MEDICAL PLURALISM IN INDIA AND AYUSH: A REVIEW

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ABSTRACT

The Indian medical domain has been described as "an eclectic 'non-system' of knowledge and practices deriving from the continuous interplay of indigenous and introduced traditions". Not withstanding this continuous interplay, since Independence, policymakers and other health system actors have attempted to, and largely succeeded in developing a discrete architecture privileging allopathic medicine over other systems. Most recently, however attempts have been made at combining the strengths of practitioners from Traditional, Complementary and Alternative Medicine (TCAM) systems of medicine under a coherent policy framework popularly known as AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpa and Homoeopathy), particularly in the movement towards Universal Health Coverage in India. The paper attempts to understand in detail how this political will developed an integrated model of healthcare where the traditional and conventional medicine has evolved into a complimentary structure. The paper presents a detailed review on Indian healthcare system and the existence of medical pluralism tracing its linkages and outcomes in the creation of National AYUSH policy.

INTRODUCTION

The Indian medical domain has been described as "an eclectic 'non-system' of knowledge and practices deriving from the continuous interplay of indigenous and introduced traditions".[14] Not withstanding this continuous interplay, since Independence, policymakers and other health system actors have attempted to-and largely succeeded in developing a discrete architecture privileging allopathic medicine over other systems. Most recently, however, attempts have been made at combining the strengths of practitioners from Traditional, Complementary and Alternative Medicine (TCAM) systems of medicine under a coherent policy framework popularly known as AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpa and Homoeopathy), particularly in the movement towards Universal Health Coverage in India.

The 1978 Alma Ata declaration called for traditional medicine treatments and practices to be "preserved, promoted and communicated widely and appropriately based on the circumstances in each country." Thirty years later, the 2008 Beijing Declaration on Traditional Medicine called for the integration of providers into national health systems, recommending systems of qualification, accreditation, regulation and communication (with allopathic providers).[37] These features of the Beijing Declaration were echoed at the 62nd World Health Assembly in 2009, putting out a call to action to United Nations member states to move forward with their plans for integration.[34] The global positioning of Traditional, Complementary and Alternative Medicine (TCAM) has issued from and tends to imply a central focus on clinical and experimental medicine[4], yet recent calls for health systems integration draw attention to features such as education, accreditation, regulation and health services provision, and the TCAM health workforce itself.

In study by Sheikh and Nambier (2011),[28,29] identified three broad trends of integration as it relates to TCA providers: self-regulation with governmental linkage, government regulation and provisioning, and hybrid/parallel models. This links roughly to the WHO parameters,

where three models are identified: 'tolerant' systems, where the national healthcare system is based entirely on biomedicine but some Traditional, Complementary and Alternative Medicine (TCAM) practices are legally permissible; 'inclusive' systems, where TCAM is recognized but not fully integrated into all aspects of healthcare; and 'integrative systems,' where TCAM is officially recognized in national drug policy, providers and products are registered and regulated, therapies are widely available and covered under insurance schemes, and research and education are widely accessible.[16]

The situation on the ground in India, hybrid in view, seems in parts to reflect tendencies across the WHO categories. The dominance of biomedicine appears to be a critical feature of India's postcolonial health system, even as pre-independence the Traditional, Complementary and Alternative Medicine (TCAM) practitioner community had played a major role in resisting colonial domination in the practice of (bio)medicine.[26] In part as a response to the reliance on allopathy throughout modern Indian history, there have been strong arguments in favour of the critical role that non-mainstream practitioners play in offering accessible, affordable and socially acceptable health services to populations.[10,11,37,38] A study in Maharashtra reported that the situation of traditional healing as a community function through shared explanatory frameworks across provider and patient is explicitly unlike typical doctor–patient relationships.[15]

India, ventured into a larger integrative framework, one that mandates the 'mainstreaming' of codified (Traditional, Complementary and Alternative Medicine) TCAM in India, collectively referred to as AYUSH, an acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpa and Homoeopathy. The National Rural Health Mission (NRHM), launched in 2005 to fortify public health in rural India, took particular interest in integrating AYUSH practitioners through facilitation of specialised AYUSH practice, integration of AYUSH practitioners in national health programmes, incorporation of AYUSH modalities in primary healthcare, strengthening the governance of AYUSH practice, support for AYUSH education, establishment of laboratories and research facilities for AYUSH, and providing infrastructural support.[6] Human resource-focused strategies included the contractual appointment of AYUSH doctors in Community and Primary Health Centres (PHCs), appointment of paramedics, compounders, data assistants and managers to support AYUSH

practice; establishment of specialised therapy centres for AYUSH providers; inclusion of AYUSH doctors in national disease control programmes; and incorporation of AYUSH drugs into community health workers' primary healthcare kits. A recent report from the AYUSH department states that NRHM has established AYUSH facilities in co-location with health facilities in many Indian states (most notably not in Kerala, where the stand-alone AYUSH facility is the chosen norm).[5] As of 2012, more than three quarters of India's district hospitals, over half of its Community Health Centres and over a third of India's Primary Health Centres (PHCs) have AYUSH co-location, serving about 1.77 million, 3.3 million and 100 000 rural Indians, respectively.[5]

Yet even this integration framework has at most an 'inclusive' character. This is reflected in findings such as 'official neglect' of traditional orthopaedic practitioners who have no registration, uniformity in interstate regulation, or institutionalised medical training.[32] AYUSH doctors contracted to Medical Officer posts in PHCs in the southern Indian state of Andhra Pradesh report numerous lacunae in the implementation of the mainstreaming initiatives in the NRHM: job perquisites are not indicated; no benefits or allowances are provided for health, housing or education, and compensation packages are much lower than those of allopathic doctors. Support for AYUSH practice is also inadequate (lack of infrastructure, trained assistants and drug supply) and unethical practices have also been reported (documenting attendance of absentees, and non-cooperation from non-AYUSH personnel).[13] Evidence from NRHM suggests that reshuffled AYUSH providers practice forms of medicine beyond the scope of their training.[24] Paradoxically, moreover, some Indian states prohibit cross-system prescription, adding ethical dilemmas for TCA practitioners who serve as the only medical practitioners in resource-poor areas.[24]

On a larger scale, current practices of integration (as in NRHM) have been described as substitution and replacement; which tend to ignore the merits of (Traditional, Complementary and Alternative Medicine) TCAM and present more barriers than facilitators of integration.[10,11] In particular, given the strong push towards co-location and other strategies of integration as part of India's move towards Universal Health Coverage, the integration of AYUSH practitioners could result in a doubling of the health workforce. Yet there are strong fears that such an emphasis on quantitative aspects of integration, that is, having the right

number of practitioners placed at facilities, is inadequate. There is a need to critically and qualitatively appraise the government infrastructure to support TCAM, identify barriers and facilitators to integration that have emerged from this rapid placement of these practitioners, and how these TCAM practitioners, allopathic practitioners and health system actors are reacting and adapting to each factor; the objective the present research adheres to.

India has over the last two centuries imbibed modern medicine and biomedical science to global standards. Indian systems of medicines like Ayurveda, Yoga are the rich heritage and strong holds of the country. Country has the advantage of contribution of these systems in the public health for past thousands of years, and also has the specialty to integrate this ancient wisdom with modern science and technology to develop novel approach for promotion of health, prevention of diseases, mother and child health as well as effective management of commonly encountered disease in primary health care, non communicable diseases, over all physical and mental wellbeing and longevity. Unfortunately, AYUSH systems have suffered State neglect for almost 200 years and even post-independence they occupy a marginal space in India's public health system. This neglect also resulted in so called research stagnancy as per conventionally accepted methodology and standards. This situation must be changed. Revitalizing the AYUSH sector with its rich repository of knowledge and practices can make India a global leader in "integrative healthcare in the 21st century". Integrative healthcare must respect the indigenous knowledge embodied in parent disciplines. It certainly does not suggest diluting the sophisticated, theoretical foundation, knowledge and practices of Indian Knowledge Systems. It implies epistemologically informed and equitable relationships with modern sciences and technology.[18]

Medical Pluralism in India

Healthcare in India presents a complex scenario that is shaped significantly by colonial and post-colonial history and politics, and is enhanced by a vibrating and thriving medical pluralism. The global trends in health seeking behaviour of citizens provide enough evidence of pluralistic choices being exercised for fulfilling different health needs. The era of integrative medicine and healthcare appears to have commenced. Politicians, policy makers, medical institutions and the education sector need to recognize this reality of "Integrative healthcare in the 21st century". India has adopted the approach of pluralistic system medicine with western medical system commonly known as allopathy, and AYUSH systems being the recognized systems of medicine. The AYUSH system incorporates Ayurveda, Unani, Siddha, Sowa Rigpa, Homeopathy along with Yoga and naturopathy as the drugless therapies. A few decades from now, single knowledge system based medical hospitals, clinics and even medical colleges, will become relics and even AYUSH systems will not be any exception. The best way ahead seems to be for AYUSH systems and modern medicine to collaborate on sound footing of scientific evidence base, in the best interest of public health. Strengthening AYUSH sector in education, research, services, industry and public health is critical to prepare the country for its journey towards integrative healthcare.[18]

In addition to AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homeopathy) which represents the tradition of codified, textual health knowledge systems other than the allopathic system, Local Health Traditions (LHT) represent the practices and knowledge of the common people and folk practitioners who follow an oral tradition of learning and passing on of the knowledge. As distinct from AYUSH, Local Health Traditions (home remedies and dietary practices for health; folk practitioners including herbalists, bone-setters, massagists, traditional birth attendants and faith healers) too have been recognized for their usefulness and people's access to them. The traditional systems were the medical system prevalent in India, being practiced by private providers much before the public system started their services. The Allopathic services reached the people initially through the public system, which was then accompanied by the private sector services. Before the introduction of modern medicines, disease treatment was entirely managed by herbal remedies. It is estimated that about 80% of the world population residing in the vast rural areas of the developing and under developed countries still rely mainly on medicinal plants. Medicinal plants are the only affordable and accessible source of primary health care for them, especially in the absence of access to modern medical facilities. Studies reveal that there are more traditional medicine providers than the allopathic providers especially in the rural areas.[38] The rationale for the inclusion of Traditional, Complementary and Alternative Medicine (TCAM) providers in the public health workforce ranges from the need for personnel to address the disease burden borne by the public health system to the desirability of providing patients with a choice of

therapeutic modalities and also nurturing of local culture. A hierarchy of systems of medicine, often unacknowledged, is exercised in most societies, with allopathy at the top, certain TCAM systems next and local healing traditions last. A pluralistic medical society, while offering patients greater options, bears tensions related to the coexistence of philosophically disparate disciplines, with unaligned notions of evidence and efficacy, and the ethical and operational challenges of the administration of a plural workforce.

Currently, there are around millions village-based and community supported traditional healers in India. Local communities have been managing malarial fevers, diarrhoea, primary health care issues and conditions, maternity care and health problems of domestic livestock with the help of ecosystem specific plant resources. Local traditions developed as ecosystem and culture specific systems having universal outlook and wide interactions.[38]

Folk healing practices

- The folk practices, (not only medical) were once an integral part of our day-to-day life and culture.
- They were improved on the basis of everyday life practical knowledge and changing customs and socioeconomic relations of the society.
- They were inseparably related to the customs, traditions and beliefs of the concerned society.
- Every community had its own unique set of medical practices and methods for improving the quality of life.
- Still they had a wider perspective about the world around them and the philosophic outlook about the relationship between man and nature.
- It formed a civilisation that was capable enough not only in absorbing the new knowledge but also in making some contributions to it.[20]

At the same time they were very focused in area of practice. For example, there were people who exclusively treated boils. Like this we had and still have bonesetters, poison healers, birth attendants and healers for specific conditions like child hood diseases, eye diseases, jaundice etc. They mainly used herbal drugs available in the neighbourhood and later on, the medicines available in the market as a result of trade relations with distant lands. Historical, sociological and epistemological evidence have led to conclude that folk healing traditions have symbiotic relationship with Ayurveda, Siddha and Unani systems.

Causes of decline

In colonial India, the British introduced western medicine as a cultural, intellectual and political tool for supremacy. While western medicine was provided with all the infrastructures and legal support, indigenous medicine was deemed unscientific and illegal and hence inferior. They couldn't ban it due to the insufficient infrastructures of the western system at that time. Also there were internal factors that hastened the process of decay such as stagnation of knowledge and non-availability of quality medicine being the main reasons. The lack of experimentation and relating to new ecological and social changes that occurred after the composition of the classical texts led to the method of treatment losing touch with current practices/conditions/reality. Also the change in the educational system (especially the erosion of the *Gurukula* system) led to the loss of its organic link with the community. Most of the time the practices are not documented and the knowledge are lost with the death of the person who practiced it. This leads to the loss of a valuable set of knowledge, which was the result of perhaps centuries of social and cultural development of the particular region.

Current Scenario

The organic relationship of the folk practices with the sociological development of the community is lost in the process of development. The folk practices are no more a part of the lifestyle of the society.[20] The cheap and cost effective treatment available in the locality using locally available herbs is no more available. This leads to increase in medical expenditure of the poor and greater dependency on modern medical system.

But they remain in some hamlets through isolated individuals who practice them. Folk traditions survive given their organic link with our lives, and their continuous renewal based on practical experience. Folk traditions are the result of centuries of assimilated knowledge and interaction, which are the intellectual property of the community concerned.

A recent study[25] had some very significant related findings as below:

- 55% of the allopathic doctors advised home remedies in combination with allopathic treatment to their patients.
- The ASHAs across the states had good knowledge about local medicinal plants and advised herbal remedies to people in the community. However, their level of responses was lower than from the household interviews

- in the community.
- Across the states, awareness regarding medicinal plants was found to exist in 47-100% households, and about food items having medicinal properties was found to exist in 54-100% households.
- More than 75% of home remedies used for diarrhoeal disease, anaemia and diabetes, as well as in convalescence and maternal and child health (MCH) conditions were validated across the states and were found to be useful and effective. This is generally indicative of the strength of people's knowledge and its links with the indigenous systems suggesting that it should be the base to build upon as a positive resource.
- The conditions for which combination or referrals were listed by the doctors tend to tally very well with the people's perceptions and use. This triangulation is a strong basis for further examination and inclusion of those found cost-effective, safe and easily accessible into "multi-pathy" Standard Guidelines for Treatment.

Challenges Facing Traditional Health Sciences of India

- The resource base is largely of plants, around 6200 species. There are also around 400 species of medicinal fauna and around 70 different metals and minerals that are used by TM in India. The biodiversity including wild populations of several hundred species are under threat.
- While the private sector including 9000 licensed industries with an estimated total turnover of around Rs. 6000 crores (around 1 billion Euro) have grown, there is insufficient data on the impact of AYUSH on the communities' health, as well as the lack of involvement in public health.
- Increasing interest by multinational pharmaceutical companies and domestic manufacturers of herbal-based medicines is contributing to a significant economic growth of the global medicinal plants sector. However, a large proportion of medicinal plant research is focused on nutraceuticals, chronic and metabolic disorders (diabetes, cardiovascular, etc.) and other diseases like HIV/AIDS, malaria, etc. Whereas, the common diseases of resource poor communities such as diarrhoeal diseases and acute respiratory tract infections (ARI) are often not addressed.
- Moreover, unlike the rural communities who use fresh/dried plant material or their crude extracts, the industry lays importance on isolation of active principles or standardized fractions since crude extracts are not patentable. However, it is often seen that a crude extract is more active compared to the isolated active fractions.[30]

Way Forward - Integration or Pluralism?

- Modern societies world over are moving towards accepting pluralistic healthcare regime
- It is evident that no single system of healthcare has capacity to solve all the health needs of society
- India's Traditional Knowledge Systems can contribute significantly to medical pluralism
- TM can provide original global solutions in several systemic disorders and in preventive and promotive health.
- TM can provide health security via ecosystem specific plants to rural households.

There is a need to discuss the local practitioners, and plan about efforts to mainstream these practitioners too. At the same time, open minded scientific attitude is needed. It would be inappropriate to expect the traditional systems to be validated by the scientific framework. Instead there is a need for evolving new disciplines to look at these innovatively and holistically. Trans-disciplinary research is largely for communication and not for validation. There is a need to combine both the reductionist and the holistic ways of researching. Also, there is need to separate the political from the economic dimensions of health and medical problems, and to isolate the purely medical from the non-medical interventions in health care. One has also to analyze the community's response to medical pluralism.

AYUSH At A Glance

India's historical trajectory along these lines is marked by an initial syncretic interest at the cusp of independence, at which point then mainstream Galeno-Islamic and Ayurvedic systems began to encounter modern allopathic medicine.[2][7][12] This is followed by official neglect and consequent de-legitimisation of these very systems of medicine post-independence.[1][19] At the turn of the 21st century, policymakers made intercalated overtures between assimilation and integration through the creation (in 1995) and rechristening (in 2003) of an eponymous Department in the Ministry of Health and Family Welfare. The Department of Indian Systems of Medicine and Homoeopathy (ISM&H) was established in the Ministry of Health and Family Welfare in March, 1995. It was re-named as Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy with acronym as AYUSH in November, 2003. A number of strategies

have been developed 2005 onwards as part of the National Rural Health Mission (NRHM) on "mainstreaming AYUSH." This includes the provision of AYUSH medications at the multiple levels of health service delivery (village, sub-centre, Primary Health Centre (PHC) and Community Health Centres (CHC)) and up gradation of PHCs to having an AYUSH doctors in addition to the existing allopathic doctor.[21] Such practices, rather than examples of integration, may be better described as substitution and replacement of AYUSH providers for allopathic providers in the face of great shortages. However necessary, such practices tend to ignore the merits of AYUSH and local health traditions and may perpetuate a legacy of stifling indigenous health systems and knowledge.[10,11,31] As a consequence, for the most part, Indian non-allopathic practitioners typically function outside the mainstream health architecture, even when explicit attempts at integration are underway. Concurrent to NRHM, various pilot or research projects in collaboration with non-allopathic practitioners have also been initiated and/or studied by international players. Examples include the Saathiya Youth Friendly network for reproductive health access, ORS and diarrhoea management and zinc therapy in Uttar Pradesh[,33] as well as and sexual health and HIV interventions with the urban poor in Maharashtra.[26]

From these examples, we can infer the efficacy of integration in relatively small-scale vertical programs. Endorsement of integration is reflected in discussions of Kerala's health system,[17] and the larger- arguably globalised[31]- imperative put forward by the World Health Organisation a decade ago. So also seems the case with India's Eleventh Plan, whose vision for AYUSH (2007) encompasses the following:

"Strengthening professional education, strategic research programmes, promotion of best clinical practices, technology upgradation in industry, setting internationally acceptable pharma-copoeial standards, conserving medicinal flora, fauna, metals, and minerals, utilizing human resources of AYUSH in the national health programmes, with the ultimate aim of enhancing the outreach of AYUSH health care in an accessible, acceptable, affordable, and qualitative [sic] manner".

In keeping with this rationale, in 2011, the High Level Expert Group (HLEG) on Universal Health Coverage called for the "active engagement and participation of appropriately trained AYUSH practitioners" and offered examples of their "optimal utilization." To this end, the HLEG recommended post creation at PHCs, CHCs and district hospitals and the involvement of non-allopathic providers in health promotion and NCD prevention; provisions for skill upgradation and support for career trajectories; and the development of an AYUSH Essential Drugs List.[8] In keeping with the policy of the Government to lay focused thrust on the Indian Traditional Systems of Medicine, the Department of AYUSH was granted the status of Ministry w.e.f. 09.11.2014. The Ministry is responsible for policy formulation, development and implementation of programmes for the growth, development and propagation of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) systems of Health Care*. Sowa Rigpa is the recent addition to the existing family of AYUSH systems.

A Universal Health Coverage framework, therefore, calls for a system-wide focus on meeting health human resource needs across India's different states, epidemiological profiles and local cultural contexts. Evidence suggests that from the perspective of at least south Indian urban Ayurvedic practitioners, this kind of institutional integration is desirable.[22] Whether this inclination is shared across systems of medicines, states and geographies is the subject of ongoing study.

Discussion

Indian health system grapples with the challenge of making services relevant to the diverse populace it serves, and medical pluralism is a policy to help address this issue. The emergence of Ministry of AYUSH to mainstream local health traditions and traditional and complimentary medicine into healthcare system provides a ray of hope in this direction. As Indian healthcare system continue to regulate practitioners across the states, both in their indigenous geographies and in diaspora, innovative policy approaches will become increasingly important, in pursuit of a more equitable medical pluralism. The strength of the AYUSH system lies in promotive, preventive and rehabilitative health care, diseases and health conditions relating to women and children, mental health, stress management, problems relating to older person, non-communicable diseases etc. While AYUSH should contribute to the overall health sector by meeting National health outcome Goals, the Department should retain primary focus on its above mentioned core competencies by providing at par status with biomedicine. A social science and public health perspective will be important in this direction to map out the requirements of AYUSH systems to progress.

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