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"Getting the water-carrier to light the lamps": Discrepant role perceptions of traditional, complementary, and alternative medical practitioners in government health facilities in India

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ABSTRACT

The government of India has, over the past decade, implemented the "integration" of traditional, complementary and alternative medical (TCAM) practitioners, specifically practitioners of Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-rigpa, and Homoeopathy (collectively known by the acronym AYUSH), in government health services. A range of operational and ethical challenges has manifested during this process of large health system reform. We explored the practices and perceptions of health system actors, in relation to AYUSH providers' roles in government health services in three Indian states – Kerala, Meghalaya, and Delhi. Research methods included 196 in-depth interviews with a range of health policy and system actors and beneficiaries, between February and October 2012, and review of national, state, and district-level policy documents relating to AYUSH integration. The thematic 'framework' approach was applied to analyze data from the interviews, and systematic content analysis performed on policy documents.

We found that the roles of AYUSH providers are frequently ambiguously stated and variably interpreted, in relation to various aspects of their practice, such as outpatient care, prescribing rights, emergency duties, obstetric services, night duties, and referrals across systems of medicine. Work sharing is variously interpreted by different health system actors as complementing allopathic practice with AYUSH practice, or allopathic practice, by AYUSH providers to supplement the work of allopathic practitioners. Interactions among AYUSH practitioners and their health system colleagues frequently take place in a context of partial information, preconceived notions, power imbalances, and mistrust. In some notable instances, collegial relationships and apt divisions of responsibilities are observed. Widespread normative ambivalence around the roles of AYUSH providers, complicated by the logistical constraints prevalent in poorly resourced systems, has the potential to undermine the therapeutic practices and motivation of AYUSH providers, as well as the overall efficiency and performance of integrated health services.

1. Background

Efforts to include traditional, complementary and alternative medical (TCAM) systems in the public health mainstream have been gaining momentum across the world (Lakshmi et al., 2015), particularly in developing countries, with the goals of enhancing populations' access to healthcare, optimizing the roles of healthcare providers, and promoting the different systems of medicine. The World Health Organization's traditional medicine strategy

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acknowledges the widespread use, accessibility, and cultural relevance of TCAM, advocates the inclusion of TCAM in public health systems for disease control and health promotion (WHO, 2002), and promotes the integration of TCAM in national healthcare systems (WHO, 2013). Many countries, such as China (Jingfeng, 1988), South Korea (Son, 1999), and Cuba (Appelbaum et al., 2006) have articulated national and sub-national policies for the integration of certain systems of TCAM into health service delivery, and for the provision and regulation of medical education, accreditation, licensing, and drug-regulation. A WHO global survey revealed that 32 percent of respondent countries had issued national policies on TCAM, and that 56 percent of the rest were in the process of developing such policies (WHO, 2005).

The Ministry of Health and Family Welfare of the Government of India comprised an autonomous unit tasked with regulation, education, accreditation, and provision for government-endorsed TCAM systems. This unit, originally established as the Department of Indian Systems of Medicine and Homoeopathy in 1995, was renamed the Department of AYUSH in 2003, and governed the provision and practice of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Sowa-Rigpa, and Homoeopathy (AYUSH) in India. It was elevated to a Ministry in November 2014. A Draft National Policy on AYUSH is in development in 2016 (Ministry of AYUSH, 2015).

The National Rural Health Mission (NRHM), 2015, launched by the government of India in 2005, emphasized the "mainstreaming of AYUSH" as a strategy to increase healthcare access for the population, and to provide AYUSH providers with a platform to practise their systems of medicine in India (Department of AYUSH, 2011). This initiative included the appointment of AYUSH providers in public health facilities, in some instances, to work alone, and in many cases, to work alongside allopathic practitioners (in an arrangement termed 'co-location'), as well as the involvement of AYUSH providers in national health programmes, such as those for the prevention and control of polio, tuberculosis, and malaria. These policies at the national level were then interpreted and implemented by the states. The establishment of new AYUSH facilities at healthcare centres at district and sub-district levels, and the upgradation of AYUSH facilities in hospitals and dispensaries, have been accomplished under the NRHM, in addition to the contractual appointment of approximately 11478 medical practitioners and 4894 para-medical workers across the country (Press Information Bureau, 2013).

Over the years, the integration of AYUSH providers into the public health system of India has proceeded in different ways, and to varying extents in the different states of India, partly due to different state interpretations of the policies. Integration as policy and health systems reforms requires attention to health goals and stakeholder roles, multi-level reform, and a reorientation of systems values (Sheikh and Nambiar, 2011). Reports from various states reveal numerous challenges, including shortfalls in recruitment and deployment of personnel, delayed or inadequate drug supply, insufficient infrastructure and personnel support, and problematic administrative structures and interpersonal interactions, in the mainstreaming of AYUSH (Chandra, 2011; SEDEM, 2010; Priya and Shweta, 2010; Lakshmi, 2012; Gopichandran and Kumar, 2012).

We conducted a study in three states of India to examine the operational and ethical challenges of AYUSH mainstreaming. The integration of the different systems of medicine in the public health system has at its centre the practitioners of the different systems of medicine. This paper presents findings on health policy and system actors' practices and perceptions related to AYUSH providers' roles in government health services.

2. Methods

2.1. Research design

The protocol for this study received ethics approval from the Institutional Ethics Committee of the Public Health Foundation of India. The study was conducted in Kerala, Meghalaya, and Delhi. These states were chosen based on their: history of TCAM practice; the entrenchment and cultural consonance of certain systems of TCAM in their communities; differing administrative set-ups for the governance of AYUSH practice; and proximity to the centre of national policymaking in New Delhi. Kerala administers Ayurveda and Homoeopathy through distinct directorates, and does not co-locate AYUSH and allopathic practitioners. In contrast, in Delhi and Meghalaya, co-location of AYUSH and allopathic practitioners is common, although separate facilities for the different systems of medicine also exist. Certain AYUSH systems have an enduring presence in Kerala and Delhi, whereas several local healing traditions, such as Khasi and Garo medicine, rather than AYUSH systems, are inherent in Meghalaya (Albert and Porter, 2015).

2.2. Research approach

We applied an action-centred approach of policy implementation analysis (Barrett and Fudge, 1981; Hjern and Hull, 1982) in which policy implementation is regarded as a series of interactions and negotiations among actors, taking place in specific social and organizational contexts, seeking to distinguish policy as interpreted by relevant social actors, from the formal articulation of policies by state institutions (Hjern and Hull, 1982).

We employed two principal techniques of data-collection: in-depth interviews; and review of policy documents. In addition, researchers' observations of the infrastructural arrangements and interpersonal interactions in the healthcare facilities were documented, and explored further in the interviews.

Reviewed policy documents included: stated national, state, and district policies for the mainstreaming of AYUSH; inter-office and intra-office memoranda on transfers, posting, in-service training, facilities, and grievances related to AYUSH personnel and supplies; and publicly available material on the internet. We mapped policy content using a framework developed for the assessment of governance architecture, functions, and policy and implementation gaps in an examination of regulation of healthcare in India (Sheikh et al., 2015).

Interviewees were drawn from a range of health policy and system actors involved in the mainstreaming of AYUSH, selected purposively based on principles of maximum variability (Silverman, 2001), in terms of age, occupation, area of expertise, years of work experience, type of employment, and geographical setting within study sites. Respondents were categorized as: key informants, including academicians, bureaucrats, and representatives of civil society organizations, with a deep understanding of the history and implementation of the inclusion of TCAM in the public health system of India; health system administrators, including state, district, and sub-district officials and supervisors at health facilities; TCAM (AYUSH and non-AYUSH) practitioners; allopathic doctors; and community representatives. In all, 196 interviews were conducted between February and October 2012. Table 1 enumerates the categories of participants across the study sites.

Interviews were audio-recorded with the respondents' permission, and only notes taken when permission for audio-recording was not granted. The majority of the interviews were conducted in English, and some in a mixture of English and local languages.