INITIATIVES FOR PROMOTION OF AYUSH INTERVENTION IN THE PUBLIC HEALTH SYSTEMS OF THE COUNTRY

A Report on Stakeholders Workshop on “AYUSH Interventions in Public Health” held on 8th And 9th February 2008, At Foundation For Revitalization Of Local Health Traditions, (FRLHT), Bangalore

Organised on behalf of Dept. of AYUSH Ministry of Health and Family Welfare, Government of India New Delhi
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Acknowledgements

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List of Abbreviations

1. AYUSH- Ayurveda, Yoga, Unani, Siddha, and Homeopathy.
2. CCRAS - Central Council for Research in Ayurveda and Siddha,
3. CCRUM - Central Council for Research in Unani Medicines,
4. CCRH - Central Council for Research in Homoeopathy
5. CCRYN - Central Council for Research in Yoga and Naturopathy.
6. CHC/SOCHARA- Community Health Cell/ Society for Community Health Awareness, Research and Action
7. FMR- Foundation for Medical Research
8. FRLHT- Foundation for Revitalization of Local Health Traditions
9. ICMR- Indian Council of Medical Research
10. LHT- Local Health Traditions
11. MAAS- Maharashtra Association of Anthropological Sciences
12. NRHM – National Rural Health Mission
13. PHC- Primary health care
14. PRA- Participatory Rural Appraisal
15. RITAM- Research Initiative on Traditional Antimalarial Methods
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Executive Summary

The delegates of the Stakeholders workshop on AYUSH Interventions in Public Health reported in this document came from different parts of the country representing, government department, academic institutions, NGOs and people’s organizations. They upheld that AYUSH systems are an integral part of health systems in our country and also welcomed the initiative to strengthen Public health systems though AYUSH systems as an essential component for health care in a holistic way.

They noted that AYUSH systems can contribute immensely in promoting good health and expand the outreach of health care. Recognizing the inherent strengths of the AYUSH and noting the National Policy on Indian Systems of Medicine and Homoeopathy-2002 they explored various ideas and projects that have attempted to integrate AYUSH in the health care delivery system and national programmes, there by enhancing the use of the vast infrastructure of hospitals, dispensaries and trained practitioners.

Cost-effective use of natural products and simple techniques of medicine preparation have been the strength of the AYUSH Systems. Lack of prioritized public health orientation has led to only a minimal participation in public health initiatives. The attempt to mainstream AYUSH systems for the benefit of huge population needs to be directed towards strengthening of AYUSH systems to make them more competent to dialogue and integrate with the present needs and systems.

Five thrust areas were identified for further action through collective initiatives and multicentric projects.

Situation Analysis of AYUSH in the current public health system.

Public Health education for AYUSH sector.

Validating AYUSH formulations and approaches in various community situations (In the context of Primary health Care and Public Health)

Promoting Social Science dialogue with AYUSH Systems.

Integration in community Health workers training with a plural approach

Participants volunteered to form small groups to take these 5 thrust areas forward. It was also suggested that an e group including the 70 invited (35 attended) could be initiated and the AYUSH department be invited to support the E group and the evolving, working groups in the five thrust areas. The report of the workshop would be circulated to all the participants with a request to stay in touch with the focal points of each of the five thrust areas so that meaningful group initiatives and multicentric projects could evolve and strengthen the efforts of the AYUSH department in the challenge of integrating AYUSH systems in public health systems of the country.
INTRODUCTION TO THE WORKSHOP

This workshop was a part of the process to strengthen and support AYUSH systems and AYUSH practitioners to be involved more actively in the Public Health Systems of the country. As a support to this initiative, the workshop was jointly hosted by Community Health Cell and Foundation for Revitalization of Local Health Traditions on behalf of Dept. of AYUSH MoHFW Govt. of India. This workshop was funded by Dept. of AYUSH.

The Objective was to evolve proposals and build perspectives through interaction in the context of mainstreaming of AYUSH in Public Health systems. The workshop focused on two main themes Public Health Education of AYUSH practitioners/teachers and Action Research Projects on AYUSH & Public Health. As a background, participants were provided a copy of National Policy and programmes on AYUSH, Task force report on XI Plan and Grant in AID schemes on Public health Initiatives and Medical education schemes. (See appendices A-D)

The conference was held at FRLHT campus Bangalore, on 8th and 9th of February 2008. 34 participants attended the workshop and these included representatives from public health organizations, community health NGOs, ISM and allopathic colleges, health research organizations/institutes and social science institutes.

Since this was a new venture, the methodology of the workshop was interactive and participatory so that the participants were not only motivated to evolve relevant projects to be supported by the available grant in aid schemes but also evolve into an informal network with increasing collaborative potential.

Dr. Kumar. M. Dhawale, Dr. Ravi Narayan and Mr. Darshan Shankar provided technical coordination for the workshop. The report is divided into three chapters.

- The first chapter provides information on the structure of the Programme; the participant list and some background of the workshop
- The second chapter provides an overview or summary of all the presentations by the participants on both days
- The third chapter provides the summary of the discussions on the way ahead and the next steps after the workshop.
- An additional section of appendices provides additional background materials presented or distributed at the workshop.

This summary report is prepared jointly by Dr. Deepak Kumaraswamy (Community health Cell) and Dr. Dyson Peter Misquita (AAROHI) with Dr. Sreeraj Sasi, who were fellows at the Community Health Cell, Bangalore and were the rapporteurs for the workshop. The Foundation for Revitalization of Local Health Traditions (FRLHT) Bangalore, were the hosts of the workshop and facilitated the logistics and the local arrangements.
Chapter I

Section of FRLHT- Campus Bangalore

(This chapter provides background information, an outline of the Programme and the participant list.)
I. BACKGROUND:

The AYUSH knowledge systems have their own frame work of health promotion and public health which include tried and tested methods, related to food and nutrition, purification of drinking water, management of widespread diseases (of skin, GIT, respiratory disorders, metabolic disorders,) and also preventive health measures, which are relevant to public health system development . The AYUSH sector however for various reasons has not thus far been involved in public health interventions.

AYUSH educational institutions reflect the alienation of the sector from public health. The UG & PG courses do not, for instance, contain any modules on the contemporary public health problems in the society even though preventive and social medicine text books are prescribed but seldom taught. Thus AYUSH teachers and students by virtue of their training are not exposed to epidemiological approaches to understanding public health problems. The Steering Committee for the AYUSH sector in the Planning Commission has emphasized the importance of training AYUSH medical personnel in public health as a pre-requisite to their involvement in the design, development and implementation and management of public health programs.

The Dept of AYUSH has recently formulated a grant in aid scheme for promotion of AYUSH interventions in public health and the 11th Plan has made a modest outlay to initiate pilot projects in this field. To take advantage of this new opportunity and potential for establishing a meaningful relationship between AYUSH systems and practitioners with the countries public health systems and national programmes an orientation workshop was conducted by two organizations committed to medical pluralism and integration of systems of medicine in collaboration with the department of AYUSH of the Ministry of Health and Family Welfare, New Delhi. These were Community Health Cell of the Society for Community Health Awareness, Research and Action (CHC/SOCHARA), Bangalore and Foundation for Revitalization of Local Health Traditions (FRLHT), Bangalore. The workshop was also cosponsored by Public Health Foundation of India (PHFI) New Delhi.

Goals and Objectives of the Stakeholders workshop:

The orientation workshop on AYUSH & public health provided background context, an overview of the experiments in India and evolved guidelines for participants to prepare projects in an interactive, participatory and collaborative way. Among the various grant in aid programmes of the AYUSH department, two types of projects were discussed at the workshop

Projects of type 1 – support for design and implementation of short-term courses on AYUSH & Public Health for AYUSH faculty / graduates deputed by ISM colleges, or NGOs and NRHM including support for implementation of field projects designed by the institutions who have deputed the trainees

- Such project would provide support for the design, development and implementation of specially designed short-term courses (6-12 months duration) on AYUSH and public health. The short-term courses are expected to be executed by a reputed medical college, which has sufficient experience in public health research and training (e.g., CMC Vellore). The course design is expected to include AYUSH knowledge related to public health so that the content of the course while it may borrow from conventional courses
subjects like epidemiology and biostatistics, it should also have sufficient grounding in AYUSH knowledge systems.

- Such projects visualize training to AYUSH medical professionals deputed by ISM colleges, community health NGOs and State Governments from NRHM. The projects would also support 3-year field projects on public health for the AYUSH professionals thus trained under the scheme so that the trained professionals can apply their training for contributing to the solution of real public health problems in the field and learning from these projects would then be introduced into the AYUSH training programmes so that more and more graduates are informed and inspired to get involved in the public health systems and national programmes of the country.

Projects of type 2 – Support for Action Research Projects on AYUSH & Public Health

Such projects would provide support for well-designed action research field projects prepared by reputed community health organizations, in collaboration with ISM colleges and research institutes, to contribute to public health problems. This could include the following components.

i) Management of communicable diseases like malaria, chikunguniya, diabetics etc
ii) Mother and child care
iii) Nutrition
iv) Anemia
v) Epidemiological studies including assessment of health and diseases
vi) Validating efficacy of traditional health practices
vii) Training of AYUSH Practitioners and Paramedics

A key outcome of the projects was the enhancement of health of rural communities in the geographical area selected for the implementation of the project using AYUSH medicines, principles and methodologies within the context of national health programmes and the NRHM initiatives.
II. Programme details of Stakeholders Workshop on AYUSH Intervention in Public Health

Venue: Foundation for Revitalization of Local Health Traditions

8th Feb (Friday)

10.00 To 11.00 am – Welcome and Self Introduction by Hosts / Participants
Opening remarks on AYUSH and Public Health Schemes
Introduction to Workshop (FRLHT/ CHC/ PHFI)

11.00 To 11.15 am – Tea and snacks

11.15 To 12: 15 pm – AYUSH and Public Health Challenges – An interactive session

Chairperson: Dr. Kumar Dhawale (Dr. M.L. Dhawale Trust, Mumbai)

Speakers: 1. Ashok Vaidya (MMRC, Mumbai)
           2. Ravi Narayan (CHC, Bangalore)

12.15 To 1.30 pm - Sharing of experiences & ideas by participants

1.30 To 2.30 pm - Lunch

2.30 To 5 pm – Project Presentations (included a short tea break of 15 minutes)

3. Assessment of main streaming of AYUSH under NRHM.
   Maharashtra Association of Anthropology: (Dr. Mutatkar)

4. Training AYUSH graduates in Epidemiology.
   Christian Medical College- Vellore: (Dr. K.R. John.)

5. RISHTA-Research and Intervention in Sexual Health – Theory to action; Project
   (Dr. Ravi Verma ICRW / Dr. Niranjan Saggurti Population)

6. Promoting Medical Pluralism at different levels.
   Society for Community Health Awareness Research and Action - Bangalore:
   (Dr. S P Tekur)

5 to 6 pm Movie: Complimentary and Alternative System of Medicine for Health Promotion at Sao Hai Hospital, Saraburi Provience, Thailand.
9th Feb, (Saturday) 2008

9.00 To 10.00 am – Orientation to FRLHT activities and walk around campus, With Mr. Darshan Shankar (Director FRLHT)

10.00 To 1:30pm- Project Presentations /Sharing of Ideas

7. Research Initiative in Traditional Antimalarial Methods (RITAM) – Dr. Prakash, Foundation for Revitalization of Local Health Traditions, Bangalore

8. Upgrading Community Based Health Care System with emphasis on Mother and Child Care through Homeopathy as a predominant therapeutic modality in Vikramgarh Taluk, Thane District, Maharashtra- Dr. K.M. Dhawale, AYUSH Consultant, ICMR / Dhawale Trust Mumbai

9. An Overview of Yoga Research and Public Health- Dr. H.R. Nagendra, Vice Chancellor, Swami Vivekananda Yoga Research Foundation, Bangalore

10. Revitalization of local health Traditions Dr. Elizabeth Negi- Martin Luther Christian University- Shillong

11. An Integrated Approach to Prevention and Treatment of Childhood Morbidities and nutritional deficiency in tribal areas with health care deprivation with emphasis on use of local medicinal plants. – Dr Tannaz J. Birdi, Foundation for Medical Research, Mumbai

1.30 To 2.30pm – Lunch

2.30 To 4 pm: Presentations continued (Including a tea break)

12. Siddha medicine for Community health Dr. Joseph Thas -Friends of Siddha medicine, Tirunelveli,

13. Experiences with Traditional Medicine - Mari Thekaekara and Dr. Mahesh Mathpati, ACCORD, Gudalur

14. Traditional and modern childbirth practices in villages of Bokaro,- Dr. Lindsay Barnes, Jan Chetna Manch, Bokaro, Jharkhand

15. Overview of the Grant in Aid Schemes – Under Discussion Dr. S.D. Sharma, Dept. of AYUSH, MOHFW, GOI, New Delhi.

4. To 5 pm: Closing Session: AYUSH and Public Health- The Way Ahead (Picking up on multidisciplinary and multicentric approaches and ideas)
### III. Participants

#### A. Core facilitators Group

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Chapter II

(This chapter highlights the main points presented or discussed during different sessions of the workshop. For convenience this chapter is divided into five sessions the first session will cover the introduction and key note address. The sessions B and E will cover the various ideas subjected to discussion during the course of the workshop. While sessions C and D covers the Demonstration of public health initiatives at various levels.)
Session A

I. Inaugural Session

The session began with a minute of silent prayer. Mr. Hariram Murthy (FRLHT) welcomed the participants and defined the workshop as a milestone for FRLHT in terms of Public Health, while giving a short introduction of FRLHT and its Activities.

Dr. Ravi Narayan (as a facilitator of the workshop and on behalf of CHC & FRLHT) gave the background and objectives of the workshop including the goal of creating a new informal network of people who are working in AYUSH and Public Health. He also explained that the conference is first of its kind and there are “serious policy efforts to support the micro and macro level activities under NRHM”. His suggested that, while there was a romanticism for AYUSH in our political system and there was no clarity about the role of AYUSH systems in Primary health care and the public health systems of the country. There was need for a serious effort to integrate AYUSH into the national health policy. He also emphasized the importance of a multidisciplinary participation and approach, so as to develop a holistic approach.

All the participants then gave short introductions about themselves and their work and shared some of their expectations of the workshop.

Dr. S.K. Ghosh expressed the need of strengthening the AYUSH systems at grass root level and gave some perspective of drug development in malaria through multi sectoral partnerships.

Dr. Leena Abraham shared her social science research perspective on AYUSH and emphasized an increasing role for social science research to explore the realm of medical pluralism which may explain some of the conflicts between the systems.

Dr. Prakash shared about the research potential of herbal health practices which could provide solutions for malaria at a local level. He described a unique Programme called as RITAM Research Initiative on Traditional Antimalarial Methods.

Mr. Abdul Kareem spoke on primary health intervention through herbs which is being tried out through primary health centers.
Mr. Harirama Murthy talked about the stake of Healers and their associations and stressed on the need for revitalization of traditional medicine through social processes, like involvement of SHG women in household gardens and remedies.

Dr. K.M. Dhawale mentioned that the collaboration in with social science institutes can help in widening activities and capacities and stressed on the need for public health reorientation and training in the AYUSH systems.

Dr. Ashok Vaidya underlined the need for integrating AYUSH into Primary health care and stressed on the integration of all the sciences in health care going beyond the biomedical and social science model.

Dr. Munir Ahmed revisited the need for Public health education and curriculum development in AYUSH systems.

Dr. S.P. Tekur highlighted the pluralistic nature of his practice and training of health workers.

Dr. R.K. Mutatkar directed the need of including AYUSH in School curriculum while Dr. Kalpana Mutatakar advocated for integrated medical systems, citing the use of Ayurveda perspective for nutritional supplements.

Mr. Dhanraj Kuldeep shared his partnering experiences with FRLHT in reviving the local health traditions.

Dr. K.S. Bose spoke on research with integrated system approach for dermatological disorders.

Dr. Akhila Bridgitte shared about her interest to undertake epidemiological studies in AYUSH Systems.

Dr. Prasenjeet Mazumdar shared his experience on Cost effectiveness of Homoeopathic medicines in Primary health centre’s in West Bengal.

Dr. K.R. John a public health professor shared his institutions experiences of teaching epidemiology to AYUSH personnel.

Dr. Lindsey Barnes expressed her interest in Inclusion of Traditional midwifery and Women health services into public health.

Dr Joseph Thas expressed his interest to share his work experience in Siddha medicine in the field of community medicine.

Dr. Mahesh Mathpati and Mari Tekkekara expressed their interest in sharing about the initiatives taken up at ACCORD.

Dr. Elizabeth Negi, from Martin Luther Christian University, Shillong, wanted to share about the MLCU initiative on local health traditions in Northeast India.

Dr. Tiwari reaffirmed the need for scientific evidence for herbal medicines.

(Some participants joined the workshop in later sessions or the 2nd day. What they shared while introducing themselves is included here.)

Mr. Darshan Shankar spoke about the potential of AYUSH systems in providing cost effective solution to the health situation of the country, and stressed the need of scientific evidence through validation of knowledge with proper technology and on a low cost scale.

Dr. Beena Varghese from Public Health Foundation of India told about her interest in health economics which could also be applied to the AYUSH systems.
Dr. Tannaz Birdi shared about validating the use of copper wires for microbial purification of water

Dr. Utpal Tatu gave an introduction to his work in malaria at IISC

Dr. Niranjan and Dr. Ravi Verma expressed their interest to share about the Research and Intervention in Sexual Health – Theory to action; Project

Dr. Nagendra one of the shared his experience over last research with yoga over last 20 years

Mr. S. D Sharma Representing AYUSH Dept. was to give technical guidelines for the project proposal and

Dr Deepak Kumaraswamy, Dr. Sreeraj Sasi and Dr. Dyason Misquita were rapporteurs in the workshop
II. Keynote Addresses- AYUSH and Public Health Challenges

The session was chaired by Dr. K.M. Dhawale and the two speakers of the session Dr. Ashok Vaidya and Dr. Ravi Narayan spoke on the public health challenges for AYUSH systems. The presentations were on two central themes interdisciplinary research and health Policy. These two presentations represented the basic structures which are key for the promotion of AYUSH systems in public health.

II.A. People’s Movement for Integrated Public Health

*Dr Ashok. D. B. Vaidya, Research Director, ICMR Advanced Centre of Reverse Pharmacology, Kasturba Health Society, Mumbai.*

Dr. Ashok vaidya started his presentation with the reminiscence of the Late Dr. N.H. Anita’s leadership of a group of professionals including himself who had met in January 1990 and resolved to build a national peoples health movement based on Gandhian principles. These included a one rupee fund to generate health awareness; developing a network of grass root health organizations; interlinking success stories and experiences for extension and learning from local health traditions and incorporating them into health care systems. This group also emphasized the need to deliver a crash course to the planning commission of India on the Gandhian approach and the need to involve young people in public policy. His subsequent presentation then represented the approaches for interdisciplinary research for AYUSH Systems. There were basically three themes in this presentation which were as follows.

**Medical pluralism:** This included an understanding of pluralist culture with immense diversity of diet, clothes and habits with the trends associated with Ayurveda medicine and the AYUSH resources present in India.

**Ancient wisdom and modern insights:** These were the areas of research priority, which could be prioritized as per need. Sighting the examples from Cinchona and Artemisia annua, he shared that it nearly took 2 millennia for active compound isolation, derivatives and pharmacology. He also emphasized on Ethnic variations of drug response, which are almost never covered i.e. A drug proved in Africans of a different ethnic order, need not bear the same results on Europeans.
This has been a proved fact. He backed up the above research insight through the studies carried out on Nyctanthes Arbor-Tristis Linn and AYUSH-64 for malaria context.

**NYCTANTHES ARBOR-TRISTIS**
Parasite Clearance and Clinical Response \(n = 20\)

![Graph showing parasite clearance and clinical response over days of treatment](image)

Source: Chhaya Godse, Ph.D. Thesis, Applied Biology, University of Mumbai, 2004

**Research Potential: Opportune Paths:** These were the crucial research techniques with present research opportunities which have surfaced the need for multi partner research, Pharmaco-epidemiology data on herbs, Observational Therapeutics to support it and validating it with **Reverse Pharmacology**. He appreciated the golden triangle project ([http://ccras.nic.in/gtp.htm](http://ccras.nic.in/gtp.htm)) as a multidisciplinary research involving AYUSH-ICMR-CSIR and emphasized the need for stronger networks between **academics, government and industry** for better opportunities in research. He concluded by quoting Bhushan Patwardhan’s statement that “The strategy we are now following is ‘from clinics to laboratories’”

**Discussions:**
Following his presentation, there was a discussion in which the prominent points raised by participants were as follows:

- The need to revise and upgrade the curriculum for AYUSH.
- The need to learn modern techniques for validation of AYUSH systems.
- Emphasis on observational therapeutics and documentation which is being neglected.
- Since we have 7 lakh practitioners, we could encourage documentation by these practitioners and collect data on selected disease condition.
- Disease modifying drugs are required for most of the communicable diseases to prevent further morbidity and mortality.
- If a plant is working in its essential extract, we need not break it down to its molecules; this is unnecessary and increases costs.
- Community health action research is required for validating the traditional practices
- Traditional practices of delayed cord cutting and squatting practice already exist, but often validation of these practices don’t emerge from India, but from the west.
- Learning should go beyond biomedicine and pharmacology to an understanding of the anthropology and sociology of health and disease for better clinical and community practice.
II.B. AYUSH and Public Health – Policy review
Ideas and Mandates (1946 – 2006)

Dr. Ravi Narayan, Community Health Advisor, Society for Community Health Awareness, Research and Action, Bangalore.

Dr. Ravi Narayan gave a bird’s eye overview of all the key Health policy documents since the Bhore committee 1946 to the NRHM of 2006, and shared the ideas and mandates for AYUSH systems.

Goals of Human Resource Development in India

The review included

- Health Survey and Development Committee Bhore Committee, 1946
- Health Survey and Planning Committee Mudaliar Committee, 1961
- The Srivastava Report - 1975
- The ICSSR – ICMR, Health For All Reports, 1981
- National Health Policy - 1983
- National Education Policy in Health Sciences Bajaj Report – 1989
- Independent Commission on Health in India (Perspectives on medical education) 1998
- Indian Peoples health Charter : Jana Swasthya Abhiyan, 2000
- National Health Policy - 2002
- Karnataka State Integrated Health Policy - 2003
- Task Force on Medical Education – NRHM, 2006
- National Policy and Programmes on Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) 2002
- Report of Task Force on mainstreaming of AYUSH systems in XI Plan 2005
Through out the presentation emphasis was on utilization of ISM personnel as resources in health care systems of country and training of AYUSH personnel for public health.

Some of the highlights of the policy overview included the following:

- Chairs of Indian Systems of Medicine should be established in all medical colleges. (Mudaliar committee, 1961)
- The need to evolve a national system of medicine for the country by the development of an appropriate integrated relationship between modern and indigenous systems of medicine (Srivastava report 1975)
- The Manual for community health workers evolved in 1978 by the Ministry of Health and Family Welfare included for the first time the chapters on Ayurveda, Yoga for health, Unani medicine, Siddha, Homeopathy, Naturopathy and medicinal plants.
- The alternative model of health care built on the best of tradition and modern science and which could be community rooted, economical and equitous should include the Ashrama concept of life, a non-consumerist approach to life, Health as individual and community responsibility, Yoga and simple and effective health care with Herbs and Naturopathy……. (ICSSR-ICMR health for all report 1981)
- Planned effort should be made to dovetail the functioning of all system practitioners and integrating their services at appropriate levels, with in specified areas of responsibility and functioning, in the over all health care delivery system specially in regard to preventive, promotive and public health objectives. (NHP 1983)
- Healthy and mutual respect for qualified practitioners of medicine irrespective of the system, is an essential prerequisite for effective health man power utilization…..Equal emphasis to be placed in UG and PG education of modern system of medicines to introduce basics concepts of ISM and Homeopathy to familiarize basic doctors and specialists with scientific basis of ISM and H (Bajaj report 1989)
- Indian Systems of medicine and Homeopathy should be appropriately involved in strengthening further the public health system of the country (Expert Committee on Public Health 1996)
- Support to be provided to traditional healing systems including local and home based healing traditions for systematic research and community based evaluation with a view to developing a knowledge base and the use of these systems along with modern medicine as part of a holistic healing perspective. (Indian Peoples Health Charter 2000)
- Urgent need to strengthen the ISM and H – to build up better working linkages, dialogue between systems – moving towards a more integrated comprehensive health policy, utilizing the potential of all systems at different levels of health care, particularly primary health and public health. (Karnataka Task Force on Health and Family Welfare -2001)
- Shirt term course for training Community Health practitioners for providing primary health care and training in Public Health also to be available for AYUSH graduates. (NRHM task force-2006)

In conclusion he expressed the need for integration, using multidisciplinary approaches.

**Discussions**

During the discussion that followed the presentations the following points came up prominently.

- Social science addressing AYUSH which could contribute to the AYUSH knowledge.
There is a lot of unlearning that a student of AYUSH systems has to undergo when he is learning about his system. A major factor contributing to this is that our system of education lacks AYUSH orientation in school education. Hence, the requirement of inclusion at various levels for better integration.

Ground realities include the fact that AYUSH practitioners are using modern laboratory testing facilities etc and such informal referral processes that have been working in India.

The importance of Community knowledge and the need to integrate within the system adequate and there is a requirement to integrate that within the system.

KAP surveys looking for health seeking behavior especially which systems peoples use for different conditions would be helpful.

The Market is accepting pluralism in its own way and we have to take this into account. Some new practices are due to commercialization and do not follow orthodox of different systems.

Legislations have an important role to play in the understanding of the limitations within AYUSH for e.g. the Tamil Nadu govt. has banned deliveries at home. This has a lot of repercussions upon the ASHA or CHWs in the state. Another point mentioned was that WHO doesn’t have a policy to legitimate the health workers from different systems. Even though the dais are highly skilled they are not adequately introduced into the system.

Health is a State system – where there is a plurality in everything, and what we lack are watch dogs – a citizen led activity, which will look and challenge the accountability of the state health program. The NRHM has recently set up Community Health Monitors to hold the system accountable at various levels.

Anti quackery act -the legal challenge of Primary health care. In terms of pluralistic health we need to stream line this law further.

The session was summed up by highlighting the challenge of integration at different levels and the need to have professionals from different systems of medicine who are like minded working together to document ideas, experiences and initiate further action towards greater integration.
Session B
Project Presentation and Sharing of ideas

I. Assessment of Mainstreaming of AYUSH under the NRHM

Prof. R. K. Mutatkar President, Maharashtra Association of Anthropological Sciences, Pune

Dr. Mutatkar put forward the project which was supposed to be conducted in Himachal Pradesh, Madhya Pradesh, Chhattisgarh & Maharashtra on the Assessment of Mainstreaming of AYUSH under the NRHM so as to get the ground level reality of AYUSH systems. He laid down the plan and tools for assessment required.

The aim was to provide outcomes to formulate policies and implementation strategies to maximize the available resource of plural therapeutic systems in health care of the people. The objective is to document status and functioning of AYUSH in Health Care Delivery.

At the outset he mentioned about the various plans through which AYUSH was to be mainstreamed in a phased manner. He indicated towards the surveys which mentioned about the popularity of AYUSH systems. However there are no real grounds on which these things could be claimed with precise authority.

He felt that the situation (ground reality of AYUSH) is to be assessed based on the evidence on the acceptability and availability of the AYUSH systems at various levels emphasizing on

- Functioning of Plural therapy and cross referrals
- Roles of AYUSH trained personnel, paramedics and traditional healers
- AYUSH IEC material
- AYUSH training, orientation and CME of medical and paramedical personnel

He also emphasized the need to develop an approach common to different AYUSH systems with a holistic approach with a data on

- Infrastructure at State, district, tehsil /block level about health care - personnel, training, budget.
- Utilization of AYUSH personnel - job charts/ responsibilities
- Referrals in AYUSH
- AYUSH components in curricula and training material of paramedics under NRHM
- Public-private-NGO-PRI partnership
- AYUSH in RCH, adolescent health, geriatric care and non-communicable diseases.
- Utilization by people of local health functionaries and traditions

Since the project was in pilot phase the study area was restricted to one district and two tehsils (taluk) in a state. With in each tehsils (taluk), the focus would be on the district hospital, Rural
hospital, two PHC's and two sub-centre's, AYUSH Dispensary, CGHS dispensary. Private Sector & Voluntary sector would also be included. The selection criteria were as per Human Development Index or better performance of AYUSH in Public Health with preference to SC, ST dominant areas.

He suggested strategies like, Interview, survey, focussed group discussions and observations which covered all aspects of the functioning of systems.

Expected outcomes were to identify issues for policy implementation which included ……

- Strengths/gap in utilization of plural therapy under NRHM
- Training, orientation and IEC requirements of medical, paramedical and local health functionaries
- PRI-NGO-CBOs roles in integration of plural therapy
- Household indigenous healing practices about preventive, promotive & curative needs
- Roles of Anganwadi system in women and child health including adolescent health.
- A Standardized methodology for such studies

Discussions:

- The discussions focussed on, synergy between AYUSH, People perceptions of the quality of services, and the need for qualitative in-depth analysis of health seeking behavior,
- One of the suggestions was to subject the tools for research (survey forms and methods) wider discussion so as to develop a common strategy for such studies in other states.

II. Training in Epidemiology – Integrating with AYUSH

Dr. K. R. John, Professor, Dept of Community Health, Christian Medical College, Vellore

Dr. K.R. John shared the experience of CMC Vellore in training AYUSH Graduates in Epidemiology. The course (M.Sc Epidemiology) started in 1995 has to date trained 23 students of which 12 are from AYUSH (Siddha: 6, Homeopathy: 6). He mentioned that the course was designed to have students from various disciplines in response to need for such a course from them.

The training curriculum included Epidemiology, Biostatistics, Health economics, Health management, research methodology, critical review of articles, conducting studies, and Geographical Information Systems. The pattern of training included conventional classroom sessions with problem based projects and assignments, workshops, basic and advanced course modules, community orientation programmes including problem solving exercises, short projects and dissertation.

He also pointed that AYUSH candidates did well in epidemiology and research methodology and become leaders in the areas health care training and research. One of them completed a Phd. However they could only find jobs in allopathic institutions in research and training posts but there was no entry into AYUSH Systems and AYUSH colleges. This needed to be explored further.
Discussions: the main points raised were:

- Elements of Community medicine exist in the texts of AYUSH and there is need to review this literature and to incorporate it into a Public health- AYUSH module.
- Inclusion of orientation AYUSH concepts and systems in the Medical College and nursing curriculum.
- Urgent need to develop approaches specific to AYUSH systems incorporating the public health research principles so as to promote AYSUH system development.

III. RISHTA project and AYUSH initiative – The narrative Prevention Counseling (NPC) as a tool for the prevention of HIV / STIs

Dr. Ravi Verma, International Centre for Research on Women and Dr. Niranjan Saggruti, Population Council

The Dr. Ravi Verma gave an introduction about the major collaborators for the Research and Intervention in Sexual Health – Theory to action (RISHTA). The project recognized Gupt rog (“Secret sexual illnesses”) as an entry point for Sexually Transmitted Infection (STI) prevention and Human Immunodeficiency Virus (HIV) risk reduction. The focus was to establish meaningful and mutually respectful partnership between Allopath and AYUSH Systems while challenging the norms about masculinity, relationships and sexuality in group and community settings.

Gupt rog was considered important because it was widely prevalent, sexually focused, culturally constructed and correlated with sexually risky behavior.

The project did not focus on the efficacy of AYUSH medicines or intervention, but with a focus on health seeking behavior in context of gupt rog and was limited to the Narrative Prevention Counseling (NPC) as a tool for the prevention of HIV / STIs the objectives were

- To Assess relative impact of engaging AYUSH providers versus Allopathic providers on HIV risk reduction at the community level,
- To assess differing impact of community education versus trained providers on HIV risk reduction at the individual level,
- To develop, test and evaluate the “Narrative Prevention Counseling” (NPC)
- To draw lessons to scale, mainstream and sustain a holistic response to HIV prevention

A set of 23 symptoms ranging from nocturnal emission to difficulty in urinating were set as symptoms for gupt rog after a detailed interview with patients. Quasi experimental design with three experimental groups, was taken

- Experimental Community # I (Male Health Clinic Established in Urban Health Center; Allopaths trained in Narrative Prevention Counseling (NPC); Community and group education)
- Experimental Community # II (AYUSH Providers were trained in NPC; Community and group education; Referral linkages)
- Control Community # III (Community and group education)
Narrative counseling process was used to help men to reconstruct sexual health issues within the framework of Masculinity, Relationships; and Lifestyle were to be done, with Monitoring and Evaluation of providers on integration of NPC for a period of 2 years.

There was the increase in STD prevention knowledge was more pronounced in case of AYUSH trained providers than the Allopathic trained providers and also there was increased satisfaction more in AYUSH intervention community than the MHC intervention community. The AYUSH personnel more complaint with Integration of NPC Model, at Assessment Level, Interpretation Level and Prevention Level.

Discussions:
Following points on AYUSH personnel came out during the discussion

- AYUSH practitioners are more people based and relate to their patient’s in a better way.
- They see the problem in a more holistic way and are often the more sought after system of medicine for sexual health
- In the study behavioral changes were seen more in the patients managed by AYUSH systems
- It was also suggested that Integration of AYUSH with STD/HIV could be beneficial.

IV. Promoting Medical Pluralism at different levels

Dr. S. P. Tekur, Member, Society for Community Health Awareness, Research and Action, Bangalore.

Dr. S.P. Tekur a pediatrician by training, who has been a key team member and resource person with CHC/SOCHARA especially in the area of medical pluralism and community based health care, gave an over view of his experiences with different systems of medicine. He is a plural practitioner, who has adapted the best from all systems of medicine. He also takes part in training of health workers and dissemination of knowledge from various knowledge systems.
Through his experience in the field he suggested two stages for Interventions which need to be much focused. One must initially focus on what the people need, and then intervene according to need based and the cost. He shared his experiences of involvement in public health through the following components.

**Traditional Dais: Post partum hemorrhage is attributed as one of the causes for maternal mortality.** He shared about the initiative in Malur where in he taught the Acu-pressure techniques to the Dais i.e. traditional birth attendants (TBA’s) for controlling placental hemorrhage in field situations with successful results. He also emphasized the need to train nurses and ANMs in such simple techniques since they are strong workforces which are being neglected.

**Nutrition:** He shared about his experiences with an NGO, RORES, Srinivasapura, where the challenge was to tackle childhood malnutrition and worm infestation and also anemia among women. A search for a solution led to various medications found to be useful for the same, but a solution in from of a nutrition supplement was worth exploring. This search led to the idea of using spirulina as a nutrition supplement and by growing it locally as an herb, and evolving a practical cost effective local supplement from it.

A study of 90 women (from a lower social economic status), who were given spirulina (one tablet twice a day) for 3 months showed a significant haemoglobin increase and weight gain. The same has been published in Health Action, a Journal published by the Health Accessories for All Trust Hyderabad.

**Indigenous Knowledge for Malaria:** Holistic approach incorporating the basic public health activities like cleaning up, personal hygiene, personal prevention measures, special measures to risk groups, and proper nutrition coupled with people’s indigenous knowledge for common ailments can be used as effective public health measure against malaria.

A pilot project in Karnataka was facilitated through SAMUHA (institution working on integrated village development) for a period of 3 years. The project was to run in 53 villages, and eventually a list of 50 remedies was prepared. From the same list the toxic remedies were eliminated, based on literature review and toxicological tests. 12 remedies remained after the filtration and finally the list was restricted this to 5 remedies.

It was noted that by the end of the first year the incidence reduced significantly, in the 2nd year there was no malaria detected, and in the 3rd year, recurrent fever reduced significantly.

**Mental health:** AYUSH has huge resources on effective solutions for rehabilitation therapy. AYUSH practitioners act as counselors because their system principles meet this demand and the systems focus on wellness rather than illness care.

**Child health:** Being a pediatrician, his experience has shown that children respond well to Homoeopathy, and it builds the immunity of the child.

**Transfer of Technology to health workers:** He opined that programmes like NRHM should look at transfer of technology to the health workers e.g. teaching BP and urine examination.
Discussion:
During the course of the description the following questions came up:

- Can our health care systems of medicine be really plural? as narrated by Dr. Tekur whose example of plural practice was a very good one.
- Is it possible for our public health system to be really plural at the programme level?

Session C
Summary of Complimentary and Alternative System of Medicine for Health Promotion at Sao Hai Hospital, Saraburi province, Thailand – A Video Documentary

The documentary provided the concept and implementation of Thai traditional medicine for the promotion of health at Sao Hai Hospital, Saraburi province, Thailand. Sao Hai Hospital is a community hospital. It started providing health services in December 28, 1993 with a 10-bed capacity. At present, it has a 30-bed capacity and 150 out-patients per day. The hospital has improved its physical structures, surroundings and working environment, and human resources; received Hospital Accreditation (HA) in 2003 and Health Promoting Hospital (HPH) in 2005; and has continuously been re-accredited.

Highlights
- Thai Traditional Medicine (Massage with hot press or a bag of health medical herbs)
- Health Home, a home stay open for people to learn and change their behaviors in order to prevent injuries and accidents

Activities
- Enhancing community’s capacity building for community volunteers
  - Exercise
  - Beautiful House Project (Na-Baan-Na-Mong)


The participants appreciated the efforts of the Thais in integrating traditional medicine with primary health care as shown in the documentary and felt that the same could also be implemented in India with some effort. This movie added to Dr Tekurs description of pluralism with a holistic solution on a result oriented basis.
Session D
Tour of FRLHT campus Introduction and Recapitulation

Mr. Darshan Shankar, Director, Foundation for Revitalization of Local health traditions
Bangalore

The Day began with a guided tour of the FRLHT campus by Mr. Darshan Shankar during which the establishment of FRLHT and its work in revitalizing local health traditions were explained to the participants of the workshop.

Mr. Darshan Shankar recapitulated the objectives of the workshop and highlighted the need for Public health intervention based on AYUSH that is of a benefit to the people at a community level. He described it from FRLHT experience:

Copper as mentioned in the old texts and also traditionally has been used to store water, and has been described to have health related benefits by providing a means to purify drinking water. An intervention that FRLHT carried out validated that water stored in copper utensils would after a period of time (8 hours) significantly kill E. coli in the water. The effect of this intervention was used to lower the incidence of water borne diseases.

The inference here was to describe to the participants that an intervention needed to have two significant components:

a. Validating the intervention
b. Adapting the intervention in providing a health benefit to the community.

The fundamental aspect therefore is that all such projects must have a community approach, and ultimately the community must benefit from it. The support components could be research, bench...
marking, pharmacological and clinical investigation and documentation. FRLHT as an institution had developed all these types of responses over the years.

Mr. Darshan also took this opportunity to sensitize the representative of the Dept. of AYUSH on the fact that the AYUSH sector has not been invited to be involved in public health interventions at all because it had not taken such initiatives. He added that it was not that AYUSH doesn’t have any contribution or utility in public health. A sub-committee of the planning commission had recently listed all the activities that the AYUSH systems could possibly take up to strengthen the public health systems further. The Dept. of AYUSH has to capitalize on this opportunity given to them and to build the focus on AYUSH and Public health in a more proactive way. This workshop was one such initiative.

He added that the design of the projects should always have an epidemiological benchmarking. The proposal will also have to have some element of strengthening the system in terms of using standardized methods. This also holds true when we have been looking at individual or clinical approaches, and now the need to look at the same with the public health lens.

Session E
Project Presentations and sharing of ideas

I. Research Initiative on Traditional Anti-Malarial Methods (RITAM)

Dr. B.N. Prakash, Research Officer, Foundation for Revitalization of Local Health Traditions.

Dr. Prakash presented the concepts and implementation of the programme called RITAM with the background on malaria situation in the country. 75% people suffering from fever in malaria endemic regions, treat themselves at home, often with traditional medicines.

Research Initiative on Traditional Anti malarial Management methods (RITAM) is a network of projects coordinated by Global Initiative for Traditional Systems of Health (GIFTS: http://www.giftofhealth.org) Oxford university, UK. The objectives of this program are to assess effectiveness of few anti-malarial management methods from folk health practices as well as Ayurveda medicine through screening of folk and Ayurveda literature, standardization of formulations, pre-clinical studies, clinical trials, promotion of the use of remedies/practices with positive clinical results through community health & education programs and facilitating commercial production with due recognition of intellectual property rights of the knowledge holders.

This study consists of two arms having equal volunteers each. One arm (study arm) on decoction twice a week for 3 months with methodological documentation. Other arm which is on placebo (control arm) where in documentation is carried out as in the first group. The volunteers are followed up for a period of 2 months after the intervention. The volunteers will be document clinically for any sort of health changes every fortnight and the data recorded initially and during the clinical documentation will be used for the analysis.
TRADITIONAL ANTI-MALARIAL MANAGEMENT STUDIES

- **Literature study**
  - 23 classical texts
  - 115 formulations
  - 166 individual drugs
  - Jvara database

- **Field & Experimental study**
  - Documentation
  - Assessment
  - Community based study
  - New plant based remedy for malaria

Source: Prakash.B.N, RITAM, Stakeholder workshop on AIPH, Bangalore.

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### COMBINED RESULTS OF VARIOUS STUDY (2004 TO 2006)

<table>
<thead>
<tr>
<th>Study period</th>
<th>Local NGO</th>
<th>No. of camps</th>
<th>Malaria incidence Study group</th>
<th>Malaria incidence Control group</th>
<th>Total population of the village</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug 2006</td>
<td>SAMBANDH Orissa</td>
<td>27</td>
<td>1 (90)</td>
<td>12 (95)</td>
<td>611</td>
</tr>
<tr>
<td>Jan 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sep 2006</td>
<td>IDEA Andhra Pradesh</td>
<td>27</td>
<td>2 (149)</td>
<td>10 (149)</td>
<td>816</td>
</tr>
<tr>
<td>Feb 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug-Dec 2005</td>
<td>SAMBANDH Orissa</td>
<td>24</td>
<td>12 (158)</td>
<td>53 (153)</td>
<td>630</td>
</tr>
<tr>
<td>Aug-Dec 2005</td>
<td>JKP Orissa</td>
<td>24</td>
<td>12 (100)</td>
<td>60 (100)</td>
<td>295</td>
</tr>
<tr>
<td>Aug-Dec 2005</td>
<td>IDEA Andhra Pradesh</td>
<td>24</td>
<td>0 (141)</td>
<td>0 (137)</td>
<td>559</td>
</tr>
<tr>
<td>Jun - Oct 2004</td>
<td>BAIF Karnataka</td>
<td>40</td>
<td>1 (88)</td>
<td>7 (937)</td>
<td>1121</td>
</tr>
</tbody>
</table>

Source: Prakash.B.N, RITAM, Stakeholder workshop on AIPH, Bangalore.

Significantly Reduced malaria incidence in the study group as compared to the control in Dandapadia, Orissa (P = 0.002) and Malisingaram-Manjaguda-Sirlamamidi, Andhra Pradesh (P = 0.018).

He concluded by stating that Traditional medical knowledge based, eco system specific herbal practices, implemented through community based participatory approaches are feasible. He also
mentioned the need for large scale, multi-centric studies emphasising on detailed pre-
erythrocytic stage studies are also required to understand the mechanism of their action.

**Discussions:** Following were the comments
- It was suggested to have another strategy that accesses the public health delivery systems
- Synthetic bed-nets used in Orissa, a DFID interest program, also use a pesticide called deltamethrine. If there is an AYUSH equivalent related product, could it be propagated by AYUSH practitioners and traditional healers?

II. **Upgrading community based health care system with emphasis on Maternal and child health care in Vikramgarh Taluka, Thane Dist. Maharashtra State.**

*Dr. K.M. Dhawale, Dr. M. L. Dhawale Memorial Trust, Thane District*

Dr. Dhawale presented a project which envisaged orienting & training the community in the concept of holistic health care through homoeopathy. The project attempts to build human capabilities at the grassroots level by developing and training a cadet of homeopathic community health volunteers CHV’s, who will lead the programme in terms of its priorities, direction and also participate in planning and evaluation. It also tries to integrate “Medical Service Provider Model with Community Development”. The vision is to have self reliable, sustainable and ecologically healthy systems, nurtured by a spirit of collaboration with progressive grass root leadership using AYUSH and local Healing measures.

He then explained strategies for involvement of community and community health workers and also withdrawal strategy. The formation of local committees would include local village based committees and also self help groups, bal- arogya samiti’s, youth groups and mahila melawas. The project is for four years in which the first phase will be pilot, which will cover the following structures and manpower.

<table>
<thead>
<tr>
<th>Population</th>
<th>50,628</th>
</tr>
</thead>
<tbody>
<tr>
<td>Villages</td>
<td>35</td>
</tr>
<tr>
<td>Padas (hamlets)</td>
<td>233</td>
</tr>
<tr>
<td>Sub centers</td>
<td>8</td>
</tr>
<tr>
<td>Proposed no of Arogyamitras (CHV)</td>
<td>35</td>
</tr>
<tr>
<td>Proposed no: of MPWs</td>
<td>10 (1 MPW for 3 CHVs)</td>
</tr>
<tr>
<td>Proposed no of Supervisors</td>
<td>3 (1 Sup for 5 MPWs)</td>
</tr>
<tr>
<td>Proposed no of Medical Officers/Social worker</td>
<td>1 (1 M.O. for 1 Sup)</td>
</tr>
</tbody>
</table>

Source: Dahwale.K.M, PPT, Stakeholder workshop on AIPH, Bangalore

The first phase will be consolidated and the project will be extended into next the PHC area. The second and third phase will consolidate the work in the earlier PHC/s and expand into the next one. The fourth phase will consolidate all the PHCs and hand over control to the communities.
Expected outcomes were aarogya mitras at almost each pada level, trained multi purpose worker, an empowered & organized community with operational committees for health, education, development & administration, reduction in the anemia of pregnancy to 20% from the current state, reduction of IMR from 106 to the national level of 59 and reduction of MMR by 90%.

Discussions:
- It was very apparent that the program opted to create a ‘Parallel system’ in addition to the existing government strategies. Participants felt a need to integrate within the existing system through setting up linkages and networking
- Withdrawal strategy should be in a phased manner emphasizing sustainability.
- Complex issue of functionally integrating the program into the mainstream govt program
- While It is important to build capacity of the community, It is necessary that we do not force the choice upon the people and help them to make their own decision.
- Suggestion to modify the project slightly to create a case control type of an intervention

III. An Overview of Yoga Research in Public Health

Dr. H. R. Nagendra, Vice Chancellor, Swami Vivekananda Yoga Research Foundation, Bangalore

Dr. Nagendra presented the experiences of SVYRF in both on going promotion and research of yoga, as well as their recent initiatives on developing yoga for new age diseases like stress.

He has been conducting studies on integrated approach of yoga therapy for conditions like bronchial asthma, nasal allergy; diabetes mellitus; hypertension & ihd; ophthalmic disorders; obesity, back pain etc; with nearly 100 research papers published in peer reviewed journals. The integrated approach of yoga therapy holds great promise for modern ailments

He also shared the work of the “stop diabetes” project of the AYUSH Dept. which was supporting a 300 sample, two arm trail. They are also in collaboration with St John medical hospital; and have collected evidence to show that regular practitioners of yoga will have significantly lower insulin resistance compared to non-practitioners as measured by Insulin Clamp.

In conclusion he emphasized the need for long term follow up studies to be taken in AYUSH for prevention and promotion of positive health.

Discussions:
- Inclusion of Yoga in School Curriculum. Yoga has a significant influence at young age and makes children more receptive to it. Making YOGA a part of the education system is important as it is still looked on as an elitist practice and not a community based system of wellness. The approach of legitimizing yoga is still being looked at from a clinical or curative point of view, even though YOGA is in reality a system of health promotion. It should be included into the physical education system in schools as a way of life.
- It was also suggested to develop a module in yoga for community health workers and other health practitioners considering the stress levels that they face on a day to day basis.
• YOGA is looked as a methodology in a secular sense in foreign countries, but in our country the debates are not scientific and get linked to religious and cultural aspects, delaying the universal acceptance of Yoga as a very effective health promotion tool.

IV. Revitalizing Local Health Traditions

Dr. Elizabeth Negi, Martin Luther Christian University (MLCU), Shillong, Meghalaya

In her presentation Dr. Elizabeth Negi shared her experience of revitalizing the local health traditions in Khasi, Jaintia and Garo Hills of Meghalaya.

The Public Health System in Meghalaya is plagued by lack of health personnel, supplies and logistic support. Remote regions and inaccessible terrain compound these difficulties. The tribal communities of Meghalaya can be viewed as societies in transition with a significant burden of non-communicable diseases such as diabetes, hypertension, cardiovascular and other chronic diseases. The National Family Health Survey 3 (NFHS 3) conducted in 2005-06 shows that in most healthcare indices, Meghalaya is well below the national average. Among the Northeast states, Meghalaya ranks last, in most of the indicators.

The MLCU conducted a “KAP Survey on Traditional Medicine in Mawlam Village, Meghalaya” during 2006. A 55 item tool was used for the household survey along with some socio demographic data. Primary reason for people still continuing with local traditions is not only because of their belief in its efficacy and usefulness but also because it is affordable. They spend on an average Rs.60/- annually for consulting local healers compared to average Rs.2600/- for other consultation with allopaths. There was a clear understanding when they would use the services of an allopath – eg. pregnancy related complications, surgical interventions.

She ended by projecting the need to conduct a participatory rural appraisal of local health traditions, encourage laboratory validation and clinical trials, and plans to compile a community knowledge register on local health traditions in a structured manner.

Discussion:
The project was appreciated for assessing traditional medicine popularity / utilization with the current health indicators. It also included a strong health economics perspective in the research activities, which will provide a good advocacy tool for policy intervention.

V. An Integrated Approach to Prevention and Treatment of Common Childhood Morbidities and Nutritional Deficiency in Tribal Areas with Health Care Deprivation with emphasis on use of Local Medicinal Plants

Dr. Tanaz Birdi, The Foundation for Medical Research (FMR), Mumbai

Dr. Tannaz Birdi described a project that attempts a community level initiative to revitalize / promote locally popular herbal remedies with documentation and scientific validation of the action of the plant by a modern laboratory.
The objective are to design and undertake pre-clinical screening assays for plants identified for acute respiratory infections (ARIs) through ethnomedical and ISM surveys, relevant social interventions, incorporate unused parts of plants cultivated for income generation into nutritional and acceptable recipes in consultation with the community for prevention of malnutrition. The overall vision is to address the morbidity of Diarrhoal Diseases, Malaria, Acute Respiratory Infections and Malnutrition.

The approaches to address the morbidity situation were assessment through PRA, giving the space for community participation. Intervention through basic public health measures, like check on water pollution and chlorination of water sources and purification of water at household level in case of diarrhoea and vector control measures in malaria.

The herbal intervention was planned after the proper validation and disease specific microbial assay. She concluded by highlighting the role of PRA which paves way for community involvement in the decision for the envisaged intervention.

**Discussions:**
During the discussion the following positive aspects were appreciated.
- Scattered sample intervention areas to see if the surrounding villages would get interested.
- The essentiality of pre-clinical tests is a requirement, so that a formulation will be determined that will cover all types of the clinical condition

It was also suggested to build up a linkage to the public health system and also explore possibilities of multi-centric trails.

**VI. Siddha medicine and community health**

*Dr. Joseph Thas, President, Friends of Siddha Medicine, Tirunelveli*

Dr. Joseph Thas reflected on his experience of attempting to introduce Siddha medicine at community level for
- Diarrhoeal
- Nutrition
- Leptospirosis
- Chickungunya
- Leprosy

Some of the mains observations were that there is a defined efficacy in the traditional texts, but there is limited implementation due to lack of confidence in this knowledge in Siddha practitioners. He felt that people are acutely aware of efficacy of a drug

The other suggestions / idea given by him were:
- Integrate AYUSH systems among themselves, before mainstreaming.
- Keep other systems of medicine as ancillaries in the existing study program for each system. Eg. The Ayurveda curriculum could include orientation to Yoga, Siddha, Unani and Homeopathy.
- Creating a system that merges the AYUSH into a separate plural course.
Discussion:
In respect to the creation of a system that merges the AYUSH into a course, it was made known to all participants that Dr. Zafarullah Chaudhury, a revolutionary health innovator in Gonoshashthya Kendra, Bangladesh, is attempting to create plurality in Alternate medicine through the peoples university (Gono bishwabidyalaya). The course would include Ayurveda, yoga, Naturopathy, acupuncture, etc. An attempt is also being made to create a hospital that is plural for the purpose of teaching.

VII. Experiences with Traditional Medicines
Mari Thekaekara/ Dr Mahesh Mathpati, ACCORD Gudalur

ACCORD (Action for Community Organisation, Rehabilitation and Development) was born in November 1985 out of the realisation that the adivasis of the Gudalur Valley were being cheated and exploited and might soon disappear off the face of the earth.

The ACCORD began as a mission for human rights, health, education, housing and culture. The mission is to redesign the systems necessary for that, to help the adivasi community cope with the onslaught of modernity on their way of life and to prepare them to emerge from their forest retreats with their heads held high proud of their culture and their people.

Association for Health Welfare in the Nilgiris (ASHWINI):
This is a charitable organization providing comprehensive health care for one of the most neglected sections of the areas where ACCORD currently works.

One of the highlights of ASHWINI's health Programme is the innovative health insurance scheme. For the adivasis used to community living for ages, the health insurance scheme was the modern equivalent of sharing their risks and helping each other in the hour of crisis. Over ten years, this Programme is being run by ASHWINI successfully, though not without problems.

ACCORD began realizing that the input of the medical systems is making traditional healing practices slowly disappear. Hence they are currently documenting the local health traditions with assistance from FRLHT. The region houses different specialists of traditional healers who are traditional bone setters, etc.

Mrs. Thekkekara commented that this workshop has helped her understand a little more about AYUSH and its role in Public health. They are currently being assisted by young Ayurveda Dr. Mahesh.

Dr. Mahesh Mathpathi narrated his efforts to mobilize the traditional healers in adivasi communities to a forum where in they can share their experiences between themselves. He also expressed the need to document the existing practices and also take up an initiative in traditional medicine in the existing institutional community health Programme like,

- Training CHWs from the community itself
- To identify and prevent illnesses like diarrhoea,
- To provide immunization and nutrition to pregnant women and children
- Improve health awareness among the adivasi community
VIII. Traditional & modern childbirth practices in villages of Bokaro

Dr. Lindsay Barnes, Project Director, Jan Chetna Manch, Bokaro

Dr. Lindsey Barnes presented the experiences of Jan Chetna Manch in both existing traditional practices, as well as its recent initiative in involving the mother-in-laws, traditional birth attendants (‘dais’), elderly women, and rural medical practitioners (RMPs) to study traditional childbirth based practices.

She gave the ground level reality picture of what takes place in the villages of Bokaro. Some of the traditional practices that has been documented in great detail are, delivery in squatting position, oral fluids and light food during labour, and delayed cutting of cord.

At the same time she emphasized on the complications associated with both traditional and modern childbirth practices. She conducted a study on combining the proven ‘good’ practices from both the systems. A total of 32 women were studied combining the best practices. Of which 30 deliveries occurred at home and rest (2) at hospital.

She emphasized the need to retain best traditional practices, which are increasing getting scientifically validated, whilst removing harmful traditions. Simultaneously we should address the harmful modern practices at source (qualified doctors, pharmaceutical companies) and encourage positive modern practices. She advocated the need for traditional and modern practitioners to learn from each other and to respect each others traditions.

Discussion:
The participants acknowledged that public health builds on traditional knowledge as well as the current accepted standards and should be sensitive to the traditional systems. It was also suggested that traditional practices should be used in lieu of episiotomy.

IX. Overview of the Schemes under discussion

Mr. S.D. Sharma, Dept of AYUSH MoHFW, GoI

He outlined the key features of the guidelines for grant in aid scheme for promotion of AYUSH interventions in public health initiatives, and also the central sector scheme for supporting reorientation training, continuing medical education and exposure programs of AYUSH. These guidelines are mentioned in the annexures, C and D. He emphasized that the proposals should be technically, administratively and financially sound. Staff and administration requirement should not exceed 40% of the overall budget. No equipment would be provided in these grant in aid schemes.

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CHAPTER III

III.1 Summary of the key issues discussed

The presentations and discussions provided insights into the state of AYUSH systems and their links with public health, both actual and potential. The focus was on exploring various ideas and initiatives through which the AYUSH department could support or undertake community health action research and training programmes. The efforts were to develop a universal and holistic approach for utilization of AYUSH systems in the public health systems of the country. The workshop clarified that there should be efforts to strengthen the existing Public Health systems rather than creating a parallel system. A wide range of issues were discussed ranging from policy issues to assessing the ground realities of AYUSH. Some of the major issues that were presented and discussed included the following (Based on a summary by Dr. Leena Abraham on the first day and Dr. Deepak Kumaraswamy for the second day)

III.1. A. People’s Movement for Integrated Public Health

• Need to develop and support a people’s health movement with a broad range of community interventions
• Need to recognize plurality of the systems.
• Improve the knowledge of modern science among AYUSH practitioners to enhance the perspectives. This would enhance the knowledge base of AYUSH systems.

III.1. B. AYUSH and Public Health – Policy review

• Critical overview of the role of AYUSH identified in public health policy in the country over the last 6 decades.
• Policy prescriptions to integrate the systems have existed in the past but this is the first time we are coming together to discuss the integration of AYUSH both in primary health care and the public health system.

III.1. C. Assessment of main streaming of AYUSH under NRHM

• Assessment of the existing situation of AYUSH mainstreaming at local, block, district, state, regional and national levels is urgently required.
• There is need to address the promotional avenues and the reward mechanisms for AYUSH practitioners involved in the system.
• The needs of the community should also be identified
• The variations of the situation in different states should be considered and hence more states should be considered and incorporated in the projects and studies.
• Legality involved in respect to integration of AYUSH practitioners in the system has to be studied carefully.

III.1. D. Training AYUSH graduates in Epidemiology/Public health.

• The influx of AYUSH graduate into CMC Vellore for the epidemiology course has been a positive experience with most of them now placed in the biomedical sector.
• Is there a way that one can orient the AYUSH Sector so that those getting public health and epidemiology training can feed into AYUSH institutions and the AYUSH sector.
• Need to have a public health / preventive and social medicine text book that is AYUSH specific and also builds on AYUSH concepts.

III.1. E. RISHTA-Research and Intervention in Sexual Health – Theory to Action; Project
• This research project established that AYUSH practitioners spend more time in talking to their patients and this can be a potential asset for health promotion oriented approaches.
• The establishment of communication and rapport building skills among practitioners is very important.

III.1. F. Promoting Medical Pluralism at different levels.
• AYUSH provider can look at a wide range of opportunities in clinical medicine and community health for integrating with other systems and the public health programmes.

III.1. G. RITAM
• The RITAM project had broad outlook based on people’s traditional interventions with encouraging results.
• Need to subject these traditional practices to rigorous tests to make it fool proof at community level specially their safety.

• This project emphasized a strategy for evolution of training and out reach for community involving community based workers.
• The need to integrate within the existing system through setting up linkages and networking was emphasized in the discussions.

III.1. I. An Overview of Yoga Research for Public Health
• Focus on YOGA as a major solution to new age illness- with a focus on reduction of stress.
• Need to explore various education avenues to promote Yoga.

III.1. J. Revitalizing of Local Health Traditions, MLCU, Shillong
• Assessment of traditional medicine based on the current health indicators
• Health economics perspective introduced as a necessary component for research into policy interventions.

III.1. K. An Integrated Approach to Prevention and Treatment of Common Childhood Morbidities and Nutritional Deficiency in Tribal Areas with Health Care Deprivation with emphasis on use of Local Medicinal Plants.
• Essentiality of validating the intervention so as to have a clarity on intervention approach
• Ensuring Community participation through Participatory Rural Appraisal (PRA).

III.1. L. Siddha Medicine for Community Health
• Need to develop adequate interaction and integration between various AYUSH systems before actually initiating the mainstreaming activity.
III.1. M. ACCORD: Experiences with Traditional Medicine

- The need to protect and revitalize the local health traditions which are in a state of erosion.
- Evolving a strategy for community participation in assessing Local Health Traditions for promotion of health integrated with livelihood security.

III.1. N. Traditional & modern childbirth practices in villages of Bokaro

- Need to retain proven good methods of traditional birth practices.
- Need to evolve a plural mixture of effective traditional and modern practices as the way ahead to strengthen women and children’s health.

On the first day the need for documentation as an important component of the Programme was the key point summarized as a common theme across the discussions and presentations emphasizing on the utility of the documented data to identify and prioritize the Public health intervention. While second day prioritized the need for validating Traditional Medicine and AYUSH integration with the linkage of such initiatives with the government supported public health system.

III. 2. The Way Ahead

The final session of the workshop led to all the participants identifying a five key themes for further follow up and collective action to take forward the agenda of integrating AYUSH into public health systems in the country

III. 2. 1. Situation Analysis of AYUSH in the current public health system.

The information on AYUSH is very scanty, and there is need to get an actual understanding of the situation on the ground. Added to this there is a lack of consequent action research or programmes for development of AYUSH. Even as we are almost in the mid-term of the NRHM in India, there is no assessment being done in regards to Mainstreaming of AYUSH in India.

The Maharashtra Association for Anthropological Sciences, (MAAS) Pune has proposed and presented an appraisal project in the following four states; Himachal Pradesh, Madhya Pradesh, Chattisgarh and Maharashtra. During the course of this workshop it was also suggested that more states could be roped into this study to increase the states being covered, so that a more representative overview of the situation in the country emerges. From the participants of the seminar it seemed possible to include the states of Kerala, Karnataka, Tamilnadu, Jharkhand and some states of the North East. The AYUSH department should consider extending the proposal of MAAS involving other Ngo partners and this extended study could be coordinated and facilitated by MAAS, who would focus on the four states in their existing study and share instruments and methodologies of survey with other participants who would cover other states.

*It was suggested that Dr. Mutatkar be the focal person for this theme and MAAS be invited to have a methodological workshop supported by the department.*

III.2. 2. Public Health education for AYUSH sector.
The inclusion of competent public health teaching into the AYUSH curriculum is very crucial to build a strong relationship between AYUSH systems and Public health in India. Furthermore, the training of existing AYUSH practitioners in Public Health is also necessary to respond to the new opportunities that are emerging for public health itself as a discipline, as well as the new ethos of pluralism and dialogue.

The AYUSH systems themselves are built on the principles of wellness, and the concepts of preventive and social medicines exist in the original texts. There is a need to document these teachings and practices with the intention of developing a Public health curriculum that is also in tune with AYUSH systems.

Alternatively, attempts have to be made to include an AYUSH component into mainstream medical and nursing education, to sensitize and orient the mainstream medical and nursing profession on the importance of traditional healing practices and AYUSH in India.

A few examples of initiatives that could be developed to strengthen this thrust area are:

- Public Health training for AYUSH graduates. (Eg: PHFI is planning to make AYUSH graduates eligible for admission to IIPH's. Similarly the CH fellowship scheme organised by CHC Bangalore is open to AYUSH graduates.)
- Training programme for AYUSH Under Graduate teachers to strengthen Preventive and Social Medicine / public Health training within the existing AYUSH curriculum.
- Development of short AYUSH orientation courses for medical and nursing colleges. (Eg FRLHT has been working on framework of such a course with Rajiv Gandhi University of Health Sciences)

It was suggested that the focal persons for this theme could be Dr. K. R. John of CMC Vellore, and Dr. Ravi Narayan of CHC; Dr. Dhawale from Mumbai and a representative faculty of the PHFI could support him in the task.

III.2.3. Validating AYUSH formulations and approaches in various community situations (In the context of Primary health Care and Public Health)

There is need for greater effort to validate the use of AYUSH medicines for particular diseases. as part of national health programmes before they can be introduced into the public health system. This has to be done at various levels of the health system. Validation gives credibility to a practice. But here we are not looking to address only validation of the system or an approach, in scientific terms but also there is a need to validate the approach as part of an integrated field programme, relevant to the social, economic and cultural situation of the people. This may require appropriate technological or methodological modifications of AYUSH clinical practice.

A few examples are as follows:

- The Dai tradition has practices that have been validated in a small field based studies and can be included in public health programmes along with modern practices.
- The RITAM project has proved the efficacy of traditional formulations and practices of the local community which can be integrated into the malaria programme.
The Spirulina trial, mentioned by Dr. Tekur has proved its effectivity in improving the hemoglobin and nutrition level of the women in the intervention area.

**More such methods and formulations could be subjected to validation efforts at community level. A small group of participants including Dr. Tannaz Birdi, (FMR) and supported, Dr. Prakash (FRLHT) and Dr.S.K. Ghosh (NMRC) volunteered to follow up this thrust area further.**

### III.2.4. Promoting Social Science dialogue with AYUSH Systems.

The importance of Social sciences in strengthening the medical sector and its public health and community health adaptation and response has been well documented. The AYUSH sector has however been very limited in the use of social sciences to subject itself to a review in a spirit of dialogue. The utility of social science research perspectives needs to be established by subjecting the AYUSH systems to research initiatives that include methodologies from anthropology, sociology, psychology, and other behavioral sciences. A few aspects that can be studied are:

- Study of AYUSH systems at the community level, with anthropological perspective.
- Study of AYUSH practitioners and systems of practice and doctor–patient and doctor community relationships with a social system perspective.
- Orientation training programmes and CMEs for AYUSH faculty to sensitize them to social science perspectives and methodology.

**Dr. Leena Abraham (TISS) offered to be the focal person for this theme and she would put up some initial proposals in this thrust area. CHC team would be interested to support her in this area as well.**

### III.2.5. Integration in community Health workers training with a plural approach

Ever since the first attempt in 1978 by the Ministry of Health and Family Welfare, (the Janata Government experiment) that led to the creation of the Community Health worker Manual which included chapters on of the Indian Systems of medicine as well as herbal medicine, there has not been any attempt to create any more plural manual in the country. More recently the Mitanin Programme of Chattisgarh and the Sahiya Programme of Jharkhand have also attempted to evolve a plural manual.

Community Health training in the NGO sector has often sensitized and included local health traditions and practices in its efforts with village based health volunteers. There is an urgent need to study and bring together all this micro and macro experience into a more substantial manual for community health workers, especially in the context of the ASHA training in the current NRHM initiative that is being experimented and introduced all over the country.
III. 2. 6. Formation of an e-Group:

It was decided that an e-group would be initiated with all the invitees of this stakeholder’s workshop including all those who had been invited and could not participate. The report of the workshop would be circulated to all of them with a request to stay in touch with the focal points of each of the five thrust areas so that meaningful group initiatives and multicentric projects could evolve and strengthen the efforts of the AYUSH department in the challenge of integrating AYUSH systems in public health systems of the country.

It was suggested that Dr. Tekur be requested to be the focal person for this theme and facilitate more initiatives in this direction, with other NGO’s and state governments, that have attempted such plural and integrated approaches in CHW training.
Appendix A

NATIONAL POLICY & PROGRAMMES ON AYURVEDA, YOGA & NATUROPATHY, UNANI, SIDDHA AND HOMOEOPATHY (AYUSH)

Presented by:

Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy. (AYUSH)
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National Policy-2002:

In order to augment the traditional systems of medicine, the Government of India put in place a National Policy on Indian Systems of Medicine & Homoeopathy (ISM&H) in the year 2002. Ayurveda, Siddha, Unani & Homeopathy systems of medicine and drugless therapies like Yoga and Naturopathy are officially recognized in India. The major objectives of this policy are:

- To promote good health and expand the outreach of health care to; our people, particularly those not provided health cover, through preventive, promotive, mitigating and curative intervention through AYUSH;
- To ensure affordable AYUSH services & drugs which are safe and efficacies;
- To facilitate availability of raw drugs which are authentic and contain essential components as required under pharmacopoeial standards to help improve quality of drugs, for domestic consumption and export;
- Integrate AYUSH in health care delivery system and national programmes and ensure optimal use of the vast infrastructure of hospitals, dispensaries and physicians;
- To provide full opportunity for the growth and development of these systems and utilization of the potentiality, strength and revival of their glory.

The Government of India created a separate Department i.e., Department of Indian Systems of Medicine & Homoeopathy in 1995, which has now been renamed as the Department of
Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH). Under the Department, there are three subordinate offices and 15 autonomous bodies. The different states of the country have also created a large number of ISM dispensaries, hospitals, college's offices and autonomous bodies in the field of ISM&H.

**Infrastructure of AYUSH:**

AYUSH has a vast infrastructure comprising Medical Colleges, Registered Medical Practitioners, Hospitals, Dispensaries and Drug Manufacturing units:

(a) Number of Institutionally trained practitioner : 4,88,714
(b) Number of Non-institutionally qualified practitioners : 2,00,088
(c) Number of Colleges : 437
(d) Admission Capacity per annum in UG Colleges : 23,280
(e) Admission Capacity per annum in PG Colleges : 2001
(f) Number of Drug Manufacturing Units : 9,832
(g) Number of Hospitals : 3841
(h) Number of beds in hospitals : 65753
(i) Number of Dispensaries : 23597

**System-wise Infrastructure of AYUSH**

<table>
<thead>
<tr>
<th>Medical System</th>
<th>Colleges Under Graduate</th>
<th>Post Graduate</th>
<th>Registered Practitioners</th>
<th>Pharmacies Licensed by Drug Control Authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayurveda</td>
<td>209</td>
<td>58*</td>
<td>4,30,890</td>
<td>8,386</td>
</tr>
<tr>
<td>Unani</td>
<td>36</td>
<td>08</td>
<td>43,108</td>
<td>453</td>
</tr>
<tr>
<td>Siddha</td>
<td>06</td>
<td>02</td>
<td>17,097</td>
<td>384</td>
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<tr>
<td>Homoeopathy</td>
<td>180</td>
<td>32</td>
<td>1,97,252</td>
<td>609</td>
</tr>
<tr>
<td>Yoga &amp;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naturopathy</td>
<td>06</td>
<td></td>
<td>495</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>437</td>
<td>100</td>
<td>6,88,802</td>
<td>9,832</td>
</tr>
<tr>
<td>Admission Capacity</td>
<td>23,280</td>
<td></td>
<td>2001</td>
<td></td>
</tr>
</tbody>
</table>

*Includes 2 colleges conducting only P.G. courses.

**National Institutes set up by the Central Government:**

i) National Institute of Ayurveda, Jaipur, Rajasthan
ii) National Institute of Unani Medicine, Bangalore, Karnataka
iii) National Institute of Homoeopathy, Calcutta, West Bengal
iv) National Institute of Naturopathy, Pune, Maharashtra
v) Morarji Desai National Institute of Yoga, New Delhi
vi) National Institute of Siddha, Chennai, Tamilnadu.

vii) National Ayurveda Hospital, New Delhi

Statutory Regulatory Bodies established by the Central Government to regulate education and practice:


Functions of Regulatory Councils:

(i) To lay down standards of education, comprising curricula, requirement of hospitals, faculties, equipment, clinical exposure and examination pattern;

(ii) To ensure adherence to laid down standards;

(iii) To maintain a Central Register of practitioners;

(iv) To recommend to the Central Government for recognition and withdrawal of medical qualifications awarded by Universities;

(v) Consequent upon amendment to the Central Council Acts, the Central Government is vested with the powers of granting permission for opening new colleges, increase of admission capacity and starting of new or higher courses of study.

The Department is exploring the areas of actual involvement in the National Health Programme through AYUSH.

Our systems of medicine and their practices are well accepted by the community and have their own areas of strength. Medicines are easily available and prepared from locally available resources, economical and comparatively safe from side effects. Because of this fact the Central Government Health Scheme, introduced in 1954 with only allopathic dispensaries has introduced AYUSH component in its network.

The effectiveness of these systems in certain diseases in which there is no or less efficacious treatment in Allopathic Systems has generated a demand for more such facilities in different parts of the country.

Specialized clinics, one each in Ayurveda, Unani and Homoeopathy in the OPD of the two Central Government Hospitals in Delhi viz., Safdarjung Hospital (Ayurveda and Homoeopathy) and Dr. Ram Manohar Lohia Hospital continued to render services. These clinics are being run on experimental basis by the three research councils viz., Central Council of Research for Ayurveda & Siddha, Central Council of Research for Homoeopathy and Central Council of Research for Unani Medicine. These clinics are attended by a larger number of patients especially of chronic diseases.

State Government of National Capital Territory of Delhi has also set up Ayurvedic Centres in 12 Allopathic Hospitals of Delhi.
Priority Programmes of AYUSH:

The Government has taken up various programmes implementation in the following areas on priority:
1. Standardization of Education & Continuing Medical Education (CME);
2. Propagation of Medicinal plant Sector;
3. Research & Development;
4. Information, Education and Communication (I.E.C.) & international collaboration;
5. *Standardization and Quality Control of Ayurveda, Siddha, Unani and Homeopathy drugs;


The following schemes are being implemented in the area of AYUSH Education during 10th Plan period - 2002 - 2007:
1. Strengthening of existing Under Graduate Colleges.
2. Assistance to Postgraduate Medical Education;
3. Re-orientation Training Programme of AYUSH Personnel
4. Short-term Continuing Medical Education (CME) Programme for General AYUSH Practitioners;
5. Scheme for Renovation and Strengthening of AYUSH Teaching Hospitals;
6. Scheme for Establishing of Computer Laboratories with internet facilities in selected AYUSH Colleges;
7. Upgradation of AYUSH colleges to the status of State Model Institute of Ayurveda, Siddha, Unani & Homoeopathy.

Schemes relating to Medicinal Plants Sector:
1. National Medicinal Plants Board and 26 State Medicinal Plant Boards have been established;
2. Establishment of Medicinal Plant Gardens.

Research & Development:

Following Research Councils have been established for research and development work:
1. Central Council for Research in Ayurveda & Siddha;
2. Central Council for Research in Unani Medicine;
3. Central Council for Research in Homoeopathy;

Extra Mural Research in AYUSH:

Department has a scheme for Extra Mural Research in Ayurveda, Siddha, Unani, Yoga & Naturopathy and Homoeopathy in priority areas (of diseases and health-care) under which scientific and medical institutions are supported for carrying out R&D work.
I.E.C. & International Collaboration:

To increase awareness among the community about the preventive, promotive and curative aspects of AYUSH, its cost effectiveness, availability of herbs used for prevention and treatment of common ailments and the techniques for growing such herbs, the Department has the following schemes:

1. Scheme for grant-in-aid to non-governmental organizations for promotion of AYUSH;
2. Awareness building on merits of AYUSH through roadshows, print and electronic media;
3. Setting up of demonstration windows/kiosks/touch screens in important public places/offices
4. Training/fellowships/exposure visits and assistance for international exchange programme, seminars, conferences, workshops on AYUSH;
5. Incentives to industry for participation in Fairs & Exhibitions.
6. Publication of Textbooks and Acquisition & Publication of Manuscripts.

QUALITY CONTROL OF AYURVEDA, SIDDHA AND UNANI DRUGS

Drugs & Cosmetics Act of 1940 & Rules there under relating to Ayurvedic Medicine:

- The Drugs & Cosmetics Act, 1940 was amended in 1964 (effective from 9.12.69) and a Chapter-IV A was added for licensing and manufacturing of Ayurveda, Siddha and Unani drugs for sale in the market. All necessary provisions of this Act in chapter -IV A were further amended in 1982 in which definitions of misbranded/adulterated and spurious drugs of ISM were given and penalty prescribed.
- Ayurveda, Siddha and Unani medicines have been defined under Section 3(a) of the Act as all medicines intended for internal or external use for or in the diagnosis treatment, mitigation or prevention of disease or disorder in human being or animals which have been mentioned in, processed land manufactured exclusively in accordance with the formula. Described in the authoritative books of these three systems specified in the First Schedule to the Act. The First Schedule to the Act gives names of 54 authoritative books of ayurvedic, 29 books of Siddha and 13 books of Unani system of medicine.

Ayurveda, Siddha, Unani Drugs Technical Advisory Board:

This is a statutory body under the Act which is functioning to further drugs control measure in respect of Ayurvedic, Siddha and Unani drugs. This Board is constituted by the Government of India in accordance with the provisions of Section 33-C of the Drugs & Cosmetics Act, 1940 (Chapter IVA) to advise the government of drug related issues.

Ayurveda, Siddha, Unani Drugs Consultative Committee:

The Government of India have constituted an Advisory Committee under Section 33-D of the Drugs and Cosmetics Act, 1940 to be called the Ayurvedic, Siddha and Unani Drugs Consultative Committee to advise the Central Government, the State Government and the Ayurvedic, Siddha and Unani Drugs Technical Advisory Board on any matter for the purpose of securing uniformity throughout India in the administration of the Drugs & Cosmetics Act, 140, in
so far as it relates to Ayurvedic, Siddha and Unani drugs.

**PHARMACOPOEIAL TESTING FACILITIES FOR AYURVEDA, SIDDHA & UNANI AND HOMOEOPATHY DRUGS:**

Pharmacopoeial Laboratory for Indian Medicine (PLIM) Ghaziabad was established in 1970 as Standard Setting-cum Testing Laboratory for Ayurveda, Siddha and Unani drugs at national level. The Laboratory has been assisting Pharmacopoeia Committee in evolving pharmacopoeial standards. The worked out standards, in the form of monographs are published by the Ministry of Health & Family Welfare for Ayurvedic, Unani and Siddha Pharmacopoeia of India. Four volumes of Ayurvedic Pharmacopoeia of India have been published containing 326 drugs.

**Pharmacopoeia Committees for laying down Pharmacopoeial Standards:**

Laying down the Pharmacopoeial standards for Ayurveda, Siddha and Unani Medicines both for single and compound drugs is an essential item of work. The Ministry had taken up the task of developing pharmacopoeial standards through Pharmacopoeia Committee.

Three different Pharmacopoeia Committees are working for preparing official formularies /Pharmacopoeias to evolve uniform standards of Ayurveda, Siddha and Unani drugs.

Completion of pharmacopoeial standards has been accored high priority and the work is targeted for completion by 2005

**Important provisions of Drugs & Cosmetics Act, 1940 and Rules there under relating to Ayurvedic, Siddha and Unani drugs:**

1. Regulation of manufacture for sale of Ayurvedic drugs through drug license system
2. Prohibition of manufacture and sale of certain drugs. Power of Central Government to prohibit manufacture etc., of drugs in public interest
4. Provision for Inspectors to visit factory.
5. Penalty for manufacture, sale etc., of drugs in contraventions of the Act.
6. Penalty for subsequent offences.
8. Prescribe methods of testing and analysis.

**Good Manufacturing practices (GMP) for Ayurvedic, Unani Siddha drugs:**

GMP for ASU drugs have been notified on 23rd June, 2000. The Good Manufacturing Practices are prescribed to ensure that:

1. Raw materials used in the manufacture of drugs are authentic, of prescribed quality and are free from contamination;
2. The manufacturing process is as has been prescribed to maintain the standards;
3. Adequate quality control measures are adopted;
4. To achieve the objectives listed above, each licensee shall evolve methodology and procedures for following the Prescribed process or manufacture of drugs which should be documented as a manual and kept for reference and inspection.
However, teaching institutions and registered qualified Vaidyas, Siddhas and Hakeems who prepare medicines on their own to dispense to their patients and not selling such drugs in the market are exempted from the purview of GMP standards.

30 apex level laboratories/scientific institutions have been funded for evolving Pharmacopoeial standards.

Enabling provision has been made to recognize private drug testing laboratory under the Act! Rules.

**Infrastructure relating to Ayurvedic Pharmaceuticals in India:**

- Manufacturing units in government and cooperative sector = 40
- Private drug manufacturing units about = 9000
- Government drug testing laboratories = 16
- State/UT licensing authorities drug controllers = 23

Domestic market of Ayurvedic Medicines is worth US $ 1000 millions

This does not include the medicines prepared by Ayurvedic doctors, for dispensing to their own patients.

**Centrally sponsored scheme for quality control of Ayurveda, Siddha, Unani & Homoeopathy drugs**

1. Scheme for strengthening of state drug testing laboratories (DTLs) for Ayurveda, Siddha, Unani and Homoeopathic drugs of the state governments/U.Ts. for quality ISM&H drugs;
2. Scheme for strengthening of Ayurveda, Siddha, Unani and Homoeopathic Pharmacies of the state governments/U.Ts. for quality ISM&H drugs;
3. Strengthening of State Drug Controllers of ISM&H, enforcement mechanism for quality control of Ayurveda, Siddha & Unani (ASU) & H drugs in states;
4. Use of modern technology and bio-technology in Ayurveda, Siddha & Unani & Homoeopathy drugs development;
5. Scheme for assisting Ayurveda, Siddha & Unani (ASU) drug manufacturing units to strengthen in-house quality control section/drug testing laboratories to meet the requirements of Good Manufacturing Practices (GMP);
6. Scheme for assistance to Ayurveda, Siddha & Unani (ASU) drug manufacturing units to improve their infrastructure to meet Good Manufacturing Practices (GMP) - Schedule “T” requirements;

**Intellectual Property Right (IPR) and Traditional Knowledge Digital Library (TKDL)**

Since time immemorial, SAARC countries have possessed a rich traditional knowledge of ways and means practiced -to treat diseases afflicting its people. This knowledge has generally been passed down by word of mouth from generation to generation. Some of them have been
described in ancient classical and other literature, often inaccessible to the common man. Documentation of this existing knowledge, available in public domain, on various traditional systems of medicine has become imperative to safeguard the sovereignty of this traditional knowledge and to protect them from being misused in patenting on non-patentable inventions, and this has been a matter of national concern. India fought successfully revocation of *turmeric* and *Basmati* patents granted by United States Patent and Trademark Office (US PTO) and *Neem* patent granted by European Patent Office (EPO). As a sequel to this, in 1999, the Department of Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) constituted an inter-disciplinary Task Force, for preparing a report on establishing a Traditional Knowledge Digital Library (TKDL). TKDL in its first phase targeted Ayurveda. Information from 36,000 formulations from *Slokas* (Verses) have been put on the portal for realizing the first stage objective of TKDL. Each *Sloka* has been transcribed in English, German, French, Spanish, Japanese and Hindi languages to ensure ease of retrieval of TK related information by patent examiners globally to avoid misappropriation of Indian. TK.

**Access Policy:**

Traditional Knowledge Digital Library (TKDL) is a database of immense value. On one side, it targets to prevent grant of unpatentable Traditional Knowledge (TK) patents at international level. On the other side, it has potential to act as a bridge between modern science and Traditional Knowledge, which may result in development of modern drugs based on our Traditional Knowledge. Therefore, policy of access to this database is to be evolved with caution. Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy has constituted an Inter-Ministerial Access Policy Committee which will try to build adequate safeguard while giving access to this vital database to global patent examiners and other at national and international level.

**MAINSTREAMING OF AYUSH**

1. The Indian Systems of Medicine and Homoeopathy have potential for treating various kinds of diseases and disorders. At present, there is a huge manpower of approximately 7 lakh practitioners of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH). The vast infrastructure of AYUSH includes about 23,000 dispensaries, 6,500 hospitals in government sector through out the country. However, this strength has remained under utilized, as the manpower is not used in the mainstream of the Health Programmes. There are several National Health Programmes, e.g., National Malaria Eradication Programme, National Programme for control of Blindness, National Leprosy Eradication Programme, Tuberculosis Control Programme, AIDS Control Programme etc. which are being administered by the Department of Health.

2. In due appreciation of requirement of mainstreaming and integration of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH), Government of India has adopted a strategy in the National Policy on Indian Systems of Medicine & Homoeopathy - 2002. 'The policy statement and corresponding actions taken are discussed as follows:

**Policy Statement:**

(a) Efforts would be made to integrate and mainstream ISM&H in health care delivery systems
including National Programmes:

**Action Taken:**

(i) Seven Ayurvedic drugs have been included in the National Reproductive Child Health (RCH) Programme for mother & child and supplied to 9 states i.e., Utranchal, H.P., U.P. Rajasthan, M.P., Chhattisgarh, Kerala, Karnataka and Tamil Nadu. Five Unani drugs have also been supplied to four cities i.e” Lucknow, Aligarh, Delhi and Hyderabad under the RCH Programme.

(ii) A pilot project relating to RCH to see the effect of Ayurveda, Siddha and Unani interventions in the ante-natal and post-natal care is being implemented in collaboration with Central Council for Research in Ayurveda and Siddha (CCRAS) and Indian Council of Medical Research (ICMR). The project is jointly funded by the Department of ISM&H and Department of Family Welfare.

(iii) Department of Health is formulating a pilot project on National Diabetes Control Programme in which Ayurveda and Yoga interventions have been included on the same footing and magnitude as allopathic interventions.

**Policy Statement:**

(b) A range of options for utilization of ISM&H manpower in the health care delivery system would be developed by assigning specific goal oriented role and responsibility to the ISM workforce. An ISM&H wing would be encouraged and supported at the primary health care level.

**Action taken:**

Following states have taken initiatives for utilizing doctors of Ayurveda and Siddha systems in the health care delivery system:

(i) In Himachal Pradesh more than 600 government Ayurvedic dispensaries have been identified for Ayurvedic doctors as well as para-medical staff to implement various National Health Programmes.

(ii) H.P. State Government has posted 80 Ayurvedic doctors in primary health centres on permanent basis. Similarly, government of Chhattisgarh has posted 82 Ayurvedic doctors, M.P. government has posted 187 Ayurvedic doctors and UUranchal has posted 121 Ayurvedic doctors in various primary health centres.

(iii) State of Tamil Nadu has posted 281 Siddha doctors in the primary health centres with Siddha medicines.

(iv) Various State Governments are in the process of integrating ISM&H systems in various Health Programmes.

**Policy Statement:**

(c) States would be encouraged to re-enact or modify laws governing the practice of modern medicine by ISM practitioners so that there is clarity of the subject.

**Action taken:**

(i) To manage day to day emergency conditions as well as to meet the gaps of ISM medicines, state governments of Gujarat, Maharashtra, M.P. and U.P. have permitted
use of allopathic medicines by ISM practitioners through gazette notifications/state
government orders. Other states have issued instructions for integrating ISM&H with
health service.

**Policy Statement:**
(d) **Referral ISM hospitals in the motherland would be renovated, modernized and upgraded to**
provide the full range of ISM treatment. **Identification of the hospitals would be made according to**
current availability of motivated staff, OPO & IPO attendance and locational advantages.

**Action taken:**
(i) To strengthen the existing teaching hospitals of Ayurveda within the available
resources, Department of AYUSH has initiated
(ii) A scheme to provide RS.20 lakhs to renovate each Ayurvedic hospital. The scheme
was implemented in the last two years of 9th Plan and is continued during the 10th
Plan. So far 20 government teaching hospitals have been provided financial support
under the scheme.

**Policy Statement:**
(e) At the PHC and district hospital level, **Central Government would encourage the setting up of**
specialty centres and ISM clinics & funds would be provided centrally for drugs listed in the
Essential Drugs Lists for Ayurveda, Unani and Homoeopathy Medicines on a declining scale for
5 years to increase choice and consumer awareness about the benefits of ISM.

**Action taken:**
(i) To set up Panchkarma/Ksharsutra clinics/centres in the existing allopathic hospitals
as well as in other hospitals, a scheme has been floated by the Department of
ISM&H to provide financial assistance. The scheme has been circulated to all the
states and was also personally explained in a meeting of the State Health Secretaries
held in August, 2003 at New Delhi.
(ii) To fill up the gaps of scarcity of essential ISM&H drugs, in the state ISM&H
dispensaries and hospitals specially in the Jural and backward areas, Department of
ISM&H has provided funds to the state governments to procure essential ISM&H
medicines @ Rs.25,000 per dispensary per year during the 10th Plan. So far 19
states have been provided financial assistance in the last two years.

**Policy Statement:**
(f) **Central government would assist speciality hospitals of allopathy who wish to establish Panch**
karma and Ksharsutra facilities for the treatment of neurological disorders, musculoskeletal
problems as well as ambulatory treatment of fistula-in-ano, bronchial asthma and dermatological
problems.

**Action taken:**
(i) Department of ISM&H has floated a scheme to establish Panch karma and
Ksharsutra clinics/centers in allopathic hospitals. Financial assistance is being
provided under the scheme during the 10th Plan period. Applications are being
invited from the state governments/U.Ts. So far five hospitals have been supported
for establishment of speciality clinics of ISM&H with grant of first installment of
Rs.42.55 lakhs.

Policy Statement:
(g) Private allopathic hospitals would be encouraged to set up specialist treatment centers of ISM&H and the hiring charges of Vaidyas /hakims/ Homoeopaths reimbursed to such hospitals entering into research collaboration protocols.

Action taken:
This issue is under consideration of the Central Government.

Policy Statement:
(h) States would be encouraged to consolidate the ISM infrastructure and raise the salary and social/professional status of ISM practitioners to encourage inflow of talent and an enhanced work-culture. The aim would be to provide parity with the Central Government pattern which has established equivalence/relativities with the allopathic profession.”

Action taken:
(i) Government of India has equated pay scales and promotion avenues for Ayurvedic doctors on the pattern of allopathic counterparts. Pay scales of Ayurvedic doctors in CGHS, ESI, NDMC and MCD are equal to those of allopathic doctors.
(ii) Some of the state governments like U.P., J&K, Maharashtra and Rajasthan have introduced equal pay scales for Ayurvedic and allopathic doctors.
(iii) Department of ISM&H has increased rate of stipend for M.D.(Ayurveda) students Le., Rs.7000, Rs.7,500 and Rs.8,000 for three year degree course. In SHU, Varanasi, NIA, Jaipur and IPGT&R, GAU, Jamnagar, Ayurvedic College Hospital, Lucknow, Ayurvedic & Unani Tibbia College Delhi and P.G.I. Ayurveda, Paprola, H.P. stipend rate for M.D.(Ayurveda) students is equal to those of M.D. Allopathy students. State governments of Himachal Pradesh and Delhi are paying stipend to the Ayurvedic Post Graduate students equal to M.D. Allopathy students.

In due appreciation of the needs for integration of ISM&H, the Central Council of Health & Family Welfare recommended in 1999, inter-alia, that at least one physician from the Indian Systems of Medicine & Homoeopathy (ISM&H) should be available in every primary health care centre and that vacancies caused by non availability of allopathic personnel should be filled by ISM&H physicians. Further, the Council resolved that specialist ISM&H treatment centres should be introduced in rural hospitals and a wing should be created in existing state and district level government hospitals to extend the benefits of these systems to the public. It also resolved that expenditure on treatment taken in ISM hospitals should be recognized for reimbursement for Central Government employees.

In 2001, the Central Council of Health & Family Welfare reiterated that the states must revisit the subject and identify specific areas where ISM practitioners can be entrusted with public health functions within the ambit of state legislation.

Apart from the above, the feasibility of introducing speciality centers or treatment centers of ISM&H at the block /Taluka level is being explored. Some states like Tamil Nadu have already introduced a wing of Siddha medicine in the district hospitals as well as Taluk hospitals. Unless the systems are practiced and people know where to get the treatment, the system cannot
flourish. Non-government organizations are being encouraged NGOs to set up speciality hospitals of ISM&H to highlight the strengths like Panchkarma. Kashar Sutra etc.

Scheme for Promoting Development of Health Care Facilities of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH):

Government of India is providing assistance under a scheme for:

(i) Establishment of Specialized Therapy Centers with hospitalization facility for Panchkarma/Ksharsutra therapy of Ayurveda or Regimenal therapy of Unani Medicine or Siddha or Yoga & Naturopathy or Homoeopathy;
(ii) Establishment of Specialty Clinics of AYUSH (system specific) as outdoor treatment centre;
(iii) Supply of Essential Drugs to State Rural & backward area dispensaries.

b. Distribution of Home Remedy Kits containing Ayurveda, Siddha, Unani & Homoeopathy Medicines in the villages where conventional Health care services are not available:
Appendix B

REPORT OF TASK FORCE ON MAINSTREAMING OF AYUSH SYSTEMS IN XI-PLAN

1. Introduction

- There is global resurgence of interest in Indian Systems of Medicine, particularly Ayurveda and Yoga. Homoeopathy also is getting popular in India and abroad. There are many indicators, which underline the shift towards global acceptance of complementary/alternative systems of medicine because of their holistic approach, cost effectiveness, cultural-friendliness and virtually no side effects. Though modern medicine has played a critically important role in reducing drastically the morbidity and mortality due to communicable diseases, Allopathy (modern medicine) falls short of patients’ expectations in non-communicable and life style related disorders.

- The National Health Policy (1983) envisaged integration of Indian Systems of Medicine & Homoeopathy with the modern medical system for the first time. This was intended to pave the way for improved outreach & delivery of health services. The Government of India established a separate department under the Ministry of Health & Family Welfare in 1995 for giving focused attention to the development and optimal utilization of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy (AYUSH), which are officially recognized systems of medicine in India. The highest policy-making body for health sector- Central Council for Health & Family Welfare resolved several times the need to have integration of different medical systems for improving health delivery. The 10th Five Year Plan reiterates the need for integration and mainstreaming of ISM&H with modern systems of medicine so that people have access to both modern as well as time tested Indian systems of health care.

- Presently, the state of policy, regulation and development of AYUSH systems in the country is by and large in accordance with the WHO guidelines for utilization of traditional medicine in national health system. Recognizing the inherent strengths of the Indian systems of medicine, the National Policy on Indian Systems of Medicine and Homoeopathy-2002 underlines the need for integration of AYUSH in health care delivery system and national programmes and optimal use of the vast infrastructure of hospitals, dispensaries and trained practitioners. The policy is aimed at promoting comprehensive & holistic health and expand the outreach of health care to the masses through preventive, promotive and curative interventions by improving the quality of clinicians and teachers by revising curricula to contemporary relevance and to re-orient and prioritize research in ISM&H to gradually validate therapies and drugs to address in particular the chronic and emerging life style diseases.
2. EXISTING STATUS

- The Indian Systems of Medicine and Homoeopathy (ISM&H) include Ayurveda, Siddha, Unani, Homeopathy and drugless therapies such as Yoga and Naturopathy. The major strength of the systems is their easy accessibility, wide acceptability, cost effectiveness, simple technological inputs for manufacture of medicines, and use of natural products. India has a vast network of governmental and private AYUSH institutions. There are 458 AYUSH colleges with admission capacity of 23,555, 98 colleges with post graduation facilities, 3,100 hospitals with over 65,000 beds, 22,300 dispensaries, 6,95,024 registered practitioners and 9,257 licensed pharmacies. In the central sector apart from 45 hospitals there are 81 dispensaries under CGHS, 54 dispensaries under central research councils, 162 under Ministry of Railways, 159 under Ministry of Labour, 28 under Ministry of Coal and 2 Ayurveda dispensaries under Ministry of Defence. The primary health network comprises of 1,42,611 Sub-centre’s, 22,974 PHCs and 3,215 CHCs. The number of PHCs is comparable to 22,300 AYUSH dispensaries, which are otherwise not symmetrically distributed.

- As per an estimate, about 70% Indian population uses traditional medicine for health care. The rate of population coverage through AYUSH is Health about 7 doctors per 10,000 population. The regulatory, administrative and institutional set ups of AYUSH are by and large similar to that for allopathic system. As far as the acceptability of indigenous medical systems is concerned, Ayurveda is popular in Kerala, Gujarat, Himachal Pradesh, Rajasthan, Karnataka, Maharashtra, Madhya Pradesh, Jharkhand, Chhattisgarh, Uttar Pradesh, Uttarakhand and Orissa. The prevalence of Unani system is comparatively higher in Andhra Pradesh, Karnataka, Tamilnadu, Bihar, Maharashtra, Madhya Pradesh, Uttar Pradesh, Delhi and Rajasthan. Siddha system is well established in Tamilnadu and of late is spreading to other southern states. Homeopathy is more or less equally spread all over the country but in higher demand in Kerala, Uttar Pradesh, West Bengal, Orissa, Andhra Pradesh, Maharashtra, Punjab, Tamilnadu, Gujarat, Bihar and North Eastern states.

3. THE PROBLEM

- The full potential of AYUSH still remains to be realized due to varied reasons. The foremost among them are lack of essential staff, infrastructure, diagnostic facilities and drugs in the existing health care network of AYUSH. The other important reasons are inadequacies in quality of training of practitioners and their non-involvement in the national health and family welfare programmes. Treatment meted out to the institutions & manpower of these systems is not at par with that being given to allopathic system. Not only there is a strong justification for the coexistence of both allopathic and AYUSH
systems in PHCs/CHCs and district hospitals, but that every effort must be made to bring about functional integration without compromising the ethical purity of either system. Many valuable insights into the best possible management of many chronic ailments may well come from non-allopathic systems of health care. However, it would be essential to take steps to ensure that the AYUSH systems grow in a pristine form by research and development of their own concepts. While use of modern diagnostic tools and quality control techniques is an absolute must to place these systems on a sound evidence base, modernization process should not be allowed to reduce these systems to a mere appendage to allopathy. We must not try and produce a hybrid doctor who has the strengths of neither system and the faults of both

4. MAINSTREAMING OF AYUSH.

- The concept of mainstreaming of AYUSH revolves around optimal use of all available human resources for health care provision in the country. Mainstreaming has essentially two aspects. Firstly, qualified AYUSH practitioners can fill the manpower gaps in Primary Health Care, particularly at the sub-centre/PHC level. Secondly, there should be a cafeteria approach of making AYUSH and Allopathic systems available under one roof at the PHC/CHC/District Hospital level for facilitating patient choice and cross-system referrals. Apart from improving peoples access to health services, it will also provide choice of treatment to the patients. There are areas, where the traditional system has overwhelming evidence of better cure and/or disease management e.g. Ayurveda has better cure for piles, fistula, jaundice, arthritis; Unani in menstrual disorder, psoriasis; Homoeopathy in allergic disorders. Similarly Yoga has proven strength in managing lifestyle disorders and psycho-somatic diseases. Therefore, there is a need for service integration by providing the best from each system to patients as a Complementary/Alternate/Adjuvant therapy. Efforts should be made to provide quality education in each of the system to develop confident physicians of each systems, visionary teachers and researchers for a need based health care. Health care involves curative, preventive, promotive and rehabilitative aspects. Therefore the education, research, drug development and practice should address all these aspects.

- As far back as in 1920, the Nagpur Session of the Indian National Congress recommended that there should be an Integrated System of Medicine & Research which should be combination of both our Ayurveda, Unani Tibb, Siddha and Modern Medicine system choosing the best out of the all and thus supporting one system by another to serve mankind to its best. For the purpose of promotion and education of Integrated Medicine, first such college was started in 1934. After Independence, the Chopra
Committee, Pandit Committee, Dave Committee & Uduppa Committee etc. constituted by Central Government also recommended Integrated System of Medicine.

5. FACTS IN MEDICINE

- Every medical discipline has something to offer in Health care- The objective of education and Research should be to harness these strengths.
- No system can tackle all the health concerns of the society- Encourage different systems to bring their best remedies in the menu on offer to patients.
- Several diseases are self limiting; no medication is needed- Educate public.
- Every system can tackle few diseases effectively- Integrate this in the Health care delivery. Public shall have a choice to avail what they want.
- No system has credible treatment option for few diseases- Try the benefit of different systems as adjuvant. Enhance the medical research in those areas.
- Majority of the health problems are at primary level. Increase the out reach of health care delivery at the village level.
- Most of these can be managed with any one of the systems of medicine.
- Each of the systems has its own unique strength to tackle few diseases for which there is no effective treatment in other systems. Educate people and professionals through the IEC programmes through Government media.

6. Status of Mainstreaming of AYUSH

6. A. Centrally Sponsored Scheme on Hospital and Dispensary

- Centrally Sponsored Scheme under the plan head of ‘Hospitals & Dispensaries’ administered by the Department of AYUSH is being utilized for creating AYUSH facilities in allopathic hospitals / dispensaries. The scheme has following components:

I. Establishment of Specialized Therapy Centre with hospitalization facility for Panchkarma / Kshar Sutra therapy of Ayurveda or Regimental Therapy of Unani Medicine or Siddha or Yoga & Naturopathy or Homoeopathy as the case may be;

II. Establishment of Specialty Clinic of ISM&H i.e. system specific outdoor treatment center;

III. Setting up of ISM&H wing in District Allopathic Hospitals – Outdoor as well as Indoor facility of one or two systems of ISM&H is required to be set under this component of the scheme; and

IV. Supply of essential drugs to State rural & backward area dispensaries.
The provision of 100% Central assistance under the scheme has facilitated States in relocation/creation of AYUSH outdoor facility in PHCs and specialized therapy facility in CHCs and AYUSH wing in District/Sub-divisional hospitals. **However, the scheme does not provide for supporting salary component of manpower required to run such facilities.** As detailed in Annexure – 1, many States have implemented the scheme. Under the NRHM operational frameworks States would be able to utilize NRHM funds for hiring AYUSH doctors for providing AYUSH facilities at PHC/CHC level. States would be able to dovetail AYUSH components in their State’s Specific action plans.

7. MAINSTREAMING UNDER NATIONAL RURAL HEALTH MISSION (NRHM)

- The National Rural Health Mission (NRHM) has been launched with a view to bringing about improvement in the health system and the outreach of health facilities for the benefit of people living in the rural and backward areas of the country. The mission seeks to provide universal access to equitable, affordable and quality health care, which is accountable as well as responsive to the needs of the people, reduction of child and maternal deaths, population stabilization, gender and demographic balance, etc. Revitalization of local health traditions and mainstreaming of AYUSH have been incorporated in visions, goals and strategies of the National Rural health mission. The objective of the integration of AYUSH in the health care infrastructure is to re-enforce the existing public health care delivery system, with the use of natural, safe and eco-friendly remedies, which are time tested, accessible and affordable. The roadmap of mainstreaming of AYUSH has been conveyed to the States through a joint letter dated 12.08.2005 from Secretary (AYUSH) and Secretary (Health) (Annexure – 2). The roadmap seeks provisioning of AYUSH facilities in PHCs and CHCs with placement of AYUSH doctors and providing medicines.

- NRHM is fully committed to mainstreaming AYUSH within the mainstream health delivery system. This involves support to the physical and functional integration of the systems so that both systems flourish under one umbrella. In line with its commitment to mainstream AYUSH activities the Department has agreed that in the current year at least 2000 AYUSH doctors in the eight EAG states and in J&K, would be located either at the PHC or the CHC. Of that 1000 would be by relocation from the existing AYUSH doctors in Government. Service. The remaining one thousand would be contractual doctors whose remuneration would be supported through NRHM funds. The state wise break up of the 2000 doctors would be based on the number of PHCs/CHCs existing in the State. In the IPHS standards for CHCs, which has been finalized by the Department of Health and Family Welfare, there is already a provision for an AYUSH wing. The Standard has been disseminated to the States. NRHM is committed to the upgradation of CHCs to IPHS. However, the matter can be communicated to the States after due approval of the
Cabinet of the Implementation Framework of NRHM. The MoU which is under preparation for the XIth Plan would also provide for mainstreaming of AYUSH on the suggested lines.

8. Can Qualified AYUSH practitioners be utilized for delivery of National Health Programmes?

- Recognized AYUSH training courses provide basic knowledge to under-graduates regarding anatomy & physiology/biochemistry in addition to clinical knowledge of their own systems. In some States e.g., Maharashtra, Punjab, Himachal Pradesh, Madhya Pradesh, Uttar Pradesh, Gujarat, Chattisgarh and Uttaranchal, these doctors have been authorized by the State Governments to practice modern medicine and are posted in PHCs. As per the judgements of the Hon'ble Supreme Court in Mukhtiar Chand and Poonam Verma cases, a medical practitioner is expected to bring a certain degree of expertise and training to his practice and could be expected to understand the indications/contraindications etc. of the medicines he prescribes to patients. These judgements basically define what is medical negligence. It is the considered view of a study carried out by National Law School, Bangalore that these judgements do not bar cross system practice as long as the same is specifically permitted by a State Government (if the State Medical Register recognizes qualified AYUSH practitioners as part of that medical register (Annexure-3)). Therefore, subject to a State Government authorizing AYUSH practitioners to prescribe certain categories of Allopathic medicines and AYUSH practitioners being provided proper orientation training, they could be utilized in the delivery of National health programmes like Malaria/TB/HIV-AIDS etc. When these programmes can be administered by ANMs there is no reason why AYUSH doctors should not be roofed in to strengthen the nation-wide implementation of these programmes.

9. Recommendation
9. A. Physical Integration

- Mainstreaming under NRHM is being pursued by facilitating convergence of AYUSH infrastructure with that of modern medicine. It has been decided to have AYUSH facilities in PHC and CHC either through relocation of AYUSH dispensaries or contractual appointment of AYUSH doctors. On account of asymmetrical budgetary provisions and infrastructure of AYUSH in the states, the task of physical as well as functional integration of AYUSH with modern medical system is progressing slowly. NRHM guidelines for supporting salary component/contractual appointment of AYUSH doctors in PHCs/CHCs are likely to be issued shortly. Relocation of AYUSH dispensaries to the nearest PHCs and creation of AYUSH facilities in remaining PHCs
has also not been undertaken by the states to the desired extent. In a recent meeting with State Directors/Licensing Authorities it has come to light that AYUSH dispensaries could be shifted to not more than 25% PHCs, remaining 75% PHCs will have to be provided with required infrastructure and AYUSH doctors & paramedical staff. Hence, to fast track mainstreaming creation of AYUSH facilities in 25% of such PHCs each year in each state should be supported for next three years under NRHM with a view to achieve 100% coverage of PHCs/CHCs in the 11th Five Year Plan.

- Hospitals and Dispensaries Scheme of Deptt. of AYUSH should be used to scale up provision of requisite Ayush infrastructure in PHCs/CHCs/District Hospitals while salaries of Ayush doctors would come from NRHM, other infrastructure and Ayush medicines should be provided under the Centrally Sponsored Scheme of Hospitals & Dispensaries.

9. B. Functional Integration
- AYUSH manpower after proper training should be utilized in National Health and Disease control programmes to fulfill the unmet needs of the health sector and augment health delivery & outreach. Department of Health needs to issue directions to the NIHFW and to the states to prepare need based training modules for AYUSH doctors and identify training centres. Similarly ASHAs, ANMs and Anganwadi workers and even Allopathic doctors working in PHCs & CHCs should be given adequate orientation training about the local health practices, simple AYUSH remedies/therapies for common ailments and uses of medicinal plants. National Institute of Health & Family Welfare and Department of AYUSH should operationalize this and bring out an action plan implementable in a specified time frame.
- Proper utilization of AYUSH practitioners in health delivery in small villages, clusters and tribal pockets is a feasible proposition, if sub-centers are manned by AYUSH doctors. Presently, the sub-centers are the first points of institutionalized health delivery under the supervision of ANMs. There is a strong case for posting an Ayush doctor to a cluster of 3 sub centers with each sub center being visited twice in a week which will improve not only the quality of health delivery but also the outreach. ANMs would be in a position to spare more time for preventive and RCH activities. AYUSH doctors apart from attending to the patients in the sub-centers could be involved in public health education/awareness activities as well.

9. C. Revision of AYUSH and Medical Education
- The AYUSH course curricula also needs modification with inclusion of orientation modules related to National Health Scenario, National Health & Family Welfare programmes, Regulatory Acts, pharmaceutical industry, global perspectives in Traditional Medicine, Complementing the public health programmes etc. There should be
regular mechanism in place for imparting periodic updates on professional knowledge to the AYUSH Practitioners and Para-medics.

- Similarly, AYUSH modules should be included in the MBBS course-curriculum for sensitizing medical students about basic principles of Indian systems, which are time-tested, cultural friendly and aimed at preventing diseases and promoting health care. AYUSH wings may be promoted in existing medical colleges for effective integration of AYUSH within the existing health care infrastructure.

Thus, The undergraduate (and perhaps the postgraduate) curricula of both these systems must have a component of orientation of the other system. The purpose is not to encourage cross system quackery but sensitize practitioners of one system regarding the strength of the others. The purpose must be to build a system of respect for the other systems and an understanding of how they can mutually complement each other to provide the most comprehensive and cost effective care.


- Integration of Research Programme for scientific validation and R & D on AYUSH relevant to the national health needs should be evolved and encouraged. Duly researched and validated AYUSH therapies and remedies with evidence of safety and efficacy should be considered for introduction in National Health Programmes. ICMR/CSIR laboratories/institutions should also undertake need-based research on AYUSH remedies for diseases of national and global importance. Ayush Research Councils must be integrated with the new Department of Medical Research which is proposed to be set up for bringing about synergy in the function of ICMR and Ayush Research Councils.

- AYUSH Research Councils should undertake collaborative protocol based peer reviewed researches in collaboration with reputed research institutions in public and private sector. Emphasis should be on collaborative studies aimed at standardization/quality control and building an evidence base for national and global acceptance of Ayush systems so that they should become central to national health care delivery and not remain at the margins.

- Research in AYUSH systems needs to be prioritized with equal emphasis on fundamental and applied researches. AYUSH Research Councils need to be completely revamped and professionalised and brought under the umbrella of Flexible Complementary Scheme of in situ promotions for attracting and retaining talents. If the Central Government is not prepared to treat them as Scientific establishments for purposes of time bound promotion, it would be far better to merge them with ICMR.

9. E. Ayurveda/Siddha/Unani Drugs Development
• Standardization and quality control of Ayurveda, Siddha, Unani drugs is a problem area as botanicals do not lend themselves to as precise a quality control as synthetic molecules manufactured under controlled laboratory conditions. This requires State of the art research for developing chemical/biological markers/chromatogram fingerprints/standardized operating procedures and phyto-chemical characterization of Bhasmas. A state of the art Ayurveda/Siddha/Unani Drug Standardization and Development laboratory should be set up jointly by the Deptt. of AYUSH and CSIR for development of pharmacopoeial standards of ASU drugs for India to capture a fair share of the approx. $70 billion international herbal market.

10. Action plan for Central Government.
   I. National Institute of Health and Family Welfare, Indian Council of Medical Research (ICMR), Central Council for Research in Ayurveda and Siddha (CCRAS) and Central Council for Research in Unani Medicine (CCRUM) should be tasked to evolve an operational framework for mainstreaming of AYUSH in national health care delivery network based on the underlying philosophy of providing choice of treatment to the patients at Sub-centres/PHCs/CHCs/district level and to facilitate cross system referrals complimentary and adjuvant uses of drugs and drugless therapies of various systems with a view to provide cost effective and comprehensive health care. Indian public health standards should accordingly be modified.

   II. There should be a proper integration of AYUSH in Directorate General of Health Services (DGHS), Central Government Health Scheme (CGHS), National AIDS Control Organization (NACO) and the proposed Department of Medical Research. AYUSH Research Councils should be brought under the umbrella of the proposed Department of Medical Research for encouraging collaborative and need based research for addressing India’s health care problems in a cost effective and comprehensive manner.

   III. Keeping Sub-Centres and PHCs without doctors either due to vacancies or absenteeism should not be allowed to continue any further. All such vacancies should be filled by qualified AYUSH doctors. A cluster of three Sub-Centres should be provided the services of a qualified AYUSH doctors who should visit each Sub-Centres twice in a week. The first resort of majority of patients in rural areas is traditional medicine instead of leaving patients to find for themselves and be fleeced by quacks, it is better to institutionalize AYUSH systems in sub-centres as a first point of reference for institutionalized health care. AYUSH doctors at sub-centres should also be involved in the administration of National Health Programmes like TB/HIV AIDS/Cancer for which they should be properly trained. This should be a priority area under the newly launched National Health Mission and States should be assisted on a 50:50% matching basis for
meeting the expenditure on posting of qualified AYUSH doctors at sub-centres on contractual basis.

IV. At present 7 Ayurveda and 5 Unani medicines have been included for distribution in 9 States and 4 cities under the Reproductive and Child Health Programme of the Department of Health and Family Welfare. This course of action should be taken to its logical conclusion. This list should be expanded more and more to include Ayurveda, Siddha, Unani and Homoeopathic medicines which have proven efficacy in treatment of various diseases and which have been standardized. ICMR, CCRAS, CCRUM and CCRH should be tasked to take this initiative further.

V. Under-graduate and post-graduate courses of various systems should be modified to reflect the global resurgence of interest in traditional and alternative medicine. Medical students of various disciplines need to internalize the basic truth that every system has something to offer and no system can tackle all the health problems. Various systems of medicine are complimentary to each other and their complimentarity should be fully utilized in providing a cost effective and comprehensive health care. Statutory bodies charged with the responsibility of regulating the education of various systems of medicine are not likely to take the lead in this direction. Sensitization/orientation modules should be developed by the National Institute of Health and Family Welfare in collaboration with ICMR/CCRAS/CCRUM/CCRH for introduction in under-graduate courses of all systems.


- Most States have expanded Ayurveda, Siddha, Unani and Homoeopathy infrastructure mostly at primary heath care level in response to locally felt needs and gaps in the existing health care infrastructure. This does not necessarily mean that they have mainstreamed Ayurveda, Siddha, Unani and Homoeopathy in their health care delivery at primary and secondary level. There is a lot of dysfunctionality in the functioning of facilities of various systems at various levels. Functional rigidities are being noticed in most States where there is little coordination between Directorates of Health and AYUSH systems.

- Having separate Directorate of AYUSH or even separate Department of AYUSH at State level is not the right approach. There should be functional integration between allopathic and AYUSH systems at the State, District, Sub-district and PHCs level with the single line administration at each level. To begin with, allopathic doctors can be expected to head Directorate, District, Sub-District and PHC set up with an Addl. Director at the Directorate level and an Addl. CMO at the District level and so on but in due course at all public health administrative positions should be filled
on the basis of inter-seniority and administrative capability should be the criteria for managerial positions in public health.

- **Integration of AYUSH with allopathy under single line administration at primary, secondary and tertiary level is crucially important for the purposes of bringing about synergy and of economy.**

**12. Conclusion**

- The long term process of mainstreaming of AYUSH has been initiated with remarkable success in the last decade. However, this has been a more or less bottom up State driven initiative in response to felt needs for health care at the District/CHC/PHC level. There is a need to spell out an overarching strategy to ensure that available resources are optimally utilized for achieving national health goals and outcomes. Given due emphasis on safety of drugs, drug standardization, evidence base, quality education infrastructure and strong regulatory systems, AYUSH systems would in due course get public acceptance in India as mainstream systems of health care. The draft approach paper for the 11th Plan rightly accepts the centrality of AYUSH systems for meeting the gaps in the primary health care. It notes “across States 6% to 30% posts of doctors remain vacant and random checks showed that from 29% to 67% doctors were absent. The trained ISM practitioners represent a valuable human resource at village and block levels. This could be leveraged and co-opted into providing primary health care”.

### Year -2003-2004

Details of specialist Wings/clinics/Centers for which grant-in-aid released under the scheme for AYUSH Hospitals

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2004-2005

STATE-WISE RELEASE OF FUND TO THE STATES/UTs UNDERCENTRALLY SPONSORED SCHEMES (CSS) Hospital & Dispensaries
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** Total amount is Rs.4,85,150/-
Dear Shri

Subject: Roadmap for Mainstreaming of AYUSH under NRHM

Mainstreaming of AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homoeopathy) is an important strategic intervention under the National Rural Health Mission (NRHM). The objective of the integration of AYUSH in the health care infrastructure is to reinforce the existing public health care delivery system, with the use of natural, safe and friendly remedies, which are time tested, accessible and affordable.

The Indian Systems of Medicine have age old acceptance in the communities in Indian and in most places they form the first line of action in case of the common ailments. No initiative which seeks to provide cost-effective health care to the rural communities can ignore the vast local knowledge base available in India in the form of the Indian Systems of Medicines.

Mainstreaming of AYUSH under NRHM was discussed in a series of meetings jointly held by both Departments. It is proposed that the following steps for appropriate utilization of AYUSH at the various level of health care set up be considered for implementation as part of the NRHM:

A. Integration of AYUSH in the Health Care infrastructure

1. All Primary Health Centres (PHCs) ought have an AYUSH doctor. If space permits, the AYUSH dispensary may be relocated in the existing building of the PHC. In places where the AYUSH infrastructure is good, the feasibility of shifting the PHC to the same building be examined. Although there could be constraints in the availability of spaces, at lease 10% of the PHCs with adequate space could accommodate AYUSH dispensaries. Action to shift the AYUSH dispensaries to such PHCs may be taken on priority during the first year of the mission period.

2. Where relocation of AYUSH practitioners is not feasible due to lack of AYUSH dispensaries, qualified AYUSH practitioners may be hired on contractual basis and funds for which would be provided from NRHM budget.

3. The guidelines for IPHS for CHCs, which have been disseminated to the states are being updated so as to adequately address the parameters applicable to the AYUSH component also. Once the guidelines are received, priority should be given for upgradation of AYUSH facilities to those standards.

4. While constructing new PHCs as per IPHS, adequate space should be provided for locating the AYUSH dispensary within the same premises.
B. : Integration of AYUSH with ASHA

1. The Accredited Social Health Activist (ASHA) is the main pillar of the NRHM and is to provide the first response of the Public Health Care chain to any illness at the village level. The first training module for ASHA includes the ASHA component as well. The in-service training modules for ANMs and MOs are also being updated to incorporate information on AYUSH.

2. As of now the ASHA drug kit would contain only one AYUSH preparation in the form of the iron supplement. However, the drug list could be expended in due course to include more AYUSH medicines. Suggestions in this regard are invited from the State Governments.

C. : Other initiatives

1. As of now, the Sub-Centres are no manned by qualified medical doctors. Suggestions have been received about making available and AYUSH practitioner at the Sub-Centre level at least on part-time basis. The feasibility of this proposal should be examined by the State Government.

2. The guidelines to include AYUSH practitioner at all levels in the NRHM including the State Health Mission, District Health Mission and Rogi Kalyan Samitis have been issued earlier. The action in this regard should be expedited.

3. It is intended to provide for flow of funds under the relevant Centrally Sponsored Schemes for the Department of AYUSH through District Health Societies for convergence at the District level under NRHM. Chief District Medical Officer would be the over-all coordinator of AYUSH related initiatives under the NRHM at the District level.

It is proposed to have total functional integration between the AYUSH dispensaries / hospitals and the health care facilities under the allopathic system so that the entire spectrum of treatments is made available to the rural poor at affordable costs. The enthusiastic participation of the states in this initiative is imperative for the success of the NRHM. We would, therefore, request you to ensure that the AYUSH component of NRHM is adequately addressed at the grass root level. We solicit you whole hearted cooperation in the matter.

(PRASANNA HOTA)  
Secretary (Health and Family Welfare)  

(UMA PILLAI)  
Secretary (AYUSH)
Annexure 3
LEGAL POSITION REGARDING PRESCRIBING MODERN MEDICINE BY AYUSH PHYSICIANS

- “IMCC Act 1970 Sec.2 (1) e, which states that the Indian Medicine means the system of Indian Medicine commonly known as Ashtang Ayurved, Siddha or Unani Tibbia whether supplemented or not by such modern advances as the Central Council may declare by notification from time to time”. Under this provision the CCIM vide the Resolution of its Executive Committee dated 30-08-1996 and a Press Note released on the same date and Notifications No. 8-5/96-Ay(MM) dated 30-10-1996, No. 8-5/2002-Ay(MM) dated 22-11-2004 and No. 28-5/2004-Ay(MM) dated 19-05-2004 supports that the institutionally qualified ISM doctors are authorized to practice allopathic medicine by virtue of their teaching and training in modern scientific system of medicine.

- The provision of IMCC Act under Sec.17 (3) (b) that the privileges (including the right to practice any system of medicine) conferred by or under any law relating to registration of practitioners of Indian Medicine for the time being in force in any State on a practitioner of Indian Medicine enrolled on a State Register of Indian Medicine. Accordingly the Supreme Court in Dr. Mukhtiar Chand & Others Vs The State of Punjab & Others No. AIR 1999, SC 468, dated 8-10-1998 declared that an Ayurvedic practitioner of a State is eligible to practice/use modern medicine if the State Act, under which he is registered, allows for the same. The provision to allow practitioners of ISM to practice allopathic medicine was allowed by the State of Punjab vide The Punjab Ayurvedic and Unani Practitioners Act 1963 and the State of Maharashtra by The Maharashtra Medical Practitioners Act 1961 and the Maharashtra Medical Education & Drugs Department by two Government Notifications dated 25-11-1992 and dated 23-2-1999, the latter for the purpose of the Sub-clause (iii) clause (ee) of rule 2 of the Drugs and Cosmetics Act, 1940 (23 of 1940).

- The Hon'ble Supreme Court of India in its decision in Subhash Bakshi and State of West Bengal in January 2003 has stated ‘while recognizing the rights of Vuids and Hakims to prescribe allopathic medicines this court also took into account of the fact that qualified allopathic doctors were not available in rural areas and the persons like Vuids/Hakims are catering to the medical need of residence in such areas. Hence, the provision which allows them to practice modern medicine was found in public interest’. 
Appendix C

SCHEME OF GRANT-IN-AID FOR PROMOTION OF AYUSH INTERVENTION IN PUBLIC HEALTH INITIATIVES.

1. Introduction
There are approximately 7.00 lakh institutionally qualified AYUSH practitioners located in urban, semi-urban and rural areas. They are fully trained in all aspects of preventive and curative care. Their potential has not so far been fully realized in public health. Increasing awareness of AYUSH’s potential in solving community health problems resulting from nutritional deficiencies, epidemics and vector-borne diseases have opened vistas for AYUSH in Public health. This scheme is meant to support coordinated programs for public health intervention of AYUSH.

2. Objectives of the scheme
The scheme will be implemented during 11th Plan initially as a pilot project with a district/block/Taluk as a unit for AYUSH intervention. The scheme is aimed at supporting innovative proposals of government and private organizations to promote AYUSH interventions for community health care and to encourage utilization of AYUSH practitioners in public health programmes.

3. Eligible organizations
• State Directorates of Health/AYUSH.
• State Institutes dealing with public health.
• Non-profit/Voluntary organizations working in the area of public health for at least five years and having a proven track record and a capable team comprising of public health specialists.
• AYUSH PG educational institutions.

4. Eligibility
• The applicant organization must have credible project management expertise and core staff.
• Applicant organization should have track record of working in the field of community health.
• Any institution that has obtained funding from any other Central Government
• Ministry/ Department for the same purpose in the last five years shall not be eligible for funding under this scheme.
• Applicant shall have to make information available regarding any assistance taken from any State/Central Agency in the last 5 years.

5. Funding Pattern
As this is an innovative area schematic pattern can not be basically laid out in the initial stages. Following activities will be supported under the scheme:

i. Development of quality training material for training of AYUSH/ Allopathic doctors on AYUSH in public health.
ii. Training of AYUSH/Allopathic doctors in delivery of AYUSH interventions in public health.

iii. Delivery of AYUSH public health interventions in one or more community blocks by an organization engaged in public health for a period of 3 years for developing a self-sustaining AYUSH public health model.

iv. AYUSH schemes for adolescent girls and geriatrics.

Use of allopathic medicines and practitioners shall not be excluded provided the main emphasis is on delivery of AYUSH interventions in public health. A project will be supported for 3 years and half-yearly grants will be released based on utilization statements audited by a Chartered Accountant on the CAGs panel and concurrent evaluation report of the Committee constituted for concurrent evaluation of the project. The Department will not take responsibility for either the staff employed by the organization or any other liability other than the grant sanctioned. Not more then 40% of the grant should be spent on staff/equipment or other administrative charges. Remaining 60% of the grant must be spent on AYUSH public health interventions including medicines. Project proposal shall indicate component-wise yearly expenditure and only 10% variation would be permissible. There is no minimum or maximum project cost. However, there should be participation of the community in the project to the extent of minimum 10% of the project cost in the form of money, user charges, space, Shram Daan, etc. Every project will be appraised on its merit.

6. Structure of proposals

The proposal should be well structured containing objectives and work plan for AYUSH intervention in the community. The proposal may focus on one or more of the following components,

I. Management of communicable and noncommunicable disease like malaria, chikunguniya etc.
II. mother and child care,
III. nutrition,
IV. anaemia,
V. epidemiological study, assessment of health index,
VI. validating efficacy of traditional health practices and
VII. Training of AYUSH practitioners & paramedics in public health.

Specific objectives of action plan, milestones, modalities of implementation and measurable outcome & anticipated impact of intervention for a three-year program in a CD Block as a unit area of coverage. The location should be spelt out in the proposal. Blocks/Districts should be selected for implementation, where institutions engaged in public health in those Districts/Blocks can take over and carry forward the initiatives and infrastructure after cessation of the project scheme. CD Blocks should be selected for project implementation where specific diseases/health problems are prevalent in endemic or epidemic proportions. Proposals should be focused on bridging the gaps of public health care with AYUSH approach. The proposal should include provision to benchmark the public health status before the start of the project so that the changes effected due to the project intervention can be measured. Wherever feasible, required inter-sectoral interface and co-operation with Local Public Health functionaries,
Panchayati Raj Institutions (PRIs) etc should also be reflected in the proposal. Measurable outputs and deliverables over 6 months time slices should be built into the project proposal.

7. Submission of application:

1. Scheme details and application format shall be available on the department website- www.indianmedicine.nic.in under the heading "Schemes" Copies of the scheme will be distributed to all potential applicants and can be collected from the Department of AYUSH. The scheme is liable for advertisement in leading newspapers for obtaining competitive proposals.

2. Eligible organisation should apply in prescribed format (Annexure) along with a brief concept note about the proposal indicating objectives, action plan outputs and outcomes including location and an indicative budget. Full proposal would be invited on acceptance of the concept. The applicant organization will be asked to make a presentation before the Project Appraisal/Approval Committee.

3. Certificate as under is required along with application from the head of the organization Certified that:

   (i) The organization shall abide by all the ‘Terms and Conditions’ of the grant stipulated by the Department of AYUSH, Government of India.

   (ii) All records and reports related to the project have been maintained separately and shall be shown and furnished as and when required by the Department of AYUSH or its authorized representatives.

   (iii) Project shall be open for evaluation of physical progress and utilisation of funds at the discretion of Department of AYUSH.

   (iv) The undersigned shall be responsible for the authenticity of the information & documents furnished in the application and proposal.

   (v) Department of AYUSH shall have the right to recover the grant or take legal action against the organization for any default or deviation from the terms & conditions of sanction of grant.

Signature
Name and Stamp of the Head of the organisation
Phone No............................
Fax No...............................
9. Project appraisal

Before consideration for approval, Project proposal will be subjected to appraisal by a Committee comprising of-

(i) Joint Secretary (AYUSH) Chairperson
(ii) Concerned Adviser in Dept. of AYUSH Member
(iii) Concerned Director of Research Council Member
(iv) Two representatives of reputed Community/Public Health NGOs Members nominated by Secretary (AYUSH)
(v) Representative of Planning Commission Member
(vi) Director/Deputy Secretary looking after NRHM in the Department of Health Member
(vii) Director (AYUSH)/Commissioner (Health) of the concerned state Member
(viii) Director in-charge of the Scheme Convener

This committee will be responsible for selection, monitoring and evaluation of the project.

10. Approval of projects:

The project proposals complete in all aspects and appraised by the Appraisal Committee will be considered for sanction of grant by a Project Approval Committee comprising of -

i) Secretary (AYUSH) Chairperson.
ii) Financial Adviser of the Ministry Member
iii) Joint Secretary (AYUSH) Member
iv) Concerned Adviser Member
v) Two renowned Community or Public Health experts nominated by Secretary (AYUSH) Members
vi) Director in-charge of the Scheme Convener

11. Concurrent Evaluation:

As this is an innovative scheme, each project would be concurrently evaluated by a committee as follows:

i. A Renowned Public Health Expert Chairperson nominated by Secretary (AYUSH)
ii. Commissioner/Director (ISM&H) of the State Member
iii. Director in-charge CRI, RRI of the AYUSH Member Research Council in that area
iv. Adviser/Dy. Adviser of the Department Convener

12. Selection process:

1. The scheme should be announced on the AYUSH website and brochures on the scheme should be widely distributed to all potential applicant constituencies.
2. Any applicant should be free to send a two page concept note which gives information on
   a) proposed objectives,
   b) track record of meritorious accomplishments,
c) profile of available staff and infrastructure,
d) information on National and International awards and
e) broad budget estimate for a four year program.

3. Concept notes approved by the appraisal committee should be invited to submit a full proposal.
4. The appraisal committee should review and select the best proposal evaluated.

APPLICATION FORM FOR SCHEME OF GRANT-IN-AID FOR PROMOTION OF AYUSH INTERVENTION IN PUBLIC HEALTH INITIATIVES

1. Name of the organization:

2. Registered Address:
   Phone Number with STD code- 
   Fax Number with STD code- 
   Email- 

3. Mailing Address:

4. Registration No. and date

5. Abstract of Audited Income & Expenditure details of last five years:

6. List of technical and non-technical personnel with experience on community/ public health employed with the organisation: (enclose the particulars of each personnel like name, gender & age, qualifications, experience)

7. Major activities of the organization:

8. Major achievements of the organization in last three years:

9. Whether any grant received earlier from Ministry of Health & Family Welfare, if so, furnish the details thereof:

10. Whether funds were/are received from any other Central/State Government source, if yes, furnish details thereof:

11. Title of the proposed project:

12. Brief about the deliverables & expected outcomes: (enclose a concept paper indicating objectives, action plan, outputs & outcomes, modalities & logistics, budgetary requirements etc)

13. Coverage area for the proposed project:
   a) Name of the District (State)
   b) Number of Talukas/Tehsils
   c) Number of Blocks
d) Approximate number of beneficiaries

14. Total amount and break up of grant required with justification for each item-

15. Attach following documents
   i) Concept note
   ii) Attested Copy of Registration
   iii) Attested Copy of Bye-laws.
   iv) Attested copies of Audited Statements of Account for last five years.
   v) Bank Account details.
   vi) A note of past activities and achievements of the organisation.
   vii) Certificate of abiding to the terms & conditions as mentioned in para 6.

16. Give two references (with address, phone number etc.) other than District AYUSH/Health Officer and State AYUSH/Health Secretary

   i) 
   
   ii) 

   Signature
   (Name and Seal of the head/authorized officer of the organization)
Appendix D

Central Sector Scheme for supporting Re-orientation Training, Continuing Medical Education and Exposure programs of AYUSH.

Introduction:

AYUSH teachers and practitioners do not have access to professional journals and web-based CME like their allopathic counterparts. There is an urgent need for re-orienting and upgrading their professional competence & skills. Emerging trends of health care and scientific outcomes necessitate time to time enhancement of professional knowledge of teachers, practitioners and researchers. Many issues of the profession can not be covered through stereotyped course curricula and need augmentation & clarification through direct interaction with the resource persons and domain experts. Good Clinical Practices and Good Teaching Practices are the two areas where AYUSH practitioners and teachers need to be regularly updated to keep up the standards of health delivery and adequate training of students respectively in accordance with the emerging demands. Similarly, use of Information Technology as a tool for widespread dissemination of AYUSH developments & updates is need of the hour in the present era of fast changing trends & methodologies. Web-based educational programs like the ones conducted by UGC are required for AYUSH for wider dissemination of current information & trends. The services of AYUSH paramedics and health workers are also of utmost importance in health care. Hence, the re-orientation of these personnel with updates and changing trends is also proposed in XI Plan. Given the growing domestic and international acceptance of AYUSH knowledge systems and their clinical applications, it is essential to upgrade the quality of AYUSH teaching and practice. In this context therefore re-orientation training and continued medical education become quite relevant. With this objective it is intended in the 11th Plan to support programmes of professional skill development of AYUSH personnel in an organized manner at reputed institutions and field levels. The scheme of assistance is switched over from centrally sponsored to central sector enabling release of funds directly to the grantee institutions. The scheme has been restructured giving flexibility for its implementation and adding new components. The proposed pattern of the scheme is based on the experience gained during 9th & 10th Plans, feedback received from various institutions and requirements for varied nature of training of AYUSH personnel and their exposure to AYUSH centres of excellence. Overall structure of the scheme is aimed at encouraging AYUSH personnel to undergo need-based professional orientation and bridge the knowledge gaps.

Scheme components:

(I) Orientation training programmes & Exposure Visits

1. One-week subject-/specialty-specific re-orientation training programme for AYUSH teachers.
2. One-week introductory programme of AYUSH systems for allopathic and foreign doctors/students.
3. One-week specialized training for AYUSH paramedics/health workers.
4. One week Management training & exposure visit of AYUSH administrators/heads of departments/institutions.

All the above programmes would be modular in nature.
(II) Continuing Medical Education (CME) Programmes & exposure visits for AYUSH doctors.

1. Theme-specific two-day CME programme for AYUSH practitioners at district and sub-district levels.
2. One-week exposure visit cum CME programme for AYUSH doctors at specialized centres of best & innovative practices.

(III) Web-based educational programmes

1. Preparation of subject-/specialty-specific AYUSH modules/CDs for wider dissemination through web-based training programmes.
2. Preparation, launch and running of web-based journal.

(IV) Publication of quarterly CME journals /Peer-Review Scientific Journals in AYUSH sector.

1. Publication of series of CME journals to facilitate distant learning of AYUSH for up-gradation of professional knowledge of practitioners.
2. Publication of peer-review journals for up-to-date education and research developments in AYUSH sector for up-gradation of professional knowledge of professionals. The support will be for printing and postage to the extent of 500 copies.

(V) Re-orientation Training/CME related innovative tools, programs and activities for use of AYUSH personnel.

1. Organizations having domain knowledge like the National Institutes viz., Rashtriya Ayurved Vidyapeeth and others and universities/deemed universities and reputed organisations having competence and wherewithal to develop and implement innovative initiatives for strengthening of orientation training/CME programs will be supported for the benefit of AYUSH fraternity

I. To develop training material, courses, modules, CDs and structured programs
II. To design and develop innovative CME courses for AYUSH practitioners;
III. To develop IT interface (software) for innovative CME courses;
IV. To establish a special cell in Health/AYUSH universities for registration of AYUSH & IT organizations and to coordinate the deputation of AYUSH teachers for training programs.
V. To provide exposure of best practices in clinical and hospital management areas to AYUSH teachers & practitioners.
VI. To conduct innovative short term training program for teachers at reputed AYUSH institutions on subjects as under-
   • Use of IT teaching aid in AYUSH education,
   • Contemporary relevance of theoretical foundations of AYUSH knowledge systems,
   • Integrated protocols for clinical documentation and diagnosis,
   • Statistical design for clinical trials based on holistic management,
   • Internal assessment/evaluation methods of students,
   • Innovative teaching methods,
   • Scope of trans-disciplinary research in pharmacognosy and pharmacology,
   • Scientific methods & tools for evaluating classical pharmaceutical processes,
   • Application of classical AYUSH systems for community/public health

A maximum of 20% of the total allocation under the scheme can be spent for this component.
(VI) National and Regional Level Workshops / Conferences for CME.

At least two National level and two Regional level workshops / conferences shall be organized in a year by reputed organizations/Centres of Excellence identified by Department of AYUSH.

- Each such workshop / conference shall focus on a particular speciality for imparting knowledge / skills / best practices to at least 150 for national level and 100 for regional level AYUSH / Allopathic practitioners.
- The concerned host institution shall make training / board / lodge arrangements for the participants as well as payment as TA/DA to them.

Eligibility criteria:

Financial assistance through the scheme will be provided to the following institutions /organizations on receipt of component-specific proposals –

(i) National Institutes, Model Colleges, Central Research Institutes / organizations and Universities/deemed universities with AYUSH faculty;
(ii) Reputed organizations and AYUSH institutions which have linkages with institutions having adequate facilities of R&D, hospital, teaching &/or training;
(iii) Central/State Resource Training Centre or Institute of Health & Family Welfare capable to undertake AYUSH training;
(iv) State AYUSH Directorates/ Boards interested to undertake District/Sub-district level training of AYUSH practitioners/paramedics/health workers;
(v) For web-based training programmes and publication of CME journals, National Open Universities/Distant Education Centres and other capable organizations will be invited and supported to work in collaboration with National Institutes/Centres of Excellence in AYUSH.
(vi) For publication of peer-review scientific journals, reputed institutions/organizations, universities and deemed universities having AYUSH faculty and other capable organizations will be invited and supported.
(vii) The National Institutes, Model Colleges, Centres of Excellence and reputed Private organisations identified by Department of AYUSH shall be eligible to take up programmes for allopathic / foreign

Funding pattern:

Financial assistance will be provided directly to institutions/organizations approved by the Screening Committee. Funds for a programme will be released to the institute on approval of the proposal as per the following pattern

a) Re-orientation/Introductory training program/ CME programme

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<thead>
<tr>
<th>Sr. No.</th>
<th>Particulars</th>
<th>Admissible amount</th>
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<tbody>
<tr>
<td>1</td>
<td>Per day boarding &amp; lodging charges of Trainees</td>
<td>Rs. 1000 per person.</td>
</tr>
<tr>
<td>2</td>
<td>Per day boarding &amp; lodging charges of outside experts</td>
<td>Rs. 1500 per person.</td>
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</tbody>
</table>
3. Travel expenses of trainees
Actual fare or up to the rail fare up to 2 tire Ac

4. Travel expenses of outside experts
Actual fare or up to the rail fare of AC 2 tier class / Economy Class Air Fare

5. Honorarium to resource persons
Rs. 1000 per session/demonstration

6. Honorarium to support staff of the host Institute for one week programme
Rs. 5000 to be shared among the involved staff members.

7. Honorarium to support staff of the host Institute for 2 day programme
Rs. 3000 to be shared among the involved staff members.

8. Training material
Rs. 500 per trainee/resource Person

9. Consolidated amount for institutional support & contingencies in one week programmes
Rs. 25,000

10. Consolidated amount for institutional support & contingencies in one week programmes
Rs. 10,000

**b) Orientation training program for paramedics/health workers:**

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<th>Sr. No.</th>
<th>Particulars</th>
<th>Admissible amount</th>
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<tr>
<td>1</td>
<td>Per day boarding &amp; lodging charges of Trainees</td>
<td>Rs. 600 per person.</td>
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<tr>
<td>2</td>
<td>Per day boarding &amp; lodging charges of outside experts</td>
<td>Rs. 1000 per person.</td>
</tr>
<tr>
<td>3</td>
<td>Travel expenses of trainees</td>
<td>Actual fare or up to the rail fare as per entitlement</td>
</tr>
<tr>
<td>4</td>
<td>Travel expenses of outside experts</td>
<td>Actual fare or up to the rail fare of AC 2 tier class / Economy Class Air Fare</td>
</tr>
<tr>
<td>5</td>
<td>Honorarium to resource persons</td>
<td>Rs. 800 per session/demonstration</td>
</tr>
<tr>
<td>6</td>
<td>Honorarium to support staff of the host institute</td>
<td>Rs. 3000 to be shared among the involved staff members.</td>
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<tr>
<td>7</td>
<td>Training material</td>
<td>Rs. 250 per trainee/resource Person</td>
</tr>
<tr>
<td>8</td>
<td>Consolidated amount for institutional support &amp; contingencies.</td>
<td>Rs. 10,000</td>
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</tbody>
</table>
C) Management training/Exposure visit of AYUSH administrators/heads of institutions and in-service doctors.

The host institute will be provided the funds for organizing the program as per applicable package rate or as per pattern prescribed for one-week orientation training program.

D) Introductory programme of AYUSH systems for allopathic and foreign doctors/students

Host institutions will be supported in the manner applicable to reorientation training program for AYUSH teachers, except expenses of foreign doctors/students, which shall not be supported through the scheme.

E) Web-based training/CME program & publication of CME journals/Peer-Review Journals-

Centres of Excellence identified by the Department of AYUSH will be invited to submit project proposal for web-based CME programmes / CME journal/Peer Review Journal. Expenditure projected in the proposal will be subjected to appraisal by an expert committee followed by approval of Screening Committee. Funds would be released in annual instalments in accordance with the Screening Committee’s recommendations. Progress report along with authenticated statement of expenditure of the preceding instalment is required before considering release of subsequent instalments.

f) Re-orientation Training/CME related innovative tools, programs and activities for use of AYUSH personnel.

The proposals will be invited from capable Government and private organizations and subjected to appraisal by a Project Committee comprising of Joint Secretary (AYUSH) as Chairman and concerned Adviser, Research Council Director and a domain expert nominated by the Department. The quantum of assistance and mode of implementation will be determined by the Screening Committee.

g) National Workshops / Conferences for CME.

Centres of Excellence/reputed organisations identified by the Department of AYUSH will be invited to submit proposals with break-up of expenditure, which will be appraised and sanctioned by the Screening Committee.

Guidelines for applying & implementing the scheme:

Following guidelines shall be followed in supporting the various programmes envisaged under the scheme:

(i) Not more than four orientation training and/or CME programmes in a year shall be allotted to an eligible institute/organization. Interested institutes may apply once in a year providing schedule & details of the programmes to be conducted. Modules of training and list of resource persons along with their qualifications, experience and specialization should be enclosed with the application.

(ii) At least 15 participants must be enrolled in an re-orientation training program. Not more than two trainees from the host institute shall participate in the program and they will not be entitled for any financial benefit except training material. In case of CME program, participation of at least 30 practitioners in urban areas and 20 practitioners in rural areas should be ensured. All the
participants except paramedics should possess the qualification included in concerned Medical Acts.

(iii) The program of orientation training/exposure visit / CME for doctors shall be conducted on consecutive six working days. CME program for practitioners shall be conducted on Saturdays & Sundays.

(iv) Participation Certificate shall be issued on full attendance only.

(v) Payment of TA/DA should be made only at the end of the programme as per admissibility or actuals, whichever is less. In case of resource persons being paid Air Fare, they may be requested to utilize apex/senior citizen fare to the possible extent.

(vi) Duration of training/CME program shall be exclusive of journey time.

(vii) Conduction of programme should commence within three months after release of grants with preparation of Schedule of the program and it should be widely circulated well in advance to institutions & State Directorates for nomination of trainees.

(viii) National programmes, experiential knowledge of experts in the field, research findings, current developments & current trends relevant to the theme of training/CME program must find place in the modules.

(ix) Resource persons: Four experts of concerned specialty (one faculty member and three external experts) are permissible for conducting CME and twelve experts of concerned specialty (four faculty and eight external experts) in re-orientation programme as per the given modules. Experts from Department of AYUSH and Research Councils as per their expertise should be called wherever required.

(x) Structure of the re-orientation training/CME program shall be as under:
   a. Two theory sessions using audio-visual aids and two practical/demonstrative sessions shall be conducted per day. Each session will be of 1½ hours duration.
   b. Each external/internal expert shall deliver two theory/practical sessions in one day in RoTP/CME.
   c. Each theory and practical session shall be followed by questions & answers and necessary clarifications/explanations.
   d. Reading material & copies of the presentations, CDs etc. should be distributed to all participants at the beginning of the program.

(xi) Institutions interested to take up orientation training/CME programs may design modules and submit the same along with application for approval. In case of pre-structured modules/package training programs prepared by Department of AYUSH, no prior approval is required.

(xii) Program for management training/exposure visit of AYUSH administrators & heads of departments/institutions and AYUSH doctors shall be worked out by the host institute(s).

(xiii) Institutions willing to conduct web-based training programs and/or publish CME journals are required to send proposals with complete technical & financial details indicating the project implementation schedule and timelines.
(xiv) The proposal of innovative initiative should be worked out in all technical & financial details keeping in mind the scope & limitations of the scheme.

(xv) No expenditure is liable to be reimbursed that has been incurred before the sanction of the grant and implementation of the approved program/activity and for other than sanctioned items.

(xvi) Re appropriation within sanctioned items of expenditure may be done to the extent not more than 10%.

(xvii) The heads of the institutions/departments/organization in whose name the grants are released are personally responsible for proper utilization of grants as per the scheme pattern.

(xviii) After completion of the training/CME programme following documents may invariably be submitted to the Department of AYUSH within one month for liquidation of grant-

a. Authenticated Utilization Certificate in the prescribed proforma to the effect that the grant has been utilized for the purpose for which it was sanctioned;

b. Audited Accounts reflecting therein the Grant-in-aid and item-by-item expenditure incurred there from;

c. A certificate that the organization has not received financial assistance for the same purpose from any other Department of the Central or the State Government or any Government/nongovernment agency;

d. Achievement-cum-performance report indicating the performance for which the grant was received; the manner in which it has been utilized; and how the grant helped to improve the performance of the participants/institution;

e. Feedback report in the proforma (Annexure C), in separate sealed envelopes, from each of the trainees and resource persons in case of Re-orientation Training/CME program;

f. A statement showing the names and addresses of the trainees, which should be certified by the Head of the Institute/College that all the trainees were registered AYUSH practitioners;

g. A statement showing the names & addresses of the resource persons participated in the programme along with their bio-data showing their qualifications, experience in the subject etc. for their further utilization, as and when required;

h. Unspent balance of the grant, if any, may be returned to the Department of AYUSH in the form of Demand Draft drawn in favour of the Accounts officer, Cash (Health) payable at New Delhi;

i. All original receipts/vouchers may be kept with the organizing institution for a period of 5 years for any audit check.

How to apply: Application for seeking grant to conduct Re-orientation Training/ and Continuing Medical Education Programme will be made, in the proforma given at Annexure-A and Annexure-B respectively,

The Director (AYUSH)
IRCS Building, 1 Red Cross Road,
New Delhi Telefax: 23327669

Programme Manager: A professional with requisite domain knowledge and work processing skills will be hired @ Rs. 20,000/- P.M. to act as the Programme Manager.
**Data Entry Operator-cum-Clerk:** One young graduate with computer abilities and experience in office processing work will be hired @Rs.10,000/- per month for handling the work related to RoTP and CME. A Project Evaluation Committee will be constituted by Secretary (AYUSH) comprising of renowned experts.

**Screening Committee:**

All proposals received under the scheme will be subjected to appraisal by the PEC and then submitted for consideration and approval by a Screening Committee comprising of –

1. Secretary (AYUSH) /JS (AYUSH) - Chairperson
2. Additional Secretary & FA or his nominee- Member
3. Joint Secretary (AYUSH) - Member
4. Adviser of concerned system - Member
5. Director in-charge of the scheme - Member
6. Director, Rashtriya Ayurved Vidyapeeth - Member
7. One renowned expert to be nominated by Secretary (AYUSH) – Member

**Annexure-A**

**APPLICATION FOR RE-ORIENTATION TRAINING (SUBJECT / SPECIALITY) PROGRAMME (RoTP) – FOR TEACHERS/PARAMEDICS OF AYUSH OR DOCTORS OF ALLOPATHY SYSTEM**

1. Name of the Institution
2. Address/ Tel. No./ FAX No./ E-Mail
4. Documents to be enclosed with the application : A certificate to this effect that the organization has not obtained or applied for grants for the same purpose or activity from any other Ministry or Department of the Government of India or the State Government or any Non-governmental organisation.
5. Additional Documents to be enclosed with the application (for private colleges established under societies Act): Copies of Articles of association byelaws, audited statement of accounts, sources and pattern of income and expenditure, etc.
6. Year of Establishment
7. Details of Departments
8. Details of faculty in the institution participating in the programme along with qualifications, date of joining and duration of experience in the subject (May attach a separate sheet) Past experience of organizing such programmes(Details)
9. Details about the previous grants if any under this Scheme (ROTP & CME)
10. Whether the following documents are sent or not (if not, the reasons) with respect to S.N.-11 .
   A) Utilisation Certificates in prescribed proforma
   B) Audited accounts reflecting item-wise expenditure
C) Achievement cum performance report/ feedback report from trainees
D) Statement showing name & full postal address of the trainees certified by the institute and
E) Certificate that all the trainees are registered AYUSH practitioners etc.

11. Whether any other grants under any scheme were received from this Department at earlier occasions. If yes, the details thereof. Whether Utilisation Certificate and other requisite documents is pending/due for such grants or sent.

12. How many programmes the institution wants to organize

13. Details of the programmes viz subjects etc.

14. Amount required with break up

15. Names of Experts/ Resource persons for conducting the programme with their current posting, date of birth and qualifications and experience in the subject for which they are invited, Tel no, E-mail, Mobile etc. (may attach separate sheet)

Signature of the Head of the Institution/ Association/ Organisation

Name:___________________________
Designation_____________________
Postal address_________________________
Tel./Fax No. & E-mail_________________________

Annexure-B

APPLICATION FOR CONTINUING MEDICAL EDUCATION (CME) PROGRAMME FOR AYUSH DOCTORS

1. Name of the Institution/ Organisation

2. Address/ Tele No./Fax No./ E Mail


4. Documents to be enclosed with the application (for all colleges): A certificate to this effect that the organization has not obtained or applied for grants for the same purpose or activity from any other Ministry or Department of the Government of India or the State Government or any other nongovernmental organisation.

5. Additional Documents to be enclosed with the application (for private colleges established under societies Act): Copies of Articles of association bye-laws, audited statement of accounts, sources and pattern of income and expenditure, etc.

6. Year of Establishment
7. Previous experience of organizing such programmes (details may be given)

8. Details about the previous grants, if any, under this Scheme (ROTP & CME)
9. Whether Utilisation Certificates in the prescribed proforma/ audited accounts reflecting item wise expenditure/ Achievement cum performance report/ statement showing name & address of the trainees certified by the institute that all the trainees are registered AYUSH practitioners etc. are sent or not. If yes, date of sending the same.

10. Whether any other grants under any scheme were received from this Department at earlier occasions. If yes, the details there of. Whether Utilisation certificate and other requisite documents is pending/due for such grants, or sent.

11. Number of programmes applied for

12. Amount required with break up

13. Names of Experts/ Resource persons for conducting the programme with their current posting, date of birth and qualifications & experience in the subject for which they are invited, Tel no., E-mail, Mobile etc

**Signature of the Head of the**

**Institution/ Association/ Organisation**

Name: _________________________________

Designation __________________________

Postal address __________________________

Tel/Fax No. ____________________________

E-mail: ________________________________
Annexure – C  
*Confidential*

**ASSESSMENT PROFORMA**  
(To be filled by the trainee at the end of the Training Programme and given to Organizing Institution in a sealed envelop)

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<td>1</td>
<td>Name &amp; Address of the Institution :</td>
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<td>2</td>
<td>Name of the Training programme :</td>
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<td>3</td>
<td>Duration of the Training Programme : From To</td>
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<td>4</td>
<td>Number of trainees attended : Good / Poor</td>
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<td>5</td>
<td>Usefulness of the programme : Very useful/ Useful / Not relevant</td>
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<td>6</td>
<td>Infrastructure available in the Institution:</td>
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<td>a) OPD : Excellent/Very Good/ Good/Average/Poor</td>
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<td></td>
<td>b) IPD : Excellent/Very Good/ Good/Average/Poor</td>
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<td>c) Laboratory : Excellent/Very Good/ Good/Average/Poor</td>
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<td>d) Library : Excellent/Very Good/ Good/Average/Poor</td>
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<td>e) Hostel : Excellent/Very Good/ Good/Average/Poor</td>
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<td>f) Herbal Garden : Excellent/Very Good/ Good/Average/Poor</td>
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<td>g) Pharmacy : Excellent/Very Good/ Good/Average/Poor</td>
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7. Assessment of Faculty

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<tr>
<th>Sl.No.</th>
<th>Name of Faculty</th>
<th>Subject</th>
<th>Quality of Teaching (Excellent/ V. Good/ Good/ Average/ Poor)</th>
<th>Quality of Lecture notes (Excellent/ V Good/ Good/ Average/ Poor)</th>
<th>Use of audio visual aids (Excellent/ V Good/ Good/ Average/ Poor)</th>
<th>Overall assessment of the faculty (Excellent/ V Good/ Good/ Average/ Poor)</th>
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<th>Facilities for stay and other amenities</th>
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<td></td>
<td>Shortcomings, if any,</td>
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<td></td>
<td>Any suggestions to be incorporated for future training programme</td>
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<td></td>
<td>Overall assessment of course/programme</td>
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|   | Excellent/Very Good/ Good/Average/Poor |

Signature of the Trainee...........................

Name ..............................................

Full Postal Address................................

........................................

........................................

e-mail:.........................................

*Note: Any trainee may send the filled-in Feedback Form or any suggestion directly to the Director, Rashtriya Ayurveda Vidyapeeth, Dhanvantari Bhawan, Road No.66, Punjabi Bagh (West), New Delhi-110 026 by post or by e-mail to: ayurgyan@rediffmail.com.*
Appendix E

CONSENSUS STATEMENT OF THE SOUTH ASIAN REGIONAL CONFERENCE ON TRADITIONAL MEDICINE AND RIGHT TO HEALTH FOR ALL

BACKGROUND

This workshop was part of a joint project by AIFO (Italian Association Amici di Raoul Follereau) in collaboration with 3 other Italian Non-Governmental Organisations (COE, MLAL and Monserrate). This initiative is co-funded by Italian Cooperation of the Italian Foreign Ministry.

The workshop in India for South Asian region was organised by AIFO/Italy. The main workshop was held in Bangalore from 13 to 15 December 2006. There were some additional preparatory meetings before these dates. Participants for this meeting came from Bangladesh, Nepal, Bhutan, India and Sri Lanka. The first two days of the meeting were held at Monarch Hotel, while the last day of the meeting was organised in the auditorium of Government Ayurvedic Medical College of Bangalore.

The meeting in India was being organised in collaboration with International People's Health University (IPHU) of the People's Health Movement (PHM) with technical guidance from World Health Organisation's (WHO) South-east Asia Regional office (SEARO) in New Delhi. Dr. K. Balasubramaniam (Sri Lanka) provided the technical coordination for the meeting.

For detailed report on workshop visit-
http://www.aifo.it/english/proj/traditional_medicine/presentation-list.htm

PREAMBLE

We the delegates of the South Asian Regional Conference on Traditional Medicine and Right to Health for All, coming from Bangladesh, Bhutan, India, Nepal and Sri Lanka, representing government departments, academic institutions, NGOs and people's organizations affirm that the celebration and fostering of cultural diversity is an essential necessity for the achievement of Health for All. The diversity of the different cultures, communities and ecosystems, translates into interaction and co-evolvement with nature. The knowledge and values embedded in this diversity have important learning’s for all of us.

Traditional knowledge systems of which Traditional healing and health systems are a part, are organic expression of the cultural diversity and of the land, forests, language and life of communities. Traditional knowledge has evolved in specific contexts and needs to be appreciated in the light of its own world view. Traditional knowledge includes both the codified and the un-codified systems of healing.

Indigenous and rural communities, particularly women have been the caretakers of the eco-systems from time immemorial. They are also the custodians of the immense
knowledge and diverse forms of culture that has evolved over millennia of peaceful and sustainable co-evolution with nature.

Historically indigenous communities all over the world have been systematically destroyed by the designs of colonization. This has been accompanied by a process of devaluing their cultures and knowledge systems. This has led to the extinction of numerous cultures and knowledge systems, and the near extinction of many others. The modern attempt at cultural and economic homogenization for the benefit of the global market has devastating effects on these cultures.

Similarly the dominance of Western bio-medicine and a science based on a Cartesian split between the mind and the matter, the industrial revolution and an attempt to control rather than co-evolve with nature, has meant that all other knowledge systems are considered as inferior or mere objects of curiosity and appropriation. This has led to erosion of knowledge and confidence of these systems and has also resulted in large scale unmet need for health care.

VISION

We reiterate the vision set out in the People's Health Charter for, “Equity, ecologically-sustainable development and peace” and, “a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives.”

EARLIER STATEMENTS

We acknowledge the following statements / declarations that reflect the continuing and historic efforts towards celebrating and preserving of diversity of healing systems:

- Convention on Bio-diversity
- The Alma Ata declaration
- The Chaibasa statement.
- The Global People's Charter for Health
- The Cuenca Declaration of People's Health Movement

TRIPS AND OTHER INTERNATIONAL TRADE REGIMES

We also express our concern at the harmful effects of the trade-led agreements that institutionalize unjust international trade regimes. The present trade regimes are inequitable and adversely affect biodiversity as well as traditional knowledge systems. The focus should be on developing strong national level laws to protect biodiversity as well as rural livelihoods. All clauses in the various regimes that encourage the extraction of natural resources, as well as bio-prospecting where age old wisdom of communities is exploited commercially with no benefit to the local people need to be reviewed and rewritten to protect the interests of the poor and marginalized persons as opposed to corporate industry.
**AFFIRMATIONS**

The present scenario is characterized by the paradox of increased usage of non-allopathic systems in developed countries and urban centers and continuing dependence of large proportions of indigenous and rural communities in the developing world on these systems. At the same time, there is a systematic erosion of these Traditional Knowledge systems as characterized by the increasing age of the surviving practitioners and the neglect of these systems by the younger generations as well an erosion of the bio-diversity that sustains these systems. This is partly a historical process, a continuation of the destruction wrought by colonization and also a result of forcibly altering the relationships between traditional communities and nature, degradation of the natural environment and the domination of the laws of the market over the laws of nature.

We affirm that Traditional Healing systems are not mere therapeutic alternatives to western bio-medicine. They are a totally different paradigm of healing and cannot be constrained to the point of interaction between a person requiring health care and a healer. Traditional systems are ways of life and holistic systems for the promotion of health in addition to having curative components, and should be treated as such. Moreover Traditional systems are individual specific and holistic and reducing them to alternatives to western medical cures is completely missing their message and significance.

Evaluation of any system of healing needs to be done systematically. At the same time it needs to be sensitive and cognizant to the paradigm and cosmovision from which it evolved. Evaluation needs to be done keeping the ultimate goal of Health for All in mind. Evaluation needs to actively and respectfully involve both the healers as well as people using the various systems to take into account their perspectives and value systems.

The natural environment is crucial for the health of the human race as well as for the sustenance of traditional knowledge systems. It is absolutely essential that any further degradation of the natural environment be stopped forthwith. Another way of degradation of the environment is by the commodification of natural resources and their exploitation for profit. Here we express our concern against the concept of Intellectual Property Rights for natural resources and traditional knowledge linked to these, especially those aspects that lead to the exploitation of communities that depend on and have protected these resources. We also strongly support the protection of traditional users’ rights in addition to protection of traditional knowledge. Along with this it is also important to protect the livelihoods and the knowledge of traditional practitioners of both the codified and un-codified systems.

We affirm that every decision taken that will impact on the people of the world should be guided by people in all aspects of decision making, implementation and evaluation.

Ultimately the health of the people anywhere in the world is an emergent state of a complex of interactions and can occur only in the context of equity, peace and ecologically sustainable development. However in today’s day and age there are

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1 Allopathic: western bio-medical system of medicine
numerous processes that are increasing inequity and poverty leading to ill-health. Thus regardless of the therapeutic prowess of any single system of medicine it is essential to make a concerted effort to wipe out poverty and inequity. It is important not to loose sight of the broader social determinants of health.

**TRADITIONAL SYSTEMS AND HEALTH FOR ALL**

All knowledge systems can contribute towards the achievement of Health for All. While resisting the tendency of any system to monopolize, we believe that every region / community must be free to develop its own system which is safe, accessible, equitous and efficacious, and does not effect the community’s self-reliance and empowerment.

Every knowledge system of the world has a crucial contribution to make towards the achievement of Health for All, no one knowledge system has a monopoly. Any attempt at domination can only be detrimental to the health of the people at large, but especially to the people who are marginalized by the present market dominated development model and continue to depend on these systems for their health in increasingly vitiated environments.

The contribution of the Traditional systems to Health for All should not be conceptualized only from the perspective of a therapeutic alternative, or their healers merely as human resources to universalize western bio-medical interventions focused on disease.

It is their holistic conceptualization of health and healing, with the emphasis on harmony and the conceptualization of health as a dynamic balance, their respect for the environment and for fellow humans and their respect of the laws of nature rather than the laws of the market that make these systems important for the achievement of Health for All.

**CALL FOR ACTION**

- *This is being done for the following levels: Global, Regional and Local.*
- *Under each it was suggested that we have two sections – one on what we want and one on specific actions that will bring these about.*

**Global**

**What needs to be done?**

- Initiation of dialogue to increase understanding between systems and initiate multi-disciplinary research.
- Initiation of processes to resist trade led agreements.
- Initiation of processes to initiate urgent efforts to protect and rejuvenate the environment.

**How to do it?**

- Formation of global level committee / study circle – initiators could be WHO and the People’s Health Movement.
- Involvement of this committee in the activities of various movements
against the trade led agreements..

- Concerted efforts to garner the political will to protect and rejuvenate the environment.

**Regional**

**What needs to be done?**

- Initiation of dialogue to increase understanding between systems and initiate multi-disciplinary research.
- Efforts to standardize and exchange resources and technologies within countries of the region.

**How to do it?**

- Formation of a SAARC level committee – the participants of this conference can be a nucleus to initiate the dialogue
- This committee can initiate dialogues with various government institutions / ministries to facilitate such resource / technology sharing.
- Exploring processes such as regional licensing, exchange of faculty, common curricula and evolution of continuing education curricula to build capacity at the regional level.

**Local**

**What needs to be done?**

- Protection of bio-diversity.
- Livelihoods of traditional practitioners.
- Documentation of bio-diversity.
- Revitalization of local health traditions.

**How to do it?**

- Formation of national level committees – including the participants and large civil society networks like the PHM.
- Initiation of micro-projects as learning and operational research.
- Conferences / workshops to disseminate various ideas / solutions.

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**A PEOPLE-CENTRED HEALTH SECTOR**

“This Charter calls for the provision of universal and comprehensive primary health care, irrespective of people’s ability to pay. Health services must be democratic and accountable with sufficient resources to achieve this. ……”

This Charter calls on people of the world to:

“…….Support, recognize and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care ….”

*People’s Charter for Health, 2000*
Appendix F
PowerPoint’s presented at workshop.