similia similibus* principle ("like are cured by like") is, at the theoretical level, the reverse of humoral medicine based on the *Contraria contraris* principle ("to treat a disease by its opposite"): It is as if the classical epistemological differences vanish at the level of daily practice. Also, the use by homeopaths of humoral concepts such as "hot" and "cold" to characterize diseases and treatment, shows that the integration is also at the epistemological level.

The main data that led us to think about the three AYUSH traditions understudy as being three local variants of the same healing system, are the types of SHPs, their etiology, and treatment as reported by the healers we interviewed. As far as the types of SHPs are concerned, our analysis shows that providers from the three traditions see both contact and non-contact SHPs, which means that they all see patients with *dhat*, *kamjori* and *garmi* problems. They also think more in terms of symptoms than in term of disease. When there are differences, the diversity is greater among healing traditions than between them, which shows that there is a mutuality of impact as illustrated by the two groups who provided opposite interpretations of masturbation and wet dreams: within each tradition, half of the providers agree that masturbation and wet dreams are SHPs; and the other half disagree (table 2).

Regarding etiology, our analysis shows that there are not three distinct etiological models, each one characterizing each AYUSH tradition. Rather, the three healing traditions seem to share the same overarching etiological model: the providers from the three AYUSH traditions see the media and friends' influences as leading to both masturbation and extramarital sex; they also see masturbation as a major cause of *dhat*

and *kamjori* problems; and extramarital sex as the leading cause of STIs and STI-like symptoms (table 3).

In terms of treatment, the dominant pattern is that vaidyas, hakims and homeopaths prescribe both AYUSH and "English" medicines in their daily practice for patients with sexual health problems. This mix of AYUSH and "English" medicines is observable nationwide in India and Nichter (1996) mentions it as "*masala* medicine". However, antibiotics are prescribed against STI-like symptoms, while traditional medicines are intended for *dhat* and *kamjori* problems: no provider prescribes antibiotics for the treatment of non-contact problems; and only a small minority of practitioners from the three healing traditions provides exclusively AYUSH medicines for the treatment of sexually transmitted problems (table 4).

The heavy penetration of allopathic medicines in the realm of the daily AYUSH medical practice seems to come along with a concomitant penetration at the theoretical level. The holism inherent to the canonical medical texts is hardly present at the "practiced" and local level in the three study communities; and one could wonder if the "dichotomized world" of allopathic medicine is in nowadays part of the AYUSH epistemology.

Holism *versus* dichotomy in the AYUSH traditions

In the fifteenth century, the Church allowed physicians to dissect human bodies. The Church however demanded that physicians only study the anatomical and physiological aspects of humans. The Church banned physicians from studying the spiritual and moral dimensions that might be resulting from dissections; spirituality and morality being the exclusive fields of clerics. As such, the Church firmly consecrated the dichotomy between body and 'soul'; and centuries later, Kepler, Galileo and Descartes gave a positivist and scientific legitimization to this dichotomy. The Church and Science hence built the foundations of a worldview based upon that dichotomy, which also serves as the basis for Western medical epistemology and practice where illness is reduced to its physical, physiological, anatomical or bodily dimension.

When "Western" medicine reached India through colonial conquest, its practice and therapeutic efficiency was welcomed, but there was less recognition of the cultural, epistemological and metaphysical costs to this acceptance. As Khare (1996:840) states, "India…disallows rigid distinctions and dichotomies between body and mind, "theoretical" and "practical", objective and subjective, and sacred and secular…Indian practitioners variously open up their therapeutic practices to more inclusive and diverse cultural knowledge, life experiences, common sense, and personal insights and insititutions". Rather than dichotomy, says Khare, India prefers a holistic therapeutic approach. However, the power of allopathy, supported by global economics, perceptions of western efficacy, media messages and changing expectations, is altering the India that so firmly believed in the link between mind and body.

The holism that Khare is writing about contrasts with what we see among the traditional healers we have interviewed in Baganwadi, Cheetah Camp and Mankhurd; and this is so because Khare's statement follows his work among Indian health practitioners who are

65 year old in average and well experienced; they have earned much fame and prestige, and among their patients are rich people, "major political leaders" and governors. This is not the case of the AYUSH providers we have interviewed, who are younger (36 year old in average), and whose patients come from the poorest urban localities of India. The young "integrationist" AYUSH healers of Mumbai slum communities do not seem to grasp the holistic approach and perspectives utilized by the providers that Khare had reported on. In fact, the integrationists' retreat from holism to symptomatic approach is one sign of their adaptation and survival strategy in the very demanding urban world of Mumbai, where about 15 million people live and have little time to spend on their diseases.

However, male sexual health problems are best dealt within a holistic method. This is so because male sexual health problems are multidimensional in that they are culturally defined, socially constructed, and emotionally experienced, and cannot be reduced to their bodily dimension. They are perceived as "secret illnesses", and are linked to several dimensions such as lifestyle, marital relationships, extramarital and marital sexual behavior, and masculinity, to mention only these domains (Schensul et al. 2004). Also, humoral epistemology and its transcultural variants that make ayurveda and unani medicine possible, is more than the foundation of medical theory and practice. Humoral and homeopathic epistemology simultaneously allows specific cultural constructions of disease (Pugh, 2003) and serves as the basis for social knowledge and social relationships (Good, 1994, 1977; Good and Good, 1992, 1980): it is a way of life (Leslie, 1992). Following AYUSH providers' concerns for adaptation and survival in a rapidly changing environment, as well their practice and perspectives on male sexual health problems, the next step in the RISHTA project consists of translating the research results into a culture sensitive approach that will reinforce and refine providers' existing skills; and will hopefully serve as the basis for re-integrating the classical AYUSH holism into the daily medical practice of AYUSH healers who see *dhat*, *kamjori* and *garmi* patients.

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Table 1: AYUSH Providers interviewed

	Community			
Medical Practice	Baiganwadi	Cheetah Camp	Mankhurd	Total
Ayurveda	5	3	5	13
Unani	3	2	1	6
Homepathy	4	4	10	18
Total	12	9	16	37

Table 2: Masturbation/Wet dreams **are** SHPs	Agree	Disagree	n/a
Vaidyas	7	4	2
Hakims	2	2	2
Homeopaths	8	10	0

Table 3: ETIOLOGY of	Vaidyas	Hakims	Homeopaths
DHAT	- Media - Masturbation	- Media	- Media - Masturbation
KAMJORI	- Media - Masturbation - *Dhat* (nocturnal emission) - Diet	- Masturbation	- Masturbation
GARMI	- Non-Marital Sex (NMS)	- NMS	- NMS

Table 4: MEDICINES GIVEN / 3 SYNDROMES	AYURVEDAS	UNANIS	HOMEOPATHS
DHAT	• AYUSH	• AYUSH • (no opinion)	• AYUSH
KAMJORI	• AYUSH • No medicines	• AYUSH • No medicines	• AYUSH • No medicines
GARMI	• Antibiotics • AYUSH • No medicines	• Antibiotics • No medicines	• Antibiotics • AYUSH • No medicines