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Less equal than others? Experiences of AYUSH medical officers in primary health centres in Andhra Pradesh

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Abstract

The National Rural Health Mission (NRHM) includes, inter alia, the establishment of an AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy) component (practitioner, trained assistants, drugs and equipment) in every primary health centre (PHC). However, five years following the launch of the NRHM, the AYUSH mainstreaming scenario is below expectations, riddled with ethical and governance issues. Accounts from AYUSH practitioners at PHCs in various regions of the state of Andhra Pradesh reveal enormous lacunae in implementation: unfilled positions, inequitable emoluments, inadequate or absent infrastructure, assistance and supplies, unethical interpersonal arrangements, and limited support from non-AYUSH personnel. The widespread negative impact of these conditions undermines the value of AYUSH, demotivating both practitioners and patients, and failing to provide the intended support to the public health system..

Introduction

Traditional, complementary and alternative medicine (TCAM) are therapeutic systems distinct from the dominant allopathic system followed in mainstream medical practice. They are classified as "complementary" when employed in tandem with the dominant system, and "alternative" when employed instead of it. The World Health Organisation defines traditional, complementary and alternative medicine (TCAM) as follows (1):

> Traditional medicine: Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.
>
> Complementary/alternative medicine (CAM): The terms "complementary medicine" or "alternative medicine" are used inter-changeably with traditional medicine in some countries. They refer to a broad set of health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system.

Based on its provenance, context and employment, a system may be traditional, complementary or alternative, or a combination of these. For example, ayurveda used concurrently with allopathy in India is "traditional" and "complementary"; homoeopathy used *instead* of allopathy in India is "alternative".

TCAM in the Indian health system

Allopathy is the dominant health care system in India. Non-allopathic therapeutic systems find a place in the formal health system in the country under a department of the ministry of health and family welfare (MoHFW). This department was established as the department of Indian systems of medicine and homoeopathy (ISMandH) in 1995, and renamed the department of ayurveda, yoga and naturopathy, unani, siddha and homoeopathy (AYUSH) in 2003 (2). It governs the education, research, practice and quality of all the systems

represented in the acronym "AYUSH", and in addition, a therapeutic system known as *sowa-rigpa,* or *amchi*, practised in the Himalayan regions and some parts of north east India. The years since the establishment of the department of AYUSH have witnessed considerable growth in AYUSH educational institutions (undergraduate and post graduate), hospitals, dispensaries and drug manufacturing units (3).

The rational use of TCAM is increasingly recognised as a vital public health need. Some of the reasons are: escalation in non-communicable and chronic diseases; resurgence of certain communicable diseases and emergence of new diseases; drug resistance; and a growing consciousness of the need to incorporate healthy behaviours into our daily lives. This awareness is expressed in international and national policies to mainstream TCAM(4), including promoting research, education, licensing, drug-standardisation and regulation, and awareness-raising. The NRHM in India is a case in point. It incorporates policies and strategies for the mainstreaming of AYUSH, with special emphasis on skill development and infrastructural support for AYUSH personnel.

AYUSH in the NRHM

The NRHM, launched in 2005 to fortify public health in India, sought to revitalise and mainstream AYUSH, specifically to strengthen human resources, infrastructure and drug quality and standardisation, supported by advocacy for AYUSH, and the establishment of inter-sectoral linkages to facilitate AYUSH practice. Activities under this initiative include facilitation of specialised AYUSH practice, integration of AYUSH practitioners in national health programmes, integration of AYUSH modalities in primary health care, strengthening the governance of AYUSH practice, supporting AYUSH education, establishing laboratories and research facilities for AYUSH, and providing infrastructural support (5).

Actions pertaining to human resources and practice include contractual appointment of AYUSH doctors in community health centres (CHCs) and PHCs; appointment of paramedics, compounders, data assistants, and managers to support AYUSH practice; establishment of specialised therapy centres; involvement of AYUSH doctors in national disease control programmes; and incorporation of AYUSH drugs into community health workers' primary healthcare kits.

Experiences of AYUSH practitioners under the NRHM

The observations made here were generated from interactions with a cross-section of AYUSH doctors contracted to medical officer posts in PHCs in Andhra Pradesh. This was supplemented by a visit to a PHC staffed by an AYUSH doctor, and the perusal of the limited formal literature on the evaluation of the integration of AYUSH into mainstream public health in India. AYUSH medical officers were contacted informally over several weeks, from March to June 2010, during training programmes that they attended, in batches drawn from all the districts of the state, and asked about their experiences in their PHCs. Medical officers practising ayurveda, yoga and naturopathy, homoeopathy, and unani were approached and communicated with. No siddha practitioner could be accessed as there are none appointed in PHCs in Andhra Pradesh at present. Responses were gathered from discussions in dyads, or in small groups of three to six doctors, yielding rich accounts of the experiences of AYUSH doctors in the NRHM. Thirty AYUSH doctors in all participated in 10 of these discussions, each of which lasted between 10 and 30 minutes. The narratives, besides highlighting a few good practices in certain PHCs, point to numerous lacunae in the implementation of the mainstreaming initiatives in the NRHM. Data gathered on these shortcomings were interpreted, and grouped into five major categories: recruitment, remuneration, facilities, technical support, and interpersonal relationships.

Recruitment

The 1,525 PHCs in Andhra Pradesh entail the appointment of an equal number of AYUSH medical officers. The positions were mandated to be filled in three phases by the year 2009. However, over 50 percent of the AYUSH medical officer positions in Andhra Pradesh were unfilled in the year 2010, the majority through never having been filled, and a few through the dismissal of the serving AYUSH medical officer. A recent review of the NRHM (6) reports that only 29 percent of PHCs across India have integrated AYUSH staff into their personnel. The low proportion of filled AYUSH medical officer positions in Andhra Pradesh, (approximately 43 percent according to a 2010 report (7)) though not as bleak as the national average, is nevertheless a cause for concern. But, although the quantum of recruitment is well below the target, the process of recruitment is commended by AYUSH doctors as transparent and in accordance with stated policy, beginning with advertising in leading newspapers, and guided by merit, and the government's categories of reservations.

The contracts, under which AYUSH doctors are recruited to PHCs under the NRHM initiative, which are meant to be renewed annually, are often not renewed in a timely manner. Many doctors report their continuing to work for months, despite the lapse of their contracts, with the implicit understanding that the delay in renewal is an expression of administrative inertia, rather than a herald of dismissal. The delay, sometimes over six months, in the renewal of contracts is observed to be a feature only of the AYUSH personnel appointments, and not of other contractual executives of the NRHM.

The contractual AYUSH medical officers report to the regional deputy director of their respective zone, under the commissioner of AYUSH of the state. Despatches include the regular attendance report (attested by the allopathic medical officer at the PHC), and the out-patient report of the consultations performed. The regional deputy director is also the official who disburses the AYUSH medical officers' salaries.

Remuneration

AYUSH medical officers unvaryingly lament their meagre salaries, as being well below the emoluments of allopathic

colleagues. The current consolidated monthly salary of Rs 9,300 (8) is reported to be based on a previous calculation of the basic pay of allopathic medical officers, and precludes both the increments in said basic pay over the years, as well as all the substantial allowances which are added to the basic pay to form the allopathic medical officer's salary. AYUSH medical officers in PHCs in Andhra Pradesh cite the comparatively higher emoluments of certain unskilled support staff in allopathic hospitals to underscore their frustration at the low salaries that they receive. The insufficiency of the salary is acknowledged in several submissions to the government, by AYUSH medical officer associations as well as their administrative superiors, for enhancement of pay, and an approach to parity with AYUSH medical officers' salaries in other states, as well as the basic (unconsolidated) pay of allopathic medical officers, which is Rs. 15,600 at present (8,9).

There are very few contractual allopathic medical officer positions for comparison: These positions come with a salary equal to the basic pay of regular allopathic medical officers, which, as detailed above, is considerably higher than the contractual AYUSH medical officer's salary. Other (non-AYUSH) contractual employees' salaries are regularly revised in accordance with Pay Commission recommendations, unlike contractual AYUSH doctors' salaries. The contractual position does not offer any perquisites, such as benefits or allowances for family, health, housing, education, and geographic location. The working hours of AYUSH medical officers are the same as those of allopathic medical officers. The range of responsibilities is different however: AYUSH personnel are not assigned emergency duties and obstetric duties. AYUSH doctors are justifiably exempt from the 'emergency allowance' over their basic pay, but the denial of a 'rural allowance' for geographic location is not defensible. There is no overlap or express sharing of responsibilities between the AYUSH and non-AYUSH departments of the PHC.

In addition to the salary, each AYUSH medical officer is allocated a contingency fund to cover expenses not already accounted for. This contingency fund, ostensibly usable for some equipment, stationery, repairs etc, is not conveyed in a timely manner to all the AYUSH medical officers. Some report not receiving the fund at all, and going to the extent of using their personal funds to institute minor repairs, and installation of equipment, such as signboards, in the PHC.

Facilities

Each medical officer is expected to be furnished with a consultation chamber, a dispensing zone, and a waiting area for patients, adding up to a minimum of 800 square feet of space (10). This includes provision for fresh construction of a building in situations where the existing structure cannot accommodate the AYUSH facility, and the PHC site has enough space. While some AYUSH doctors report satisfactory, and a small minority, excellent, infrastructural provision, numerous doctors describe the premises provided to them as grossly inadequate. Accounts were communicated of verandahs and cramped storerooms being pressed into service as consulting, drug storage, and drug dispensing spaces. Besides space, furniture and equipment are reported to be in short supply in several PHCs.

The supply and replenishment of medications, across systems of AYUSH, leave a lot to be desired at many PHCs. While some doctors complained of the delay of several months, in the initial stocking of medications, others reported prompt primary stocking followed by months without replenishment. Considering that many AYUSH medications, eg certain ayurvedic and unani formulations, are too expensive for PHC patients to afford to procure from private pharmacies, this inadequate supply may mean the difference between receiving AYUSH treatment and being denied it. The inability to obtain stocks of appropriate medication is a common grievance of AYUSH doctors in PHCs across the nation, as revealed by an evaluation of service delivery under the NRHM in four states (11).

Technical support

Every PHC is expected to be populated with a trained AYUSH compounder, an assistant to dispense medication and provide therapeutic services on the prescription of the medical officer. Reports reveal that the position of an assistant is not filled in some PHCs, and that assistants appointed at certain PHCs are not appropriately skilled, leaving the doctor to undertake the dispensing in addition to the prescription. For instance, some individuals appointed to assist unani medical officers, are not literate in Urdu, and thereby not competent to decipher prescriptions in Urdu and dispense medications labelled in Urdu. Besides the compounder, every AYUSH medical officer is assigned a sweeper and nursing orderly, to help with the maintenance of the AYUSH facility at the PHC and with patient flow during consultation hours: This post is also unfilled in some cases. It bears mentioning that the emoluments of the AYUSH support staff are low, specifically Rs. 4800 per month for a compounder, and Rs. 3900 per month for a sweeper and nursing orderly (9).

Interpersonal relationships

A few AYUSH medical officers enjoy collegial and cordial relationships with their allopathic counterparts, as well as the other personnel working at the PHC. Some report minimal interaction, and no adverse communication, with the allopathic medical officer and other PHC personnel. Several others recount unpleasant interactions with the allopathic medical officer, and several of the other PHC personnel. These range from tacit disapproval and deprecatory references by the non-AYUSH personnel at the PHC, to verbal discouragement of potential patients from visiting the AYUSH doctor, and blatantly unethical interpersonal arrangements between the allopathic and AYUSH doctors. For instance, the allopathic medical officer may fraudulently document the attendance of the absent AYUSH medical officer, in exchange for a financial consideration, or as part of a reciprocal arrangement. Some AYUSH doctors are reported to have been asked to perform case-taking, diagnosis and prescription of allopathic medications on behalf of the

absent allopathic medical officer. This is clearly against the law, not to mention unethical, as not all AYUSH students are trained in allopathic pharmacology and licensed to prescribe allopathic medications. In premises shared by allopathic and AYUSH medical officers, it is reported that the sweeper and nursing orderly assigned to the centre, although notionally able to work for the AYUSH facility as well as the allopathic, may not work at the AYUSH facility. AYUSH medical officers cite interpersonal tension and an antagonistic attitude towards AYUSH as reasons for this.

The NRHM envisages the participation of AYUSH personnel in national health programmes(5). However, the guidelines for such participation are not elucidated, with the result that the involvement of AYUSH personnel in national programmes is predicated on the interpersonal equation between the allopathic medical officer and the AYUSH doctor. Thus, some PHCs see a high level of involvement of AYUSH personnel in national health programmes, some moderate, eg, participation in the pulse polio programme, and many others see no participation of AYUSH personnel in national health programmes. Clear guidelines on the roles of AYUSH medical officers in national health programmes are urgently needed to resolve this, to harness all health personnel appropriately, and strengthen national health programmes.

Conclusion

In summary, few AYUSH doctors report positive experiences of technical and social support in their work at PHCs. The straitened economic situation is universally lamented, by those with positive, as well as those with negative, social and infrastructural circumstances. AYUSH doctors observe that besides the few patients sceptical from the start, numerous patients enthusiastic at first get discouraged with time from using AYUSH treatments, under the conditions prevalent at several PHCs.

The procedures to "mainstream AYUSH" in PHCs have placed AYUSH and allopathic systems in a largely parallel configuration – with separate reporting channels, fiscal and logistical structures, and distinct duties – not providing optimal scope for the deployment and development of AYUSH. The negative impact of the circumstances of AYUSH in PHCs is widespread, affecting practitioners, patients, and eventually the nation at large. The effects range from minor delays in treatment, to job-dissatisfaction, interpersonal tension and the calling into question of the professional integrity of medical practitioners. The value and practice of AYUSH are undermined, demotivating both practitioners and patients. The injury to public health lies in the denial of proper AYUSH treatment to the many who may desire, and benefit from, it; the denial of a platform to AYUSH practitioners to contribute to public health; and the denial to the nation of the public health gains to be made from the optimal application of AYUSH to public health challenges, including health promotion and disease prevention. The dissonance between the stated goals of revitalising and mainstreaming AYUSH and the reality of inequitable implementation is patent. The injustice to AYUSH practitioners, and patients, and by extension to the national community, calls for a systematic evaluation of the integration (particularly the underlying structural and social issues) of AYUSH into the public health mainstream in India, and the implementation of prompt remedial measures.

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