Policy Brief on Local Health Traditions and Implementation Framework in context of National Health Policy 2017

A Compelling Social Imperative to strengthen Local Health Traditions to realize National Health Policy in India

Local health traditions (LHTs) in India have been progressively gaining policy as well as practice attention. While advocacy from civil society as well as community-based organizations (CBOs) has contributed to the cause, concerted efforts from the part of practitioners of LHTs viz. the Traditional Community Health Practitioners (TCHPs), often quoted in common parlance as folk healers to group themselves into official networks has also provided further impetus. Local health traditions continue to play an important role in primary health care. With more than a million practitioners of local health traditions and close to 200 million households having such knowledge, India perhaps is one of the few countries in the world that largely depends on LHTs but the contributions of LHTs and practitioners are largely ignored while economics and health policies are discussed at various levels. With more than 6500 medicinal plants, animal parts, minerals and metals in use while imparting local health care, the contributions of local healers is immense but never recognized nor rewarded.

A disturbing fact is that with each passing decade, LHT practices are getting eroded due to continued lack of policy and program support. However the demand for LHTs seems to stay. A majority of the current generation of TCHPs are dependent on other trades/occupations for their livelihood as more than often, their services are in the realm of a humanitarian endeavor with inadequate monetary returns. There is a distinctive lack of interest in their successive generations to carry forward this legacy in the absence of formal policy recognition and positioning. There thus exists a clear and imminent threat of extinction to this cultural legacy of our nation and calls for immediate and effective interventions from policy makers.

Support for Traditional Medicine (TM) echoes through the corridors of international and national policy. The Alma Ata Declaration of 1978 exhorted nations to provide Universal Access to primary healthcare. It sought to give directions to National governments to provide health care by making fullest use of local, national and other available resources and utilize all categories of health workers, including physicians, nurses, midwives, auxiliaries and
community workers as applicable, as well as traditional health practitioners to work as a health team. This declaration was the first of its kind by the World Health Organization and its member states that globally acknowledged the role of TM and particularly its non-codified practitioners. It is important to note that it is only folk and oral traditions that constitute TM in most parts of the world barring India and China, which also have codified traditions (1).

The first National Health Policy of India (NHP 1982) that was formulated shortly thereafter noted that practitioners of indigenous and other systems of medicine in the nation enjoyed high local acceptance and respect and thus it was imperative to enable each of these systems to develop in accordance with its genius (2). A World Health Congress on Traditional Medicine held in China in 2008 had recommended that “Governments should establish systems for the qualification, accreditation or licensing of traditional medicine practitioners”. It exhorted these practitioners to upgrade their skills and knowledge to meet their respective national requirements in relation to health (3). A report of the Task Force on Health and Family Welfare, Government of Karnataka, India (2001) acknowledges that folk health culture had been generated over centuries by sensitive and intelligent people and had some elements in it which were drawn from the classical codified stream. It also recognized the fact that folk health traditions, on the whole, were being eroded, resulting in a loss of resources and allies to the movement of health for all. It recommended that household health traditions and folk medicine be revitalized, folk practitioners be recognized and utilized as part of the primary health care system and research into these traditions and cultures should be supported (4). The WHO Traditional Medicine Strategy (2014-2023) document also exhorts member states to establish provisions for the education, qualification, and accreditation or licensing of Traditional and Complementary Medicine practices and practitioners based on needs and risk assessment (5).
Local Health Traditions found their very first mention in the second National Health Policy document that was launched in 2002 when it recognized the need for the revitalization of folk health traditions related to birth attendants, herbal healers, bone setters and *visha vaidyas* as an agenda in the Indian Systems of Medicine (ISM) sector for selective identification, reinforcement, validation and propagation for use in the wider community (6). The National Rural Health Mission statement of 2005 explicitly mentions revitalization of LHTs as a goal and a supplementary strategy under the broader heading of mainstreaming Ayurveda, Yoga, Unani, Siddha, Swa-Rigpa and Homeopathy (AYUSH) (7). While co-location of AYUSH Physicians in Primary Health Centres (PHCs) and Community Health Centres (CHCs) has been one of the key strategies towards mainstreaming of AYUSH, precious little has been done in relation to the cause of LHTs so far.

Globally countries have attempted mainstreaming TCHPs into their health delivery services and met with success. Thailand has developed legal and other standards for the certification of the status of healers and towards integrating them in community health. The role of traditional birth attendants in improving primary health care and the role of traditional healers in the management of the HIV/AIDS epidemic in Africa is well documented. China has fully integrated traditional and complementary medicine (T&CM) practitioners into its healthcare system. In the Republic of Korea and Vietnam T&CM practitioners are provided legitimacy to practice in both public and private hospitals (5). India could take a cue from these models.

**Investing in health care - the missing link**

India currently spends 1.18% of its GDP (Roughly around Rs. 1.80 lakh crores per year) towards Public Health with a per capita expenditure at approximately USD 22 per person per year. This falls quite short of comparative spending by a few neighborhood nations of South Asia (Table 1).

<table>
<thead>
<tr>
<th>Sl.No</th>
<th>Nation</th>
<th>Public Health Expenditure (as % of GDP)</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Afghanistan</td>
<td>2.9%</td>
</tr>
<tr>
<td>2.</td>
<td>Bangladesh</td>
<td>0.8%</td>
</tr>
<tr>
<td>3.</td>
<td>Bhutan</td>
<td>2.6%</td>
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<tr>
<td>4.</td>
<td>Maldives</td>
<td>10.8%</td>
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<tr>
<td>5.</td>
<td>Myanmar</td>
<td>1.0%</td>
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<tr>
<td>6.</td>
<td>Nepal</td>
<td>2.3%</td>
</tr>
<tr>
<td>7.</td>
<td>Pakistan</td>
<td>0.9%</td>
</tr>
<tr>
<td>8.</td>
<td>Sri Lanka</td>
<td>2.0%</td>
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Only 27% of the nation's population is covered by Public health insurance schemes whereas the remaining bracket is left to fend for itself in terms of seeking health coverage (9). India ranks 187th among 194 countries in Public Health spending (10). Media reports point out that by effect an event of hospitalization for the most backward 20% of the country can contribute to 15 times their usual monthly expenditure (11). Various reports on rural indebtedness in India attribute it to the increasing health expenditure by rural households as a second most important cause after livelihood related borrowings. It is estimated that 55 million Indians fell into poverty because of their healthcare spending during the period 2011-12 (12). Near to 25% of the rural and urban population experienced hospitalization in a calendar year and private hospitals accounted for treatment of 58% of the rural population. An average amount of Rs.509 was spent by the rural population for non-hospitalized treatment of an ailment (13).

A National Task Force was set up by the Department of AYUSH in 2009 for validation, reinforcement and propagation on a wider level of LHTs within the directions of the second National Health Policy framework.
Reconciling TCHPs: The success story from India

The Foundation for Revitalization of Local Health Traditions (FRLHT), a not-for-profit organization working on traditional health and medicinal plant conservation in India has led various initiatives for the validation of community-based traditional knowledge and for advocating legitimacy for Traditional Community Health Practitioners (TCHPs). FRLHT had developed a tool called “Documentation and Assessment of Local Health Traditions (DALHT)” which validated local health practices of traditional healers within a community and strengthen their efforts to provide primary health care services at the community level by a process of meeting with different stakeholders related to health in a village or community. This group would include traditional healers, community members, community leaders and a representative of one of the codified systems of medicine such as Ayurveda, Siddha and Unani. This process would help in validating relevant and effective practices.

Responding to one of the recommendations of the AYUSH National Task Force of 2009, a pilot scheme for Accreditation and Certification of Prior Learning (ACPL) was implemented in one district each of six states, i.e. Chhattisgarh, Gujarat, Karnataka, Orissa, Rajasthan and Tamil Nadu. These states were selected owing to the rich vibrant presence of local health traditions over here and having districts with strong tribal presence. This was implemented by the Centre for Traditional Knowledge Systems of Indira Gandhi National Open University in 2011, in collaboration with Quality Council of India (QCI) and FRLHT with financial assistance from Department of AYUSH, Government of India. In Karnataka alone, 111 of a total 507 applicant TCHPs were certified through a 9 step process of assessment in the following 3 streams of practice – Common ailments, Jaundice and Traditional Bone Setting.

A rigorous experimental study was conducted by FRLHT in districts of Odisha and Andhra Pradesh from 2005-2008, in relation to the efficacy of traditional plant-based malaria prophylactic medicine which was being practiced by rural communities over here. The intervention group exhibited 5-10 times reduction in the reported cases of malaria during the endemic season as compared to the control group.

The ACPL experience and attempts such as the current national scheme pursued by FRLHT along with Quality Council of India (QCI) to create competency based standards for voluntary assessment, training and certification of TCHPs point out that there is indeed the potential for capacity building of these health human resources and that processes with sufficient rigour can be adopted towards the same.
Revitalization of LHTs and mainstreaming of AYUSH into the Public Health system of India was specified as a goal and supplementary strategy in the Mission Document of the National Rural Health Mission (NRHM) 2006 to strengthen the public health system at all levels (7). The subsequent 11th Five year plan (2007-2012) had allocated a token financial outlay to strengthen LHTs by virtue of which the Department of AYUSH had subsequently managed to establish a North Eastern Institute of Folk Medicine (NEIFM), a National Institute, and now under the Ministry of AYUSH, at Arunachal Pradesh, India to promote and strengthen the use of LHTs. However, this is all that has been done so far. A national study conducted in multiple states of India post-the roll out of NRHM pointed out utilization of AYUSH by at least 60-98% households in 1/3rd of the states surveyed and the reported use of LHTs by 80-100% of the households in a majority of the states including well-performing ones. This was attributed to the felt need of the community for these services based on the inherent strengths of these systems as appreciated and understood by the community (14). Studies done on the manifestations of the mainstreaming strategy of AYUSH under NRHM have highlighted additional issues such as challenges with respect to recruitment of AYUSH physicians at the PHC and CHC levels (15), technical, social and financial support issues (16), shortage of essential AYUSH medicines at the health centres and challenges to genuine AYUSH healthcare (17). Meaningful AYUSH engagement under the public health system will need not only qualified and empowered healthcare providers and essential drugs in adequate numbers but also essential support staff, particularly health workers who have a sense of belonging with the codified systems of AYUSH and can act as effective outreach cadre for services to reach the last mile.

It should be very evident to policymakers and planners that the current institutional health care delivery model has its limitations in terms of adequate human health resources, institutional healthcare delivery centres and inadequacies in equity and access in providing Universal Health Coverage. Therefore, it is necessary to urgently empower communities to become self-providers in respect of basic aspects of primary health care and thus become self-reliant. Strengthening LHTs is one critical and culturally sensitive measure to enhance health security of millions of rural households.
The recently released National Health Policy (NHP 2017) has explicitly recognized the role of Local Health Traditions in India and recommends formal recognition of both the practices and practitioners through a certification process of their knowledge to deal with primary health care.

In lieu of the favorable policy support under National Health Policy (NHP) 2017 and in the light of the great legacy of India’s medical heritage and learning from the recent history of fluctuating and weak administrative and program support, seven key operational recommendations are herewith being proposed for implementation of NHP 2017 within the next three years:

1. Annual AYUSH schemes of the Ministry to have clearly defined deliverables in relation to strengthening and revitalization of LHT components and interventions.
2. Facilitate establishment of National and State level Councils for LHTs with self-regulatory mechanisms for the conduct and practice of TCHPs.
3. Utilize NEIFM in the North East and establish similar centres of excellence in north, south, central, east and west Indian regions to support a systematic and rigorous processes for competency-based assessment and promotion on the model of QCI-FRLHT Voluntary Certification Scheme for TCHPs.
4. Utilize certified TCHPs as AYUSH Community Health Volunteer Workers with community based roles for primary healthcare services, similar to the Accredited Social Health Activists (AYUSH ASHAs).
5. Develop District Health Resource Centres for documenting, validating and protecting local health traditions in relation to their knowledge and raw material. This could initially be linked to local NGOs and/or academic institutions working in this field and to the mechanisms of the National Biodiversity Authority and the public health services, as recommended based on findings of the National Health Systems Resource Centre (NHSRC) 2010 study.
6. Support a major Information Communication Technology (ICT) enabled initiative to disseminate reliable knowledge of home remedies, nutrition, preventive and promotive healthcare to millions of households.
7. Dedicate a part of the “Centers of Excellence Scheme” of the Ministry of AYUSH for the non-codified traditions, in order to strengthen specific aspects of LHTs such as varmam, traditional birthing, bone setting and kalari to develop standard guidelines for practice.
References


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