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General article

Challenges of mainstreaming: Ayurvedic practice in Delhi Government health institutions

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ABSTRACT

This paper is an attempt to understand the project of mainstreaming in India's health care system that has started with an aim to bring marginalized and alternative systems of medicine in mainstream. The project has gained much attention with the establishment of Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) in the year 2003, which is now a ministry. It has ushered some positive results in terms of growth of AYUSH hospitals and dispensaries. However, it has also raised challenges around the theory and practice of mainstreaming. With an emphasis on Ayurvedic practice in Delhi Government Health Institutions, this article has tried to analyze some of those challenges and intricacies. Drawing on Weber's theory of bureaucratization and Giddens's theory of structuration, the paper asks what happens to an alternative medical system when it becomes part of the bureaucratic set-up. Along with the questions of structures, it also tries to combine the question of the agency of both patients and doctors considered to be the cornerstone of the Ayurvedic medical system. Although our study recognizes some of the successes of the mainstreaming project, it also underlines the challenges and problems it faces by analyzing three points of view (institutions, doctors, and patients).

1. Introduction

The mainstreaming of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH) as a policy commitment of Government of India gained a renewed importance with the establishment of a separate Department of AYUSH in 2003. After that, a positive impact has been observed in the growth of almost all AYUSH services. In the following developments, several state governments such as the Delhi Government started making budgetary allocations for something that they had brushed aside until then. Though export of Ayurvedic medicines, raw drugs, and expertise has been the main thrust of the central Department of AYUSH, a new insertion started with the inclusion of alternative therapies. Further, the establishment of National Rural Health Mission (NRHM) in 2005 [1] made a crucial impact. The NRHM aims for an integrative health structure in which AYUSH systems of medicine and Western medicine would together serve the people in the public health system [1–3].

Mainstreaming, as defined by the Department of AYUSH, refers to "integration of infrastructure, manpower and medicines of AYUSH systems to strengthen the public health care delivery and strengthen the AYUSH systems at grass root level by establishing a linkage with western medicine in a collaborative way" (Department of AYUSH is a central government body, now Ministry of AYUSH, which is working primarily for the mainstreaming of AYUSH in public health care system). The integration of quality AYUSH services in the public health care system by co-locating them with allopathy is to provide a choice of treatment to the patients, especially those who are dependent on government health facilities. The Ministry of AYUSH aims to promote AYUSH systems at the grassroots level by improving outreach and quality of health delivery in rural areas. Many scholars [4,5] see it as an adjustment. Shankar [6] views this mainstreaming as "functional integration" in which allopathy and AYUSH systems functioning together under one roof. In his view, in the future mainstreaming will lead to a new pluralistic regime of "integrative medicine." Mainstreaming, in Weberian ideal-typical form, involves the encompassing of alternative medical systems in the bureaucratic form of social

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organization [7]. This mainstreaming refers to the incorporation of alternative medical services that were hitherto organized in relation to social and community demands and that were without centralized control, into the bureaucratic system of state administration and market mechanisms. Drawing on Giddens's idea of structuration [8], this paper looks at Ayurvedic Health Institutions as social structures that were considered important aspects of providing and defining health and illness. Moreover on the other, the study has looked at doctors and patients' views to consider the question of agency in health and illness, which is grounded very much in their socioeconomic and cultural contexts. The process of mainstreaming has raised important questions such as: what kinds of changes have the medical systems undergone? What does this say about state regulation of medical pluralism? How do patients make choices seeking in government hospitals? These questions draw the subject under sociology of medicine, which enquires into the complexities of mainstreaming in relation to its social context.

The sociological study of alternative systems of medicine in contemporary India requires an understanding of medical pluralism and its different facets, namely, popular, scientific, administrative, and interpersonal. The idea of medical pluralism developed in the countries of the global South where a biomedical monopoly of health care has been a rule. In this context, Minocha [9] has discussed how alternative approaches, strategies and programs have tried to rectify the biomedical domination. Leslie [10] and Khan [11] have suggested for a contextual research for medical pluralism in terms of a critical analysis of the issues of power. Bhardwaj [12] argues how this medical pluralism is resulted in increasing degree of professionalization, systemic articulation of the Indian medical systems. Sujatha [13] shows how the overemphasis on identifying effective pharmacological formula from Indian System of Medicines and standardizing them undermines their internal structures of folk medical knowledge. The NRHM report [1] discusses the dangers of integration of AYUSH with dominant health service structure because of their different worldviews, philosophical frameworks and logic, different conceptions of the body and mind, and different theories of physiology, pharmacology, and pharmaceutics. The report rightly points out that integration in the present Indian context is one sided in which there is the only integration of AYUSH systems with allopathy. The integration of allopathy with AYUSH is not happening in a similar way. Sujatha and Abraham [4] have raised some immediate concerns with regard to medical pluralism in contemporary Indian society. By co-locating AYUSH practitioners in Primary and District Health Centres, the aim is to provide allopathic services in remote areas which does not amount to any recognition of AYUSH systems' therapeutic value. This argument is helpful to understand the crucial linkages of public-private partnership and the nature of the relationship of Indian systems of medicine with the state in the 21st century. Priya [5] argues that each knowledge system has its own merits and in public health, a method needs to be developed to bring together these systems. She argues that AYUSH systems are relevant for public health not only due to their therapeutic value or their utilization by a large section of the underserved but also because they represent principles of quality practice and ethics that can be learnt and incorporated within the health system to the benefit of all. Shankar [14] advocated for integrative health care to make public health care system more pluralistic in nature. He argues that integrative healthcare appears to be the future framework for healthcare in the 21st century that involve radical changes in medical education, research, clinical practice, public health and the legal and regulatory framework.

However, the above-mentioned theoretical and analytical models often confront other problems when it comes to the level of practice, for example, lack of detailed diagnosis, irregular medicine supply, and lack of basic infrastructural facilities. In this paper, I have tried to problematize the idea of "mainstreaming" focusing primarily on the aspects of practices.

2. Methodology

This article is an outcome of author's fieldwork in eight standalone and co-located Government Ayurvedic Health Institutions of Delhi in the years 2008–2011. It has been observed that mainstreaming has different connotations in different spatial contexts. It is also assumed that mainstreaming has shown a positive result in metropolitan cities as compared to rural areas because of the better health facilities available in metropolitan cities. Several studies have underlined this achievement [1]. Being a national capital, Delhi works as a model for policymakers as well as scholars trying to understand the impact of policy implementation of mainstreaming. Delhi also shows several strands of mainstreaming that is rarely possible to observe in other places. A city with huge migrant population also reflects on the values and associations based on which people decide their medical choices. With public and private co-located and standalone institutions and urban and semi-urban constituents, Delhi becomes a rare site to observe the intricacies of mainstreaming.

The study is done in eight Ayurvedic institutions (among eight Ayurvedic institutions, three standalone and five co-located Ayurvedic institutions have been selected for the study.) under the central, state, and municipal governments. The sample institutions were selected mainly in the urban and semi-urban areas of Delhi on the basis of institutional origin and their status as standalone or co-located institutions as well as their location in Central, State and Municipal Government Institutions. The study compares Ayurvedic Health Institutions at two levels: Central, State and Municipal Institutions and standalone and co-located institutions under these government bodies. Comparing Central, State and Municipal Health Institutions, the Central and Delhi Government Institutions (both standalone and co-located) have relatively good quality services as compared to municipal institutions. Again, the standalone Institutions of Delhi Government and Municipal Corporation of Delhi (henceforth MCD) are qualitatively better as compared to co-located health institutions. The similarities and differences between institutions are analyzed on the basis quality of Ayurvedic services such as classification of disease, method of diagnosis and treatment, patients' strength, the social background of patients, the source of medicines, and epidemiological data of patients.

The sample of informants within the selected institutions was chosen purposively with an aim to find the difference in Ayurvedic health services from the perspectives of institutions, patients, doctors and other officials in the context of mainstreaming and medical pluralism. In every institution, with regard to patients' interviews, 30 out-patient interviews (both standalone and co-located) and 10 in-patient interviews (standalone) have been taken. With regard to doctors, in standalone Ayurvedic institutions, three doctors' interviews from each Ayurvedic specialization and in co-located Ayurvedic institutions, three Ayurvedic and two allopathic doctors' interviews have been taken. Among other officials, head of the institutions such as medical superintendents and deputy medical superintendents, paramedical staffs, nurses, attendants, have been interviewed. Besides this, a large mass of out-patient department (OPD) data were collected from these institutions to carry out an analysis of the patients, their background and complaints.

Despite offering some new insights in the fields of sociology of health and medicine and public health, the study recognizes some of its limitations. One faces these limitations because of different institutional structures, variations in numbers of patients, huge