AIDS
Community

AIDS COMMUNITY
Consolidated Reply

Query: Non-Allopathic Care providers for STI, from London School of Tropical Medicine (Experiences/Advice).

Compiled by E. Mohamed Rafique, Resource Person; research provided by Seema Kochhar, Research Associate.
31 March 2006

Original Query: Dr. E. M. Sreejit, London School of Tropical Medicine, UK.

Posted: 11 March 2006

My name is Sreejit. I am presently pursuing my Masters in Public Health. Prior to this, I was working in the field of HIV and STI in Mumbai, where one of my responsibilities was Capacity Building of Health Care Providers (HCP) in HIV and STI. While conducting sessions on Syndromic Management as prescribed by the WHO Guidelines for Medical Officers, I have learnt that a large segment of patients are seeking Cure for STI from Non-Allopathic HCP including BAMS, BHMS, Chemists, Pharmacists, Nurses, ANM and others. So, the rationale of effectively covering this segment of patients by training Non-Allopathic HCP in Syndromic Management and granting license to them for prescribing the necessary STI antibiotics used in Syndromic Management is no doubt a sound one. Therefore only by introducing favourable amendments to present licensing policies can we avoid moments of dilemma and embarrassment during training programs for HCPs in STIs when we are faced with the situation of having to say, "Right now, we are not allowed to tell these HCPs to prescribe antibiotics".

The Training of Non-Allopathic HCP by most implementing agencies has not been satisfactory. Most important, licensing Non-Allopathic HCP to prescribe Allopathic drugs used in Syndromic Management has not occurred. These two factors have fuelled an unregulated practice of STI care by these HCPs. Accordingly, it seems that our STI programs are covertly or overtly encouraging this practice. So, I would like to learn from members the following:

1. How do NGOs and implementing agencies presently answer the question of unlicensed Non-Allopathic Care providers prescribing or dispensing scheduled antibiotics?
2. What is being done at the policy level to enable Non-Allopathic Care providers to prescribe or dispense antibiotics for STI? Has NACP-III looked into these facets of STI Cure?
3. What do members feel should be done at the policy level to help programs like Syndromic Management to cross these licensing hurdles?

Responses were received, with thanks, from:

1. **Dr. Davidson S. Solomon, SHADOWS, Chirala**
2. **Joy Abraham, Center For Development Initiatives (CDI), Mumbai.**
3. **Laxminarayan Tripathi, President, DAI Welfare Society, Mumbai**
4. **Dr. Ravishwar Sinha, USAID-MOST, New Delhi**
5. **Dr. Chandrakant Lahariya, Lady Hardinge Medical College, New Delhi.**
6. **Dr. Amit Bhanot, PSI Avahan program, New Delhi.**
7. **Shankar Talwar, Action Research Centre, Mumbai**
8. **Dr. Aseem Mishra, Vijayanagar Institute of Medical Sciences, Karnataka.**
9. **Ashok Row Kavi, Humsafar Trust, Mumbai Metro**
10. **Dr. E. Mohamed Rafique, UNAIDS, New Delhi**

Summary of Responses

Members' responses to the query on non-allopathic health care providers revealed that Syndromic Management of STIs, using algorithms, is a cost effective method of stopping STI transmission in resource-constrained settings. Responses from members presented two different schools of thought – on the one hand, one group was clearly in favour of training and using non-allopathic HCP for syndromic management of STI and on the other hand, groups stressed on the dangers of allowing non-allopathic HCP to prescribe medication for treating STIs.

Members shared that many patients prefer to go to non-allopathic HCP, as they believe that conventional hospital treatment is inaccessible and costly and there is stigma attached with visiting STI clinic in public hospitals. Members pointed out that drugs for STI were not always available in public health facilities, and non-allopathic HCP seemed to be more sensitive to these patients compared to allopathic HCP.

Acknowledging that at many places non-allopathic HCP are prescribing and/or dispensing scheduled antibiotics, members held the view that lawmakers should licence the non-allopathic HCP to use allopathic medicines for syndromic management of STIs. Members mentioned that the success of DOTS in TB has strengthened the case for syndromic management in STI as they feel it is important to treat STI regardless of the system of medicine practiced by the HCP. Members suggested coming together of councils of different systems of medicine to form a policy for dispensing STI drugs. Members felt that amendment at the policy level would enable training of non-allopathic HCP who are preferred over the allopathic HCP by certain groups such as Hijras. As an instance, members cited that DAI Welfare society in Mumbai, had agreed to provide training to non-allopathic HCP in syndromic management of STIs.

Citing the example of Corticosteroid use in Agra exceeding the usage in UK, as a whole, members drew attention to the risks associated with indiscriminate use of steroid and drugs, without training, by non-allopathic HCP. Members cautioned that if law certifies non-allopathic HCP for one treatment they would play havoc, as it was not merely a question of treatment but of correct diagnosis as well.

Members referring to patients right to quality care including access to STI treatment and emphasised that health education must be provided to these patients and they can be seen in routine OPD by medical officers with referral to Dermatology and Venereal diseases specialists where needed. Members quoted examples of Humsafar Trust and PSI , which train and update private medical practitioners on use of syndromic management for treating STIs. Additionally

members suggested that all district hospital, CHC and PHC should separately stock drugs for syndromic management and provide it free of cost to all patients. They suggested government encouraging medical institutes to increase seats and include short-term courses in medicine for traditional medicine healers and citied how providing free sterilized blades to trained village dais helped to bring down infant mortality rates.

Members underlined the increased risk of HIV in people suffering from STI, pointing toward the utility of training non-allopathic HCP in syndromic management of STI to minimize the impact of HIV. At the same time, a member mentioned the new Maharashtra legislation, which works against the non-allopathic HCP and questioned the feasibility of training non-allopathic HCP, referring to them as quacks. They expressed that NACP III has not looked into the role of non-allopathic HCP in syndromic management of STI.

Since over 90% of STI patients seek treatment from the private sector, and that too from non-allopathic HCP, members pointed towards a need for an amendment in the law to allow prescription of STI drugs by the non-allopathic HCP. At the same time, they emphasised the need to regulate non-allopath treating STI patients and having quality health care services available through public health systems including free drugs for STI.

Comparative Experiences

DAI Welfare Society *(From Laxminarayan Tripathi)*
In 2004, this CBO by and for the Hijra community, started working with Family Health International on a targeted intervention project with the objective of orienting the preferred private health care providers and identify and train other health care providers. It found Hijras accessed treatment for STI from Non-Allopathic providers who they preferred over Allopathic ones, as the latter were not sensitive to their needs. In addition, the need for covering Hijras in other geographical areas makes it necessary to train non-allopathic practitioners in syndromic STI Management.

Key Clinic Network *(From Amit Bhanot)*
PSI with assistance from IntraHealth International is working for decreasing the prevalence of curable STIs among men as part of Avahan initiative of Bill and Melinda Gates Foundation. The project has set up a network of MBBS doctors, promotes as Key Clinic Network, and regularly updates and trains them on Syndromic Management of male STIs.

Humsafar Trust *(From Ashok Row Kavi)*
Humsafar Trust has found it difficult to motivate private medical practitioners (PMP) to work with MSM and Hijras even when it arranged free training and IEC material on syndromic management of STIs. To overcome this, they conducted private visits and campaigns based on sending clients from the nearest sex sites to select interested PMP who agree to open dispensaries for some extra time to make some more money.

Related Resources

Recommended Documents

Effective STI care in Mumbai, India for HIV/AIDS prevention (*From Shankar Talwar, Action research Center, Mumbai)*
Talwar S, Int Conf AIDS 2004 Jul 11-16; 15:(abstract no. C10198)
http://www.aegis.com/conferences/iac/2004/C10198.html

Examines different programmatic issues pertaining to STI care in Mumbai including STI care infrastructure, care-seeking behaviour, and the quality of care.

Rural Indian Women's Care-seeking Behavior and Choice of Provider for Gynaecological Symptoms *(From Dr. Aseem Mishra, Vijyanagar Institute of Medical Sciences, Karnataka)*
Manju Rani ,Sekhar Bonu, Studies in Family Planning, September 2003, Vol. 34, No. 3
Abstract viewable at: http://www.popcouncil.org/publications/sfp/sfpabs/sfpabs343.html
Paid Subscription required for the full study:
http://www.popcouncil.org/publications/sfp/sfpsubs.html

Study shows that 70% of rural women sought care from private providers for STI symptoms, pointing towards a need to train private providers.

Management of Sexually Transmitted infection *(From Dr. E. Mohamed Rafique, Moderator)*
World Health Organisation, New Delhi, 2001
http://whqlibdoc.who.int/searo/2001/SEA_STD_42.pdf *(Size: 148 KB)*

Details that large majority of STI patients seek care from the private sector and so this sector should be considered as an equal partner in the national STI programme.

From Seema Kochhar, Research Associate

Reproductive Tract Infections
Reproduced from the PATH website at www.path.org. Year 2006.
http://www.rho.org/html/rtis_keyissues.htm

Summarizes major research areas related to prevention and control of RTIs, particularly in low-resource settings including involving private sector in STI control

Control of Sexually Transmitted Diseases: A Handbook for the Design and Management of Programs
Dallabetta, G.A., Laga, M., and Lamptey, P.R. (Eds), Family Health International, (1996).
Available at Family Health International. Contact: aidspubs@fhi.org

Provides a comprehensive account of STI management, prevention, and addresses issues related to curative and preventive services that STI managers should take into account.

Current status of syndromic management of sexually transmitted infections in developing countries
Vuylsteke, B,Sex Transm Infect 2004 80: 333-334
http://sti.bmjjournals.com/cgi/content/full/80/5/333
Proves how syndromic approach offers enormous advantages over clinical diagnosis and laboratory diagnosis and has helped in rationalizing and improving STI management.

Recommended Organisations

Intrahealth and PSI Avahan Program, New Delhi (From Davidson Solomon and Amit Bhanot)
http://www.intrah.org/index.php?option=com_content&task=view&id=100&Itemid=135
PSI/New Delhi, The Gates Office, 7/16 Nehru Enclave, Kalkaji Extension, New Delhi 110 019 India
Phone: 011-91-11-516-29-370/1/2 Fax: 011-91-11-5162-9373

A network of trained doctors on syndromic management of male STI through Key Clinic Network in Andhra Pradesh, Karnataka, Tamil Nadu and Maharashtra

Dr. Davidson S. Solomon, SHADOWS, Chirala

1) Licensing of Non-Allopathic Health Care Providers (HCP) for using Allopathic Medicines in Syndromic Management is in the hands of the law makers. As treatment of STI has to be completed once the patient arrives at whatever HCP the patient chooses, many organizations have chosen to train HCP regardless of the system of medicine practiced by them. This in a way makes good sense and has been advocated by WHO as stated in your query. The web page of IntraHealth and PSI at http://www.intrah.org/index.php?option=com_content&task=view&id=100&Itemid=152 shows the picture of a Key Clinic of PSI in the state of Karnataka. In many places of our country like in Karnataka and Andhra Pradesh there are only Non-Allopathic practitioners available. Statistics of STIs treated in the Key Clinics can be got from PSI India offices and the STI treatment achievements of Operation Lighthouse can be seen in the web pages of PSI and USAID.

2) Recommendations made by NACP III Planning team are yet to see the light of day.

3) Law makers and Academicians should work together to exempt STI Syndromic drugs and the faster it is done, the quicker it will pave for more treatment of STI cases.

Joy Abraham, Center For Development Initiatives (CDI), Mumbai.

Center For Development Initiatives (CDI) aims at improving the health and well being of people who have limited or no access to health information and services. CDI focuses on the Sexual and Reproductive Health of people and communities in disadvantaged and marginalized positions of society, particularly those vulnerable to HIV, STI and RTI, and People who lack access to high quality sexual and reproductive health services. Therefore, the issues on treating STI that is raised is very important, yet difficult for many of us to put a response in writing. However, here is my attempt.

1) While most of the NGOs and implementing agencies in Mumbai, Thane and Navi Mumbai have now changed over to Allopathic practitioners, I am sure there are still places in this mega city where unlicensed Non-Allopathic Care providers employed under the various AIDS projects are prescribing or dispensing scheduled antibiotics for treating STIs.

2) We are looking forward to see if this is reflected in the new policy of our National AIDS Control program. For a surety I know this was not discussed in this list before.

3) I think that the various Councils of the different systems of Medicine should come together and form a policy for dispensing of STI as well as drugs for other diseases that are becoming a scourge.

Laxminarayan Tripathi, President, DAI Welfare Society, Mumbai

Well I am sorry to have taken such a long time to write to you all after joining the AIDS Community of Solution Exchange. My organization is DAI Welfare Society, a CBO which is one of its own kind in whole of South East Asia. DAI Welfare Society is a CBO of, for and by the Hijra community. The Hijras are the only community which has been persistent in India since ages. Though the most visible sexual minority community, it is ignored by all.

Now for Sreejit's questions:
1. How do NGOs and implementing agencies presently answer the question of unlicensed Non-Allopathic Care providers prescribing or dispensing scheduled antibiotics?
For this one, I will have to go back a little in time... . By the end of 1999 a lot of Hijras started dying of AIDS setting off a panic in the community. At that time DAI approached the Mumbai District Aids Control Society (MDACS) and was given a grant for an Intervention mainly on prevention and awareness among the community. The Hijras as was their practice continued to access treatment for STI from Non-Allopathic providers whom they preferred over the Allopathic ones as the latter was not sensitive to the Hijras. Since 1999 Dai has been working on HIV and AIDS related issues in Mumbai. In 2004 DAI Welfare Society also started working with Family Health International (FHI) on a Targeted intervention called 'Aastha' Project under the Bill Melinda Gates Foundation's (BMGF) 'Avahaan' Project for Mumbai that focused mainly on HIV prevention through STI Management.

One of the objectives in the 2004 'Aastha' project was to **orient the preferred private Health Care Providers**: We had agreed that an assessment would be done to find out the preferred health care providers, who are providing sexual health services to the Hijra community. These health care providers will be invited to a two day orientation workshop where the project details will be shared and their knowledge updated on STI management. It was envisaged that at least six health care providers will participate in the orientation workshop that will be facilitated by FHI, Family Planning Association of India (FPAI) and DAI.

Another objective in the same project was **to identify and train other Health Care Providers**: Under this other Health Care Providers who are empathetic to Hijras would be identified and invited to the common trainings being planned under the FHI programs.
The point here is that such objectives had to be framed keeping in mind the existing scenario. We all know that the mainstream society in India does not accept Hijras, who are often, objects of ridicule, mockery and exploitation. The social and cultural practice of exploitation with discrimination coupled with poverty illiteracy and limited opportunities of employment have forced the community onto a path of high-risk behaviour. The combination of high-risk behaviour with limited prevention alternatives has resulted in increased vulnerability of Hijras to HIV/AIDS and STI infections. Discrimination by the society included Health Care Practitioners and so Hijras preferred to be treated by those Health Care providers who were till the end of 2004 not Allopathic. Even after securing the services of an Allopathic Practitioner sensitized to the community and who was comfortable working with Hijras, the need for covering those Hijras in other geographic areas was felt, as envisaged in the second objective that was quoted.

2. What is being done at the policy level to enable Non-Allopathic Care providers to prescribe or dispense antibiotics for STI? Has NACP-III looked into these facets of STI Cure?
Not much has been done. In fact this has not been discussed in any conference, that I have attended. There is a definite need to amend existing policies in the light of our community's experiences. The Gender, Service Delivery and TI Working Group of NACP III should look into these facets of STI Cure.

I agree with Sreejit when he says that as a Trainer he is faced with a dilemma. Needless to say only if existing policies are amended, can Non-Allopathic Doctors be freely trained to treat those Hijras who prefer them over the Allopath.

3) What do members feel should be done at the policy level to help programs like Syndromic Management to cross these licensing hurdles?
DAI has faced a lot of hurdles to enable Non-Allopathic Care providers to prescribe or dispense antibiotics for STI. Though Non-Allopathic Care providers are well accepted by the Hijras, our evaluators has never been happy with them. Efforts to train them in Syndromic Management has not been successful either. In the light of these experiences it is felt that our supporters namely FHI, FPAI, MDACS, Avert Society and BMGF should join hands to influence the policy makers. if this is done DAI stands to benefit as Hijras generally prefer Non-Allopathic Doctors who are more sensitive to them. Also Allopathic Doctors cannot cover the whole dispersed Hijra populations in the metros of Mumbai, Thane and Navi Mumbai.

Lastly I would like to know what was the experience in other developing countries where they have Non-Allopathic Doctors. I am sure that would help.

Dr. Ravishwar Sinha, USAID-MOST, New Delhi.

You have posed a very pertinent and important question.

Need and inequality fuelled by poverty - the question becomes all the more relevant for the developing world. The fact is that these drugs are given by non-doctors. Now the question that begs to be answered is it right versus practicality. I would have my reservations about allowing legally the prescription of any drug without training. I have in my clinical practice seen numerous complications and loss of life due to the giving of drugs without proper training. Let's take Corticosteroids for example. I remember reading an article some years ago that the consumption of corticosteroids in Agra division was in excess of the consumption of corticosteroids in the whole of UK. We know well the complications and the masking that the use of corticosteroids does. Similarly, in STI or AIDS Case management it would be risky to use steroids or drugs indiscriminately, without training, as there is all the chance that low dosage, inadequate dosage that would cause more harm than good. Moreover, the AIDS patient is a potentially resource-starved person and is likely to take the cheapest treatment.

I think and agree with you that the challenge lies in team forming, with adequate training and supervision mechanism built in, for the health service providers along with a technically well-trained supervisor and medical personnel, as is practical in the field situation. All patients have a right to quality care, which is a continuing challenge for the health service providers and all strategies must aim for this quality. Therefore, policies made must ensure that these rights are respected while at the same time provision for access to STI or AIDS treatment be made.

I look forward to the comments and suggestions that come forth.

Dr. Chandrakant Lahariya, Lady Hardinge Medical College, New Delhi.

Your query is very pertinent to the Indian scenario. Most of the care providers for any problem related to sexual and genital health issues are Non-Allopathic, rather Non-Medical like Hakeems, Vaidya or Shafakhana wala and most of them haven't got any formal training in Medicine but are

just Traditional Healers. So calling them Non-Allopathic would be an insult to trained HCPs in Indian System of Medicine (ISM).

Being a public health person, I wouldn't recommend that any Chemist, Pharmacist, Nurse or Traditional Healer should be allowed to prescribe antibiotics. Even though, here in the case of STD/RTI, I understand the issue is a bit different. We have to understand why people go to these healers? The answer is known to all who have worked at the community level. At First, the patients believe that hospital treatment is inaccessible and costly. Second, though there are special clinics in the public hospitals which are not crowded at all, there is stigma attached with them. This puts off patients who don't want to go to such places and prefer to visit a HCP in a dinghy area.

My experience is that patients suffering from RTI and STI are common in General OPDs although lesser in number. Its only at the late stage of such disease that patients report to a health facility. After a long wait, usually drugs are not available for STD management in most Government hospitals. Doxycycline, Ciprofloxacin, Metronidazole and Candid pressaries cost a fortune for these patients. Moreover as both partners need to be treated in most cases the cost further goes up. That's why the patient goes to untrained HCPs who gives unknown drugs, even corticosteroids, which are cheap but provides immediate symptomatic relief. Danger of this treatment is not known to the poor and ignorant patients. If such HCPs are certified for one treatment then they will play havoc as its not a question of treatment only, but also one of correct diagnosis of the illness which should also be made. Diagnosis is not possible with only a short training in all the cases.

In my opinion, the solution is health education on the line of TB, Hansen's Disease (Leprosy) etc. These patients must be seen in routine OPDs by Medical Officers and where ever Dermatology and VD specialists are available the deserving patients may be referred to them from all the Government health facilities. This will remove the stigma attached with the illness.

To address the second issue, drugs for such illnesses should be provided free of cost to all such patients and there should be a separate stock of drugs for Syndromic Management, which should not be utilized under any other heading. All health facilities including District Hospitals, CHC and PHC should have these drugs under essential medicine supply. Health education and IEC campaigns regarding information to the people that treatment of STD/RTI are available free of cost at all Government health facilities should be widely publicized.

I am looking forward to the opinions and solutions suggested by others also.

Dr. Amit Bhanot, PSI Avahan program, New Delhi.

This is in response to Dr Solomon's posting on this exchange, which is appended. We would just like to clarify that PSI with assistance from IntraHealth International is working for decreasing the prevalence of curable STIs among men as part of India AIDS Initiative Avahan program funded through the Bill and Melinda Gates Foundation.

Our role is in setting up a network of MBBS doctors practicing Allopathic Medicine and updating them on the latest STI management protocols in the Syndromic Management of male STIs as advocated by WHO and NACO. The network is being promoted as Key Clinic Network (KCN) in the four project states of Andhra Pradesh, Karnataka, Tamil Nadu and Maharashtra.

Our teams map out the Allopathic Health Care Providers currently treating male STI patients in identified high risk areas based on commercial sex activity. If these Allopathic providers meet the criteria set out by the project, then further discussions are carried out with KCN doctors through workshops and in clinic meetings by support visits incorporating the best practices in performance improvement.

Of course, with respect to the original query by Dr. Sreejit, we would be highly interested in the work carried out by agencies in involving Non-Allopathic care providers in STI management and also the recommendations by NACP III regarding the same.

Shankar Talwar, Action Research Centre, Mumbai

Please find appended a paper available at http://wwwaegis.com/conferences/iac/2004/C10198.html presented by me at the 15th International AIDS Conference in Bangkok, Thailand - July 11-16, 2004. The recommendations made there in are so relevant to the query raised by you, were well accepted by the Conference delegates as well as by AEGiS and International AIDS Society. However, in our own land there is more shyness than acknowledgement that we are training Non-Allopathic Care providers for treating STIs. Should we not practice what we preach? Or if we practice it why not be open?

Effective STI care in Mumbai, India for HIV/AIDS prevention.
Int Conf AIDS 2004 Jul 11-16; 15:(abstract no. C10198)
Talwar S
Action Research Centre, Thane, India

ISSUES: Effective STI control programs have helped minimize the impact of HIV/AIDS around the World. However, in some resource poor situations, such efforts have not been possible for reasons, such as, poor health infrastructure, difficulty in reaching out large number of high-risk individuals, and poor quality of care. Further, programs have suffered due to lack of knowledge about how different high-risk groups seek care for such infections.

DESCRIPTION: This paper examines different programmatic issues pertaining to STI care in Mumbai, which is considered the epicentre of HIV/AIDS in India. Based on the situational analysis, a cross-sectional view of STI care infrastructure, care-seeking behaviour, and the quality of care is presented in this paper.

LESSONS LEARNED: A few big teaching hospitals in Mumbai have become de-facto government STI care centers. However, more than 80% STI patients are known to seek care from private providers for reasons, such as, easy accessibility, familiarity, and low consulting fees. On the other hand, lack of privacy and drugs are some of the barriers for seeking care in government hospitals. Two successive surveys indicated that health care providers were using poorly standardized STI case management. More than half of the providers were not giving drugs recommended by WHO/NACO. On the positive side, majority providers were interested in undergoing training on syndromic management of STIs.

RECOMMENDATIONS: Strengthening community based government health centers in the city would have greater positive impact on STI/HIV prevention. All the non-allopathic and non-qualified providers need to be provided with further training on syndromic management of STIs. Government STI/HIV prevention programs should involve private providers to have wider impact. Involving NGOs in organizing training of private providers would help reduce the gulf between the private and public health initiatives in STI/HIV prevention.

Keywords: AEGIS, Acquired Immunodeficiency Syndrome, HIV Seropositivity, HIV Infections, Infection, India, Health Services Needs and Demand, Health Personnel, Private Sector, Public Health, Humans, prevention & control, economics

Dr. Aseem Mishra, Vijayanagar Institute of Medical Sciences, Karnataka.

One of the studies at http://www.popcouncil.org/publications/sfp/sfpabs/sfpabs343. html which is appended, shows that 70% of rural women sought care from Private providers for STI symptoms. So the rationale of training private providers is only logical. We all know that in rural areas Allopathic Care providers are hard to come by. This combined with the fact that the presence of STI provides the portal for entry of HIV escalates the importance of training Non-Allopathic Care providers for STI treatment as overriding.

Rural Indian Women's Care-seeking Behavior and Choice of Provider for Gynecological Symptoms

Manju Rani is Director, Social Welfare Department, Indian Administrative Services, Government of Rajasthan, India. E-mail: manju_rani@hotmail.com. Sekhar Bonu is Special Secretary (Medical and Health), Government of Rajasthan, India.

This study uses data from the India National Family and Health Survey–2 conducted in 1998–99 to investigate the level and correlates of care-seeking and choice of provider for gynaecological symptoms among currently married women in rural India. Of the symptomatic women surveyed, 31 percent sought care, overwhelmingly from private providers (70 percent). Only 8 percent of women consulted frontline paramedical health workers. Care-seeking behaviour and type of providers consulted varied significantly across different Indian states. Significant differentials in care-seeking by age, caste, religion, education, household wealth, and women's autonomy suggest the existence of multiple cultural, economic, and demand-side barriers to care-seeking. Although socially disadvantaged women were less likely than better-off women to consult private providers, the majority of even the poorest, uneducated, and lower-caste women consulted private providers. Geographical access to public health facilities had no significant association with choice of provider, whereas access to private providers had only a moderately significant association with that choice. The predominance of use of private services for self-perceived gynaecological morbidity warrants the inclusion of private providers in the national reproductive health strategy to enhance its effectiveness. (Studies in Family Planning 2003; 34[3]: 173–185)

Ashok Row Kavi, Humsafar Trust, Mumbai Metro

Excellent paper by Shankar Talwar. It was badly needed to have a frank exposition of what the poor are facing. Whereas on one hand we are talking of "medical tourism" to attract the American dollars from patients in the West wanting first-class treatment, in India itself we are throwing our people into the arms of the Non-Allopathic Medical Practitioners - to the wolves literally! We all know how the rich and powerful rush abroad for "medical treatment" whereas we seem to be abdicating our responsibility to the poor of India. I'm really depressed by the way the poor are made to compromise and take anything on offer whereas the rich get the best treatment money can buy. At least this is what Shankar Talwar's paper seems to say. It's not just shame I feel but utter helplessness and anger that our sick and dying must lie by the wayside, whereas the Western medical "tourists" get treated like Maharajas. Should we allow this? I ask the Indian educated political class.

Though Shankar's paper reflects the exact situation on the ground level, we must seriously ponder as to how to change the situation. As an NGO working with marginalized MSM and MSWs, we discovered that Private Medical Practitioners (PMP) are only interested in extra income and how to increase it. We had done mapping of PMP through Dr. Athar Quereshi who worked briefly for us in 2003 and 2004. We called in those who were interested in working with MSM and Hijras. Very few turned up even though we were willing to give free training and IEC material on Syndromic Management of STIs. The response was very poor despite our best efforts. Now we have tried private visits and campaigns based on sending clients from the nearest sex sites to select interested PMPs who would keep their dispensaries open for some extra time and make some more money. This seems to impress the PMP who then agrees.

Altruistic reasons for STI treatment are too far-fetched for words. How are we going to even collect information on these Non-Allopathic care providers? There are all kinds starting with "chetkins" (witches) to "jadi-boothi-wallahs" on the roadside who promise eternal erections with iguana-oil and "kabuliwallahs" using strange powders. The new Maharashtra legislation against "magic medicine" is set to attack all placebo-based Non-Allopathic care givers from Indic-based religions whereas quackery abounds in and around other religious places of worship. All one has to do is visit the Annual Fair at Bandra to see the horrendous wax models of body parts and even human babies promised in return for prayers at the altar.

I am puzzled as to how we are going to train diploma-holders of traditional Unani and Ayurvedic healers who are more trained in quackery like treating the "Daath complex" and the "leakage of sperm during wet dreams". Total nonsense goes under such treatments where whole cups of ghee and rice starch soups are offered to "thicken sperm and increase fertility". I did a huge article on it in Free Press Journal in the early 1980s which I cannot trace now.

Why is the government not forcing medical institutes to increase seats and short-term courses in medicine for traditional medicine healers. During the Janata Government, just offering sterilized blades to cut the umbilical cords of new-borns, given to trained village dais, cut death rates by half during delivery. We need care givers from slum populations to be trained to offer care for small sums in return. Thus old widows can earn say Rs. 10 plus a meal, per shift to look after sick people covering dysentery and vomiting, taking temperatures correctly, give re-hydration treatment and know when to call the doctors, for example. I have an old mother of eighty who needs 24-hours care after a cerebral stroke and have trained a needy woman on how to look after her. She earns Rs. 100 per day which takes a huge slice of my salary. Surely, more such trained people in the market may mean jobs for many. Rs. 3,000 per month is a good salary for any poor person in India.

Dr. E. Mohamed Rafique, UNAIDS, New Delhi

In an attempt to answer your query, which has a lot of background to it I feel a need to set things in perspective .So...

Syndromic Management of STI

All of us have learnt of the epidemiological synergy between STI and HIV. We are also agreed that the control of STI leads to control and prevention of HIV transmission. Therefore, diagnosis of STIs at the very onset and prompt treatment is the most important strategy not only for effective prevention of STI but also HIV. Management of STIs through Syndromic Approach using algorithms can play a crucial role to stop STI transmission. Moreover, it is cost effective in resource poor settings and has the advantage of avoiding the need to wait for the laboratory test results; thereby enhancing compliance to treatment and overall cure rate.

Why Syndromic does not sell with Allopathy
The concepts of Syndromic Management are difficult for Allopathic Doctors to buy into as it goes against the grain of what they have been taught. After being trained for nearly a decade in both Medicine and Venereology to follow rigorously the steps of patient history, clinical examination, lab and other investigations followed by diagnosis and only then treatment, it took Dr. Johannes Van Dam and team including Dr. L. K. Bhutani the best part of five workshop days to convince - that too only some of us - on the Syndromic concept during the early 90s National Consultations.

The Private Allopathic sector
The importance of the private sector is highlighted with the official estimate that only 5–10% of patients across all economic classes with STIs present to public sector care. (http://sti.bmjjournals.com/cgi/content/full/77/5/393 National AIDS Control Organization. Country scenario 1997–98. New Delhi: Ministry of Health and Family Welfare, 1998.) Most of the services are curative and the private sector is rarely involved in prevention of illness, so much so, that even after nearly ten years of our initial training the report http://whqlibdoc.who.int/searo/2001/SEA_STD_42.pdf of an Inter-country Workshop at Yangon, Myanmar, 16-20 July 2001, with Dr. L. K. Bhutani as a facilitator shows as its first recommendation the following: "As a large majority of STI patients seek care from the private sector, this sector has an important role to play in STI prevention and control and should be considered as an equal partner in the national STI programme."

The Private Non-Allopathic sector
This sector in India has enjoyed almost nil licensing procedures which in turn has blurred the distinction in the eyes of those who seek STI treatment between qualified Non-Allopathic Health Care Practitioners (HCP) including BAMS, BHMS; and the other practitioners of Indian or Indigenous Systems of Medicine without any qualification.

The Private unqualified sector
These are the quacks who are unqualified in any system of Medicine. They make up for their lack in clinical acumen with good communication skills and the best of bedside manners.
The tendency of reduced bedside manners with increasing qualification has been the bane of most Allopathic Doctors. Patients therefore feel at ease with a pleasantly behaved though unqualified practitioner than a judgmental but qualified Allopathic practitioner. It is to this sector that most STI patients report.

The NGO sector
In the not-for-profit NGO sector there is a predominance of NGO activity in the delivery of interventions in the field of reproductive health in general, and HIV and AIDS in particular. The programmes initiated by NGOs tend to have a greater degree of flexibility and more opportunities for innovation than can be provided in the public sector. Many NGOs have had to use trained Health Care Workers or Non-Allopathic Practitioners for treatment of STIs in their projects, mostly due to lack of availability of Allopathic Practitioners. One constraint that I have often seen is the low salaries paid to Allopathic Practitioners in the project-owned clinics.

The Market dynamics
One reason for Allopathic practitioners opposing Syndromic management which I also initially felt when I was being trained in Syndromic Management was the fear of loosing the few, hard-to-come-by STI patients to the Non-Allopath. We then feared that by training Non-Allopaths in Syndromic Management and equipping them to treat STIs would drive patients away from experts like us to them. It took a long time for the likes of Dr. Van Dam and Dr. Salil then Joint Director in NACO to convince us that the patients we feared loosing were already lost to us.

The Challenge of Scheduled Drugs
Allopathic Drugs used in Syndromic management of STI are Scheduled Drugs. The Law is clear that prescription of these should be by Allopathic Doctors only. Given the emergency of controlling HIV transmission the proponents of Syndromic Management have often argued that there is a definite need for an exception or amendment of this law to be passed. For example in meetings of the partners of BMGF with the Health Secretary this was discussed.

A precedent?
The success of DOTS in TB has strengthened the case for Syndromic Management in STI. DOTS also uses Scheduled drugs and the strategy is the drugs are given by Health Care Workers and other supporters. However, the difference is the diagnosis is established in DOTS by Allopaths and may not be so in STI. Some NGOs from the PSH Projects in Kerala where I worked, reimburse unqualified Health Care practitioners at Allopathic practitioner's rates if they refer STI Cases to them for first time diagnosis to ensure Syndromic Management.

The Way forward
- Given the absolute need to curb transmission of HIV through the portals of STI, the Syndromic approach to STI is required.
- As over 90% of STI patients seek treatment from the private sector and that too from unqualified Non-Allopaths it is only logical that this group be trained.
- At the same time there is a need to regulate Non-Allopaths to treat STI with continuing education and supervision which is easier said than done.

To make all this feasible it seems logical to amend existing laws on prescribing scheduled STI drugs. Till then reimbursement of unqualified Practitioners for cases referred seems to be a via-media approach.

Many thanks to all who contributed to this query!

*If you have further information to share on this topic, please send it to Solution Exchange for the AIDS Community in India at aids-se@solutionexchange-un.net.in with the subject heading '**Query: Non-Allopathic Care providers for STI, from London School of Tropical Medicine, (Experiences/Advice)***

Disclaimer: *In posting messages or incorporating these messages into synthesized responses, the UN accepts no responsibility for their veracity or authenticity. Members intending to use or transmit the information contained in these messages should be aware that they are relying on their own judgment.*

Copyrighted under Creative Commons License "Attribution-NonCommercial-ShareAlike 2.5". Re-users of this material must cite as their source Solution Exchange as well as the item's recommender, if relevant, and must share any derivative work with the Solution Exchange Community.

Solution Exchange is a UN initiative for development practitioners in India. For more information please visit www.solutionexchange-un.net.in