

## A REVIEW ON MAINSTREAMING OF AYUSH AND REVITALIZATION OF LOCAL HEALTH TRADITIONS UNDER NRHM

JANMEJAYA SAMAL\*

*International Union Against Tuberculosis and Lung Disease (The Union)  
Pune, Maharashtra (India)*

**Abstract: Background:** The concept of mainstreaming of AYUSH by co-location services with Allopathy has been in the official plan document since the IXth five year plan. National Rural Health Mission has finally implemented it on a countrywide scale in 2005. The National Rural Health Mission (NRHM)'s strategy of 'Mainstreaming AYUSH and revitalization of local health traditions' is mainly confined to co-location of AYUSH doctors in primary and secondary health facilities in many states while few other states have planned other activities that strengthen AYUSH services beyond mere contractual appointment of AYUSH doctors. **Objective:** To review the implementation of Mainstreaming of AYUSH and revitalization of local health traditions implemented under NRHM. **Methodology:** The research adopted a review based study. Secondary data were obtained from the web portals of pertinent Government departments such as Department of AYUSH, Ministry of Health and Family Welfare and National Rural Health Mission, Government of India for the purpose of review. **Discussion:** 'Mainstreaming of AYUSH and revitalization of local health traditions' shows a great degree of co-location but issues related to AYUSH doctors and paramedics, strengthening AYUSH and revitalization of local health traditions, Training & orientation of AYUSH doctors and paramedics need to be addressed properly in order to justify mainstreaming of AYUSH and revitalization of local health traditions. **Conclusion:** Mainstreaming of AYUSH and revitalization of local health traditions should not only be limited to co-location of AYUSH facilities under the roof of allopathic facilities rather it should transcend beyond to address pertinent issues such as proper training and orientation of AYUSH workforce, universal recruitment policy, provision of drugs and necessary equipments, infrastructural correction.

**Keywords:** AYUSH, Local Health Traditions, National Rural Health Mission

### INTRODUCTION

Indian System of Medicine has its origin in India that evolved through a continuous process of transformation from its original Vedic form to modern day AYUSH system. AYUSH is an acronym for Ayurveda, Yoga & Naturopathy, Unani, Sidha and Homoeopathy and are the six indigenous systems of medicine practiced in India and other neighboring South East Asian countries (Samal J, 2014). In fact India is the only country to legalize these six traditional systems of medicine and accepted as the complete system of medicine. A separate department called department of Indian System of Medicine and Homoeopathy was formed in 1995 and was renamed in 2003 as the department of AYUSH under the aegis of Ministry of health and Family Welfare, Govt. of India (AYUSH in India, 2014 and NHSRC, 2011). The concept of mainstreaming of AYUSH was an idea in the IXth five-year plan before it was actually implemented in the country

by NRHM in 2005. This was felt in order to give increased attention to these systems in the presence of a strong counterpart in the form of Allopathic system of medicine that led to 'architectural correction' in the health service under NRHM. NRHM came in to play in 2005 but implemented at ground level in 2006 and introduced the concept of 'Mainstreaming of AYUSH and revitalization of local health traditions'(NRHM, 2005 and NRHM, 2005) to strengthen public health services. This convergence has been envisaged with the following objectives-

- Choice of treatment system to the patients,
- Strengthen facility functionally,
- Strengthen implementation of national health programmes (NHSRC, 2011 and NRHM, 2005).

### OBJECTIVE

The primary objective of this review was to assess the implementation of 'Mainstreaming of

---

\* Research Consultant

AYUSH and revitalization of local health traditions' implemented under NRHM. The specific objectives of this review were to assess the status of AYUSH workforce, training and orientation of AYUSH workforce and recommend strategies to strengthen these services under NRHM.

### Methodology

The study adopted a review based assessment. Secondary data were obtained from the web portals of pertinent Government departments such as Department of AYUSH, Ministry of Health and Family Welfare and National Rural Health Mission, Government of India for the purpose of review.

### DISCUSSION

The Planning commission working group report on "access to health system including AYUSH" in the year 2006 mentions that AYUSH facilities should be provided under the same roof of PHC/CHC under NRHM. The strategies recommended in the report mentions that the AYUSH workforce should be arranged by relocating them from the existing dispensaries where there is no building or can be hired as a contractual staff with NRHM funds. Medications and related equipments and infrastructure facilities should be provided through the centrally sponsored scheme of hospitals and dispensaries which had received good response from states in the last two years in the Xth five year plan. Proposals were also made regarding the up-gradation of existing AYUSH hospitals and dispensaries. Furthermore the plan proposed to merge the 'Vanaspati van' scheme that was started by the department of Family welfare under RCH-1 by creating a National Medicinal Plant (NMP) Scheme. The NMP scheme proposes to cover 30, 00 hectares of area with herbal garden in ten states (**Planning Commission, 2006**).

Subsequently the National Rural Health Mission was implemented in the year 2005 on 12<sup>th</sup> of April. NRHM introduced the concept of 'Mainstreaming of AYUSH and Revitalization of Local Health Traditions' to strengthen public health services (**NHSRC, 2011**). Under the broader umbrella of mainstreaming of AYUSH and revitalization of local health traditions AYUSH facilities have been co-located with 331 (44.3%) District Hospitals (DH), 1885 (36.3%) Community Health Centers (CHC) and 8461 (34.6%) Primary Health Centers (PHC) by 31<sup>st</sup> April 2014. Similarly 2.61, 0.46 and 0.1 million of rural population were

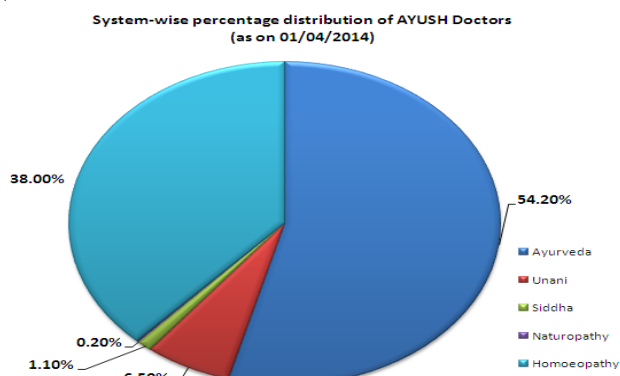
being served per DH, CHC and PHC respectively in the country in 2014. Contractual appointment of 10933 AYUSH Doctors and 5419 AYUSH Paramedical staff has been recorded by this time. Uttar Pradesh ranked top (1829 appointments) in the contractual appointment of AYUSH Doctors followed by states of Bihar and Odisha that accounts for 1384 and 1316 appointments respectively. Likewise, 5419 contractual appointments of AYUSH Paramedical Staffs were recorded by 31<sup>st</sup> March 2014. A maximum of 1584 paramedical staffs were appointed in the state of Andhra Pradesh, followed by Uttar Pradesh, Madhya Pradesh, Tamil Nadu, Uttarakhand and Rajasthan that appointed 733, 526, 475 413 and 401 paramedical staffs respectively. Arunachal Pradesh, Delhi, Goa, Madhya Pradesh, West Bengal and Daman Diu are the only five States and one Union Territory (UT) where there are no contractual appointments of AYUSH Doctor. There were 11 States and UTs where no AYUSH Paramedical staffs were appointed on contractual basis as on 31<sup>st</sup> March 2014 that includes Arunachal Pradesh, Assam, Bihar, Delhi, Gujarat, Himachal Pradesh, Mizoram, Nagaland, West Bengal, D & N Haveli and Daman & Diu (**AYUSH in India, 2014**). In addition the following figures show the status of AYUSH system in India under NRHM in which figure No.1 shows the distribution of AYUSH doctors in India, the figure No.2 shows the state wise distribution of AYUSH doctors appointed on contractual basis under NRHM, the figure No.3 shows co-location of AYUSH facilities under different health facilities in India and the figure No.4 shows rural population (in lakh) served by AYUSH facilities at various health facilities (DH/CHC/PHC) in India as on 01/04/2014 (**AYUSH in India, 2014**). This sort of co-location under different health facilities indicates that AYUSH workforces have a greater contribution towards equitable distribution of health workforce in rural India (**Samal J, 2013**).

Having understood the current status and background of AYUSH system and its emergence with mainstream health care system in India, the following paragraphs assess the implementation of AYUSH system under NRHM, issues with few of the components and strategies to overcome those bottlenecks.

### AYUSH Doctors/Paramedics:

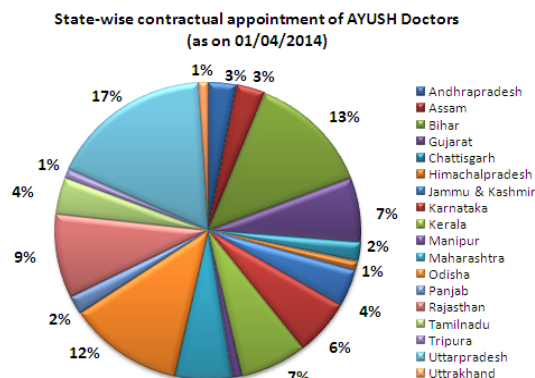
At the end of first phase of NRHM a retrospective look indicates that it is not mainstreaming of AYUSH rather mainstreaming of AYUSH

**Figure-1.** Distribution of AYUSH doctors in India by 01/04/2014.#



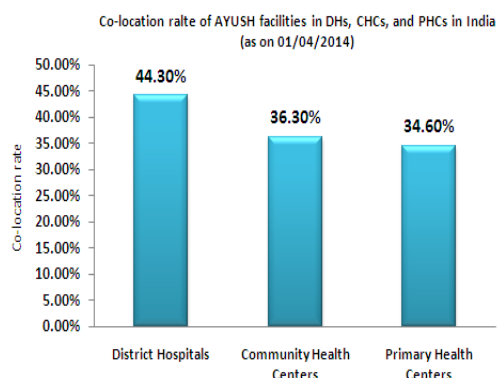
# Source- Department of AYUSH, MOHFW, Govt. of India

**Figure-2.** State wise distribution of AYUSH doctors appointed on contractual basis under NRHM till 2014.#



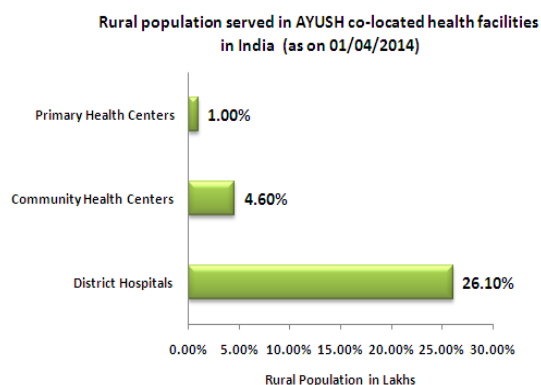
# Source- Department of AYUSH, MOHFW, Govt. of India

**Figure-3.** Co-location of AYUSH facilities under different health facilities in India as on 01/04/2014#



# Source- Department of AYUSH, MOHFW, Govt. of India

**Figure-4.** Rural population (in lakh) served by AYUSH facilities at various health facilities (DH/CHC/PHC) in India as on 01/04/2014#



# Source- Department of AYUSH, MOHFW, Govt. of India

providers in the form co-location of AYUSH doctors and paramedics. This is evident because of lack of proper machinery to ensure quality AYUSH services by the AYUSH doctors and paramedics co-located at various health institutions. To make it simpler it may be said that AYUSH doctors/paramedics may provide quality health care services as health care providers like their allopathic counterparts but not the AYUSH services exclusively as envisaged under NRHM. In many states AYUSH doctors have undergone SBA (Skilled Attendance at Birth) and related trainings to get equipped with the skills required to handle minor surgical and obstetric emergencies with the use of certain allopathic medications but the legal issues pertaining to it have not been dealt with properly and is same with IMNCI (Integrated Management of Neonatal and Childhood Illnesses) as well. Similarly AYUSH induction training has been imparted in many states but is not properly

planned to make them good public health administrators. Involvement of AYUSH doctors with SHS (State Health Society), DHS (District Health Society) or RKS (Rogi/Rugna Kalyan Smiti) is either limited or not known. Planning for providing adequate AYUSH drug is lacking (NHSRC, 2011). Though all the AYUSH doctors are provided with a TOR (Term of Reference) but its true ground level implementation is skeptical in terms of over use/under use.

**Strengthening AYUSH services and Revitalizing Local Health Traditions:**

There are various additional and innovative programmes taken up by different states/UTs. Some of them are discussed below as reflected in the state programme implementation and planning (PIP) document. But the ground level implementation needs to be analyzed further (NRHM, 2008; NRHM, 2009 and NRHM, 2010).

· **IEC/BCC-** The PIP of Different states/ Union Territories mentions that various Information, Education and Communication (IEC)/Behavior Change Communication (BCC) activities have been organized to sensitize the community regarding the benefit of AYUSH & LHT services (**NRHM, 2008; NRHM, 2009 and NRHM, 2010**).

· **Specialty Clinics/Wards-** Ksharasutra clinics for ano-rectal disorders and Panchakarma therapy for intensive and specialized treatment have been mentioned by half of the states in their PIP (**NRHM, 2008; NRHM, 2009 and NRHM, 2010**).

· **AYUSH health programmes-** School Yoga programme and Yoga camps are some of the AYUSH health programmes mentioned by states like Orissa, Punjab and Andhrapradesh. Tripura being little ahead mentions about sensitization of primary school teachers regarding the importance of Yoga. Rajasthan mentions about 'SUPOSHANAM' a community nutrition programme for tribal women and Ayurved mobile units (**NRHM, 2008; NRHM, 2009 and NRHM, 2010**).

· **Outreach activities-** Jharkhand, Himachalpradesh, J&K and Orissa mentioned about utilization of AYUSH doctors in mobile medical unit. Madhyapradesh and Tripura mentioned an innovative programme of AYUSH call center in their PIP(**NRHM, 2008; NRHM, 2009 and NRHM, 2010**).

· **Establishment of AYUSH Epidemic cell-** Tamilnadu and Keral are using AYUSH services for the prevention and control of epidemics e.g. use of Homoeopathy for controlling Chikungunya outbreak. RAECH (Rapid action epidemic cell of Homoeopathy) is a major AYUSH initiative highlighted in Kerala PIP (**NRHM, 2008; NRHM, 2009 and NRHM, 2010**).

· **Local health traditions-** The IPHS (Indian Public Health Standards) prescribes setting up of an herbal garden in Sub center and PHC premise within the available space, which has not been reflected in any of the state PIPs <sup>(1)</sup>. Furthermore a few states have mentioned some innovative activities such as; Chattishgarh has mentioned "AYURVED GRAM", "DADI MAA KI BATUA" and J&K PIP mentions to include home remedies in AYUSH drug kit. Madhyapradesh has mentioned about "GYAN KI POTLI" which also includes use of home remedies

that are accessible and affordable for various common ailments. Haryana has planned courses on local health traditions for unemployed youth (**NRHM, 2008; NRHM, 2009 and NRHM, 2010**).

### **Training and orientation of AYUSH doctors and paramedics:**

Training and orientation of AYUSH doctors is one the important agenda of NRHM. This is required to a great extent because of the Term of References (TOR)/ job responsibilities of an AYUSH doctor. There are some job responsibilities mentioned under the TOR which are beyond the scope of an AYUSH doctor as per his/her educational training and exposure. Let us pick up some of the job responsibilities mentioned in the TOR of AYUSH doctors in Orissa; conducting minor surgery, abscess surgery, conducting normal delivery and insertion of IUCD (Intra Uterine Contraceptive Device) are beyond the scope of the AYUSH doctors as per their training and exposure. Similarly planning and implementation of national disease control programme, national health programmes such as immunization programme, Reproductive and Child Health programme, supervision of Village Health Nutrition Day and Pustikar Divas, implementation of IMNCI (Integrated Management of Neonatal and Childhood Illnesses) requires lot of training and orientation of AYUSH doctors. The importance of training is known very well however timely training is not being conducted in many parts of the country (**Samal J, 2015**).

India has a rich and living tradition of healing. As early as in 4000 BC Sushrut, the father Indian surgery stressed the need to integrate theory and practice. 'What is observed and demonstrated directly in practice and what is instructed in Shastra (classical text) have to be mutually and judiciously integrated for the growth of knowledge (**National Commission on Macroeconomics and Health, 2005**). This is the classical example of an idea of integration born way back in 4000 BC. Mainstreaming of AYUSH is also a sort of integration with mainstream health system and is a core strategy envisaged under the National rural Health Mission with an objective to improve outreach and quality of health care delivery in the rural areas. The objective of integration of AYUSH with the health care infrastructure is to reinforce the existing health care delivery system, with the use of natural and safe remedies, which are time tested, accessible,



and affordable (NRHM, 2005; NRHM, 2015; Ministry of Health and Family Welfare, 2011 and World Health Organization, 2011). Here it is important to note that albeit NRHM brought out the concept of integration but is not homogenous every where in the country. There are great variations in its implementation in terms of co-location of AYUSH facilities at District hospitals, Community health centers and Primary health centers and is also reflected in the contractual recruitment of AYUSH doctors and paramedics. Although it becomes a state issue at some point of time but the Dept. of AYUSH, MOH&FW, Govt. of India should play pivotal role in framing policies and strategies at least for the technical implementation and financial and administrative implementation may lie with respective states. Traditional medicine has not been appreciated only for its usefulness but also for its affordability. In a Knowledge, Attitude and Practice survey by Dr Elizabeth Negi in Mawlam village, Meghalaya it was found that people spend 60 rupees annually for consulting a traditional therapist whereas they spend 2600 rupees for an allopath (**Foundation for revitalization of local health traditions, 2008**). Asia has seen the most progress in incorporating Traditional Medicine in to the health system, which has been approached in two different ways “Integrative approach and Parallel approach”. India is having the second approach where the modern and traditional are separate with in the national health system. But NRHM brought the integrative approach with a greater limitation as is not complete and comprehensive in education and practice like China and Vietnam (NHSRC, 2011). According to Foundation for Revitalization of Local Health Traditions report there are around 1 million village based and community supported traditional healers in India (**Foundation for revitalization of local health traditions, 2008**).

The process of integration of ISM in the national health care delivery system can be strategically perceived at three horizons. Firstly, the Ayurveda and Unani physicians have to be incorporated in to all PHC teams with adequate therapeutic resources at their disposal. They should be trained in basic PHC emergency and obstetrics skills. Secondly, all municipal and district hospitals should have full fledged AYUSH outpatients, wards and Panchakarma units with adequate resources. The hospital management should be trained and sensitized to give due importance to ISM in patient

care. Thirdly the tertiary medical centers should have advanced centers incorporating education, research and sophisticated services (**National Commission on Macroeconomics and Health, 2005**).

## CONCLUSION

Mainstreaming of AYUSH and revitalization of local health traditions is one of the innovative step by the ministry of health and family welfare, Government of India to bring untapped AYUSH workforce and services in to mainstream health care system in India. However it is perceived that the concept is poorly limited to mainstreaming of AYUSH doctors only and the AYUSH services are neglected. Hence it should not only be limited to co-location of AYUSH facilities under the roof of allopathic facilities rather it should transcend beyond to address pertinent issues such as proper utilization of AYUSH services, proper training and orientation of AYUSH workforce, universal recruitment policy, provision of drugs and necessary equipments and infrastructural correction

## REFERENCES

1. AYUSH in India. Planning & Evaluation Cell, Ministry of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH). Government of India. 2014.
2. Department of AYUSH, Ministry of health and Family welfare, New Delhi, Govt. of India.
3. Foundation for revitalization of local health traditions (FRLHT). Initiatives for promotion of AYUSH intervention in the public health system of the country-A report on stakeholders’ workshop on “AYUSH intervention in public health” held on 8<sup>th</sup> and 9<sup>th</sup> Feb 2008, at FRLHT, Bangalore.
4. Ministry of Health and Family welfare, Mainstreaming of AYUSH under NRHM, Modified Operational Guidelines, (Updated on May 2011) Dept. of AYUSH, New Delhi, Government of India.
5. National Health System Resource Center. National Rural Health Mission, Mainstreaming of AYUSH and revitalization of local health traditions under NRHM, An appraisal of the annual state program implementation plans 2007-2010 and mapping of technical assistance needs. Ministry of health and family welfare, New Delhi, Government of India.
6. National rural health mission (2005-2012). Ministry of health and Family Welfare (2005). Mission document, New Delhi, Government of India.
7. National Rural Health Mission, 2005: Framework of Implementation 2005-2012, New Delhi Ministry of Health & Family Welfare, Government of India.

8. National Rural Health Mission, 2007-08: *State Programme Implementation Plans 2007-08*, State specific, Ministry of Health & Family Welfare, Government of India.
9. National Rural Health Mission, 2008-09: *State Programme Implementation Plans 2008-09*, State specific, Ministry of Health & Family Welfare, Government of India.
10. National Rural Health Mission, 2009-10: *State Programme Implementation Plans 2009-10*, State specific, Ministry of Health & Family Welfare, Government of India.
11. National Commission on Macroeconomics and Health, 2005: *Report of the National Commission on Macroeconomics & Health Aug 2005*, Ministry of Health and Family Welfare, Govt. of India, New Delhi.
12. Planning Commission 2006: *Working group on "Access to Health Systems including AYUSH"*, New Delhi, Planning Commission, Government of India.
13. Samal J. Indian public health standards for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy facilities: An assessment. *Int J Med Public Health* 2014; 4:331-5.
14. Samal J. Role of AYUSH doctors in filling the gap of health workforce inequality in rural India with special reference to National Rural Health Mission: A situational analysis. *Int J Adv Ayurveda Yoga Unani Siddha Homeopathy*. 2013; 2:83-9.
15. Samal J. Role of AYUSH workforce, therapeutics, and principles in health care delivery with special reference to National Rural Health Mission (NRHM). *AYU*. 2015;36(1)
16. World Health Organization country cooperation strategy 2006-2011, India. *Supplement on traditional medicine*, WHO country office for India, New Delhi.