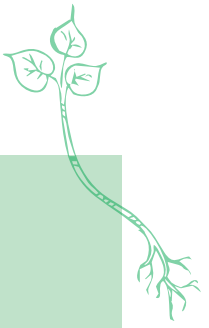
MAINSTREAMING AYUSH & REVITALIZING LOCAL HEALTH TRADITIONS UNDER NRHM

A Health Systems Perspective

NHSRC
National Health Systems Resource Center
National Rural Health Mission
Ministry of Health and Family Welfare
Government of India
New Delhi



MAINSTREAMING AYUSH

&

Revitalizing Local Health Traditions

UNDER

NRHM

AN APPRAISAL OF

THE ANNUAL STATE PROGRAMME IMPLEMENTATION PLANS 2007-10

AND

MAPPING OF TECHNICAL ASSISTANCE NEEDS

Contributions and Acknowledgements

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MESSAGE

With the increase in the number of lifestyle disorders, there has been a resurgence of interest in the AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy) System of Medicine both globally and within the country.

Recognizing the strength of AYUSH system within its holistic and personalized system of medicare, Bovt. of India has initiated a number of steps for its propagation and promotion. In view of this, revitalization of local health traditions as well as mainstreaming of AYUSH is envisaged as one of the important goals under the National Rural Health Mission (NRHM) Launched by Govt. of India in the year 2005. Prior to the launch of the Mission, the Deptt. of AYUSH has been implementing a Plan scheme called ' Hospitals & Dispensaries' from the 10th Plan onwards which has now been subsumed under the NHRM. The Departments of Health & Family Welfare and AYUSH have been joined working towards the attainment of this goal by pooling their resources and personnel.

Under the mainstreaming of AYUSH, 6896 medical practitioners have already been engaged under NRHM for serving the rural population. AYUSH facilities are being co-located within the Primary Health Centres (CHCs) and District Hospitals (DHs) so as to provide option to the people to choose either of the systems for meeting their health needs. So far AYUSH facilities have been co-located in 6228 PHCs, 1302 CHCs and 147 DHs and about Rs. 582.02 crores have been spent for mainstreaming of AYUSH under NRHM.

Realising that mere co-location AYUSH facilities with allopathic hospitals is not the only desirable step to attain the goal, the Department is trying to widen the scope of the scheme by supporting exclusive AYUSH hospital & dispensaries as well under NRHM. Besides, funding is also to be provided under new norms for upgrading infrastructure and providing equipments and drugs to various hospitals and dispensaries. Some of the key features of the NRHM like Rogi Kalyan Samiti, Programme Management Units are also being provided to the hospitals & dispensaries.

As a part of mainstreaming of AYUSH, all states have been requested to restructure their AYUSH set up and technically equip their personnel at various levels with core skills and capabilities. AYUSH education is being revamped. Focus is also an validating the efficacy, safety and quality of the AYUSH drugs. AYUSH research is covering unexplored area to find effective treatments for diseases like Cancer, HIV/AIDS etc., Public Health Interventions through AYUSH is an emerging area. Thus efforts are being made to restore the old glory to these age old systems and provide dignity to its practitioners.

The National Health System Resource Centre (NHSRC) is set up under the NRHM for providing necessary technical support to NRHM. It has been supporting the mainstreaming of AYUSH through technical advice, co-ordination, collection of data, periodic reviews, research studies, evaluation and publication. I am indeed very happy to see that due to the tireless efforts made by Dr. Ritu Priya and her team an excellent report on mainstreaming of AYUSH under NRHM has been develped. Of course there is a hope for further improvement. With the collection of more data and availability of better inputs, I and sure that the NHSRC will be able to bring out similar useful publications in future. I do hope that this excellent publication will be of immense use to the AYUSH/allopathic practitioners, policies maker, technical persons and academicians in understanding AYUSH system,

Govt. policies & programmes and the challenges in the AYUSH sector in the context of implementing NRHM.

I wish the NHSRC all success.

New Delhi

(S. JALAJA)

Secretary

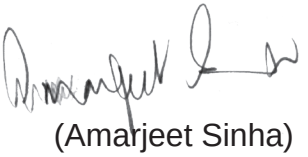
Dept. of Ayurveda, Yoga & Naturopathy,
Unani, Siddha and Homoeopathy (AYUSH)
Ministry of Health & Family Welfare
Government of India

MESSAGE

The National Rural Health Mission is committed to Mainstreaming AYUSH and Revitalizing Local Health Traditions as a way of bringing about architectural correction in the system of health care delivery in the rural areas of the country. Integration of AYUSH and local health care traditions has an important role to play in developing an integrated system of health care to provide better and accessible health care services to all, and especially to the rural population. A health system perspective, as espoused in this publication, brings these areas into focus.

This publication has been worked out by analyzing programme implementation plans under NRHM of last 3 years since 2007-08 to 2010 along with CRM recommendations and opinion of the experts in the field. It has also taken into consideration, the pre-existing AYUSH infrastructure and services in the states. Earlier recommendations made by planning bodies have been used to identify several support activities to strengthen outputs and outcomes by the NRHM strategies.

I am sure that this document will be of help in subsequent planning and implementation of AYUSH and local health traditions for crafting an equitable and cost-effective health care delivery system. I would like to acknowledge the collaborative effort made by NHSRC, bringing together inputs from the Department of AYUSH, MoHFW, reputed NGOs and several experts in this field for their contributions in preparing this document.



(Amarjeet Sinha)

Joint Secretary
Ministry of Health & Family Welfare
Government of India

FOREWORD

This document started as an exercise at extracting the components in the annual NRHM programme implementation plans (PIPs) of the States to understand how and to what extent they are attempting to operationalise the NRHM strategy of 'Mainstreaming AYUSH and Revitalizing Local Health Traditions'. This was one of the cross-cutting analyses we undertook for an examination of State planning for various health system components. We found that several State PIPs had planned for multiple activities while other state plans showed that not much thinking had been done on the issue. As we identified the strengths and gaps, technical assistance needs got identified. It was thought that a section briefly introducing the various dimensions that need to be addressed to maximize outputs from the inputs going into the rural health services under this head, would be useful for further planning. The two substantive messages this report conveys are: Mainstreaming of AYUSH is much more than merely placing AYUSH service providers at the PHCs and CHCs; and that the Local Health Traditions, which have been ignored by most State plans, need to be incorporated within a conceptualization of the health care system so that they can be appropriately supported by state planning. They are autonomous forms of self-care and the initiation points of locally accessible primary health care that can be promoted through a few simple activities by the rural health service system.

Systems of health and healing, their knowledge base, their practices, the providers' social base and the hierarchy between various categories among them, their interaction with the patients and communities, the norms and ethics they espouse, as well as the organizational, financing and regulatory structures, all come together to create a health service system. In India, we are very fortunate to have a wide array of knowledge systems related to health. While modern medical science and technology have gained dominance, practices generated outside its field of knowledge, both old and new, continue to co-exist. Both health care providers and the general people often resort to a combination of two or more systems. While the unwritten knowledge that is passed on through the oral tradition and as practices is often dubbed as 'folk practice', the knowledge that has been systematized and codified as texts has received greater legitimacy as 'traditional' or 'alternative' systems. In recent years, the frontiers of modern medical research have verified the significance of traditional practices for strengthening health care and several developed countries are incorporating them into their health systems as well.

The Government of India has supported the development of at least six systems besides modern medicine, if not more. The acronym AYUSH represents Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy for which a network of government services have been set up by the centre and the states. Amchi or Tibetan Medicine in the western Himalayan region and acupuncture also receive support in some states. However folk medicine has survived with little or no official support. While anthropologists have documented folk knowledge and practice, and botanists have documented medicinal plants and their folk uses, the official approach has largely been to view them as a source of knowledge about medicinal plants and herbs that are to be exploited as economic resources for commercial gain. Interventions for strengthening the use of LHTs that have positive validation have been developed by civil society organizations and States need to draw upon their experience to identify what activities would be appropriate for state services to undertake.

The organization, training and practices of each form of health knowledge tend to change and become specific to the regional context as a result of the live presence of other forms. However, this interaction between forms of health knowledge has largely been at an informal level. We need to view all the forms of health knowledge as parts of a whole 'health service system'. It is a system that is dynamic internally as well as changes under influences from outside. If rational planning is to be done for the public health services, a holistic systemic view is required--that health care starts from the home and

goes through the primary and secondary level services to the tertiary hospital, that it includes use of various knowledge systems, and that all these are valid parts of a continuum of care. Then we will be able to come up with realistic context-specific plans for strengthening the health services that are rational based on the criteria of effectiveness, safety, accessibility and affordability for all sections. Maternal and child health services, disease control programmes and clinical guidelines for patient care, all could benefit from including this continuum of care in a framework that rationally integrates the contributions of all systems of knowledge.

There are three possible directions for strengthening AYUSH contribution within the public system. One is to strengthen services of the AYUSH institutions by urgently addressing issues of quality of infra-structure, human resources, supplies, R&D and management structures. This would lead to continuation of their development in parallel as stand-alone services, with the freedom to develop as per their scientific logic and norms of practice. The second is to enhance inter-action between the systems, encourage cross-referral between them, etc. by placing services under one roof, even while they strengthen themselves internally in parallel. The third is to move towards an integrated medicine to develop primary and secondary care protocols that draw upon the strong contributions each one can make.

As of now, the NRHM has created the opportunity for the second approach by co-locating services of the AYUSH at the CHCs and PHCs (leaving out yoga and naturopathy). This has been termed the 'mainstreaming of AYUSH'. 'Revitalization of the local health traditions' has also been included in the NRHM strategies, but its modalities have not been set out. As found during the appraisal of State Programme Implementation Plans for NRHM, several of them were allocating substantial amounts for AYUSH co-location at rural health facilities as well as other activities, while others were not planning for this strategy at all. To our surprise we found that several states have initiated activities beyond those envisaged in the NRHM framework of implementation, that would strengthen the outcomes of co-location, whether or not financially supported by NRHM. The NRHM seems to have created the environment in which the states could undertake these 'innovations', many of which are not new as ideas but are being taken up on any significant scale for the first time. However, we also recognized that there is still a long way to go before there can be a comprehensive and integrated vision of the health service system. This report therefore expanded beyond merely presenting the analysis of PIPs to include a brief discussion on the various dimensions that need to be considered from a health service system perspective. It has also limited itself to the supply side strengthening issues and not got into the epistemological issues of the different world-views underlying the modern and other systems.

However, commercialization of these systems as a part of the 'medical and health industry' that includes the providers is a loss in many ways. While it adds to health care costs, takes away natural resources from out of reach of the local communities, it also destroys a non-commercialized model of care that allowed people to think that it is possible to organize health care as a community activity available to all. In an age when 'user fees' and service 'packages', 'medical tourism' and 'health spas' are becoming one corporatized model of health care, the folk herbalists and home remedies provide a diametrically opposite view that would be useful to build a holistic and equitable health service system. Our hope is that this document will further stimulate action for strengthening AYUSH services and revitalizing LHT and provide the States with ideas for planning innovations that they can operationalise under the NRHM.

Ritu Priya

Advisor, Public Health Planning,
National Health Systems Resource Centre

Acronyms and abbreviations

AMG	Annual Maintenance Grants
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga, Unani, Siddha, Homeopathy
BAMS	Bachelor of Ayurveda Medicine & Surgery
BHMS	Bachelor of Homeopathic Medicine & Surgery
BMJ	British Medical Journal
BSMS	Bachelor of Siddha Medicine & Surgery
BUMS	Bachelor of Unani Medicine & Surgery
CAM	Complementary & Alternative Medicine
CCRAS	Central Council for Research in Ayurveda & Siddha
CCRH	Central Council for Research in Homeopathy
CCRUM	Central Council for Research in Unani Medicine
CCRYN	Central Council for Research in Yoga & Naturopathy
CCIM	Central Council for Indian Medicine
CDAC	Centre for Development of Advance Computing
CHC	Community Health Centre
CME	Continued Medical Education
CRM	Common Review Mission
CSS	Centrally Sponsored Scheme
DH	District Hospital
DHAP	District Health Action Plan
DHS	District Health Society
EAG	Empowered Action Group
EDPT	Early case Detection & Prompt Treatment
FRLHT	Foundation for Revitalization of Local Health Traditions
FRU	First Referral Unit
FW	Family Welfare
GDP	Gross Domestic Product
GOI	Government of India
GTP	Golden Triangle Partnership
H& FW	Health & Family Welfare
HIV/AIDS	Human Immune Deficiency Virus/Auto Immune Deficiency Syndrome
HMIS	Health Management Information System
HR	Human Resource
HUD	Health Unit District
ICDHI	Independent Commission for Development of Health India
ICU	Intensive Care Unit
IEC	Information Education Communication
IMNCI	Integrated Management of Newborn and Childhood illnesses
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
IPR	Intellectual Property Rights
ISM & H	Indian Systems of Medicine & Homeopathy
LHT	Local Health Traditions
M&E	Monitoring & Evaluation
MBBS	Bachelor of Medicine & Bachelor of Surgery
MMR	Maternal Mortality Rate
MMU	Mobile Medical Unit
MO	Medical Officer
MOHFW	Ministry of Health & Family Welfare

MPHC	Mini Primary Health Centre
NCD	Non Communicable Diseases
NDCP	National Disease Control Programme
NE	North East
NGO	Non Government organization
NHP	National Health Programmes
NHSRC	National Health Systems Resource Centre
NISCAIR	National Institute of Science Communication & Information Resources
NMPB	National Medicinal Plant Board
NRHM	National Rural Health Mission
OPD	Out Patients Department
PG	Post Graduate
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PPP	Public Private Partnership
PUHC	Primary Urban Health Centre
QC	Quality Control
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
ROP	Record of Proceedings
SAMC	State AYUSH Monitoring Cell
SBA	Skilled Birth Attendance
SC/SHC	Sub Centre/ Sub Health Centre
SDH	Sub Divisional Hospital
SHS	State Health Society
SHSRC	State Health Systems Resource Centre
SIHFW	State Institute of Health & Family Welfare
SMPB	State Medicinal Plant Board
SPMU	State Programme Management Unit
TA	Technical Assistance
TCM	Traditional Complementary Medicine
THP	Traditional Health Practitioner
TK	Traditional Knowledge
TM	Traditional Medicine
TOT	Training of Trainers
UG	Under Graduate
UT	Union Territory
VHSC	Village Health and Sanitation Committee
WHO	World Health Organization

Contents

Executive Summary

Health Systems Policy Perspective on AYUSH & Local Health Traditions

1. The NRHM strategy of 'Mainstreaming AYUSH & Revitalizing Local Health Traditions' has largely come to be perceived as 'Co-location' of AYUSH doctors in the rural primary and secondary level facilities. While most States have planned for this, it is important to note that at least half the States have planned other activities that strengthen AYUSH services well beyond merely the contractual appointment of AYUSH doctors.
2. However, analysis of the annual NRHM Programme Implementation Plans (PIPs) of States reveals that only a few of them have given adequate thought to the planning and implementation of these measures. Even for the co-location, there are issues that need to be dealt with for optimizing outcomes.
3. What are these issues and why are they important? How should they be dealt with? To answer these questions, and draw up operational plans, it seems necessary to understand the history and role of AYUSH and LHT in planning for health services development. To do so, we have briefly traced the policy framework from the documents of the Planning Commission, Department of AYUSH and NRHM that call for co-location and integration; the forms of integration envisaged in the debates on role of TM & CAM; and then identified what issues need to be addressed from a health systems perspective to optimize the outcomes of co-location.
4. Integration of modern medicine and traditional knowledge in health is an idea that has been discussed from the time of the Independence struggle even before 1947, as a way of dealing with people's health problems and the basis for planning a health system for India, based on the premise of the inherent worth of these systems. Drawing upon the strengths of all health knowledge and strengthening health care bottom up, from the home or community/village based measures that are accessible to the rural and poor, right up to health centers, dispensaries and hospitals of all systems were the underlying arguments for such a framework proposed for development of health services in India.
5. In the post-Independence period, while colleges of ISM & H increased, (almost equaling the number of graduates produced in modern medicine), and the network of dispensaries and hospitals was expanded markedly, a one-way integration occurred in the form of incorporation of the concepts of the modern medical science into the curriculum of the ISM & H graduates. Also, despite the enlarging institutional infrastructure, ISM & H received only 3% of the government's health budget. Little attention was given to quality of infrastructure or services of the ISM & H. The dominance of modern medical science and technology was 'established'.
6. As distinct from AYUSH, Local Health Traditions (home remedies and dietary practices for health; folk practitioners including herbalists, bone-setters, massagists, traditional birth attendants and faith healers) too have been recognized for their usefulness and people's access to them. Ethnobotanists have studied the properties of medicinal plants and herbs. A large number of NGOs have worked to document and sustain their use. However, the access to the medicinal plants and herbs as well as the legitimacy of these practices has declined.

7. On the other hand, people continue to use ISM & H as well as LHT, Their worth is being widely recognized, especially to supplement modern medicine in areas where it has limitations. There is also a growing recognition of the worth of TM and LHT even within modern medical science, and there is growing international demand for them. Yet the system of dominance is modern medicine or Allopathy in the Indian health system. Therefore, there is a need for 'mainstreaming of AYUSH' within the health service system and for 'revitalizing LHT' in the community.

Mainstreaming AYUSH & Revitalizing LHT under NRHM

8. 'Mainstreaming AYUSH' implies the bringing of a side-practice or 'weak stream' into the dominant stream. While this ignores the extent of utilisation of AYUSH & LHT in our population and its growing importance and viability in the field of medicine, 'mainstreaming' is relevant for the institutional structures of health care provisioning by the public system. This hierarchy between Modern Medicine and AYUSH and the side-lining of AYUSH is evident in the infrastructure, financing and worldview within the public health care system. The strategy of co-location of AYUSH practitioners within the existing modern medicine facilities brings the *weakly supported* and *less developed stream (not fundamentally weak stream)* of AYUSH services into the 'mainstream' public health facilities. Viewed from a wider societal perspective, in the present times it is difficult to establish what is 'mainstream'

9. 'Mainstreaming of AYUSH' by co-location of services with Allopathy has been in the official plan documents since the IXth Five Year Plan. It has finally been implemented on a country-wide scale by the National Rural Health Mission announced in 2005. The NRHM primarily envisages this as a strategy to:
   - Provide choice of treatment systems to the patients,
   - Strengthen facility functionality,
   - Strengthen implementation of the National Health Programmes

10. However, the opportunities this co-location at PHCs, CHCs and DHs provides are far greater:
    - One, bringing the AYUSH graduates to strengthen the human resources situation at these facilities, primarily practicing Allopathy or at least working under its framework.
    - Second possibility in the co-location is a way of correcting the architectural flaw in the present health care system, that of denying legitimacy to people's practices and local health traditions as well as to knowledge systems other than the dominant modern medicine (Allopathy). Modern medical sciences as well as the frontiers of practice of modern medicine recognise the value of these as TM (Traditional Medicine)/ Complementary or Alternative Medicine (CAM). The co-location strategy provides choice to patients under one roof.
    - Once this legitimacy is accepted, a third possibility opens up – of cross referrals across systems to utilization of the strengths of each for the benefits of patients and the health of communities.
    - The fourth opportunity it provides is for mutual strengthening of the modern and AYUSH systems by an interaction between them. To implement the principle of equity and empowerment of AYUSH to play an effective role in Public Health, each system needs to be revitalized through constant questioning, reinterpretation and addition of new dimensions with use of modern technologies to understand its fundamentals.

11. The planning and implementation of AYUSH and LHT components was analyzed by us through:
    (i) State PIPs for 3 or 4 years (from 2006-07 to 2009-10, as available for each state), against the NRHM framework of implementation and the Indian Public Health Standards.

(ii) Quarterly reports by states on implementation of the NRHM (as reported in Dec. 2008)

(iii) Findings of the two Common Review Missions that have assessed progress of implementation of the NRHM (Nov.-Dec. 2007and 2008).

The analysis took into consideration the backdrop of the pre-existing AYUSH infrastructure and services in the states. In addition to the set of activities proposed under mainstreaming AYUSH by the NRHM framework of implementation, several other planning bodies have made additional recommendations -- Annual reports from the Department of AYUSH, the Planning Commission Task Force on AYUSH for the Xth and XIth plans, Steering Committee on AYUSH subgroup on Public Health, National Mission on Medicinal Plants (Operational guidelines), National Policy on ISM & H (2002), Report of the National Commission on Macroeconomics and health, 2005, Independent Commission for Development and Health in India (ICDHI) representing civil society and reputed NGOs in the field of AYUSH. These were used to identify several supportive activities that would be necessary to optimize outputs and outcomes of the NRHM strategies.

Planning & Implementation under the NRHM

12. Under the NRHM, 4981 AYUSH doctors and 934 Paramedics have been recruited on contract for co-location. As reported by states, about 44% of DHs, 24% of CHCs and 17.6 % of PHCs have co-location of AYUSH providers. In the years that they have planned for AYUSH and LHT,

- 16 states have allocated 1-3% of their NRHM budgets for this component,
- 4 have budgeted 3-10% and
- 12 states have budgeted over 10% in the years for which the budget was available.

13. Drugs, equipment and buildings are funded by the department of AYUSH, while the NRHM flexi pool funds the providers hired on contractual basis for the co-location. The IPHS provide the ideal level of services to be reached by each facility, from sub-centers to PHC to CHC to DH. These give the HR requirement, space and building, medicines and equipment as well as cultivation of a herbal garden in the SC and PHC premises.

14. Co-locations seem to be the only activity followed promptly across all states, but with wide variations. Several of the States with strong existing services of AYUSH in the public health services, such as, Gujarat, Rajasthan, Himachal Pradesh, and J&K, have rolled out the recruitment of AYUSH doctors for PHCs and CHCs under the NRHM to a greater degree than others. However, while continuing to strengthen its AYUSH services, Kerala is reluctant to co-locate them. There are reports of the State Directorates/ Cell of AYUSH not being involved in the activities of mainstreaming under NRHM, leading to loss of synergy and lack of technical supervision for the co-located personnel. Therefore, this raises the following concerns and issues:

'Is it Mainstreaming of the 'AYUSH systems' or mainstreaming of the 'AYUSH providers'?

- The role of AYUSH doctors and paramedics in the co-located facilities needs much more attention for quality service delivery.
- While the role of AYUSH and LHT can be significant in RCH, this has not been adequately worked out. Punarnavadi Mandoor, the anti-anemia Ayurveda medicine, is the only one to have been widely included in the programme.
- AYUSH doctors are being given training in SBA in only 6 states & IMNCI in 3 states. Since both require procedures specific to Allopathy such as injections & episiotomy & prescription of allopathic medicines, the legal issues need to be dealt with.
- Training of AYUSH doctors in managerial

and public health functions is not adequately planned.

- Membership of AYUSH doctors in the SHS, DHS and RKS (planning, management and monitoring bodies created under NRHM) at various levels has been reported by most States, but their level of involvement is not known.
- Many additional and innovative activities are planned across states but their micro planning and implementation needs much more technical and managerial assistance.
- District level planning has been done on mainstreaming of AYUSH under NRHM in a few states (as per the CRM).
- Planning for ensuring adequacy of appropriate AYUSH drugs is lacking.

15. There is confusion among the States about the division of financial allocations by the NRHM and the Department of AYUSH at the Centre.

Other Activities for strengthening AYUSH services and Revitalising the LHT

16. There are various additional inputs planned by some states under the following heads:
    i) **IEC/BCC:** Sensitization activities for the general public about AYUSH & LHT.
    ii) **Speciality clinics/wards:** Half the states mention special AYUSH clinics or wards, especially a Ksharasutra therapy wing for ano- rectal diseases and Panchkarma clinics for intensive and specialized treatment at the CHC or DH.
    iii) **AYUSH health programmes:** States like Orissa, Punjab, and Andhra Pradesh write in the PIPs about School Yoga Programmes and Yoga camps. The Tripura PIP also mentions sensitization of Primary school teachers regarding importance of yoga,'Suposhanam', the Special nutrition programme for the tribal women is stated in the Rajasthan PIP, Ayurveda Mobile Units is also an activity mentioned in the Rajasthan state PIP.
    iv) **Outreach activities:** Utilization of AYUSH doctors for the Mobile Medical Units in some States, such as Jharkhand, Himachal Pradesh, J&K and Orissa. Call centres for AYUSH in Madhya Pradesh and Tripura is a major innovation mentioned in their PIPs.
    v) **Establishment of AYUSH epidemic cells:** Tamil Nadu and Kerala are using AYUSH in public health for preventive activities and epidemic control, e.g. Homeopathy for responding to the Chikungunya outbreaks. RAECH (Rapid action epidemic cell of homeopathy) in Kerala is a major AYUSH activity highlighted in the state PIP.
    vi) **Local health traditions:** The IPHS prescribes the setting up of an herbal garden within the space available in the Sub centre and PHC premises (see annexure-IV). Most state PIPs have not mentioned this activity in particular. However, some states have:
        - the Chhattisgarh PIP has mentioned an innovative activity--the 'Ayurveda Gram" concept (Annexure-V),
        - "*Dadi ma ka batua*" is an innovative scheme stated in the J&K PIPs, which plans to include traditional home remedies in the AYUSH drug kit; Madhya Pradesh has an innovation called *Gyaan ki Potli* which too plans to include prevalent and useful local health traditions / remedies which are accessible and affordable for various ailments as a step forward for LHT revitalization.
        - Haryana has planned for courses on Local health traditions for the unemployed youth.
    vi) **Management and Technical Strengthening:** Almost half the states have planned some strengthening of management and technical support to the AYUSH services.

States like Rajasthan mention in the PIPs of year 2008-09 about the formation of the State AYUSH Monitoring Cell (SAMC) for AYUSH services. Chhattisgarh too has a separate technical wing in the SHSRC for AYUSH. On a similar pattern, under the NRHM Kerala, Jharkhand, Mizoram, Tripura, Delhi and Goa, have planned for establishing a resource centre or a separate cell for AYUSH.

Financial Allocations under NRHM

17. Despite the incomplete data available, budgetary allocations by the States demonstrate that, in comparison with the earlier central contribution to AYUSH services in the States, the NRHM budget has increased it, to various degrees in different states, say from 2 to 100 times. Of the three years from 2007-08 to 2009-10 the budgetary allocation for the AYUSH component was available in the 35 State /UT PIPs for only 69 out of the 105 State -Years. Even in this, two third of the State -Years, an aggregate of as much as 636.38 crores was proposed.

Major Gaps & Technical Assistance Needs

18. Thereby, AYUSH services in the public sector are getting strengthened. However, the requirements for making full use of the opportunity are not yet adequately conceptualized or planned for. Some concerns that emerge are:
    - Inadequate inputs for optimizing the co-location strategy.
    - Re-locating doctors from even the well-established AYUSH facilities means weakening of AYUSH since they loose independent space, and there is loss of services to patients who were using them.
    - Further legitimization of practice of Allopathy by the AYUSH practitioners, without any policy framework for cross-practice or integrated practice.
    - No plans to orient the allopathic doctors to the strengths and role of AYUSH and LHT. Their non-appreciation of these is based on ignorance of research findings at the frontiers of modern medicine and the experiential knowledge of common people.

19. Thereby the Technical Assistance needs that have been identified are outlined below.

At national level:

i) Assessment of the roles being performed and services delivered by the AYUSH personnel under NRHM and in the public health system as a whole, and strategically planning Mainstreaming of AYUSH and revitalization of local health traditions in an integrated and comprehensive manner.

ii) Issuing guidelines to states for:
    - Defining the service inputs by AYUSH doctors in co-located facilities towards fulfilling the service guarantees.
    - Training and capacity building of AYUSH personnel for National Health Programmes and Public Health needs to be well defined.
    - Orientation of the Health personnel other than of the AYUSH systems for sensitizing them towards AYUSH and the local health traditions.
    - Both the above should enhance the cross-referral across systems, thereby optimizing the provision of benefits of all systems to the patients.
    - Drug and equipment needs to be reflected in the PIPs based on a needs assessment and monitoring of supplies.
    - Appointment of the Paramedical staff along with the AYUSH Doctors wherever they are colocated/relocated at various facility levels.
    - Integration of LHT with AYUSH services at the village, sub-centre and PHC levels so as to fulfill the NRHM goal of

revitalizing local health traditions.

- Adequate planning and inputs of AYUSH systems and LHT at each facility level and within the district and state health planning process.
- Including the AYUSH doctors as members of the SHS, DHS and RKS.and orientation of all members of these committees
- Developing criteria for selection of AYUSH doctors to be relocated from existing functioning stand-alone AYUSH facilities to the PHC/CHC, based on the patient load and the level of infrastructure.

iii) Identifying the maximum potential inputs of AYUSH for contributing to services guaranteed at each facility level and integrating them into respective components, such as provision of basic and specialized care at primary and secondary level facilities, maternal health and child health.

iv) Enriching and augmenting the role of ASHAs in the context of use of and referral to AYUSH services as well as revitalizing LHT.

v) Improving the quality of professionals of AYUSH.

vi) Developing indicators for AYUSH services to be used in the HMIS.

At State level:

i) Mainstreaming of AYUSH and revitalization of local health traditions need to be strategically planned in an integrated and comprehensive manner.

ii) Ensuring experience based planning with timelines for implementation of activities and financing clarity of various budgetary sources involved in the Mainstreaming Strategy for AYUSH.

iii) Setting up a State level agency to develop an integrated policy perspective on the role of AYUSH & LHT within the overall health system as well as its planning and implementation. Locating an AYUSH Resource Centre within the SHSRC is proposed.

In Conclusion

20. Thus, the NRHM has provided an opportunity for strengthening the AYUSH services within the public health services and revitalizing the LHT within the community. The AYUSH systems and practitioners have to rise to the occasion and make maximal use of it. The Department of AYUSH at the centre has geared up to meet the challenge. Its guidelines to all the states to make separate annual plans for AYUSH are a step towards overcoming the hegemony of Allopathy.

21. The challenge to the public health system is how it visualizes the place of AYUSH and LHT within the health service system of the country. International experience shows how viewing them as the base to build upon for a continuum of care, from home and community, to health centers and dispensaries, to hospitals; letting each system grow according to its own epistemological orientation; and cross referral based on mutual appreciation and respect serves the people best. It is to be hoped that the NRHM will be able to foster this spirit.

This Report

This document primarily identifies the issues pertaining to operationalising the strategy of mainstreaming of AYUSH and the technical assistance needed to carry it forward effectively. It is based on a desk review and rapid appraisal of the various State Programme Implementation Plans (PIPs) for the three years from 2007-08 to 2009-10, leading to identification of technical inputs needed to strengthen the initiatives by States under NRHM. *We are aware that this is a very partial representation of*

the activities actually being undertaken at ground level since they are not always documented in the PIPs. While we have incorporated the field reality from our own field visits as well as from the Common Review Mission reports, we would welcome feedback and inputs, especially about innovations and additional activities that have strengthened the AYUSH services & LHT in their experience.

- Section I provides a brief overview of AYUSH & LHT in heath care policy and planning in India. It outlines the supportive components that are necessary from a system's perspective for enhancing outcomes of AYUSH and LHT activities in the public health service system.
- Section II presents an overall situation analysis of the planning for mainstreaming of AYUSH and revitalising LHT under the NRHM from the PIPs of all 29 states and 6 Union Territories, It identifies the common gaps and lists the innovations that have been adopted by some states.
- Section III gives the overall budgetary allocations to the AYUSH component under NRHM.
- Section IV contains a brief summary of Technical Assistance needs to address the gaps identified by the PIP analysis and by the Common Review Missions. It also suggests the modalities to be operationalised to meet these needs.
- Section V contains eight Annexures, the first containing extracts of the details of the AYUSH component in each state PIP. The others are documents related to government regulations, orders and schemes pertaining to AYUSH & LHT.
- The bibliography lists the references used for this document and other background documents.

Section – 1

INTRODUCTION

AYUSH & LHT in Health Care Policy & Planning

Mainstreaming AYUSH and Revitalizing Local Health Traditions

A. The Policy Framework and NRHM

1.1 The concept of 'Mainstreaming AYUSH' finds place in the policy documents of the Government of India since the IXth five year plan. The Department of Indian Systems of Medicine and Homoeopathy (ISM & H) was created in March, 1995 [re-named as Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH)[1]] in November, 2003 with a view to providing focused attention to development of these systems. The government has given support to the ISM & H as part of its planned development of the health sector ever since Independence. This support has clearly been weak relative to the dominance of the Allopathic system and hence the need was felt to 'mainstream' what have been, and continue to be, widely used knowledge systems and practices in the country. This has become part of the 'architectural correction' of the health services envisaged by the National Rural Health Mission (NRHM).

1.2 Local Health Traditions (LHTs) refer to health promotive, preventive and curative methods having general acceptance and prevalence among households of different socio-economic strata. While these have common roots with the indigenous textual systems, it is not necessary that these practices conform exactly to different ancient health systems and their texts. They may be practiced by the households themselves as 'home remedies' or through the services of various traditional and folk practitioners. Although they have no legal sanctity, they are time tested through people's experiential knowledge. As such, these practices need to be examined in the light of present knowledge and for strengthening ecologically sustainable ways of understanding health & disease, promoting health and treating ill-health. The LHT are important for sustaining and strengthening the AYUSH systems as well. Therefore 'Revitalizing' of LHT is another strategy of the NRHM.

1.3 The National Policy on ISM & H, 2002, had emphasized the need for integration of ISM & H with the Allopathic services as well as strengthening the ISM & H services in the public health service system. It had spelt out strategies for:

- Integration of ISM & H with the National Health Programmes and Primary Health Care delivery system.
- Operational use of ISM & H in Reproductive & Child Health (in 11 areas of antenatal, natal and postnatal care).
- Revitalization of Local Health Traditions.
- Making Available Home Remedy Kits (with herbal medicines).
- Inter-Sectoral Co-operation (School education, industry, culture, tourism).
- Promotion of herbariums for local health care as well as sources of livelihood (being propagated by the AYUSH department, Bio-technology dept. and by NGOs).
- Administration of the ISM Sector.
- Exposing the Indian & Foreign Allopathic /Modern graduates to Indian systems of Medicine.

1 AYUSH is an acronym for Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homeopathy, but it covers 7 legally recognized systems of medicine including the above as well as Amchi. These represent the systematized forms of health related knowledge with their texts, formal traditions and institutions.

- Building awareness for AYUSH systems
- Intellectual property rights and patents
- Education and research

1.4 The National Rural Health Mission, announced in 2005 and implemented on the ground in 2006, has formulated 'revitalising local health traditions and mainstreaming AYUSH' at the primary and secondary levels as one of its strategies to strengthen the public health services (NRHM Framework of Implementation, 2006). This convergence of AYUSH with the allopathic health services has been envisaged to:

- Provide choice of treatment systems to the patients,
- Strengthen facility functionality,
- Strengthen implementation of the National Health Programmes.

1.4 The report of the Working Group on "Access to Health Systems including AYUSH" (Planning Commission 2006) mentions that under the NRHM all PHCs and CHCs would provide AYUSH facilities under the same roof. It recommended that:

- The AYUSH manpower would be arranged either by relocation of AYUSH doctors from *the existing dispensaries that do not have their own buildings*, or from contractual hiring of AYUSH doctors with NRHM funds.
- The other infrastructure and supply of medicines to PHCs and CHCs would be financed through the Centrally Sponsored Scheme of Hospitals and Dispensaries which had received a very good response from States in the last two years of the Xth Plan. Hence, it was proposed to substantially increase the Plan provision for this scheme to Rs.625 crores in XIth Plan.
- Upgradation and assistance to existing AYUSH hospitals and dispensaries was also proposed as a minor modification in the scheme.
- During the XIth five year plan, it was proposed that a National Medicinal Plant (NMP) scheme be initiated and that the 'Vanaspati Van' scheme which was being implemented by the Department of Family Welfare under RCH-I, be merged within it. (The merger was done in 2002, without any outcome review being publically available.) The NMP scheme proposed to cover 30,000 hectares of area with Herbal Gardens in 10 states. (See Annexure IX for details on the National Mission on Medicinal Plants.)

1.5 The Indian Public Health Standards (IPHS) have stated the minimum requirement of human resources, infrastructure, drugs and logistics for implementation of the mainstreaming of AYUSH component, from the sub-centre level up to the district hospital with 500 beds (Annexure IV).

B. Health Systems Policy Perspective & Supportive Strategies for optimizing the outcomes of Mainstreaming AYUSH & revitalizing LHT

The use of all available systems of health and healing has been considered important, both nationally and internationally. Within the overall framework of modern medicine, multiple roles have been envisaged for 'other systems':

- making use of the practitioners of traditional systems and folk medicine for public health programmes and services,
- allowing the systems a subsidiary role in health care as Complementary and Alternative Medicine (CAM),
- Creating a new scientific paradigm that integrates traditional and modern medicine.

'Mainstreaming AYUSH' focuses on the first, but this provides the opportunity to initiate moves towards the second, and may even facilitate the third. Reviewing the opportunities and challenges in the Indian context, a number of areas for support to strengthen the outcomes of mainstreaming can be identified.

1 Integration of traditional medicine with Allopathy

Developing an integrated view of health care, from self care by people, to primary, secondary and tertiary services of all pathies—including LHT, AYUSH and Allopathy—is necessary for a systemic approach. However, integrating AYUSH with a dominantly Allopathy based health service structure is an extremely serious and challenging task with a contentious history. It is an extremely complex task to integrate different medical knowledge systems because they are based on different worldviews, philosophical frameworks and logic; different conceptions of the body and mind; and different theories of physiology, pharmacology and pharmaceutics. Various related perspectives and experiences provide lessons to draw from, nationally and internationally.

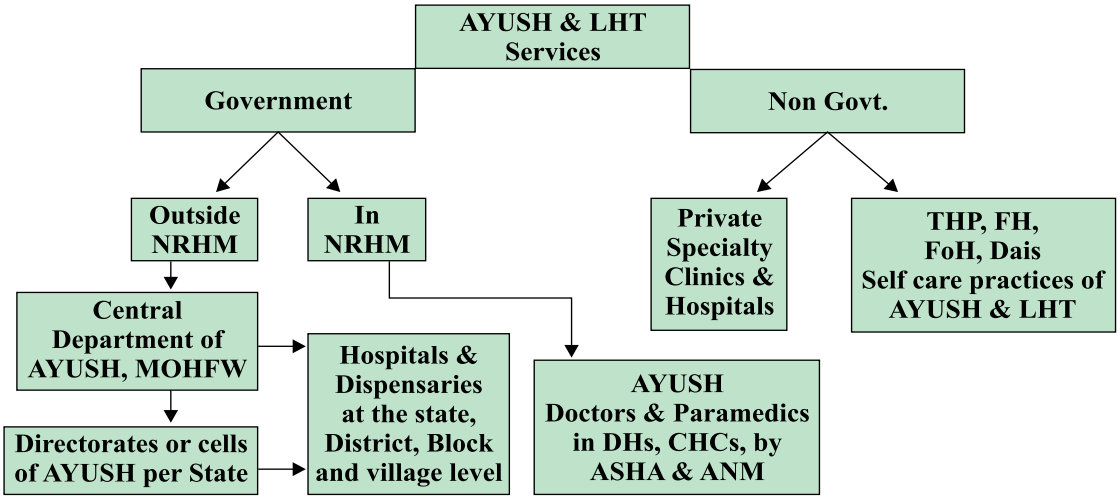
Opportunities in the Indian Context

India has a comparative advantage in the area of 'Complementary Medicine' and can be a world leader in the field. This is because India has an immensely rich and mature indigenous medical heritage of its own and strong foundations in western biomedical sciences. It is the only country which has provided legal status to seven non-allopathic systems of medicine, namely Ayurveda, Yoga, Unani, Siddha, Homeopathy, Naturopathy and Tibetan / Amchi Medicine. All these systems function today in India, as parallel streams along with Allopathy as the mainstream, with very little interaction between them.

The size of the AYUSH sector in India is impressive. Apart from China there is no other country which has an educational infrastructure for undergraduate and post-graduate education in Traditional Medicine. Over 25,000 AYUSH Practitioners qualify every year from 456 AYUSH colleges. There are over 7 lakh registered AYUSH practioners in the country (Dept. Source of AYUSH: Refer the pie diagram on page 23). There are 1355 hospitals with 53296 beds and over 22,000 dispensaries providing primary health care. However, by the few accounts available, their quality of infrastructure and functioning generally appears to be run-down; However, there is insufficient data on the quality and social impact of the health services provided by either the government run institutions or the private ones.

LHT consists of the use of home remedies as well as a range of folk practitioners. Broadly classified, traditional health practitioners, folk healers, faith

AYUSH & LHT Services in the Public and Private Sectors within and outside the NRHM



(THP = Traditional Health Practitioners, FoH = Folk Healers, FH = faith healers, Dais=traditional birth attendants)

healers and dais[2] constitute the work force. Several new forms of healing are emerging, such as electro-magneto therapy, quantum healing, Pranic healing, Reiki and colour therapy among others, it is still debated whether they should be considered part of the LHT.

Integration

- In India, integration of pathies has been viewed in very diverse ways, from mere co-location that covers up for the lack of an MBBS doctor in the PHCs and CHCs for basic curative care and implementation of national health programmes with little concern about the benefits of the AYUSH systems themselves; to active use of 'alternative medicine' and 'complementary medicine' that helps overcome the iatrogenesis and limitations of Allopathy; to a complete scientific integration. The last has been attempted in terms of the AYUSH under-graduate curriculum including the basic bio-medical sciences (anatomy, physiology, etc.), but there is no exposure of the MBBS students to AYUSH and their principles.
- While a few institutions have integrated knowledge and practices of the various AYUSH systems[1], there is not a single formal institution in the country wholly dedicated to research and good clinical practices that integrates Allopathy and the AYUSH systems.
- As a dominant trend, medical professionals and policy makers in India still seem to be carrying the residues of the colonial modernization vision which for political and economic reasons suppressed indigenous knowledge. This outlook however is undergoing a change in the wake of growing global experiences about the limitations of such an approach in health care, as well as in light of the findings of the latest research in the medical sciences that have proved the worth of traditional practices in promotive, preventive, curative, and palliative care.
- What is happening in practice seems to be a range of interactions, both in the public and private sectors, generating a combination of

2 AYUSH practitioners = Graduates from colleges of the specific system(As recognized under the second, third and fourth schedule under Central Council of Indian Medicine Act 1970,see Annexure VIII)
Traditional Health Practitioners (THP)= Non- institutionally qualified who learnt a textual system through a hereditary passing on of knowledge or from an older practitioner
Folk Healers (FoH) = non-textual 'system' learnt hereditarily or from another teacher, the '*guru*', often addressing a specific health problem
Faith Healers (FH) = those who use non-material means of prevention or treatment, invoking 'spiritual' forces to do so, may or may not combine with herbal/animal medicines
Dais = traditional birth attendants (TBAs)

the AYUSH and LHT with Allopathy. Within public health, the 'ksharasutra' campaign is on, including in allopathic hospitals. Yoga, naturopathy and herbal remedies are in use for prevention and control of non-communicable diseases, and Homeopathy is being used for control of Chikungunya as well as by paediatricians for patients. Therefore, what would be the optimal utilisation of the AYUSH systems at the PHC and CHC level needs to be defined.

Under NRHM

On a more practical level, and in an immediate time frame, optimising the opportunity provided under NRHM by more than one pathy being located under one roof for a kind of functional integration would require mutual understanding and creating an environment of mutual respect amongst medical professionals trained in different systems. It will involve an appreciation of the strengths and limitations of different medical systems and based on this appreciation, a carefully worked out code of ethics for cross referrals. Such a plan of functional integration can immediately provide better options and informed choices to millions of health care seekers and one need not wait for more complex research led epistemological integration to be completed. Legal as well as scientific issues become relevant here, besides cost-effectiveness, accessibility and acceptability.

Table No. 1

Challenges for AYUSH & LHT in Indian Context	
National policy and regulatory frameworks	• Lack of recognition of significant role of AYUSH Systems and AYUSH providers in spite of their legal recognition in the country and also a separate department under the Ministry of Health &Family Welfare. • Inadequate allocation of resources for development of AYUSH services and capacity building. • Inadequate framework of AYUSH education in contemporary context. • AYUSH not integrated into national health care systems, but functioning as a parallel system. • Lack of proper regulatory and legal mechanisms for integrated practice. • Lack of a clear definition for defining 'quacks', leading to harassment of traditional healers. • Unequal distribution of benefits of indigenous knowledge and products.
Safety, Efficacy and Quality	• Inadequate evidence-base for AYUSH therapies and products. • Lack of international and national standards for ensuring safety, efficacy and quality control of AYUSH therapies and products. • Lack of appropriate registration of AYUSH providers. • Inadequate support for research to generate advances in the systems. • Lack of research methodologies based on an appropriate amalgamation of the AYUSH system's theoretical foundations and modern science. • Lack of standards for quality assessment of AYUSH facilities.

Challenges for AYUSH & LHT in Indian Context	
Access	• Destruction of sources of raw material for AYUSH remedies and LHT (deforestation and other forms of ecological degradation); including by unsustainable use of medicinal plant resources due to unregulated commercial exploitation. • Lack of data measuring access levels and affordability • Lack of official recognition of role of AYUSH providers • Lack of cooperation between AYUSH providers and allopathic practitioners.
Rational Use	• Lack of confidence among practitioners of AYUSH systems. • Weaknesses in education and training for AYUSH providers • Lack of information on AYUSH among allopathic practitioners • Lack of communication between AYUSH and allopathic practitioners, and between allopathic practitioners and consumers • Lack of information for public on rational use of AYUSH and Local health traditions. • Unscrupulous practice by some practitioners of traditional and folk medicine, just as a section of allopathic practitioners exploit the vulnerability of the ill.

International Perspective

- Internationally, Traditional Medicine (TM) is widely used, is growing rapidly, and has gained substantial economic importance.
- TM and indigenous medicine are comprehensive terms used to refer both to systems such as traditional Chinese medicine, Arabic medicine, Indian Systems of Medicine like Ayurveda, Yoga, Unani and Siddha, TM therapies include medication therapies -if they involve use of herbal medicines, animal parts and /or minerals and non medication therapies -if they are carried out primarily without the use of medication, as in the case of Yoga, Acupuncture, manual therapies and spiritual therapies.

Middle-income Industrial cum Peasant Societies

- In developing countries, broad use of TM is often attributed to its accessibility and affordability, and also because it is firmly embedded within wider belief systems.
- Asia has seen the most progress in incorporating its traditional health systems into national policy. In some Asian countries such as China the development has been a response to mobilising all healthcare resources in meeting national objectives for primary health care. In other countries such as India & South Korea, change has come through politicisation of the traditional health sector and a resultant change in the national health policy *(Gerard Bodeker, BMJ, 2001).*

Two basic policy models have been followed

- An integrated approach where modern and traditional medicine are integrated through medical education and practise (e.g. China, Vietnam), and
- A parallel approach, where modern and traditional medicine are separate within the national health system (e.g. India, South Korea).

China

- In China the integration of traditional Chinese medicine into the national healthcare system began in response to urgent national planning needs to provide comprehensive healthcare services. Integration was guided by health profes-

sionals trained in modern medicine; harmonization with modern medicine was the goal. The state administration of TCM manages the entire sector ranging from legislation, regulation and policy through to hospital administration, drug control and international economic and academic cooperation.

- As of today hospitals practicing traditional Chinese medicine treat 200 million outpatients and almost 3 million in patients annually. This was accomplished by a science based approach to the education of traditional Chinese medicine and an emphasis on research. Both were supported by a substantial organizational structure. To many observers, modern medical control over the terms and process of integration has resulted in the loss of important aspects of traditional theory and practise.

High-income Industrialised Societies

- In countries where the dominant health care system is based on allopathic medicine or where TM has not been incorporated into the national health care system, TM is often termed as 'Complementary, alternative or non conventional' medicine. In many developed countries popular use of Complementary and Alternative Medicine (CAM) is fuelled by concern about the adverse effects of chemical drugs, questioning of the approaches and assumptions of allopathic medicine and greater access to public health information. At the same time, longer life expectancy has brought with it increased risks of developing chronic, debilitating diseases such as heart disease, cancer, diabetes and mental disorders. For many patients, CAM appears to offer gentler means of managing such disease than does allopathic medicine.

USA & UK

- Therefore, developed countries are now formally exploring the science behind CAM. The National Center for Complementary and Alternative Medicine (NCCAM) in the U.S.A is the Federal Government's lead agency for scientific research on complementary and alternative medicine (CAM). It is one of the 27 institutes and centers that make up the National Institutes of Health (NIH) within the Department of Health and Human Services.

  [NCCAM, National Institutes of Health Bethesda, Maryland, USA] Refer - webreferences

  The Department of Health, United Kingdom, has ongoing research projects under Public health improvement schemes on Complementary & Alternative Medicine.

  [Department of Health United Kingdom] Refer - webreferences

All these aspects need to be considered by the policy makers for effectively mainstreaming the AYUSH systems and LHT in India. The following table provides the WHO outlook on integration related issues and strategies for effective amalgamation of traditional medicines into the health systems.

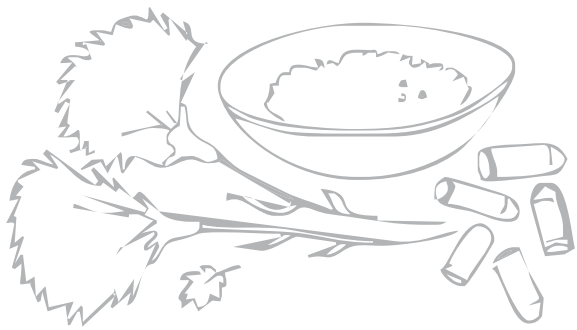


Table No. 2

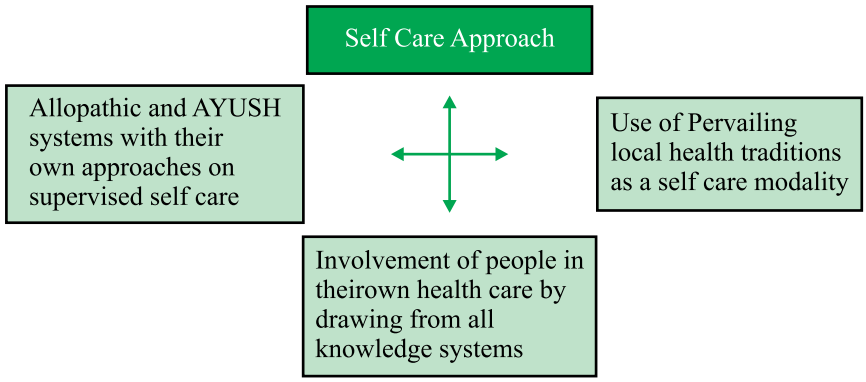
WHO Traditional Medicine Strategy 2002–2005 — objectives, components and expected outcomes		
Objectives	**Components**	**Expected Outcomes**
Policy: Integrate TM/CAM with national health care systems, as appropriate, by developing and implementing national TM/CAM policies and programmes	**1. Recognition of TM/CAM** Help countries to develop national policies and programmes on TM/CAM	1.1 Increased government support for TM/CAM, through comprehensive national policies on TM/CAM 1.2 Relevant TM/CAM integrated into national health care system services
	2. Protection and preservation of indigenous TM knowledge relating to health: Help countries to develop strategies to protect their indigenous TM knowledge	2.1 Increased recording and preservation of indigenous knowledge of TM, including development of digital TM libraries
Safety, Efficacy and Quality: Promote the safety, efficacy and quality of TM/CAM by expanding the knowledge base on TM/CAM, by providing guidance on regulatory and quality assurance standards	**3. Evidence base for TM/CAM:** Increase access to and extent of knowledge of the safety, efficacy and quality of TM/CAM, with an emphasis on priority health problems such as malaria and HIV/AIDS	3.1 Increased access to and extent of knowledge of TM/CAM through networking and exchange of accurate information 3.2 Technical reviews of research on use of TM/CAM for prevention, treatment and management of common diseases and conditions 3.3 Selective support for clinical research into use of TM/CAM for priority health problems such as malaria and HIV/AIDS, and common diseases
	4. Regulation of herbal medicines: Support countries to establish effective regulatory systems for registration and quality assurance of herbal medicines	4.1 National regulation of herbal medicines, including registration, established and implemented 4.2 Safety monitoring of herbal medicines and other TM/CAM products and therapies
	5. Guidelines on safety, efficacy and quality: Develop and support implementation of technical guidelines for ensuring the safety, efficacy and quality control of herbal medicines and other TM/CAM products and therapies	5.1 Technical guidelines and methodology for evaluating safety, efficacy and quality of TM/CAM 5.2 Criteria for evidence-based data on safety, efficacy and quality of TM/CAM therapies

WHO Traditional Medicine Strategy 2002–2005 — objectives, components and expected outcomes		
Objectives	**Components**	**Expected Outcomes**
ACCESS: Increase the availability and affordability of TM/CAM, as appropriate, with an emphasis on access for poor populations	**6. Recognition of role of TM/CAM practitioners in health care:** Promote recognition of role of TM/CAM practitioners in health care by encouraging interaction and dialogue between TM/CAM practitioners and allopathic practitioners	6.1 Criteria and indicators, where possible, to measure cost-effectiveness and equitable access to TM/CAM 6.2 Increased provision of appropriate TM/CAM through national health services 6.3 Increased number of national organizations of TM/CAM providers
	7. Protection of medicinal plants: Promote sustainable use and cultivation of medicinal plants	7.1 Guidelines for good agriculture practice in relation to medicinal plants 7.2. Sustainable use of medicinal plant resources
RATIONAL USE: Promote therapeutically sound use of appropriate TM/CAM by providers and consumers	**8. Proper use of TM/CAM by providers:** Increase capacity of TM/CAM providers to make proper use of TM/CAM products and therapies	8.1 Basic training in commonly used TM/CAM therapies for allopathic practitioners 8.2 Basic training in primary health care for TM practitioners
	9. Proper use of TM/CAM by consumers: Increase capacity of consumers to make informed decisions about use of TM/CAM products and therapies.	9.1 Reliable information for consumers on proper use of TM/CAM therapies 9.2 Improved communication between allopathic practitioners and their patients concerning use of TM/CAM

2 The Self-Care Approach as an Integrative Tool

Both the traditional and western biomedicine represent theory and practice for managing human health, the approaches differing in basic concepts but also converging on many aspects of healthy lifestyle and public health. Self-care is one such dimension. Healthy lifestyles and life patterns are recognized by both as the cornerstone of health.

- Self care can be for promotion of good health, prevention of disease or treatment of diseases, especially for early stages, simple acute and chronic problems or long-term illnesses requiring constant monitoring and medication.
- In the international and Indian health arena today, there are attempts to appropriate the concept of self-care for commercial gain. A people empowering self care approach requires that:
- Lay people understand their body and not only have access to, but also learn to digest and critically evaluate health-related information (from advertisements, newspapers, books, journals, internet, etc.) that could inform their activities. Appropriate information about all available systems would be useful for rational decision-making.



Self care can be both an individual strategy and a collective community activity.

- The desirability of empowering communities to take care of their health problems themselves has been raised since long. Often it is argued that self-care is an ingredient of the Primary Health Care strategy with its focus on peoples' health in peoples' hands.
- Self care is also central to all clinical interventions, as a way to involve people in their own health care. Better health care largely depends on the level of willingness and competence to engage in self care.
- Modern medical treatment for chronic illness requires intelligent monitoring and modulation of dosage etc. by the patient herself/himself and this is being incorporated into the current regimens for patient management. However it does not mean an open access to all medications over the counter.
- Sharing of experiences and information within the community and between sufferers of specific problems
- In India, like in many other low- and middle-income countries, vertical, hierarchical social structures prevail, creating an environment which allows for a greater power of the doctor, and is not very suitable for the self-care approach. But the roots of our culture strongly advocate for such an approach, with a strong foundation of the AYUSH systems of medicine and the local health traditions prevalent in our country. Moreover the self care approach would also serve as a common point of consensus

between various knowledge systems towards health care.

- Indian systems of medicine, homeopathy etc. lay strong emphasis on healthy lifestyles and diet regimens for a healthy living along with stress combating techniques for a healthy body and mind which forms an important dimension of self care.

Ayurveda is a system of health and well being that puts as desirable 'taking charge of your own health into your own hands'. Through knowing your body constitution and making use of the appropriate herbs and spices, fresh organic food, appropriate exercise, with a sensible daily routine you can live on a constant path of self-improvement in health and well-being. Similarly yoga and other systems also advocate this approach strongly.

3 Revitalizing Local Health Traditions

The local health traditions of India are ecosystem and community specific. They are autonomous and community rooted, yet they form the folk roots of the AYUSH. Communities transmit their health knowledge from one generation to the other through an oral tradition without the aid of schools and colleges, within families and within the guru-shishya paramparas of healers. Also, these are not static but in some ways adapt to changing times.

- It is estimated that there are around 1 million village based and community supported traditional healers in India (FRLHT, www.frlht.org.in, 15/12/2008). Strengthening use of home remedies and the traditional community health workers holds the key to self reliance of rural communities in primary health care. The task of strengthening or revitalization is however a complex sociological and educational endeavour. It involves documentation, rapid assessment and participatory research. Differentiating between the various types of healers (as discussed earlier) and their role in the present context is important to understand and define, so that malpractice and exploitation is curbed but barriers are not created for their services continuing to benefit the people.
- Medicinal plants and herbs form an important ingredient for the LHT and their declining availability is a serious concern. In the eleventh five year plan the Department of AYUSH has allocated a larger budget than ever before for an integrated development of medicinal plants and herbs. It is extremely important for policy makers and social activists to ensure that this budget line is creatively and effectively utilized.
- The National Medicinal Plant Board (NMPB), the State Medicinal Plant Boards (SMPB) and NRHM must work in collaboration to define guidelines to preserve the large medicinal fauna and their utilization in the primary health care. The 'Ayurveda gram yojna' being followed in a few states under the NRHM are the kind of innovations which must be assessed for effectiveness and the experience disseminated to other states to learn from. NGO role in this area like FRLHT and JJVS (Jan Jagran Vikas Samitis) must be explored and innovatively followed in the States. (Refer Annexture VI)

4 Administration of the AYUSH Sector

Although there are 18 directorates of AYUSH in various states they are not functioning independently and purposefully in most places. To harness the growing importance of AYUSH nationally and globally there is a need for political, administrative and financial systems to implement the policies and constantly review and update them.

- As per the National policy on ISM &H 2002, the state level secretaries and directors of AYUSH in major states are meant to oversee and facilitate the implementation of AYUSH services. However, managerial infrastructure at district and block level needs to be strengthened by the states through earmarked outlays. There is an immediate need to develop much more interaction and involvement strategies of this existing administrative structure of AYUSH.

- NRHM too has provisions to involve AYUSH personnel in the State and District Health Societies in all planning and monitoring activities which must be very seriously explored. A few States have initiated setting up of AYUSH cells in the NRHM Programme Management Unit (SPMU) or even for setting up separate SAMC for all AYUSH services (such as Rajasthan).
- Despite this large scale implementation of the strategies for mainstreaming AYUSH, there is very little documentation of the functioning of services of the AYUSH systems. Little is known about the issues of access, availability, quality of infrastructure, human resources, record keeping and HMIS of AYUSH services.

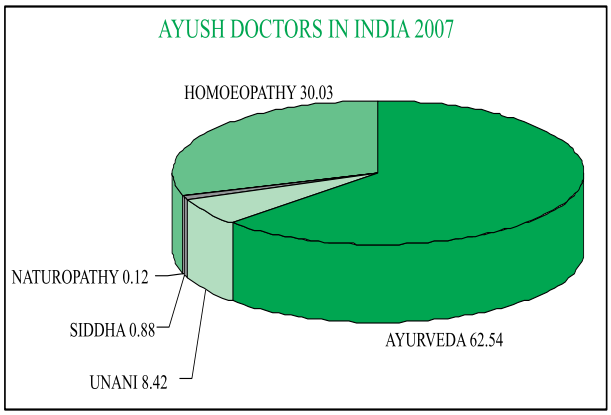
5 Intra AYUSH Integration and Public Health

- Constitution of AYUSH is an issue in itself as this acronym represents at least six different knowledge systems. Its use reflects the even greater bias of public health policy when it places these six together, against one i.e. Allopathy. Use of the acronym also masks the diversity among the health care systems that it represents. While there are some theoretical and therapeutic overlaps between some of these systems they remain as distinct knowledge systems with their own texts, training and professional associations. It is not their theory and practise that holds them together but their history, politics and epistemic commonality. Yet there is a diversity of theoretical foundations and principles even among them.
- Each of these systems has its own strengths and limitations, There are also significant variations within each system. Further they are not uniformly spread across the country. Ayurveda is a significant system dominant in Tamil Nadu, Kerala and almost across many states followed by Homeopathy and Siddha/Unani etc in the southern states, Yoga too is spread across while Amchi is confined to hilly areas specially Himachal Pardesh and Jammu &Kashmir etc. In North East and Jharkhand it's the tribal health traditions that are common.
- Does mainstreaming AYUSH take into account these differences among the systems across the country? It does, to the extent that the choice of the practitioner of which of the AYUSH systems is to be co-located depends on the traditional cultural preference of the local community (e.g. Siddha in Tamil Nadu, Ayurveda in Kerala and Uttarakhand, Unani in Kashmir and Ayurveda in Jammu, Amchi in Ladakh and the upper regions of Himachal Pardesh).
- However, there is a need for information sharing, developing guidelines and enabling structures for health care providers to facilitate and promote cross-referral across the AYUSH systems and with Allopathy.
- Public health care should be redefined to include the possibilities that these systems offer in order to promote health and prevent disease. Mainstreaming AYUSH and LHT therefore demands an understanding of public health going beyond the current allopathic perspectives that define public health in India so that once again an opportunity to optimise the strengths of the AYUSH systems towards better public health may not be lost.

6 Strengthening Technical Resources for AYUSH

- As per the provisional state wise distribution provided by the Department of AYUSH there are more practitioners of AYUSH in India.(registered practitioners in 2007 were 7,25,338) than of Allopathy (registered practitioners in 2007were 6,96747), (Central Bureau of Health Intelligence, National Health Profile, 2007)

  This widespread resource needs to be strengthened, retrained and utilized to effectively acquire its appropriate role and status within the health care delivery system of the country. Starting with, the AYUSH human resources within the public system would be appropriate, even though they are proportionately much less in the public services. This requires strengthening of



Source: Department of AYUSH, MOHFW, GOI

- Quality of professionals.
- Development of high performance in clinical services of respective systems through strengthening of infrastructure, logistics and working conditions.
- Development of public health orientation in professionals of these systems.

- The centers of excellence in AYUSH systems need to be identified. There are various reputed NGOs across the country as well as the national centers of the government for research in the various systems which can be effectively utilized for Continuing Medical Education of AYUSH professionals to provide quality services.
- An agency to examine issues pertaining to AYUSH paramedical professionals—their current status, level of skills, quality of training programs and service conditions at various levels be set up in collaboration with NRHM Directorate and the Dept. of AYUSH.
- The need seems to be also for making practitioners of other systems and the population aware of what AYUSH has to offer and how / where the services are available so that patients are referred to / go to use the expertise available to encourage its further development.

7 Academic Excellence in teaching

Education reform is one of the priority areas of the Department of AYUSH. The essential infrastructure required in AYUSH teaching institutions in terms of hospitals, laboratories, pharmacies, medicinal plant gardens and various teaching departments have to be prescribed under the minimum standards of UG/PG education. Well qualified and expert teaching faculty in a requisite number to be made mandatory to check the mushrooming of substandard AYUSH colleges. The Department of AYUSH, GOI is providing grants to AYUSH Colleges to develop them as model institutions. This activity is to be followed and monitored effectively.

- While there are large number of institutions imparting UG and PG education many of them lack the prescribed professional staff and clinical infrastructure due to sub critical investments and at times, poor vision. These lacunae naturally compromise the quality of AYUSH medical education and thus affect the quality of practitioners being produced by these institutions.
- The current teaching and research in AYUSH suffers from three main handicaps (Darshan Shankar, July-Sep 2008 *Health for the Millions on Mainstreaming AYUSH*), due to which they remain confined as side streams:

  First the unfamiliarity of teachers with basic philosophical and logical framework that underlie the AYUSH knowledge systems.

  Second is that they do not know the dialectic between systemic theory and structural theory and are thus unable to establish a comparative, constructive and balanced dialogue between AYUSH systems and Modern Science.

  The third major handicap is the lack of orientation in formal teaching of contemporary public health, and preventive and promotive health care needs of the society.
- Building confidence in their own system and in themselves should be an essential part of their education so that they are able to interact as equals with their allopathic colleagues, and be able to learn from each other without compromising on the principles of their system.
- Major policy decisions regarding the necessary changes in the curriculum must be made to make it much more applicable in the contemporary context.

8 Futuristic Research & Development

- The research programmes in the AYUSH sector although largely of a trans-disciplinary nature, are generally conceived in an epistemologically insensitive way. They generally tend to reduce the systemic parameters and concepts of AYUSH into the structural parameters of Allopathy. These programs are mostly located in Govt. institutions or in AYUSH Post Graduate medical colleges. There are also a few research centres in the private sector, some of them in allopathic hospitals, a few in leading pharmaceuticals companies and public trusts.
- Limitations in research on AYUSH:
  - Sub critical Inputs (Low Budgetary Support, Poor infrastructure)
  - Fragmented Efforts (Many areas-Little Focus)
  - Little Efforts with Traditional Approach
  - Limited Inputs of Modern (Western) Science &Technology
  - Lack of Rigour (QC & Standards: Inclusion/exclusion)
  - Re-establishment with Changed Scenario (Climate, Life-style)
  - Limited Efforts on pharmacopoeial Standards
  - Poorly Conducted Clinical Trials (Research Designs)
  - Little Appreciation of Statistical Methods
  - Some Efforts at Documentation of TK
  - Lack of Framework for IPR Protection
  - Limited Efforts at International Cooperation
- There are currently few research centres among AYUSH institutions which are wholly dedicated and focussed on fundamental research that is based on theoretical foundations of the AYUSH knowledge systems. This is a matter of serious concern for AYUSH because it can weaken the roots of the traditional systems.
- Practise based evidence generation is also a very important research area of concern to be seriously undertaken to optimize the available expertise in actual practise. While there are a large number of practitioners innovating clinical and delivery modes to suit the present context, there is little documentation of their efforts. This is an area needing urgent attention.
- Dialogue between the different AYUSH systems is needed for strengthening of their common epistemological roots, to generate theoretical advances within the systems based on these roots, and to give greater confidence to each of these systems. Dialogue even with other 'alternative medicine' systems would be useful. Further, dialogue is needed with Allopathy and with public health. ('Dialogue' implies an interaction of ideas between two views, with the assumption of equality between them.)
- AYUSH systems have proven strengths in many areas and official campaigns have been initiated for these, such as Geriatric Care, Mother & Child care, Ano rectal disorders, worm infestations and skin disorders. Dept of AYUSH is also working on the Golden Triangle Partnership project (GTP is a research initiative by the Department of AYUSH in collaboration with the CSIR and ICMR to bring safe, effective and standardized treatment for identified disease conditions of national /global importance with different research councils. TKDL (Traditional Knowledge Digital Library) is also a major initiative for safeguarding the traditional wisdom and Intellectual property in India by NISCAIR (National Institute of Science Communication & Information Resources).
- Initiatives like AYUSOFT software developed by CDAC (Centre for Development in Advanced Computing) in collaboration with Ayurveda experts for the practitioners, examples from renowned private practices in Homeopathy etc and Yoga must be taken into account before designing any research programmes.
- Whereas several research projects have been undertaken in the last three decades across the various AYUSH research councils including

project on malaria, filarial, anaemia, reproductive health, there is no critical report on the quality or impact of these projects on the health sector in India.

The policy makers too are blinded by the reductionist framework of modern science which has a very visible scheme of evidence, based on measurements of shape, size, weight, scales and rates of change of discrete structures (molecules, cells, tissues etc.). They have not been educated to understand the systemic framework of AYUSH, e.g. (the vata /pitta /kapha concepts of Ayurveda, Miasms of Homeopathy and Pranayama concept in Yoga) which cannot be measured on quantitative parameters as systemic entities can only be measured on qualitative parameters. Due to this epistemological insensitivity these systems are declared unscientific. Thus there is an urgent need to review the research areas and disseminate the relevant findings.

Conclusively, research in AYUSH can be broadly of 4 types:

- On drugs/therapeutics/ health promoters/ prevention;
- clinical diagnosis and management;
- relevance of AYUSH and mass application of the above;
- On quality of services.

Quality of research is poor due to —epistemic insensitivity and lack of public health orientation, quality of research institutions & research personnel, policy makers who provide funds to prioritised areas.

9 Legal issues pertaining to AYUSH and Local Health Traditions

In spite of the legal recognition of the AYUSH systems, there is a lot of scepticism prevailing regarding their scientific validation and extent of usefulness in the contemporary context. As discussed many a times in this report the epistemic insensitivity and ignorance has resulted in this scepticism which hails these scientific systems to be obsolete, placebo and quackery.

There is much confusion about the legality of practice of AYUSH and other related systems. This extends even more to cross practise between AYUSH and Allopathy. This is where there is great scope for innovatively designing mechanisms that allow optimal use of all systems with provision of access of services to all sections without compromising on a minimum standard as judged by the system being used.

This would require clear definitions of cross practice, quackery and malpractice as a first step.

While there is a section of AYUSH practitioners primarily using Allopathy to effectively provide services in underserved areas (Annexure VII), there are also many engaging in malpractice, and yet there still exist a large no. of AYUSH and traditional healers whose practice can stand a rigorous test of time and epistemologically conscious scientific validation.

Folk practitioners without any formal degree or certificate but with traditional knowledge and practices that are found beneficial by the communities they serve, and who do not claim to be a 'doctor' need a different form of recognition and regulation. This could be through mechanisms that involve 'registration' with the local panchayat (as initiated by the Rashtriya Guni Manch Annexure VI).

Where the patients or community makes a complaint of negative impacts of the services provided by any form of practitioner, whether Allopathic, AYUSH or Folk, an enquiry must be conducted and criminal proceedings undertaken.

The Act that defines "medical Practitioner" in the Indian Medical council Act to the MBBS degree holders, disqualifying the 7 lakh degree holders of AYUSH system - registered under the Indian Medicine Central council act 1970 and Central Council of Homeopathy act of 1972 of the Govt. of India should be reviewed.

Policy makers must address the issue of quackery legally in an immediate time frame, and disseminate adequate information on definition of quackery and its differentiation from these systems and practices.

Existing legal provisions given in Annexure -VII.

C. Implications for the Plans under NRHM

In the spirit of the NRHM- that has espoused the strategy of local, context specific interventions with flexible financing, community participation and adoption of evidence-based initiatives-- the mainstreaming of AYUSH and revitalising LHT should be understood in terms of their own inherent value as well as forming one of the frontiers of medical science today. It remains to be seen whether the States will be able to make use of the opportunity and to what extent.

Planning and implementation of the NRHM strategy related to AYUSH services varies greatly across states, dependant on the existing level of development of AYUSH services in the state, and the development emphasis of the state

Studies suggest a widespread utilisation of the LHT and AYUSH, but this seems to be largely outside the public sector services. Despite the existence of considerable resources of AYUSH workforce all over the country, they generally remain underutilized. However, the issues of why the public sector services remain underutilised needs to examined and addressed. The poor quality of infrastructure and human resources in the public AYUSH facilities, their low financing in absolute terms relative to that of the allopathic services, and the dominance of the modern medical paradigm which is ignorant about AYUSH and brand it as inferior or quackery or placebo are all likely explanations.

The objective of mainstreaming of AYUSH through co-location at PHCs and CHCs has inherent within it four possibilities:

- One, bringing the AYUSH graduates to strengthen the human resources situation at these facilities, primarily practicing Allopathy or at least working under its framework.
- Second possibility in the co-location is a way of correcting the architectural flaw in the present health care system, that of denying legitimacy to people's practices and local health traditions as well as to knowledge systems other than the dominant modern medicine (Allopathy).Modern medical science as well as the frontiers of practice of modern medicine has begun to recognise the value of these as TM (Traditional Medicine)/Complementary or Alternative Medicine (CAM). The colocation strategy provides choice to patients under one roof.
- Once this legitimacy is accepted, a third possibility opens up – of cross referrals across systems to utilization of the strengths of each for the benefits of patients and the health of communities.
- The fourth opportunity it provides is for mutual strengthening of the modern and AYUSH systems by an interaction between them. To implement the principle of equity and empowerment of AYUSH to play an effective role in Public Health, each system needs to be revitalized through constant reinterpretation and up scaled with use of modern technologies to understand its fundamentals.

However, if we are to learn from past experiences, then this new co-location strategy in its current format may become yet another instance of mere instrumental use of AYUSH to support the allopathic public health care system and use them as substitutes within an allopathic framework.

AYUSH systems can contribute to NRHM effectively only when their goals are seen to converge to a common point with the NRHM goals. While it is important that the dominant sections of the health services recognise the value and role of the AYUSH and LHT, it is equally important to challenge the AYUSH systems to find AYUSH solutions and strategies for contributing to the NRHM goals of strengthening maternal and child health services as well as preventive and curative measures as a whole. Only then will there be a meaningful mainstreaming of the AYUSH in the public health care system. It can then be a step toward an effective streamlining of AYUSH as vibrant systems.

Section – II

Planning for AYUSH & LHT Under NRHM

Analysis of State PIPs

(2007-08/08-09/09-10)

Planning for AYUSH and LHT under NRHM

1.1 The appointment of AYUSH doctors within primary health care facilities pre-dates the NRHM in several states, primarily as substitutes in the absence of an allopathic graduate. More formal planning for this co-location has been initiated under the NRHM.

1.2 AYUSH Component in the PIPs:

AYUSH components had been included in the NRHM PIPs of 24 of the states by 2008-09 (NRHM State Data Sheets 30/04/08) and in the year 2009-10 as many as 30 States and UTs (NRHM State Data Sheets 31/12/2008) have included these components. Most states are seized of the primary strategy and related activities that make up a Mainstreaming AYUSH plan and are struggling to put them in place. Often, various activities are mentioned in the PIPs but corresponding budgetary plans are not mentioned indicating inadequate operational planning.

1.2 The Programme Implementation Plans across the States follow a similar format for their plans based on the NRHM Finance Management Report guidelines. The plan is divided into 5 parts, each containing the specific strategies and activities:

Part A- deals with the RCH strategies and activities.

Part B- deals with the NRHM additionalities (focused on systems strengthening).

Part C- deals with Immunization related strategies.

Part D- deals with the National Disease Control Programs.

Part E- deals with Convergence

AYUSH & LHT are included in parts B (B-18 of Additionalities) and E of the PIPs. Some states have developed innovations beyond this and included them in other parts such as RCH (Part A).

1.3 The Department t of AYUSH has sent guidelines to the states for a separate PIP for AYUSH for the plan year 2009-10. It requires a Part A that deals with mainstreaming of AYUSH and Part B that deals with its streamlining and strengthening. Part A, deals with (i) Mainstreaming under NRHM, and (ii) the departments' activities for mainstreaming (see Annexure IV). The 2009-10 plans is the fourth PIP for the NRHM, and there has been a progressive increase in the AYUSH component over the years. A separate PIP for AYUSH, as per the Department's guidelines, will consolidate the gains and strengthen the planning and management of the AYUSH sector as a whole.

1.4 While AYUSH activities have been incorporated in almost all State PIPs, the significance of the LHT component has not yet found as much place.

The details of AYUSH components in each State PIP are given in Annexure-I. A consolidated Master chart for each category of states/UTs using data from the State NRHM data sheets of 31/12/2008 and from the PIPs is also given in Annexure-I. These master charts were consolidated into one national data set (Table-3)

Table No. 3

Mainstreaming AYUSH & Revitalizing Local health traditions in State PIPs (2007-10) & Quarterly State Reports (as on 31st Dec. 2008)					
ALL-INDIA					
Mainstreaming strategies	**High Focus States Non NE**	**NE**	**Non-High Focus**	**Small states and UTs**	**Total**
AYUSH Component in the PIPs	10/10	8/8	10/10	5/7	33/35
Institutions with AYUSH services co-located / Total no. of Institutions (as per the NRHM Quarterly State Data Sheets 31/12/08)					
D H	110/292	24/72	108/183	9/23	251/570 (44%)
CHC	413/1806	70/217	472/2007	15/15	970/4045 (24%)
PHC	2020/11132	118/1110	1743/10048	27/80	3908/22370 (17.5%)
3. Total AYUSH Doctors appointed as on 31.12.08	2888	447	1520	36	4891
4. Total AYUSH Paramedics appointed as on 31.12.08	865	31	34	4	934
5. Training of AYUSH Doctors					
a) SBA	5	0	1	0	6
b) IMNCI	2	0	1	0	3
c) NHP	9	5	5	3	22
d) AYUSH / CME/any other e.g Public Health Management	3	2	2	4	11
Integration with ASHA /ANM	8	0	3	2	13
Drugs & Equipments Procurement	9	6	7	4	26
Additional activities					
Specialty services/wings	8	3	3	3	17
School Health Programme	1	0	3	1	5
Tribal health linkages	5	0	0	0	5
IEC&BCC	8	4	4	2	18
LHT Promotion	6	2	1	0	9
Herbal Gardens in facilities	4	1	1	0	6
Village level	3	0	0	0	3
Outreach activities					
MMU with AYUSH	3	0	1 1 NA	0	4 1NA

Mainstreaming AYUSH & Revitalizing Local health traditions in State PIPs (2007-10) & Quarterly State Reports (as on 31st Dec. 2008)					
ALL-INDIA					
Mainstreaming strategies	**High Focus States Non NE**	**NE**	**Non-High Focus**	**Small states and UTs**	**Total**
AYUSH health Melas	9	2	3	1 1 NA	15 1 NA
Call Centres for AYUSH	1	1	0	0	2
AYUSH Management Strengthening	6	2	8	0	16
AYUSH Technical Strengthening	7	4	7	1	19
Total AYUSH budgets in the PIPs (07-10)	23002.33 Lakhs 1 NA	14737.9 Lakhs 1 NA	23504.78 Lakhs	2392.71 Lakhs 1 NA	63637.72 LAKHS 3 NA
% of AYUSH budget in NRHM	1-3%- 6 3-10%-1 >10 %-2 1 NA	1-3%-3 3-10%-2 >10 %-2 1 NA	1-3%-6 3-10%-2 >10 %-2	1-3%-1 3-10%-0 >10 %-5 1 NA	1-3%- 16 3-10%- 4 >10%- 12 3 NA

The following table provides an analysis across states using the PIP analysis, the quarterly state NRHM implementation reports as on 31/12/2008 (i.e. the data in the master charts) and the Common Review Mission findings. It helps identify the major gaps in planning and implementation.

Table No. 4

	Activities Planned	Gaps
A	**Mainstreaming at PHC/CHC/DH levels** **(Co-location Strategy):** The contractual appointment of AYUSH doctors in PHC/CHC/DH is one of the most promptly followed activities in almost all states, under NRHM. Recruitment of AYUSH doctors in huge numbers on contractual basis (4891) and AYUSH paramedics (934) has been achieved so far (as per the State Data Sheets 31/12/2008 based on their quarterly reports.) Some states are posting an AYUSH doctor at all DHs; Rajasthan and Andhra Pradesh have posted two doctors per hospital. Most states are posting AYUSH practitioners at CHCs but one as against the two posts prescribed by the IPHS. A large number of AYUSH doctors are posted at PHCs, but it is only at 17.5% of PHCs, as against 24% CHCs and 44% DHs, It is also still to go far to reach the 50% of PHCs that has been specified by the NRHM. Postings at PHCs is high in 13of the 35 States and UTs. The state NRHM PIPs show that, while in 2007-08 many states had no plans for this activity, all states have included it in 2008-09, and further progress in appointments and co-location is underway in 2009-10. States strong in services of the AYUSH systems, such as Kerala, Gujarat, Rajasthan, Himachal Pradesh and J&K are showing variations in adoption of co-location, from reluctance to co-locate while continuing to strengthen the parallel services (as by Kerala) to varying degrees of roll out of the recruitment of AYUSH doctors for PHCs and CHCs. Amongst the High focus states the maximum no. of co-locations are reported in Orissa followed by Rajasthan, J&K, Uttarakhand & Chhattisgarh. U.P & Bihar have still not started with the co-locations though Bihar has planned for 1 AYUSH MO at 50% of PHCs & 100% APHCs. J&K and Rajasthan also report the appointing of a fair number of paramedics. States like Andhra are appointing AYUSH doctors as per the local preference of the AYUSH systems i.e. in some areas Ayurveda doctors and in others Unani and Homeopathic doctors.	1. ***Assessment of the no. of AYUSH personnel against the no. of facilities:*** The State data sheets (Dec 2008) show a large variation in the figures given for institutions with AYUSH services as against the figures for no. of AYUSH doctors appointed. Part of the discrepancy is because of pre NRHM appointment of AYUSH practitioners in some states. 2. ***Assessment against implementation of previous plan*:** The State PIPs do not clearly mention the activities planned in the previous year which could not get implemented and the reasons.. If they are being carried over and more activities planned for the next year, the State plans to ensure implementation is not clearly indicated. 3. ***Assessment of the roles of AYUSH practitioners:*** Although the IPHS lays down the presence of AYUSH personnel at various levels of Primary Health Care, mentioning provision of 'preventive, promotive and curative health care' (Annex -2) and implementation of the NHP, there is a lack of clarity in the extent to which they are expected to use their own system and Allopathy. *There is an immediate need to define roles of AYUSH MOs posted at each level. There is no information about any guidelines by the states or by NRHM, except those stated in the IPHS.* It has been reported, by the CRM (in Orissa, Maharashtra and Uttar Pradesh among other states) that AYUSH doctors are working in the PHCs more as a form of 'substitution' (of the MBBS doctors) rather than as a form of co-location. 4. There is little information on the quality of AYUSH services in the co-located facilities.

	Activities Planned	Gaps
B	**Training of AYUSH Doctors/Paramedics:** The IPHS mentions training of AYUSH doctors in imparting health services related to national health &family welfare programmes. 22 States have planned training in NHPs. Most of the training activities are mentioned in the PIPs under the mainstreaming component in part B (NRHM additionalities) or in part E (Convergence). In some of the state PIPs e.g. Chhattisgarh, H.P., Orissa, U.P, Uttarakhand and Karnataka training of AYUSH doctors in SBA and IMNCI have been stated under either the RCH or Convergence . Till 2007-08/09 not many states had planned training in the CME/Public Health management/ NRHM & Mainstreaming strategy for AYUSH, but in 2009-10, many states like Chhattisgarh, Haryana, Karnataka, and Uttarakhand have planned such trainings of AYUSH doctors.	**Gaps in the no. of AYUSH personnel recruited and trained:** Neither the PIPs nor the reports reflect the no. of AYUSH manpower trained against the no. recruited, and therefore do not allow assessment of the adequacy of planning and budgetary provision for this crucial activity. Role definition after the mentioned trainings is a major gap, as many legal issues are relevant here which are not being given adequate attention, e.g. AYUSH doctors training in SBA and following use of episiotomy, injections, medicines etc. The States that have not planned for training of the co-located Doctors in public health management and NRHM require togive immediate attention in this area of capacity building.
C	**Involvement of ASHAs & ANMs in use of AYUSH & LHT (Integration with ASHA/ANMs):** Provision of training in AYUSH component to ASHA and AYUSH medicines in the drug kit has been planned in the NRHM framework for implementation, and many of the state PIPs mention the training of ASHAs (such as of the ASHA in Madhya Pardesh, the Mitanin in Chhattisgarh, Sahiyya in Jharkhand). As per the State data sheets 31/12/2008, AYUSH personnel have been included in ASHA training in 21 States. Orissa state PIP mentions supportive supervision by Block level AYUSH doctors in the ASHA programme. Provision of Ayurveda iron supplement (Punarnavadi mandoor) in the drug kit has been stated in some PIPs. Inclusion of training component on local health traditions amongst the ASHAs recruited in various states is found in PIPs of some states such as Chhattisgarh (Ayurvedgram & Mitanins), M.P (Dadi ma ka batua), and Jharkhand but is not reflected in most of them. Involving Mitanins in Chhattisgarh in the Ayurvedgram Yojna is also a good initiative for other states to follow.	If an AYUSH doctor is not involved in the training of ASHAs in some states, this needs to be corrected. Complex drugs in the drug kit e.g. of Homeopathy, would require extensive training inputs and would be difficult for use by the ASHA, but the use of commonly available herbal remedies and preventives can be promoted by her. Other drugless and simple home remedies under AYUSH could also be thought of. The ASHA training module does have a chapter on home remedies, but its implementation in primary health care delivery is not reflected in the PIPs or CRM reports. Local knowledge of the village must be incorporated in the ASHAs training in order to strengthen or re-establish people's own knowledge and practices that are safe and of proven value. This would require District level identification of 5-10 locally used medicinal plants that could be included in the training, and not preparation of a national level universal list. ASHA's awareness regarding the availability of AYUSH services so as to appropriately refer people to AYUSH services is as important as her knowledge of the nearest Allopathic facility. This is a major gap to be filled in all states. • No. of ASHAs given AYUSH training is not reflected in the state data sheets of NRHM. • No. of ASHAs given AYUSH drugs in the drug kit is not mentioned.

	Activities Planned	Gaps
D	**Drug & Equipment:** The IPHS mentions of a drug list for all the AYUSH Systems separately (Annexure -IV). The drug list mentioned in the IPHS is common for both PHC and CHC. No mention of the list of the equipments for speciality clinics set up at the CHCs in the state PIPs or the IPHS. Unlike the previous years, a few of the states have mentioned drug provisions for the co-located PHC/CHC/DH in the PIP for 2009-10.	There is nothing in the state PIPs about ensuring adequate supplies of drugs. Also, it needs to be ensured that the supply corresponds to the system of the AYUSH doctor co-located at the facility. Information about the no. of outdoor and indoor patients receiving AYUSH treatment in the co-located hospitals/ health centre would be necessary to assess/plan the adequacy of drug availability. Information on bed occupancy ratio would also help. The budget plans for AYUSH drugs and equipment should be fully mentioned in the PIPs. Apart from the pharmacy drugs the co-located doctors must be trained in use of local medicinal plants and the proposed herbal gardens in the facility as per the IPHS. This is a major gap as far as the use of drugs is concerned as medicinal plants form the backbone of the AYUSH sector.
E	**AYUSH doctors role in planning, and administrative bodies:** The NRHM framework has State Health Societies [SHS], District Health Societies [DHS], and Rogi Kalyan Samities [RKS], for the planning, management and monitoring of various activities at each level. Guidelines for the composition of these bodies include the AYUSH doctor as a member. The NRHM state data sheets of December 2008 show that 27 States have included AYUSH officers in the Health Society, 24 states have added them in the State Health Mission and Rogi Kalyan Samitis.	Not many State PIPs mention of such inclusion of the AYUSH doctor in the planning and administrative bodies. In the states where they are members, the level of attendance in meetings and degree of involvement would be important to know so as to assess the effectiveness of their participation.
F	**Additional activities:** Other than the co-locations, many of the states are undertaking some noticeable activities for mainstreaming AYUSH as per the awareness and prevalence of the AYUSH system in the area. i) **IEC/BCC sensitization activities for AYUSH & LHT:** Many of the state PIPs mention the I.E.C/ BCC activities about AYUSH and the budgets allocated for the activity. AYUSH health melas mentioned in many State PIPs, e.g. J&K, Himachal Pradesh, A.P., Rajasthan, and Punjab all mention some or the other such activity.	Though many activities are carried out as per the state demands and local preferences, planning, monitoring and management of these activities are not clearly stated in the PIPs. The budget allocated for such activities is also not clearly demarcated in many PIPs, indicating a lack of seriousness about this activity. It is also important for tracking the effective implementation of the activities planned. IEC/BCC activities need to be planned and implemented on a much larger scale and in a systematic manner as per States requirements. National guidelines for innovative IEC/BCC activities may be prepared by the Department of AYUSH in collaboration with NIHFW in priority areas of intervention for AYUSH.

	Activities Planned	Gaps
	ii) **Speciality clinics/wards:** Half the states mention special AYUSH clinics or wards. Opening up of a Ksharasutra therapy wing for Ano- rectal diseases and Panchkarma clinics for intensive and specialized treatment at the CHC and District hospitals is followed in many states with relatively good Ayurveda infrastructure, like Gujarat, Rajasthan, Uttarakhand, Himachal, and Kerala. Additional paramedics have been appointed to assist the AYUSH doctors in the states following this activity.	The equipments/drugs and the manpower needed for functioning of these specialty clinics is not mentioned clearly in the PIPs. Even if not financed by the NRHM route, it would be good to reflect the activity in the plans so that convergence is facilitated.
	iii) **AYUSH health programmes:** Several States are implementing the various national campaigns and schemes initiated by the department of AYUSH such as Geriatric Campaign, Mother & Child Homeopathy campaign and Kshar sutra campaign. States like Orissa, Punjab, and Andhra Pradesh write in the PIPs about the School Yoga Programmes and Yoga camps. Tripura PIP also mentions of sensitization of Primary school teachers regarding importance of yoga. 'Suposhanam', the Special nutrition programme for the tribal women is stated in the Rajasthan PIP. Ayurveda Mobile Units is also an activity mentioned in the Rajasthan state PIP.	There is still a lack of information about these schemes and campaigns in the States. Sharing of additional activities across states would also be useful. Exposure to the possible innovations would allow other states to plan those suitable for their context.
	iv) **Outreach activities:** This year some states, such as Jharkhand, Himachal Pradesh, J&K and Orissa have mentioned utilization of AYUSH doctors for the Mobile Medical Units. Call centres for AYUSH in M.P & Tripura is a major innovation mentioned in the PIP.	The Mobile units under NRHM in Orissa are all manned by AYUSH doctors. Their roles in such a service need to be clarified. To improve access to AYUSH services, much more concrete planning for outreach activities must be done.
	v) **Establishment of AYUSH epidemic cells**: TN and Kerala are using AYUSH in public health for preventive activities and epidemic control, e.g. homeopathy for responding to the Chikungunya outbreaks. RAECH (Rapid action epidemic cell of homeopathy) in Kerala is a major AYUSH activity highlighted in the state PIP.	This is an important innovation since there is no mechanism at present under NRHM to ensure quality of implementation of the co-located AYUSH component or for technical supervision.

	Activities Planned	Gaps
	vi) **Local health traditions:** One of the goals of NRHM is revitalizing the Local Health Traditions. The IPHS (see annexure -IV) prescribes the setting up of a herbal garden within the space available in the Sub centre and PHC premises. Most state PIPs have not mentioned this activity in particular. However the Chhattisgarh PIP has mentioned an innovative activity--the 'Ayurveda Gram" concept (Annexure-V). This concept got initiated by the directorate of ISM and NRHM is promoting its operationalization. "*Dadi ma ka batua*" is another innovative scheme stated in the J&K PIPs, which plans to involve traditional home remedies and in the AYUSH drug kit .This year Madhya Pardesh has innovation called as *Gyaan ki Potli* which too plans to include prevalent and useful local health traditions /remedies which are accessible and affordable for various ailments as a step forward for LHT revitalization. States like Haryana have also planned for courses on Local health traditions for the unemployed youth. vii) **Management and Technical Strengthening:** Almost half the states have planned some or the other kinds of management and technical support to the AYUSH services. Strengthening technical support in the form of research and development to management support in the form of monitoring cell in Rajasthan are some of the activities states are taking up. States like Rajasthan mention in the PIPs of year 2008-09 about the formation of the State AYUSH Monitoring Cell (SAMC) for AYUSH services. Chhattisgarh too has a separate technical wing in the SHSRC for AYUSH. On a similar pattern, Kerala, Jharkhand, Mizoram, Tripura Delhi and Goa, have planned for establishing a resource centre or a cell for AYUSH.	Only 9 State PIPs mention this activity. A few which do mention it, do not reflect any micro-planning or strategies to implement the activities under this head. VHSCs have yet not been sensitized to the activities for revitalizing LHT. The states that plan for LHT related activities do so as a separate head and do not relate it strategically to the mainstreaming of AYUSH and involvement of AYUSH doctors. Herbal gardens in the facilities is a major step to revitalize one dimension of LHT i.e. use of medicinal plants which must be adequately planned in line with colocation, local herbalists must be clubbed with the colocated practitioners for effective use of their medicines., e.g. gunis in rajasthan, vaidus in H.P. etc. Non-governmental organizations, such as Foundation for Research in Community Health (Bangalore) and the Rashtriya Guni Manch of the Jagran Jan Vikas Samiti (Udaipur), have undertaken extensive activities for strengthening of the LHT (see annexure-VI for their activities). They can provide good practices to States or States can partner with NGOs to operationalise this component. Specific strategies and activities need to be planned under this head with focused attention to the quality of service delivery to facility functionality. HMIS plan for AYUSH needs to be put in place after technical inputs. The PIPs lack in micro planning related to strengthening these major heads. Much more coordination is required to effectively implement the plans of the states in this regard.

Summarising the Analysis

From the above analysis across the states and Union Territories, a general conclusion that can be drawn is that the strategies of Mainstreaming AYUSH and Revitalizing Local Health Traditions are receiving greater attention under the NRHM than they had before, but the initiatives have not received adequate thought and a lot more still needs to be done to aid in strengthening their planning and implementation. Some States have initiated this component only in 2009-10.

Co-location of AYUSH services in the rural primary and secondary level health facilities is the major strategy. However, examples of several other services as well as supportive measures that have been planned and implemented are also available. Focus on the LHT is still weak in most states.

Not enough is known about the role and quality of the co-located services.

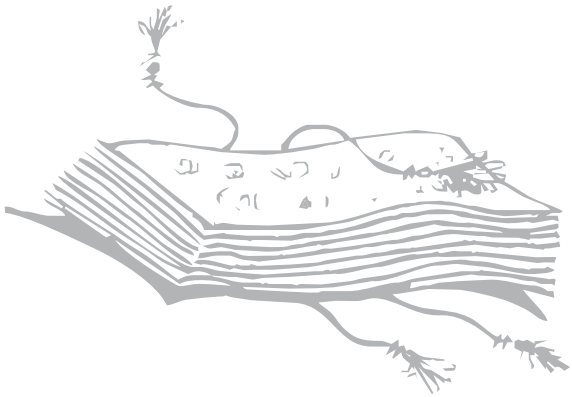
The 2nd CRM Report has made specific recommendations:

- "Mainstreaming AYUSH is not merely mainstreaming the AYUSH provider" but to provide users with a greater choice of services by having the AYUSH service providers in the same facility; not to use them as additional allopathic care providers.
- Wherever an AYUSH doctor is being used as a substitute for an Allopathic doctor, there is a need to specify through standard protocols the level of care that can be provided by them and give them training and legal framework for such care as per the prevailing legal provisions in the State.

Unfortunately, few States have planned for AYUSH and LHT as part of a comprehensive, integrated and decentralized health care system. Rather, 'mainstreaming' seems to be viewed as another stand alone activity. As the planning processes get progressively strengthened, it is to be hoped that a more systemic view will emerge.

Section – III

Budgetary Allocation



Financing AYUSH

1.1 Since the First Five Year Plan AYUSH has been getting only 2-4% of the National Health Budget. In the Xth plan, the cumulative expenditure of the Department of AYUSH was approximately Rs.1100crores. This is 2.75% of around Rs.40, 000 crores that was spent for the allopathic sector. Even in the XIth plan, the outlay for AYUSH (around Rs.5000 crores) is still less than 3% of the health budget for the allopathic sector (120,000 crores).

1.2 The National Health Policy on ISM&H 2002 had recommended that the allocation to AYUSH be raised to 10% of the total health plan at the Central level and further growth to be designed to climb at the rate of 5% in every five year plan.

1.3 Budgetary allocations for AYUSH mainstreaming activities under NRHM come both from the NRHM flexi pool and the AYUSH department.

NRHM provides for contractual appointment of doctors and paramedics whereas the Department of AYUSH, GOI provides for buildings, equipments & drugs. The Centrally sponsored scheme for Hospitals and Dispensaries by the Dept of AYUSH provides assistance to the eligible hospitals/polyclinics/including medical college hospitals for making required alteration /partitioning/repair etc. in the existing building, equipment& furniture, special medicines, training of medical & paramedical staff required for the purpose and for meeting small contingent expenditure. No new construction activity has been included in the scheme. Funds are provided in the Plan period for purchase of essential equipment, furniture, stationary, consumables and medicines. Lump sum assistance for meeting contingent expenditure are planned to be given proportionately on implementation of the project.

Table No. – 5

Central Budget Allocations for AYUSH and NRHM from the Dept. of AYUSH & NRHM Flexi pool (2006-07 to 2008-09).									
Year	**2006-2007**			**2007-2008**			**2008-09**		
Budget Heads	Plan	Non plan	Total	Plan	Non Plan	Total	Plan	Non plan	Total
Total AYUSH (Hospitals& Dispensaries)	280.94 crores	71.30 crores	352.24 crores	434.20 crores	75.41 crores	509.61 crores	-	-	NA
Total NRHM	-	-	18640.64 crores	-	-	21993.55 crores	-	-	16733.91 crores
NRHM Budget from the AYUSH dept.	60.07 crores	0	60.07 crores	108.00 crores	0	108.00 crores	-	-	NA
NRHM Flexi pool for AYUSH	-	-	50.10 crores	-	-	50.42 crores	-	-	70.146 crores

Sources: Notes on demands for Grants, 2007-08 Department of AYUSH, MOHFW and NRHM Quarterly State Data Sheets -Status as on 30th April 2008 (latest available in December 2008).

Overall Budget analysis[1]

- The Central allocation from the Department of AYUSH GOI was available only for the years 2006-07 and 2007-08. Compared to this, it is clear that NRHM funds have multiplied the Centre's contribution to AYUSH services in the States to varying degrees, with an increase ranging from 2-100 times.
- Clarity about the NRHM budget component and AYUSH Dept. component is lacking in the PIPs and almost none of the states except a few from last year and this year have clearly demarcated the funds under these two budget heads.
- Over the three years there is an increasing trend in allocation for Mainstreaming with increase in the 'High focus non-NE' states in 2008-09 and NE States in the year 2009-10.
- Some of those with good infrastructure have used NRHM funds for further strengthening the activities, others which are beginning to initiate AYUSH activities such as the union territories and a few small non high focus states have used a large proportion of NRHM funds (over one-fourth) for this component.
- The EAG states data seem to have 2 sets of figures on the allocation %, one less than 3% and the other in the range of 7-18% .There is an increase in the allocations in the year 2008-09. The lower allocations in the year 2009-10 are probably the unspent budget spilling over.
- States such as Himachal Pradesh, Madhya Pradesh and Uttarakhand with 7-18% of allocations are those which already have a fairly large infrastructure of AYUSH services; however states like Rajasthan & Orissa in spite of having good AYUSH infrastructure have used less of NRHM funds for Mainstreaming activities.
- States like Chhattisgarh, Madhya Pradesh and Jharkhand have allocated separately for activities towards revitalizing Local Health Traditions unlike other states who have not planned for this head.
- In the North Eastern States there has been a marked increase in the allocations in the year 2009-10 with Mizoram and Tripura allocating 4 and 7% respectively and the remaining 4 states (barring Meghalaya) with 1-3%. These states already have a better level of existing AYUSH infrastructure. Meghalaya with over 30% allocation but weak NRHM and health systems planning performance in AYUSH & Allopathy requires a review of utilization to assess the value of this high allocation.
- In the Non High Focus Large States 0-3% allocation is seen in 6 States, 3-10% in 2 states and above 10 in the remaining two States. West Bengal has the lowest allocation of 0.1%. Almost no activity has been planned under this head even when the State has fairly weak AYUSH infrastructure in the public health system. Maharashtra, with only 0.2% allocation on the other hand, has the largest AYUSH infrastructure in the country. Goa reflects very high allocations in the year 2009-10 with limited AYUSH infrastructure.
- In the Union Territories and Small non high focus States high allocations are made in the year 2009-10. Delhi allocated 1% of its NRHM budget in spite of large infrastructure, Puducherry and Dadar & Nagar Haveli show 3-10% allo-

1 Methodology adopted for the above analysis: (Please refer the All-India data sheet in the previous chapter, and the master charts for each category of States/UTs in Annexure-I).

i) NRHM PIP proposals are taken as proxy for allocations since ROPs do not give the allocation under this head. The Dept. of AYUSH also was unable to provide any further budgetary details.

ii) The expenditure is not available and not indicated in the PIPs of next year. However the proposed allocation presumably takes the unspent amount of the previous year into account.

iii) Therefore we have taken the aggregate allocation of all years for which data was available.

iv) The % of total NRHM budget that has been allocated to AYUSH & LHT has been computed as the aggregate of the years for which data was available.

v) As stated above, breakup of budgetary source (NRHM & Dept. of AYUSH) is not always clear.

vi) The % allocations across the years for the purpose of analysis have been divided into three categories as 0-3 %, 3-10% and above 10%.

cation. Chandigarh allocated 13%, Andaman & Nicobar Islands and Daman & Diu more than 20% over the years.

- A lot more inputs and analysis are required for budget tracking at the state and central level of AYUSH, apart from the NRHM funds for enhancing the planning process and its implementation. NHSRC Finance Division and the department of AYUSH may make efforts in collaboration to design a mechanism for budget tracking across the states to aid in proper planning strategies for mainstreaming AYUSH.

AYUSH Budget under NRHM PIPs: 2009-10

State	Budget proposed in Final PIP*(in lakhs)	Budget approved in NPCC** (in lakhs)	Remarks in ROP
High focus states			
Bihar	3915.85	3915.85	
Chhattisgarh	424.27	424.27	
Jharkhand	132.97	129.37	Budget for mobility support not approved
Madhya Pradesh	2120.00	1730.00	
Orissa	307.69	307.69	
Rajasthan	1625.22	1625.22	
Uttar Pradesh	4150.08	4150.08	
Uttarakhand	11.30	532.40	As per supplementary to ROP
Himachal Pradesh	521.5	NA	
Jammu & Kashmir	1382.85	107.59	Support to ISM Dept. through AMG, untied funds not approved
North Eastern States			
Arunachal Pradesh	124.20	174.60	
Assam	707.28	601.68	
Manipur	707.28	601.68	
Meghalaya	162.48	159.24	
Mizoram	18.0	18.00	
Nagaland	45.90	45.90	
Sikkim	13.80	13.80	
Tripura	567.661	354.941	
Other States			
Andhra Pradesh	1722.10	1722.10	
Delhi	1.70	1.70	
Goa	510.43	166.62	Activities other than Human Resource not approved
Gujarat	1541.40	1476.54	(Hospital component transferred to Dept. of AYUSH)
Haryana	559.36	456.14	
Karnataka	1322.53	1322.53	
Kerala	983.77	983.77	
Punjab	200	0	Funding transferred to Dept. of AYUSH
Maharashtra	607.98	0	State asked for support at SDH/DH level. NRHM support- PHC/CHC level.
Tamil Nadu	701.10	701.10	
West Bengal	NA?	NA	
Grand Total	**25088.7**	**21722.81**	

* Proposed budget in the PIPs presented to sub-committee given in Annexure –I. After the Sub- committee discussion the States revised the PIPs and final version was presented in the NPCC.

**Budget approved for NRHM AYUSH component as given in the NPCC Record of Proceedings.

Section – IV

A Mapping of Technical Assistance Needs for Mainstreaming AYUSH & Revitalizing Local Health Traditions under NRHM

Technical Inputs for Strengthening AYUSH and LHT Initiatives to Meet NRHM Objectives

The primary basis of this identification of Technical Assistance needs is

i) The analysis of State PIPs against the NRHM framework of implementation and the IPHS, and

ii) Findings of the two Common Review Missions that have assessed progress of implementation of the NRHM (Nov.-Dec. 2007and 2008).

The analysis took into consideration the backdrop of the pre-existing AYUSH infrastructure and services in the state. In addition to the set of activities proposed under mainstreaming AYUSH by the NRHM framework of implementation, several other planning bodies have made additional recommendations. -- Annual reports from the Department of AYUSH, the Planning Commission Task Force on AYUSH for the Xth and XIth plans, Steering Committee on AYUSH subgroup on Public Health, National Mission on Medicinal Plants(Operational guidelines), National Policy on ISM & H (2002), Report of the National Commission on Macroeconomics & Health (August 2005), Independent Commission for Development and Health in India (ICDHI) representing civil society and reputed NGOs in the field of AYUSH were used to identify several supportive activities that would be necessary to optimize outputs and outcomes of the NRHM strategies.

Table No. 6

Sl. No.	TA task needs	TA task Description	TA task Modality
1.	Assessment of the roles being performed and services delivered by the AYUSH personnel under NRHM and in the public health system as a whole.	A survey for assessing • The no. of AYUSH personnel in position at co-located facilities • The roles performed by the co-located AYUSH personnel. • Patient satisfaction. • Community need for AYUSH services • Lacunae in service delivery.	The survey may be conducted in all the states collaboratively by the NHSRC and the Department of AYUSH. This is already in progress.
2.	Issuing guidelines to states to define the service inputs by AYUSH doctors in co-located facilities towards fulfilling the service guarantees and strategic operationalization of positioning AYUSH in Public Health System.	To clearly define the roles of practitioners of various systems within the health care system as a whole and of the co-located practitioners under NRHM more specifically, given the objective of strengthening of the health system at all levels. The legal issues involved will need consideration and some policy decisions need to be taken in this regard. To strengthen State Health Missions particularly in RCH and District Health Societies in AYUSH activities.	A technical consultative committee could be formed with members from Dept of AYUSH, Dept of Health & FW and NHSRC to take policy decisions regarding roles of AYUSH doctors in NHPs, RCH programmes etc. To operationalise the defined roles, a manual could be prepared in collaboration with the Dept. of AYUSH and NHSRC for AYUSH doctors on their responsibilities. Another manual would be needed for sensitization of allopathic doctors, nurses and paramedics about the strengths of AYUSH systems and the mainstreaming strategy of NRHM.
3.	Training and capacity building of AYUSH personnel for National Health Programmes and Public Health needs to be well defined.	Appropriate guidelines on training to be framed based on the roles identified.	Department of AYUSH and NIHFW to develop general guidelines on content of training programs for AYUSH in Public Health which must then be directed to the states to follow as per their requirements.
4.	Orientation of the Health personnel other than of the AYUSH systems for sensitizing them towards AYUSH and the local health traditions.	Developing guidelines for orientation programmes to sensitize the allopathic doctors, nurses and paramedics about the strengths and role of AYUSH systems and LHT in the health care delivery system.	Department of AYUSH and NIHFW need to develop common guidelines on training issues which must then be directed to the states to follow as per their requirements.
5.	Quality Monitoring of AYUSH Services	Setting up systems to look after the two key areas i) AYUSH in the HMIS ii) Monitoring to include both the technical and the management components.	Department of AYUSH and NHSRC to collaboratively identify the data elements & indicators for AYUSH services.

Sl. No.	TA task needs	TA task Description	TA task Modality
6.	To ensure adequate planning and inputs of AYUSH systems and LHT at each facility level and within the district and state health planning process.	Participation of AYUSH doctors in the management and governance bodies at each level (SHS/DHA, RKS, and VHSCs). Consideration of the assessment of quality of AYUSH services should be included in the planning process and activities planned to fill the gaps for providing quality services.	Instructions need to be issued from the NRHM directorate for compliance with guidelines for composition of the respective bodies, and to involve AYUSH members in the decision making processes. Orientation training for the AYUSH doctors in public health, management and governance issue will make their contribution more meaningful.
7.	Improving the quality of professionals of AYUSH	Involving AYUSH institutions (both colleges and reputed NGOs) in the management of rural hospitals/health centers where co-location is envisaged.	An agency to examine the issues involved in general and specifically in context of each state. Directorate of NRHM, in collaboration with the Department of AYUSH could set up a task force on reviewing and upgrading education in AYUSH colleges and services offered in AYUSH institutions.
8.	To identify the maximum potential inputs of AYUSH for contributing to services guaranteed at each facility level and integrating them into respective components, such as provision of basic and specialized care at primary and secondary level facilities, maternal health and child health.	To use the findings of studies already existing on the efficacy of specific AYUSH and LHT preventive methods and therapies, as well as invest in focused action research projects in order to establish viability of AYUSH solutions for NRHM goals.	Action plans to be framed by NRHM in collaboration with the various research councils under the Department of AYUSH [CCRAS, CCRH, CCRYN, and CCRUM] and reputed NGOs working in this field. Supporting small pilot projects in specific states via NGO-government partnership, to demonstrate the ways to add value to the co-location strategy by designing and implementing training modules for Doctors and health workers on integrative Medicine.
9.	Role of ASHA needs to be enriched and augmented in the context of use of and referral to AYUSH services as well as revitalizing LHT.	A matrix needs to be developed for various common health problems and options/alternatives for prevention and treatment from various systems. There is a need to develop a consensus list of inputs the ASHA can give. Use of locally available medicinal plants and herbs must be included in the ASHA training. Various uncomplicated, drugless therapies under AYUSH (e.g. yoga/acupressure/puncture) should also be considered.	The ASHA Mentoring Group could form a sub-group to take special inputs from AYUSH experts from the national colleges/ research councils/ centers of excellence in the NGO sector to develop the guidelines and module. States should similarly adapt these at local levels for ASHA training and drug kit suited to local/district specific context. District level local home/ herbal remedies should be identitified and the ASHA should be taught to recognize and use them.

Sl. No.	TA task needs	TA task Description	TA task Modality
10.	Integration of LHT with AYUSH institutions at a mass level so as to fulfill the NRHM goal of revitalizing local health traditions.	Develop guidelines for implementation of the IPHS requirement of growing medicinal plants in the sub-centre and PHC compound. Review international, State and NGO experience to optimize the involvement of local healers, herbal plants and their cultivation. Examples from various states on innovations with regard to LHT could be considered..	Collaborative efforts by NHSRC, civil society organizations and the National Medicinal Plant Board, could be under the centrally sponsored scheme of national mission on medicinal plants.
11.	Mainstreaming of AYUSH and revitalization of local health traditions need to be strategically planned in an integrated and comprehensive manner.	The continuum from people's practices, local health traditions to AYUSH services provided at PHCs, CHCs and referrals at secondary & tertiary level hospitals should be clearly defined. The IPHS requirement of growing medicinal plants in the sub-centre and PHC compound could be linked to local herbalists. This herbal garden should also be integrated with the provision of AYUSH services by the co-located providers. These measures should be included for setting up indicators for monitoring this mainstreaming component. ANMs too could be considered for being trained similar to the ASHAs in use of AYUSH and LHT.	A Standing Committee could be set up by the NRHM directorate in collaboration with the Department of AYUSH and mandated the task to examine the issue at the national and state levels in a mini mission mode for AYUSH & LHT.
12.	Drug and Equipment provision needs to be reflected in the PIPs based on need assessment and monitoring of supplies.	The financing of drugs and equipments is being undertaken by Dept. of AYUSH. This must be based on need assessment of the required drugs and equipments at facility, district and state levels. Mechanisms for monitoring of adequate and regular supply of quality medicines need to be set up.	Estimates need to be made of adequate inputs for IPHS guidelines-based AYUSH drugs and equipment at all facility levels. Incorporation of AYUSH drugs and equipments requirements in DHAPs & State PIPs to be undertaken by NHSRC in collaboration with Dept of AYUSH.
13.	To ensure appointment of the Paramedical staff along with the AYUSH Doctors wherever they are colocated/relocated at various facility levels.	The AYUSH wing or the Doctors cannot deliver adequate services at the facilities without proper assistance by the paramedics and coordinated team work, thus recruitment of paramedics to be mandatorily followed wherever AYUSH doctors are posted. To involve authentic AYUSH Pharmaceutical industry through personnel with degree in AYUSH pharmacy.	Appropriate guidelines must be sent to states to include this dimension in their PIPs. During appraisal of State PIPs it must be ensured that AYUSH paramedics are adequately planned and budgeted for,

Sl. No.	TA task needs	TA task Description	TA task Modality
14.	To ensure experience based planning with timelines for implementation of activities and financing clarity of various budgetary sources involved in the Mainstreaming Strategy for AYUSH.	To develop guidelines for the states to prepare PIPs with consideration to and documentation of achievements against previous years' PIP, activities planned for the current year with their expected timeline and the budgetary sources for various activities pertaining to this strategy.	Dept. of AYUSH and NHSRC may jointly prepare a structured approach for planning, based on their experience with state/district level planning, in which the activities, their timelines and budget are planned with consideration to the last year's performance.
15.	Need to have a State level agency to develop an integrated policy perspective on the role of AYUSH & LHT within the overall health system as well as its planning and implementation.	To respond to the national guidelines suggested in the task modalities as above (1-14).	To set up AYUSH Resource centers within SHSRCs which are meant to give technical support with creative and innovative solutions for health systems strengthening.

*During the making of this report Dept. of AYUSH has released a Manual for AYUSH Doctors on Mainstreaming Strategy and also organized Master TOTs for AYUSH officials in various states in collaboration with NIHFW.

Section – V
ANNEXURES

Annexure - I

State wise PIPs & Master Charts

a) High focus Non NE States

P.S.: The empty coloumn in the upcoming tables represents the data not available during the making of this report.

1. Mainstreaming AYUSH in the State PIP-Bihar

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	31	31	31	
AYUSH Hospitals	26	26	26	
Beds	2325	2325	2325	
Dispensaries	634	634	634	Relocated disp.not reflected
Registered Medica Practitioner	165047	165047	165047	Few practitioners of AYUSH in Govt. Employment.
Drug Manufacturing Units	256	256	256	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs.29 lakhs	-	-	Details of budget not available
Total NRHM budget	Rs 68070.2 lakhs	Rs 69526.48 lakhs	Rs 102986.8 lakhs	
Total AYUSH under NRHM PIP	-	No activity proposed	Rs 2237 Lakhs	This is only the salary comp. this year for AYUSH doctors.
%of AYUSH in total NRHM	-	-	2.17%	Specific data not available for previous years.
NRHM Component	-	-	-	
AYUSH Dept. Component	-	-	-	
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level	331 AYUSH doctors out of the total of 662 MOs posts to be created at the PHCs.	331 AYUSH doctors out of the total of 662 MOs posts to be created at the PHCs.	Provision of 1 AYUSH doctor at each APHC on contract (1243 APHC.)	Detailed activities for AYUSH not included in PIP.
Co-location by diversion or new recruitment	-	-	-	Details of recruitment and collocation not given for the previous years.
Training of AYUSH doctors	-	Training of AYUSH doctors for NDCP and Family welfare has been proposed.	-	
Drug provisions				No details available
Integration with ASHA /ANMs				No activity proposed

Subject	2007-2008	2008-2009	2009-2010	Comments
NRHM PIP-Additional Activities				
State specific innovative activities	Proposal to involve Practitioners of AYUSH in the state to promote the small family norms, late marriage and child bearing. State Health Society formation to provide managerial and technical support for NRHM, which will also look after AYUSH activities.	Ministerial representation of AYUSH in SH mission, but budget provision / RKS participation not planned.	Convergence plan Strategy has been developed under Intersectoral convergence for: Increased participation of AYUSH department with the health department to identify the points of common interest such as rational management of common diseases, communicable diseases control Programme and disease surveillance.	The service rules related to practitioners of ISM in government employment are not well defined. Proposed this year to constitute State level inter department standing committee to initiate policy review for convergence and develop implementation procedures.

2. Mainstreaming AYUSH in the State PIP-Chhattisgarh

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	9	9	9	
AYUSH Hospitals	13	13	13	
Beds	605	605	605	
Dispensaries	692	692-85 =?	?	No. of Dispensaries relocated /total not clear.
Registered Medical Practitioner	1024	1024	1024	
Drug Manufacturing Units	69	69	69	
Budgets				
Total AYUSH budget(from the Dept. of AYUSH MOHFW)	Rs 366.29 lakhs			Budgets data not available
Total NRHM budget	Rs.22523.8 lakhs	Rs.22361.3lakhs	Rs 36409 lakhs	
Total AYUSH under NRHM PIP		Rs.178lakhs	Rs 773.97lakhs	
%of AYUSH in total NRHM		0.79%	2.125%	
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/ CHC /DHs Level		AYUSH wing in 15 out of 16 district hospitals Ayurveda Doctors are posted in about 200 mainstream Public Health facilities	AYUSH wing in 39 CHCsAdditional Compounders to 52 CHCs,100 PHC(Tribal)	Funded by European Union Partnership(from this year)
Colocation by diversion or new recruitment		85 AYUSH Dispensaries are relocated in PHC.		The budget for this shall be pooled from the routine budgets available for AYUSH Dept.

Subject	2007-2008	2008-2009	2009-2010	Comments
Training of AYUSH doctors		SBA and IMNCI Trainings for AYUSH doctors.	Training for AYUSH Doctors on SBA &IMNCI=10 First Batch Training of total 40AYUSH Personnel on Public Health Management.	Training components must also include AYUSH Principles for RCH.
Drug provisions	The state medicinal plant board has been constituted [2003]and functionalized.	Series of schemes are run to promote medicinal plant cultivation, non-timber forest produce collection, production of traditional medicines etc.	Essential medicine for AYUSH centers in rural, remote and tribal areas (1049 units)	Being a herbal state, this area has been accorded high priority
Integration with ASHA/ANMs		All 60092 Mitanins (ASHA equivalents) got trained in AYUSH based household remedies.	Mitanin will work as a convenor in the working committee of 25 Ayurgram villages in coordination with AYUSH and SHSRC 35000AWW proposed for training in AYUSH. (5000ANMs for next phase.)	
NRHM PIP-Additional Activities				
State specific innovative activities		1 Development of AYUSHDEEP [Rs 34 lakhs] and AYUSHGRAM [Rs 10llakhs] programme. It envisages covering at least one village in 146 blocks of the State initially. At present 121 villages out of 86 development blocks have been identified for this programme.	1 VHSC will work as working committee in developing 25 Ayurveda grams with the coordination of AYUSH department while Mitanin will be convenor for it. 2 SHRC technical support in the field of AYUSH mainstreaming and Medical education this year.	The untied grants for the facilities as budgeted now shall come from the European Union State Partnership Programme. Dissemination of guidelines, registration and training are budgeted from NRHM This is done under the Flexible fund for AYUSH deep Samitis for monitoring (16 lakhs)

Subject	2007-2008	2008-2009	2009-2010	Comments
		2 AYUSH specialty clinics in 24 Public Health facilities. 3 AYUSH Mela in Block and District headquarters.[Rs 68.40 lakhs] 4 Maternity and child wards in Ayurveda college.[Rs 55.00lakhs] 5 Integrated epidemic cell[Rs 5.20lakhs] 6 AYUSH technical assistance at SHSRC[5. Rs 40 lakhs]	3 Establishment of AYUSH polyclinics in District Hospitals.(6)with Panchkarma &ksharasutra therapies. 4 District Ayurveda officers are placed in all the 16 districts of the state. Telephone connections to 5 DH (AYUSH). 5 AYUSH melas in block and district head quarters	

3. Mainstreaming AYUSH in the State PIP-Jharkhand

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	3	3	3	
AYUSH Hospitals	3	3	3	
Beds	242	242	242	
Dispensaries	206	206+397=?		New dispensaries no. not reflected.
Registered Medical Practitioner				
Drug Manufacturing Units				
Budgets				
Total AYUSH budget(from the Dept. of AYUSH MOHFW)	Rs.17 lakhs			
Total NRHM budget	Rs 26292.3 lakhs	Rs 27034.3 lakhs	Rs 42992.75 lakhs	
Total AYUSH under NRHM PIP	Rs 126.00 lakhs	Rs 997.7l lakhs?	Rs 143.5 b4 lakhs	
%of AYUSH in total NRHM	0.47%	3.6%	.33%	
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level	194 AYUSH doctors at PHC/CHC.	397 newly created AYUSH dispensaries. 299 AYUSH paramedical posted along with the doctors.	Process for recruitment of 300 doctors from AYUSH has also been initiated by the Directorate AYUSH.	Salary component not clearly mentioned in PIPs.
Colocation by diversion or new recruitment		Integration of AYUSH services in 188 CHC/Block PHC with appointment of contractual AYUSH Doctors.	District Level Herbal Garden along with AYUSH Dispensary + maintenance of (AYUSH + Allopathy)24 CHCs	
Training of AYUSH doctors	Training of AYUSH doctors in Primary Health Care and NDCP proposed.	Training of AYUSH doctors in Primary Health Care and NDCP.	Training in IMNCI for AYUSH Doctors planned	Primary health care training in AYUSH?

Subject	2007-2008	2008-2009	2009-2010	Comments
Drug provisions	Provision of Rs. 25,000/- to supply drugs per AYUSH dispensary has been projected as per NRHM norm.	Provisions of Medicines for District AYUSH wing and Specialty Therapy Centers proposed to be opened in the state. Herbal garden at PHC and Sub centre level.		
Integration with ASHA/ANMs	Training module for SAHIYYA and ANMs has to be updated to incorporate information of AYUSH.	Drug kit provided to Sahiyya [ASHA equivalent] will contain one AYUSH preparation in the form of iron supplement.		
NRHM PIP-Additional Activities				
State specific innovative activities		1 One Yoga Therapy Centre will be opened in the District Headquarters Hospitals. 2 Sanyukta aushadhalaya=30 units created. 3 Project: Promotion of Naturopathy. Treatment of illness through Community Health Resort started.	1 Strengthen AYUSH Directorate with technical Assistance. A technical Consultant for AYUSH would be appointed. 2 <u>Develop Advocacy for AYUSH</u> Organize AYUSH Mela bi-annually at the district level. AYUSH Doctors shall be involved in IEC, health promotion and also supervisory activities. Also AYUSH doctors shall be involved in RCH Camps. 3 Research & Promote tribal system of medicine in integration with AYUSH. 4 Department will propose Herbal Garden in every CHC and District Hospitals along with AYUSH dispensary+ maintenance Cost.	Jharkhand is a herbal /tribal state and this strategy would definitely enhance coverage of health services.

4. Mainstreaming AYUSH in the State PIP-Madhya Pradesh

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	40	40	40	
AYUSH Hospitals	57	57	57	
Beds	298	298	298	
Dispensaries	1623	1623	1623	
Registered Medical Practitioner	57593	57593	60,000	Updated new no. in the PIP.
Drug Manufacturing Units	633	633		
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs.737.02 lakhs			
Total NRHM budget	Rs.54404.5 lakhs	Rs.57565.2 lakhs	Rs.85951.25 lakhs	
Total AYUSH under NRHM PIP		Rs.5804 lakhs	Rs.4853.68 lakhs	
%of AYUSH in total NRHM		10.5%	5.64%	
NRHM Component				
AYUSH Dept. Component				**C**omponent wise not available.
NRHM PIP-Main strategies				
Mainstreaming at PHC/ CHC /DHs Level	One lady MO at 500 PHCs / CHCs@Rs.12000/- per month for 8 months. One doctor at 200 selected PHC/CHC @ Rs.12000/-p.m. for 10 months.	1 Out of the total 270CHC 28 CHCs have AYUSH doctors. In 242 CHCs AYUSH doctor & Pharmacist/ Compounder shall be made available through contractual appointment. 2 Total PHC=1152, In 984 PHCs AYUSH doctor shall be made available through contractual appointment.	147 new AYUSH Dispensaries at PHC/ CHC. Specialty AYUSH services at 28 CHCs. AYUSH practitioner and Pharmacist/Compounder at CHC/PHC/SHC level (2064 lakhs) Core action group Planning, execution, establishment of office of AYUSH counselor in the state & district health society, & monitoring expenses @ 6%(274.73lacs).	Number of AYUSH Facilities co- located (System wise) in DH s, CHCs and PHCs before the launch of NRHM (Shifted 197 Dispensaries)

Subject	2007-2008	2008-2009	2009-2010	Comments
		3 In all 8835 SHCs AYUSH doctor should be made available through contractual appointment. 4 Administrative decision has been taken to post AYUSH Lady Doctors in PHCs on contractual basis @ Rs. 12000/P.M. to increase the accessibility of essential obstetric care.		
Colocation by diversion or new recruitment	Contractual appointment of 400 AYUSH Doctors shall be done @ Rs.12,000/- Per Month thereafter 10% increment in salary shall be done for the mission	Under AYUSH plan, provision is kept for contractual appointment of 400Ayurvedic, 400 Homeopathic and 200 Unani Doctor. An amount of Rs. 1584.00 Lakhs has been proposed for this activity. Contractual appointment of 400 AYUSH Pharmacist/Compounder shall be done @ Rs.5,000/- Per Month		
Training of AYUSH doctors		Training programmes for AYUSH doctors.	Training of Doctors & Health workers(Rs.157.67lakhs)	Specific training components not defined.
Drug provisions	Supply of AYUSH medicines to PHCs and CHCs.	Supply of medicines to SHC/PHC/CHCS.	Supply of equipments/ medicines at 800 PHC/ CHC	
Integration with ASHA/ANMs		All 60000 Community Health Volunteers called Mitanins are trained on household herbal remedies.	Supply of generic drugs for common ailments to ASHA, ANM, AWW's	

Subject	2007-2008	2008-2009	2009-2010	Comments
NRHM PIP-Additional Activities				
State specific innovative activities	1 Construction of AYUSH wing at J.P.Hospital, Bhopal. 2 Dadi Ma ka Batua-an innovative scheme-AYUSH treatment by locally available traditional remedies through NGO'S[Rs.7.00 lakhs]	• AYUSH IEC and BCC to be implemented. • AYUSH mobile medical units. • AYUSH health Melas. • Workshop on AYUSH. • AYUSH practices to be encouraged in school health programme. • Ayurveda Gram Yojna to be implemented. • Panchkarma therapy centers and specialty clinics have been started in a number of Allopathic health facilities so as to provide choice for the community	AYUSH IEC, BCC Promotion of healthy life styles Program Management Support Centre Mobile Medical Unit (To be integrated with Department of Health) AYUSH Health Melas Inclusion of AYUSH chapter in schools. National/International exposure visit, conferences AYUSH research activities in M.P Survey & mapping of AYUSH activities in M.P AYUSH Call center & Facilitation center Dept. of ISM & H will conduct workshop namely PRAACHIN GYAN KI POTLI & state level mela for the benefit of ailing people.	All the activities planned within set timelines and budget lines.

5. Mainstreaming AYUSH in the State PIP-Orissa

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	14	14	14	
AYUSH Hospitals	14	14	14	
Beds	673	673	673	
Dispensaries	1266	1266	1266	No. of relocated disp. Not reflected
Registered Medical Practitioner	7571	7571	7571	
Drug Manufacturing Units	195	195	195	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs.3626.96lakhs			
Total NRHM budget	Rs.34520.4 lakhs	Rs.33810.2lakhs	Rs.52314.75lakhs	
Total AYUSH under NRHM PIP	Rs.225 lakhs	Rs.649lakhs	Rs.289.5lakhs	All the components except recurring expenditure for AYUSH units approved.
%of AYUSH in total NRHM	0.65%	1.9%	0.55%	
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/ CHC /DHs Level	In 314 PHCs AYUSH physicians to be posted.	To ensure availability of AYUSH at each block PHC, at least 2 MOs, one of them AYUSH practitioner, are available all the time. In 314 block PHCs 153 Ayurveda doctors and 121 Homeopathic doctors to be posted. Another 1162 AYUSH doctors are proposed to be placed in the PHCs.	Appointment of 1162 AYUSH Doctors in PHC (N). Further plans of converting them to 24*7 PHCs. Appointment of 314 AYUSH paramedics planned.	Large no. of AYUSH Doctors colocated in various institutions.

Subject	2007-2008	2008-2009	2009-2010	Comments
		An AYUSH Doctor shall be provided to each of the PHCs (New) which shall enable the function-alisation of the unit.		
Colocation by diver-sion or new recruit-ment				40%of the PHC(N) are without doctors and posting only AYUSH doctor here won't serve the purpose of colocation.
Training of AYUSH doctors	Induction training of AYUSH doctors was planned for 314 doctors (one MO in every Block) and subsequently 274 doctors joined, out of which, 125 have already been given training.	Three days Thematic training of AYUSH MOs on major National Programmes. AYUSH doctor training of basic accounts – (RS.6 crores). Initiative taken to involve doctors of AYUSH in malaria control through EDPT, blood slide collections and BCC at the health facilities.	Training of all AYUSH Paramedics appointed planned. Training of existing AYUSH doctors in SBA.	AYUSH doctors services in their own system also need to be strengthened other than the NHP & substituting the allopaths.
Drug provisions			**S**trengthening the Drug procurement system and recurring expenditure for AYUSH units.	
Integration with ASHA/ANMs		The services of block level AYUSH doctors shall be utilized for providing supportive supervision in the ASHA Programme.	The services of block level AYUSH doctors shall be utilized for providing Supportive supervision in the ASHA Programme.	Both year PIPs have same statements without activities and budget line.

Subject	2007-2008	2008-2009	2009-2010	Comments
NRHM PIP-Additional Activities				
State specific innovative activities		Establishment of Ayurveda treatment wings at District Head Quarter Hospital. Development of digital GIS layer for AYUSH institutions The 314 AYUSH doctors shall be assisted by one paramedic each. The hiring and engagement of the paramedic and their training shall be undertaken in 2008-09. To improve the access and to popularize AYUSH treatment, camps are proposed to be conducted at the district level.	Special IEC camps for popularizing AYUSH treatment. Institutional medicinal plantation in one hospital on a pilot basis. Conduct Integrated health camps with honorarium for AYUSH doctors and medicines.	

6. Mainstreaming AYUSH in the State PIP-Rajasthan

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	18	18	18	
AYUSH Hospitals	114	114	114	
Beds	1191	1191	1191	
Dispensaries	3739	3739	3739	
Registered Medical Practitioner	30258	30258	30258	
Drug Manufacturing Units	268	268	268	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs.974.13lakh			
Total NRHM budget	Rs 54818.5lakhs	Rs 53532.6lakhs	Rs 78306.52 lakhs	
Total AYUSH under NRHM PIP	Rs 1000 lakhs	Rs 1690lakhs	Rs 1998 lakhs	
% of AYUSH in total NRHM	0.88%	5.83%	1.56%	
NRHM Component	Rs 8.430 cr	Rs 48.47cr		
AYUSH Dept. Component		Rs 23.44cr	Rs 107.10 cr?	
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC/DHs Level	750 AYUSH doctors and 750 compounders to be hired @Rs.8000/ and &Rs.5000/per month respectively.	Contractual recruitment of 1000 AYUSH Doctors and Compounders/ nurses to be completed. [Budget=Rs.4847lakh]	374 more AYUSH nurses to be recruited this year. Untied fund for 18 DH & 96 other AYUSH Hospitals proposed.	In all 1100doctors +631 AYUSH nurses recruited over the years till 09.
Colocation by diversion or new recruitment		250-1000 PHCs, have planned to contractually appoint AYUSH MOs.		

Subject	2007-2008	2008-2009	2009-2010	Comments
Training of AYUSH doctors		Training for AYUSH doctors and nursing staff.[Budget =RS.50.00 lakhs]	500 AYUSH doctors and 500 nursing personnel will be given training in batches. Each batch will consist of 40 persons. total number of batches will be 25.	
Drug provisions		AYUSH medicines to be made available to AYUSH units established at 1000 PHCs.		
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities		Establishment of state AYUSH monitoring cells. (SAMC). [Rs.107.50lakhs] "Suposhanam "special nutrition programme for Tribal Women.[RS.16.26 lakhs] Establishment of OT for Ayurveda surgery. [RS.320.00lakhs] IEC for AYUSH [Rs.10.00 lakhs] Establishment of Ayurveda Mobile Unit [RS.11.00lakhs] Treatment of Piles/fistula by Kshar Sutra [Rs.30.00lakhs	Providing AYUSH services at 33 AYUSH Hospitals At the Programme management level, an Assistant Director – AYUSH has also been appointed	The State will contribute 15% share on the total allocation made by Government of India during 2009-10 amounting to Rs. 107.10 crores.

7. Mainstreaming AYUSH in the State PIP-Uttarakhand

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	6	6	6	
AYUSH Hospitals	10	10	10	
Beds	377	377	377	
Dispensaries	530	530	530	No. of relocated disp. Not reflected
Registered Medical Practitioner	1106	1106	1106	
Drug Manufacturing Units	79	79	79	
Budgets				
Total AYUSH budget(from the Dept. of AYUSH MOHFW)	Rs.1646.02lakhs			
Total NRHM budget	Rs.8444.0lakhs	Rs.9236.6lakhs	Rs.13990.75 lakhs	
Total AYUSH under NRHM PIP	Rs.2207lakhs	Rs.2158lakhs	Rs.1425lakhs	
%of AYUSH in total NRHM	26.04%	24%	10.18%	
NRHM Component	Rs.5.41crore	Rs.9.97crore	Rs.1097+63.2 lakhs	
AYUSH Dept. Component	Rs.16.66crore	Rs.11.60crore	Rs.265cr	
NRHM PIP-Main strategies				
Mainstreaming at PHC/ CHC /DHs Level	Contractual recruitment of AYUSH doctors, pharmacist and MPWs 116 Medical Officers are Proposed to be hired at PHC this year.	Of the total of 232 PHCs, 116 Medical Officers are proposed to be hired this year	Presently AYUSH doctors, nursing staff, Pharmacists, Nursing staff and multipurpose workers are posted in 23 CHCs and 116 PHCs under NRHM. This year proposed to post them in additional 13 CHCs and in all the 179 PHCs in Government building.	
Colocation by diversion or new recruitment	Contractual appointment of Medical Officer & paramedical staff in 23CHCs	Contractual appointment of Medical Officer & paramedical staff in 23CHCs		

Subject	2007-2008	2008-2009	2009-2010	Comments
Training of AYUSH doctors		Modular Training of AYUSH MOs.	50 AYUSH MO and 25 AYUSH Staff nurses to be trained in SBA. Clinical trainings in Ayurveda 100 MOs Training in Kshara-sutra = 15 MO Training in Atyayik Chikitsa/basic obs &gyn Administrative train-ing 20 MOs Training in hospital management 12 Skill Up gradation of Pharmacist 100 Skill Up gradation of Ayurveda Nurses 30	
Drug provisions		Provisions of AYUSH medicines at PHCs &CHCs		
Integration with ASHA/ANMs			Training of ASHA in AYUSH Mainstream-ing	
NRHM PIP-Additional Activities				
State specific innova-tive activities	AYUSH component will be supporting the Building, Equipment, Medicines, Training and some miscel-laneous amount for establishment of spe-cialized therapy center with regimental therapy of Unani, Panchkarma or Ksharasutra thera-pies of Ayurveda or Yoga and Naturopathy or Homoeopathy in Government Allopathic hospitals & polyclinics.		Up gradation of the Ayurveda colleges at Gurukul and Rishikul which have 150 and 154 beds respectively to the level of FRU is also proposed For Awareness Programme and IEC campaigns on strengths of AYUSH through TV/Radio/ Pamphlets/Newspa-per/Posters Proposal for Reviving LHTs (Local Health Traditions) by work-shops and seminars and documentation	

Subject	2007-2008	2008-2009	2009-2010	Comments
			Innovative Proposals through Ayurvedic system 1 Anemia free Uttarakhand a) Ayurvedic Medicine 2 Worm infestation a) Ayurvedic Medicine 3 Skin Disorder a) Ayurvedic Medicine Publication of AYUSH Journal State level health AYUSH Mela in each district @Rs.3 lakhs per districtX13	

8. Mainstreaming AYUSH in the State PIP-Uttar Pradesh

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	35	35	35	
AYUSH Hospitals	1988	1988	1988	
Beds	12223	12223	12223	
Dispensaries	1871	1871	1871	No. of relocated disp. Not reflected
Registered Medical Practitioner	921319	921319	921319	
Drug Manufacturing Units	2258	2258	2258	
Budgets				
Total AYUSH budget(from the Dept. of AYUSH MOHFW)	Rs.1133.91lakhs			
Total NRHM budget	Rs.145942.5lakhs	Rs.148037.4lakhs	Rs.220143.1 lakhs	
Total AYUSH under NRHM PIP		Rs.10 crores?		
%of AYUSH in total NRHM				
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/ CHC /DHs Level	Recruitment Advertisements for Contractual Appointments Rs.75,000/- at State and Rs.10,000/-per district[Rs.1.75lakhs] Training of ISM lady doctors and GNMs Rs.37,800/-per district[Rs.3.78lakhs] Honorarium to ISM lady doctors Rs. 8000/- per month[Rs.115.20lakhs] IEC activities Rs 5000 per block[Rs.0.50lakhs]	It is proposed to ensure provisioning of space and infrastructure at 1000 PHC. Positioning of AYUSH practitioners at PHCs. AYUSH lady Medical Officers are also being deployed at the PHCs to promote institutional deliveries. 172.80lakhs for honorarium to ISM lady doctors, rest all same.	Deployment of 300 AYUSH practitioners at vacant Additional PHCs.	Budgets are not mentioned against the proposed activities.

Subject	2007-2008	2008-2009	2009-2010	Comments
Colocation by diversion or new recruitment			AYUSH facilities to be provided by either relocation or contractual hiring of AYUSH Practitioners.	
Training of AYUSH doctors	Training of AYUSH doctors in SBA is also being proposed under the comprehensive training programme.	Training program for AYUSH practitioners		
Drug provisions				
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities	AYUSH lady medical officers and General Nursing Midwives are also being deployed at the PHCs to promote institutional deliveries In the year 2006-07, this activity was started in 6 districts where service utilization has increased and the number of institutional deliveries has also increased. A team of 3 lady ISM doctors (AYUSH) and 3 GNMs are working successfully in each unit for providing comprehensive obstetric and newborn care.	It is proposed to scale-up this activity in 10 additional districts each year	AYUSH practitioners who are operating from rented/donated buildings in the vicinity would be co-located to the Block PHCs.	

9. Mainstreaming AYUSH In State PIP-Himachal Pradesh

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	174	174	174	
AYUSH Hospitals	27	27	27	
Beds	477	477	477	
Dispensaries	1127	1127	1127	No. of relocated disp. Not reflected
Registered Medical Practitioner	8803	8803	8803	
Drug Manufacturing Units	84	84	84	
Budgets				
Total AYUSH budget(from the Dept. of AYUSH MOHFW)	Rs.705.06lakhs			
Total NRHM budget	Rs.6769.9lakhs	Rs.7102.9 lakhs	Rs.11751.56 lakhs	
Total AYUSH under NRHM PIP	Rs.890.6 lakhs	Rs.1590.848 lakhs	Rs.521.5 lakhs	Budget for only manpower in 07-08
%of AYUSH in total NRHM	13%	22.4%	4.4%	Massive increase in AYUSH allocations overall in 08-09
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level	AYUSH MO and 1 pharmacist for 66 CHCs	Establishment of AYUSH units in PHCs &CHCs by contractual appointment of AYUSH doctor/pharmacist/MPW.	Establishment of AYUSH units in 100 PHCs	Activities planned for 07-08 not achieved.
Colocation by diversion or new recruitment	To create new positions in 66 CHCs	250 PHCs, 70 CHCs to be covered in 08-09 & 448 PHC &110 CHCs next year onwards.		
Training of AYUSH doctors		Training of AYUSH doctors/paramedics in national health programmes.	Training to AYUSH Doctors / paramedical in National Health Programmes	

Subject	2007-2008	2008-2009	2009-2010	Comments
Drug provisions		Provision of AYUSH medicines in Sub centres.		
Integration with ASHA/ANMs	Training on use of drug kits to be provided to all AWW during their training on NRHM proposed Combined drug kits to be provided to all AWW			AYUSH involvement not clearly mentioned
NRHM PIP-Additional Activities				
State specific innovative activities	Promotion of Herbals gardens in collaboration with department of forestry will be the responsibility of Parikas Aspatal Kalyan Samities in Ayurvedic hospitals will be formed in all Ayurvedic hospitals and be goverened by common guidelines issued by the State under NRHM.	I.E..C for AYUSH. AYUSH health melas Establishment of AYUSH speciality centre in rural hospitals.	Financial assistance to RKS established in AYUSH institutions.	Amchi Practioners and Instutions are present in substantial number.

10. Mainstreaming AYUSH in State PIP-J&K

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	3	3	3	
AYUSH Hospitals	5	5	5	
Beds	355	355	355	
Dispensaries	588	588	588	
Registered Medical Practitioner	3908	3908	3908	Unani and Ayurveda are quite popular in the State
Drug Manufacturing Units	16	16	16	
Budgets				
Total AYUSH budget(from the Dept. of AYUSH MOHFW)	Rs.127.25lakhs			
Total NRHM budget	Rs 8676.8 lakhs	Rs 9060.6 lakhs	Rs 15826.88 l lakhs	
Total AYUSH under NRHM PIP	Rs 30l lakhs	Rs 181 lakhs		
%of AYUSH in total NRHM	3.4%	2.5%		
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level	Contractual recruitment of AYUSH doctors.	Contractual appointment of AYUSH & Amchi /doctors &paramedical staff.	RKS are proposed to be established for all the AYUSH facilities viz ISM Hospitals and 418 ISM Dispensaries in the State. one AYUSH doctor along with a pharmacist for all the DHs (14), all CHCs/SDHs (85)	State had hired one AYUSH Doctor & Pharmacist for every PHC (375) in the State.
Colocation by diversion or new recruitment	AYUSH practitioners were collocated in 10 PHCs.	Seven AYUSH practitioners in PHCs were appointed on contract. AYUSH facilities collocated in 2 CHCs.	Providing one AMCHI in all the PHCs, CHCs & DH in that region (Leh & Kargil).	

Subject	2007-2008	2008-2009	2009-2010	Comments
Training of AYUSH doctors	Training programmes for AYUSH practitioners. Participation of AYUSH doctors in NHP.	Training of all AYUSH &AMCHI doctors on NHP of health department as well as disease surveillance &notificationof outbreaks.	Provision of funds for AYUSH dispensaries for organising RCH sessions	
Drug provisions		Medicine kits to be supplied for prophylactic &health promotive cases.Iron supplements to be added	Provision of AYUSH Doctor & additional Drugs as a special innovative activity for delivering services to the seasonal, temporary and shifting tribal and nomadic settlements.	
Integration with ASHA/ANMs			ASHA kits having generic drugs (both Allopathic and AYUSH) have been supplied to ASHAs.	
NRHM PIP-Additional Activities				
State specific innovative activities		Participation in village health days	One AYUSH doctor and a pharmacist are proposed for the 78 existing mobile medical teams for the Gujjar & Bakarwals (tribes) The incentive is being proposed for both allopathic and AYUSH doctors. Involve AYUSH/ AMCHIs in RCH initiatives for additional coverage of services	

Mainstreaming AYUSH & Revitalizing Local Health Traditions in State PIPs 2007-10												
High Focus States Non NE												
	Mainstream-ing strategies	**Bihar**	**Chhat-tisgarh**	**Hi-machal Pradesh**	**J&K**	**Jharkhand**	**M.P.**	**Orissa**	**Rajast-han**	**U.P.**	**U.K.**	**Total**
1	AYUSH Com-ponent in the PIPs	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	8 states planned for all 3 years, 2 States started from this FY
2	Colocations in the Institutions / Total no. of Institutions(as per the NRHM Quarterly State Data Sheets 31/12/08)											
a)	D H	0/25	15 /16	0 /12	0/14	24/24	0/48	0/32	63/33	0/70	8/18	110/292
b)	CHC	0/70	92 /118	0 /71	0/80	0/194	0/270	231/231	73/337	0/386	17/49	413/1806
c)	PHC	0/1648	353/518	0/443	317/374	0/330	0/1149	1162/1279	178/1499	0/3660	10/232	2020/11132
3	Total AYUSH Doctors ap-pointed as on 31.12.08	0	225	0	371	163	0	1153	601	428	1	2888
4	Total AYUSH Paramedics appointed as on 31.12.08	0	0	0	236	0	0	0	629	0	0	865
5	Training of AYUSH Doctors											
a)	SBA	N	Y	Y	N	N	N	Y	Type of train-ing not defined in PIP.	Y	Y	5 States planned for this.
b)	IMNCI	N	Y	N	N	Y	N	N	N	N	N	2 states planned for this.

Mainstreaming AYUSH & Revitalizing Local Health Traditions in State PIPs 2007-10												
High Focus States Non NE												
	Mainstream-ing strategies	**Bihar**	**Chhat-tisgarh**	**Hi-machal Pradesh**	**J&K**	**Jharkhand**	**M.P.**	**Orissa**	**Rajast-han**	**U.P.**	**U.K.**	**Total**
c)	NHP	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Almost all have planned.
d)	Any other / CME/Public health /AYUSH/ LHT NRHM etc.	N	Y	N	Y	N	N	N	N	N	Y	3 states have planned for other than routine trainings.
6.	Integration with ASHA /ANM	N	Y	Y	Y	Y	Y	Y	N	Y	Y	8states have begun with the plan-ning
7.	Drugs & Equip-ments Procure-ment	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Most of the states have planned but clear budget heads not there.
8	Additional activities											
a)	Specialty ser-vices/wings	N	Y	Y	Y	Y	Y	Y	Y	N	Y	8 states planned, budgets unclear
	School Health Programme	N	N	N	N	Y	N	N	N	N	N	Very few have planned.

Mainstreaming AYUSH & Revitalizing Local Health Traditions in State PIPs 2007-10												
High Focus States Non NE												
	Mainstream-ing strategies	**Bihar**	**Chhat-tisgarh**	**Hi-machal Pradesh**	**J&K**	**Jharkhand**	**M.P.**	**Orissa**	**Rajast-han**	**U.P.**	**U.K.**	**Total**
	Tribal health linkages	N	Y	N	Y	Y	N	Y	Y	N	N	4 states
b)	IEC&BCC	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Most of them have.
c)	LHT Promotion	N	Y	N	N	Y	Y	Y	N	Y	Y	6 have Planned
i)	Herbal Gardens in facilities	N	Y	N	Y	N	Y	Y	N	N	N	Only 4 have planned.
ii)	Village level	N	Y	Y	N	Y	N	N	N	N	N	3 states.
d)	Outreach activi-ties											
i)	MMU	N	N	N	Y	Y	N	Y	N	N	N	3 States planned for this.
ii)	AYUSH health Melas	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Almost all states have planned this.
iii)	Call Centres for AYUSH	N	N	N	N	N	Y	N	N	N	N	Only M.P. has planned this activity.
e)	Management Strengthening	N	Y	N	N	Y	Y	Y	Y	N	Y	6 states have planned this activity

Mainstreaming AYUSH & Revitalizing Local Health Traditions in State PIPs 2007-10												
High Focus States Non NE												
	Mainstream-ing strategies	**Bihar**	**Chhat-tisgarh**	**Hi-machal Pradesh**	**J&K**	**Jharkhand**	**M.P.**	**Orissa**	**Rajast-han**	**U.P.**	**U.K.**	**Total**
f)	Technical Strengthening	N	Y	N	Y	Y	Y	Y	Y	N	Y	7 States have planned
	Total AYUSH budgets in the PIPs (07-10)	223.74 lakhs*	951.97 lakhs **	3002.9 lakhs***	482 lakhs**	1266.54 lakhs***	5433.68 lakhs**	1163.5 lakhs***	4688 lakhs***	NA	5790 Lakhs***	
	% of AY-USH budget in NRHM	2.17%	1.62%	11.17%	2.7%	1.2%	7.42%	1%	3%	NA	18%	

*indicates financial data available for one year

** indicates financial data available for two years*** indicates financial data available for all three years

Annexure - 1

State wise PIPs & Master Charts

b) High Focus North East States

1. Mainstreaming AYUSH in the State PIP-Arunachal Pradesh

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	1	1	1	It is proposed to set up an institute of Folk Medicine in the state
AYUSH Hospitals	3	3	3	
Beds	70	70	70	
Dispensaries	47	47	47	
Registered Medical Practitioner	94	94	94	
Drug Manufacturing Units				
Budgets				
Total AYUSH budget(from the Dept. of AYUSH MOHFW)	Rs.17 lakhs			
Total NRHM budget	Rs.4339.4lakhs	Rs.4347.0 lakhs	Rs.6411 lakhs	
Total AYUSH under NRHM PIP				No data available
%of AYUSH in total NRHM				
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level		Contractual recruitment of AYUSH doctors at PHCs. Number not stated. Total MOs to be recruited for 82 PHCs. The monthly salary would be Rs 20,000/- Per month for MOs.		No expenditure against the major component approved in P.I.P for the year 2007-08.

Subject	2007-2008	2008-2009	2009-2010	Comments
Colocation by diversion or new recruitment	42 AYUSH doctors are appointed on contractual basis under NRHM. 10 AYUSH dispensaries relocated at PHCs. No. of PHCs where AYUSH physicians appointed = 10	5 AYUSH MOs would be recruited on contract to be posted in the non functional PHC.		
Training of AYUSH doctors		Training of AYUSH doctors in National Health programmes [Rs.15.00 lakhs]		
Drug provisions		AYUSH medicines, referral books &equipments to be provided by the department of AYUSH.		There are more than 500 known species of medicinal plants available in Arunachal Pradesh which can be put to use for manufacturing the Ayurveda, homeopathy, Unani and Siddha drugs.
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities	Eleven AYUSH Medical Officers posted in 11 District Hospitals. 8 of them are in CHCs, 10 in PHCs and 8 in GH / Dispensaries under specialty clinic	Specialty clinics in 3 areas will be collocated to the nearby PHC/CHC.		Data with budget lines not available.

2. Mainstreaming AYUSH in State PIP-Assam

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	5	5	5	
AYUSH Hospitals	5	5	5	
Beds	320	320	320	
Dispensaries	481	481	481	Relocated disp. not mentioned
Registered Medical Practitioner	1111	1111	1111	
Drug Manufacturing Units	52	52	52	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs.153.96lakhs			
Total NRHM budget	Rs.64227.6 lakhs	Rs.57849.4 lakhs	Rs.100336l akhs	
Total AYUSH under NRHM PIP	Rs.3600 lakhs	Rs.457 lakhs	Rs.3318.534lakhs	
%of AYUSH in total NRHM	5.6%	1%	3.3%	
NRHM Component			Rs.876.214 lakhs	
AYUSH Dept. Component			Rs.2442.32lakhs	
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level		Proposal for convergence of AYUSH in the mainstream by providing 50 homeopathy doctors in the MPHC and SHC. The homeopathy doctor will be posted in the health institutions where there is no Ayurveda doctor.[Rs.78 lakhs] AYUSH doctors in PHCs[254 total]Rs. 15000 per doctor per month[Rs.393lakhs]	Setting of 24 AYUSH Wings (14 for Ayurveda & 10 for Homeopathy) Manpower proposed for the wings Specialist /MD=14 Ayurveda 10 Homeo GDMO=14+10 Paramedics/therapists=24 Pharmacist=24 MPW=24	

Subject	2007-2008	2008-2009	2009-2010	Comments
Colocation by diversion or new recruitment			Establishment of OPD Ayurveda in 50 PHCs / 25 CHCs OPD Homeo in 100 PHCs / 25 CHCs Establishment of specialty clinic (Epidemic cell) of Homeo at DH.	
Training of AYUSH doctors		Training and orientation courses for 26 homeopathy and 39 Ayurveda intern doctors.	TOT on Mainstreaming AYUSH at district and Block level=30 doctors.	TOT by the Dept. of AYUSH & NIHFW
Drug provisions			Proposed for the Dept of AYUSH funding.	
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities		Inclusion of AYUSH health Melas.	A state task force for Assam for campaign on Homeopathy Mother & Child care. Formation of State Homeo Resource Centre Establishment of specialized ksharasutra & Panchkarma centre (4) Malaria control Pilot Project in Homeopathy. Setting up State AYUSH Training and Research Institute and AYUSH Systems resource Centre. IEC/BCC activities proposed. Mobile vans for AYUSH proposed =4 Programme Management unit for AYUSH. Expenditure for training materials, honorarium to resource persons for LHT promotion proposed.	

3. Mainstreaming AYUSH in State PIP-Manipur

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	0	0	0	
AYUSH Hospitals	3	3	3	
Beds	75	75	75	
Dispensaries	9	9	9	
Registered Medical Practitioner	NA	NA	NA	
Drug Manufacturing Units	NA	NA	NA	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs.882.13lakhs			There is no separate department of AYUSH in the state. An AYUSH cell exists under the Directorate of Health services, Manipur.
Total NRHM budget	Rs.6668.1 lakhs	Rs.6340.9 lakhs	Rs.10633 lakhs	
Total AYUSH under NRHM PIP		Rs.162 lakhs		
%of AYUSH in total NRHM		2.5%		
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level	34 AYUSH Doctors including Specialist AYUSH Doctors and 34 AYUSH Pharmacists are recruited on contractual basis and posted in 14 functioning CHCs and 20 PHCs to be up-graded as 24/7 centers.	40 more AYUSH Doctors were placed in another 40 strategic PHCs		
Colocation by diversion or new recruitment		74 AYUSH MOs on contract at PHC& CHCs		
Training of AYUSH doctors				

Subject	2007-2008	2008-2009	2009-2010	Comments
Drug provisions		Drugs worth Rs.6.83 lakhs under NRHM.		
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities				The Infrastructure up-gradation and drugs needed for all the AYUSH Centers will be supported under AYUSH CSS.

4. Mainstreaming AYUSH In State PIP-Meghalaya

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	0	0	0	Proposal for North Eastern Institute of Ayurveda &Homeopathy at Shilong (Rs. 675 million).
AYUSH Hospitals	8	8	8	
Beds	80	80	80	
Dispensaries	22	22	22	
Registered Medical Practitioner	240	240	240	
Drug Manufacturing Units	1	1	1	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs.23.30 lakhs			Fund for AYUSH from centre increased massively [2000 times.]
Total NRHM budget	Rs.6227.2 lakhs	Rs.6091.4 lakhs	Rs.10132lakhs	
Total AYUSH under NRHM PIP	Rs.2020 lakhs	Rs.1839 lakhs		
%of AYUSH in total NRHM	32.4%	30.19%		
NRHM Component		Rs.1839 lakhs		
AYUSH Dept. Component		Rs.95.70 lakhs		
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level		it will be possible to recruit on contract around 15 AYUSH doctors (10 Nos. for PHC and 5 Nos. for CHCs) in the health department this year.	Construction of AYUSH Clinics -26 as 24X7 PHCs	Since the state does not have any medical college in the AYUSH system it has to depend on getting AYUSH doctors from outside the state

Subject	2007-2008	2008-2009	2009-2010	Comments
Colocation by diversion or new recruitment		An MPW will be hired on contract for each of the 35 Health Institutions with AYUSH doctors.	Appointment of 15 more AYUSH doctors planned.	
Training of AYUSH doctors		3 day training on different national health programmes for AYUSH doctors Other training programme		
Drug provisions		A separate budget for purchasing medicines will be made. Supply of medicine to the AYUSH Clinic	24x7 PHC each Unit (1 Lakh from the Dept.of AYUSH for medicines).	
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities		It is proposed to have one AYUSH Clinic at the PHCs also. Equipment & furniture for 15 PHCs/ CHCs getting new AYUSH doctors on contract also proposed.		

5. Mainstreaming AYUSH in State PIP-Mizoram

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	0	0	0	
AYUSH Hospitals	0	0	0	
Beds	14	14	14	
Dispensaries	1	1	1	
Registered Medical Practitioner	0	0	0	
Drug Manufacturing Units	0	0	0	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs.17.0lakhs			
Total NRHM budget	3669.9 lakhs	Rs 3784.3 lakhs	Rs 6565 lakhs	
Total AYUSH under NRHM PIP	Rs 18lakhs	Rs 18lakhs	Rs 529.84lakhs	AYUSH Budget not separately defined.
% of AYUSH in total NRHM	0.5%	0.44%	8%	
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level	since 1st April 2007 with 10 AYUSH doctors engaged on contract basis under NRHM.@15000/- p.m.		10 AYUSH doctor at District Hospital 10 Doctors by the State Government To strengthen the AYUSH facility supporting staff is proposed.	
Colocation by diversion or new recruitment		AYUSH doctor - Rs 18 lakh (Remuneration of 10 AYUSH doctor at District Hospital)		Colocation at the CHC and PHC level not mentioned / Planned

Subject	2007-2008	2008-2009	2009-2010	Comments
Training of AYUSH doctors		TRAINING/ CME -Rs.5 lakhs. (Rs.50, 000/- per AYUSH Unit x 10 Units) Lump sum as per existing CSS Scheme of AYUSH Wing in District Allopathic Hospital.		
Drug provisions		MEDICINES Rs.80 lacs. (Rs.8 lakhs AYUSH Unit x 10 Units)Lump sum as per existing CSS Scheme of AYUSH Wing in District B.	Drugs & Equipment to be purchased for District AYUSH hospital	
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities		CIVIL WORKS (Infrastructure etc) Rs.1026.50lkhs CONTINGENCY - Rs.20 lakhs. (Rs.2 lakhs AYUSH Unit x 10 Units) Lump sum as per existing CSS Scheme of AYUSH Wing in District Allopathic Hospital. I.E.C. - Rs.3 lakhs. (Rs.30, 000/- per AYUSH Unit x 10 Units) Lump sum as per existing CSS Scheme of AYUSH Wing in District Allopathic Hospital.	*I.E.C. – Publication* Advertisement of Ayurveda/ Homoeopathy etc. Recurring Assistance for SHC (AYUSH) at State level. Budgets under following heads have been proposed. Operational Cost Conveyance Contingencies	The development of AYUSH sector in Mizoram is at the initial stage.

6. Mainstreaming AYUSH In State PIP-Nagaland

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	0	0	0	
AYUSH Hospitals	3	3	3	
Beds	10	10	10	
Dispensaries	16	16	16	Relocated disp. not mentioned
Registered Medical Practitioner	1997	1997	1997	
Drug Manufacturing Units	52	52	52	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs.52.00lakhs			
Total NRHM budget	Rs 5618.8 lakhs	Rs 5427.5 lakhs	Rs 9007lakhs	
Total AYUSH under NRHM PIP	Rs 38 lakhs	Rs 38 lakhs	Rs 2810.56 lakhs	Salary of 21 AYUSH doctors.
%of AYUSH in total NRHM	0.67%	0.7%	3.1%	
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level	No. of AYUSH dispensaries re-located to PHC=0	Chief Medical Officer/AYUSH = 11 Medical Officers including specialists (sub district facilities)/from AYUSH also = 370 21 AYUSH doctors have been selected under NRHM and they have been posted at different CHCs spread over different districts	Construction of Administrative block, MO quarters. Construction of 6 Yoga Centers at 6 DH.	
Colocation by diversion or new recruitment		No. of PHCs where AYUSH physicians appointed = 16		

Subject	2007-2008	2008-2009	2009-2010	Comments
Training of AYUSH doctors			Training of MO proposed.	
Drug provisions			Equipments /drugs Proposed for 97 PHCs & 21 CHCs.	
Integration with ASHA/ANMs				No activity mentioned
NRHM PIP-Additional Activities				
State specific innovative activities			Construction of 10 bedded hospital at Kohima. Construction of training Centre at Kohima under AYUSH. One State Botanical Graden. IEC for AYUSH proposed.	

7. Mainstreaming AYUSH in State PIP-Sikkim

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	0	0	0	
AYUSH Hospitals	1	1	1	
Beds	10	10	10	
Dispensaries	2	2	2	less no. of dispensaries
Registered Medical Practitioner	0	0	0	
Drug Manufacturing Units	3	3	3	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs 186.25 lakhs			
Total NRHM budget	Rs 1796.3 lakhs	Rs 1956.2 lakhs	Rs 3226 lakhs	
Total AYUSH under NRHM PIP		Rs 16.56 lakhs	Rs.54.1 lakhs	This year PIP better planned.
%of AYUSH in total NRHM		0.33%	1.68%	
NRHM Component			Rs.19.1 lakhs	
AYUSH Dept. Component			Rs.35.1lakhs	
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level	Recurring Cost of 4 AYUSH Doctors approved in 2007-08 @ Rs.15000 pm Recurring Cost of 4 AYUSH Paramedics approved in 2007-08 @ Rs.8000 pm	Appointment of 2 AYUSH Doctors in 2 New CHCs by 2008-09, Appointment of 2 AYUSH Paramedics in 2 New CHCs by 2008-09	Establishing AYUSH wing in the district. Appointment of 2 MOs for CHCs,two new Paramedics Establishing a fully functional AYUSH wing at State referral Hospital. The wing will consist of Ayurveda Treatment wing with Panchkarma therapy unit,one small yoga centre and one pain management centre in indigenous system in first phase.	At present there is only 1 AYUSH hospital in the state. AYUSH doctors are also scarsely available in the state.
Colocation by diversion or new recruitment	None of the AYUSH dispensaries relocated to PHC.	In 16 PHCs AYUSH doctors appointed.		
Training of AYUSH doctors				

Subject	2007-2008	2008-2009	2009-2010	Comments
Drug provisions			Drugs for CHC's, District and state after appointment of Doctors proposed	
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities			Awareness generation and treatment camp for outreach areas. Districts have projected certain activities to augment the process of mainstreaming like extensive IEC/ BCC, funds for AYUSH clinic, AYUSH books for library, operational & contingency fund for day to day activities etc.	

8. Mainstreaming AYUSH In State PIP-Tripura

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	0	0	0	
AYUSH Hospitals	2	2	2	
Beds	20	20	20	
Dispensaries	148	148	148	
Registered Medical Practitioner	145	145	145	
Drug Manufacturing Units	0	0	0	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs.17.00lakhs			
Total NRHM budget	Rs 8814.4 lakhs	Rs 8578.8 lakhs	Rs 14408 lakhs	
Total AYUSH under NRHM PIP	Rs 378 l lakhs	Rs 176 lakhs	Rs 1793.75lakhs	Budget for only salary component calculated in 07-08 PIP.
%of AYUSH in total NRHM	3.3%	1.6%	6.9%	
NRHM Component		Rs 3090 lakhs	Rs 600.16lakhs	
AYUSH Dept. Component		Rs 1672 lakhs	Rs 1193.60lakhs	
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC/DHs Level	Chief Medical Officer/AYUSH 04 Medical Officers I/C, CHC including specialists (sub district facilities) / from AYUSH also including SDH 10	Recruitment of 60 AYUSH Doctors. @ Rs. 15000/- pmx 9 months Recruitment of 25 Pharmacists as support staff for AYUSH doctors@ Rs. 7000/pm* 9 months	Total 32 Institutions proposed for colocation with one Ayurveda and Homeo Doctor. (4DH, 4SDH, 9CHC, 15 PHC) 40 new pharmacists are proposed to be recruited. 96 additional support staff proposed.	Till date 57 Health Institutions are colocated(newly established OPDs)
Colocation by diversion or new recruitment	28 AYUSH doctors appointed in 06-07 & 30 more doctors are to be recruited in 07-08	Co-location of AYUSH OPD in Govt. Hospital Recruitment of 60 AYUSH doctors and 118 pharmacists.	Infrastructure strengthening of colocated institutions and dispensaries (funds for medicines, repair renovation, furniture, equipments etc.)	

Subject	2007-2008	2008-2009	2009-2010	Comments
Training of AYUSH doctors		Capacity building on AYUSH: All ASHA will be trained on AYUSH. Refresher training of 188 Homeo and 188 Ayurveda doctors on NRHM	Training of 269 Doctors and 121 pharmacists under Mainstreaming of AYUSH and RCH/Immunization	
Drug provisions		Drugs provisions. [Rs.90lakhs] Fund has also been released from the Medicinal Plants board of Tripura to develop nurseries of medicinal plants of Rs. 1, 50,000/-.	Essential drugs for 80 Homeo dispensaries / hospital. Essential drugs for 41 Ayurveda dispensaries and 1 Ayurveda hospital.	
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities		Sensitization of Primary School Teachers regarding importance of 'Yoga' Budget required Rs.5 lakhs Fund has also been released from the Medicinal Plants board of Tripura to develop nurseries of medicinal plants of Rs. 1, 50,000/-. Strengthening of State AYUSH cell.	Strengthening of AYUSH cell 2 Contractual AYUSH MO for posting at state HQ. IEC Assistance in local dailies, melas AIR, Doordarshan etc Organization of health camps Proposal for revival of LHT(Incentives to MOs, awareness programme on LHT, training, identification of medicinal plants, materials etc)	

Master chart for NE high focus States.

Mainstreaming AYUSH & Revitalizing Local health traditions in State PIPs 2007-10										
High Focus North East States										
S.no.	**Mainstreaming strategies**	**A.P.**	**Assam**	**Manipur**	**Megha-laya**	**Mizoram**	**Nagaland**	**Sikkim**	**Tripura**	**Total**
1	AYUSH Component in the PIPs	Y	Y	Y	Y	Y	Y	Y	Y	All NE states have at least some com-ponent this FY.
2	Colocations in the Institutions / Total no. of Institutions(as per the NRHM Quarterly State Data Sheets 31/12/08)									
a)	District Hospitals	12/14	0/21	0/7	0/5	8/8	0/11	2/4	2/2	24/72
b)	CHC	15/31	0/100	14/16	0/26	9/9	21/21	0/4	11/10	70/217
c)	PHC	15/85	0/610	60/72	0/103	0/57	0/84	0/24	43/75	118/1110
3	Total AYUSH Doctors appointed	37	232	68	20	10	21	3	56	447
4	Total AYUSH Para-medics appointed	0	0	25	0	0	0	6	0	31
5	Training of AYUSH Doctors									
a)	SBA	N	N	N	N	N	N	N	N	None of the states have planned
b)	IMNCI	N	N	N	N	N	N	N	N	None of the states have planned

Mainstreaming AYUSH & Revitalizing Local health traditions in State PIPs 2007-10										
High Focus North East States										
S.no.	**Mainstreaming strategies**	**A.P.**	**Assam**	**Manipur**	**Megha-laya**	**Mizoram**	**Nagaland**	**Sikkim**	**Tripura**	**Total**
c)	NHP	Y	Y	N	Y (RCH training)			Y	Y	All 8 have planned for some or Other form of training.
d)	Any other /CME/Pub-lic health /AYUSH/ LHT NRHM etc.					Y	Y			
	Integration with ASHA /ANM	N	N	N	N	N	N	N	N	None of the states have planned
7	Drugs & Equipments Procurement	Y	N	N	Y	Y	Y	Y	Y	In the FY 09-10 bud-get plans mentioned
8	Additional activities									
a)	Specialty services/ wings	Y	N	N	N	N	Y	N	Y	2 states planned for this.
	School Health Pro-gramme	N	N	N	N	N	N	N	N	None of the states have planned
	Tribal health linkages	N	N	N	N	N	N	N	N	None of the states have planned
b)	IEC&BCC	N	N	N	N	Y	Y	Y	Y	

Mainstreaming AYUSH & Revitalizing Local health traditions in State PIPs 2007-10										
High Focus North East States										
S.no.	**Mainstreaming strategies**	**A.P.**	**Assam**	**Manipur**	**Megha-laya**	**Mizoram**	**Nagaland**	**Sikkim**	**Tripura**	**Total**
c)	LHT Promotion	N	N	N	N	N	Y	N	Y	
i)	Herbal Gardens in facilities	N	N	N	N	N	N	N	Y	
ii)	Village level	N	N	N	N	N	N	N	N	None of the states have planned
d)	Outreach activities									
i)	MMU	N	N	N	N	N	N	N	N	None of the states have planned
ii)	AYUSH health Melas	N	Y	N	N	N	N	N	Y	
iii)	Call Centres for AYUSH	N	N	N	N	N	N	N	Y	
e)	Management Strengthening	N	N	N	N	N	N	Y	Y	
f)	Technical Strengthen-ing	N	Y	N	N	Y	Y	N	Y	
	Total AYUSH budgets in the PIPs (07-	NA	7375.5 Lakhs***	162 Lakhs*	3859 lakhs**	565.84 lakhs***	357.05 lakhs***	70.76 lakhs**	2347.75 lakhs***	
	10)						1.7%	1.36%	7%	
	% of AYUSH budget in NRHM	NA	3%	2.5%	31.3%	4%				

*indicates financial data available for one year

** indicates financial data available for two years*** indicates financial data available for all three years

Annexure - 1

State wise PIPs & Master Charts

c) Non High Focus Large States

1. Mainstreaming AYUSH In State PIP-Andhra Pradesh

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	13	13	13	
AYUSH Hospitals	22	22	22	
Beds	1314	1314	1314	
Dispensaries	1096	1096	1096	Relocated disp. not mentioned
Registered Medical Practitioner	30049	30049	30049	
Drug Manufacturing Units	433	433	433	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs.927.20lakhs			
Total NRHM budget	Rs 59783.5 lakhs	Rs 59743.5 lakhs	Rs 86883.94 lakhs	
Total AYUSH under NRHM PIP	Rs 1576 lakhs	Rs 1722 lakhs	Rs 4694.14 lakhs	
%of AYUSH in total NRHM	2.63%	2.8%	5.40%	Budget under AYUSH and NRHM not specified
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level	PIP of 2007-08, the consolidated salary for Medical Officer fixed at Rs.12500/-p.m and as per guidelines was reduced to Rs.9300/-p.m,	It is proposed to provide 50% of the 1570 PHCs with Ayurveda facilities, 30% with Homeopathy, 10% with Unani and 10% with Naturopathy systems of medicine. Creation of AYUSH facilities in 439 PHCs [Rs.1529.50 lakhs]	Creation of AYUSH facilities in Primary Health Centres: to create AYUSH facilities in 439 PHCs every year and the coverage of the different disciplines will be as follows: • Ayurveda 50% • Homoeopathy 25%	Decided to create AYUSH facilities in 1317 PHCs out of 1570 PHCs, 156 CHCs out of 195 CHCs

Subject	2007-2008	2008-2009	2009-2010	Comments
		There are (195) Community Health Centers in the state. Out of these AYUSH facilities have already been created in (39) CHCs by way of relocation of AYUSH Dispensaries. Thus, (156) CHCs have to be now covered under NRHM for creation of AYUSH facilities. Creation of AYUSH facilities in 52 CHCs is proposed this year. [Rs.162.60 lakhs]	• Unani 20% • Naturopathy 5% Creation of AYUSH facilities in Community Health Centres: to create AYUSH facilities in 52 CHCs every year	
Colocation by diversion or new recruitment				
Training of AYUSH doctors		Training of AYUSH doctors in National Health programmes Rs.15.00 lakhs	Training of AYUSH doctors in National Health programs Compounders Training Programme (1317 compounders)	
Drug provisions				
Integration with ASHA/ANMs		There are 25,000 ANMs and 55,400 Women health volunteers in the state. These 80,400 functionaries are proposed to be given 2-day training in home remedies and use of medicines provided in the home remedy kit. It is estimated that this training will cost Rs.125/- per person per day inclusive of boarding, lodging and information material.		

Subject	2007-2008	2008-2009	2009-2010	Comments
NRHM PIP-Additional Activities				
State specific innovative activities		Preparation and distribution of IEC Material on AYUSH Rs.15.00 lakhs At State level, the Government has constituted a State Programme Coordination Committee with an AYUSH commissioner to integrate and coordinate all programmes and projects in the Health Sector in the State and help in developing and nurturing a holistic perspective on all public health issues.	Preparation and distribution of IEC Material on AYUSH	

2. Mainstreaming AYUSH In State PIP-Goa

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	2	2	2	
AYUSH Hospitals	2	2	2	
Beds	65	65	65	
Dispensaries	14	14	14	Relocated disp. not mentioned
Registered Medical Practitioner	564	564	564	
Drug Manufacturing Units	9	9	9	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)				
Total NRHM budget	Rs 1338.5 lakhs	Rs 1241.8lakhs	1582.688 lakhs	
Total AYUSH under NRHM PIP			681.55 Lakhs	
%of AYUSH in total NRHM			43.0%	
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level		In the initial phase two Homeopathic physicians and six Ayurvedic physicians are employed.	Establishment of 5 AYUSH Clinic at PHC/CHC/UHCs and DH	No separate administrative set up to look after and oversee AYUSH activities.
Colocation by diversion or new recruitment				
Training of AYUSH doctors			Training and CME for AYUSH doctors of the State.	
Drug provisions			Drug testing laboratory and Inspection.	
Integration with ASHA/ANMs				

Subject	2007-2008	2008-2009	2009-2010	Comments
NRHM PIP-Additional Activities				
State specific innovative activities		Goa has been chosen to organize a state level campaign on Homeopathy for Mother and Child care.	Proposal to set up an administrative set up (AYUSH cell) Separate budget for construction and maintenance of separate AYUSH wing / unit. proposed. IEC activities including health mela S, camps.community awareness meetings, Yoga classes,and publicity. Programme officer appointed to plan and promote AYUSH activities. School health programme on AYUSH.	

3.Mainstreaming AYUSH In State PIP-Gujarat

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	32	32	32	
AYUSH Hospitals	62	62	62	
Beds	2728	2728	2728	
Dispensaries	726	726	726	Relocated disp. not mentioned
Registered Medical Practitioner	29744	29744	29744	
Drug Manufacturing Units	526	526	526	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs 2624.20lakhs			
Total NRHM budget	Rs 38057.9 lakhs	Rs 38273.1lakhs	Rs 56259.44lakhs	
Total AYUSH under NRHM PIP	Rs 447 lakhs	Rs 1677lakhs	Rs 1400lakhs	Budget for only manpower calculated during 08-09
%of AYUSH in total NRHM	1.17%	4.3%	2.4%	
NRHM Component		Rs 32.49 lakhs		
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level		Creation of AYUSH facilities in 25 district hospitals. Creation of AYUSH facilitiesi in 252 CHCs Creation of AYUSH facilities in 1073 PHCs.	Creation of AYUSH facilities in 23 Districts Hospital. Creation of AYUSH facilities in 277 CHCs Creation of AYUSH facilities in 1066 PHCs.	
Colocation by diversion or new recruitment		Till now 357 AYUSH doctors have been posted out of 482 proposed.	655 AYUSH professionals co-located at PHCs and 168 at CHCs	
Training of AYUSH doctors			Training of AYUSH doctors on routine Immunization	

Subject	2007-2008	2008-2009	2009-2010	Comments
Drug provisions		Provisions of AYUSH medicines at PHCs& CHCs	Cotrimoxazole will be made available adequately with AYUSH personnels,FHW, AWW etc.	
Integration with ASHA/ANMs		The drug Kit will consist of allopathic as well as AYUSH medicines.		
NRHM PIP-Additional Activities				
State specific innovative activities		To conduct Pilot project to control anaemia through AYUSH. To conduct school mega camps for better health and prevention of diseases. Support to AYUSH unit for Diagnosis camps.	Rogi Kalyan Committee has been formed and Rs. 5 lakhs has been released to all 28 hospitals Support to Convergence between Health & AYUSH Department (State Level Coordinator for AYUSH) Appointment of AYUSH doctors/ MBBS doctors in Mobile Health Units s	

4. Mainstreaming AYUSH In State PIP-Haryana

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	7	7	7	
AYUSH Hospitals	10	10	10	
Beds	895	895	895	
Dispensaries	511	511	511	Relocated disp. not mentioned
Registered Medical Practitioner	26508	26508	26508	
Drug Manufacturing Units	394	394	394	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs 147.75lakhs			
Total NRHM budget	Rs 13759.9lakhs	Rs 15184.3lakhs	Rs 21516.5lakhs	
Total AYUSH under NRHM PIP		Rs 168 lakhs	Rs 947.3 lakhs	
% of AYUSH in total NRHM		1.10%	4.34%	
NRHM Component			Rs 559.33625lakhs	
AYUSH Dept. Component			Rs 3888.25lakhs	
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level		Identified 40 Community Health Centers (CHCs) to integrate AYUSH and allopathic system of medicine. The Medical Officers of AYUSH system will be placed in these CHCs, preferably by April, 2008. The state is planning to upgrade 160 PHCs to provide 24 x 7 services	16 District AYUSH Referral Centre-AYURVEDA 21 Distt. AYUSH Referral Centre & 91 CHC-HOMEO	
Colocation by diversion or new recruitment		50 MOs and 50 Pharmacists are proposed to be hired on contract basis.		

Subject	2007-2008	2008-2009	2009-2010	Comments
Training of AYUSH doctors			TOT on Mainstreaming of AYUSH under NRHM at State Level CME/Seminars on recent advances research on specific diseases in AYUSH	
Drug provisions			Renovation repair equipment and Drug procurement at 51 CHC out of 91, r 307 PHC out of 427, and 50 out of 157dispensaries is proposed. Equipment/Furniture forIISM & R and SIHFW (AYUSH) also proposed.	
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities			Up gradation of Institute of Indian Systems of Medicine and Research Consultant AYUSH SIHFW AYUSH IEC/BCC 1 year diploma for unemployed youth Revitalization of Local Health Traditions Monitoring of AYUSH activities planned	

5. Mainstreaming AYUSH In State PIP-Karnataka

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	73	73	73	
AYUSH Hospitals	164	164	164	
Beds	9746	9746	9746	
Dispensaries	687	687	687	
Registered Medical Practitioner	26714	26714	26714	Relocated disp. not mentioned
Drug Manufacturing Units	159	159	159	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs 767.33lakhs			
Total NRHM budget	Rs 39595.3lakhs	Rs 42465.6lakhs	Rs 63528.75lakhs	
Total AYUSH under NRHM PIP		Rs 1032.42 lakhs		
%of AYUSH in total NRHM		1.3%		
NRHM Component		Rs 791.90lakhs		
AYUSH Dept. Component		Rs 240.52lakhs		
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level		Contractual recruitment of AYUSH doctors at 331 PHCs.	AYUSH integration with PHCs 600 Taluk Hospitals 29 District Hospitals 12	Current status of co-location is 477
Colocation by diversion or new recruitment			24x7 PHCs with one additional AYUSH Doctor = 600	
Training of AYUSH doctors			AYUSH medical officers working in PHC's will be trained for multi skill mainly: maternal health SBA, IMNCI, Immunization, disease control programmes and other national health programmes.	
Drug provisions		To provide AYUSH drugs at PHCs where doctors are provided.		

Subject	2007-2008	2008-2009	2009-2010	Comments
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities	Separate budgetary provision has been made under the NRHM PIP for FY 06-07 for initial stocking of required AYUSH drugs in these PHCs.			

6. Mainstreaming AYUSH In State PIP-Kerala

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	20	20	20	
AYUSH Hospitals	160	160	160	No. of institutions other than Ayurveda is negligible
Beds	5327	5327	5327	
Dispensaries	1327	1327	1327	
Registered Medical Practitioner	25731	25731	25731	
Drug Manufacturing Units	1148	1148	1148	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs 922.47lakhs			
Total NRHM budget	Rs 21857.2lakhs	Rs 23510.8lakhs	Rs 33807.13lakhs	
Total AYUSH under NRHM PIP	Rs 1203.1 lakhs	Rs 683 lakhs	Rs 2470.9 lakhs	
%of AYUSH in total NRHM	5.5%	2.9%	7.3%	
NRHM Component			Rs 983.77lakhs	
AYUSH Dept. Component				

Subject	2007-2008	2008-2009	2009-2010	Comments
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level	it was proposed to provide funds for health institutions in the Ayurveda and Homoeo streams also.	Starting of new dispensaries in selected 100 gram panchayat.	Over 100 Panchayaths have been identified wherein Ayurveda & Homeopathy institutions can be started with little help from NRHM. It is proposed to provide basic staff and drugs for these institutions through NRHM. Untied Funds, Annual Maintenance Grant, Hospital Management Society Grant for following AYUSH institutions 31 Homeo hospitals 525 homeo dispensaries 115 ayurveda hospitals 747 ayurvedic dispensaries	Colocations not yet started.
Colocation by diversion or new recruitment		Contractual appointment of medical and paramedical staff in 100 gram panchayats.		
Training of AYUSH doctors	Provisions of medicines and dispensary material.			
Drug provisions				
Integration with ASHA/ANMs				

Subject	2007-2008	2008-2009	2009-2010	Comments
NRHM PIP-Additional Activities				
State specific innovative activities		It was proposed to start specialty clinics in the 14 District Ayurveda Hospitals. Strengthen RAECH (Rapid	Homoeopathic and Ayurvedic systems of medicine, there are PHCs / CHCs, sub divisional hospitals and District Hospitals. Hence, funds for Hospital Management Societies in other systems of Medicine are now proposed. Upgradation of AYUSH Hospitals Wide scale strategy to deal with life style diseases, also in collaboration with AYUSH and its related branches such as naturopathy, yoga etc. developed at SHSRC	

7.Mainstreaming AYUSH In State PIP-Maharashtra

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	8281	8281	8281	Max number. in india
AYUSH Hospitals	101	101	101	
Beds	11388	11388	11388	
Dispensaries	516	516	516	
Registered Medical Practitioner	105516	105516	105516	large number of ayurvedic graduates in health services
Drug Manufacturing Units	705	705	705	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs 416.62 lakhs			
Total NRHM budget	Rs 67114.2lakhs	Rs 70167.5lakhs	Rs 104540lakhs	
Total AYUSH under NRHM PIP	Rs 114lakhs	Rs 195.6 lakhs		.
% of AYUSH in total NRHM	0.16%	0.27%		
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at P H C / C H C / D H s Level	Procedure of AYUSH centres opening started in Civil Hospitals	AYUSH facilities to be made available at all IPHS hospitals, 50 health institutions to be supported for AYUSH through AYUSH funds, doctors, paramedical staff and medicine will be provided	Bigger (8) districts hospitals are provided with indoor and outdoor facility of AYUSH. For this AYUSH department grant is being utilized	

Subject	2007-2008	2008-2009	2009-2010	Comments
Colocation by diversion or new recruitment		Staff proposed for AYUSH Centre in health institutions: Consultant AYUSH, AYUSH MO = 3 (Ayurveda, Homeopathy, Unani) Pharmacist, therapist, attendant Establishment of AYUSH wing is in progress in all the 23 district hospitals, out of which 8 hospitals have started providing services.	Other 15 district hospitals are being provided salary of doctors and staff from AYUSH grant sanctioned from additional ties. Medicines for these centers will be procured from IPHS funds.	
Training of AYUSH doctors				No activity proposed over the years.
Drug provisions				
Integration with ASHA/ANMs				No activity proposed over the years.
NRHM PIP-Additional Activities				
State specific innovative activities				No activity proposed over the years.

8.Mainstreaming AYUSH In State PIP-PUNJAB

Subject	2007-2008	Rs 2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	16	16	16	
AYUSH Hospitals	21	21	21	
Beds	1484	1484	1484	Relocated disp. not mentioned
Dispensaries	650	650	650	
Registered Medical Practitioner	26199	26199	26199	
Drug Manufacturing Units	149	149	149	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs 171.00 lakhs			Funds required from the department not detailed.
Total NRHM budget	Rs 16196.9lakhs	Rs 17324.3lakhs	25077.19lakhs	
Total AYUSH under NRHM PIP		Rs 424.80 lakhs (manpower)	Rs 4312.80 lakhs	Only highlighted for contractual appointment
%of AYUSH in total NRHM			17.19%	
NRHM Component				
AYUSH Dept. Component		Rs 424.80 lakhs		
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC/DHs Level		Contractual appointment of AYUSH doctors at PHC & CHC	121 Ayurveda Medical Officers have been appointed and 112 Homeopathic Medical Officers are being appointed. Very shortly, the regular posts of the Ayurveda department shall be filled through Punjab Public Service Commission. Establishment of 7 ISM wing in district hospitals	

Subject	2007-2008	Rs 2008-2009	2009-2010	Comments
Colocation by diversion or new recruitment		All AYUSH doctors to be trained in the National Health Programmes.	One AYUSH doctor to be appointed in all PHCs and Two (one Ayurveda and one Homeopathic) in all CHCs	
Training of AYUSH doctors			All AYUSH doctors to be trained in national health programmes. AYUSH doctors to dispense medicines under the National Health Programs.	
Drug provisions		AYUSH drugs to be supplied in the ASHA drug kits.	AYUSH medications to be supplied to SC, PHC and CHC in the state.	
Integration with ASHA/ANMs			AYUSH medications to be a part of the drug kit provided to ASHA. ASHA to be trained to propagate AYUSH in the community	
NRHM PIP-Additional Activities				
State specific innovative activities		As part of the school health programme where feasible the AYUSH doctors would organize yoga camps.	All AYUSH personnel to participate in the monthly meetings at PHC and CHC. Their work plan and attainments to be reflected in the reports of the PHC and CHC. AYUSH doctors would be made a part of the RKS and they would participate in its meetings. Support to the AYUSH MO's from the allopathic system to ensure convergence 1EC BCC activities Yoga camps	

9. Mainstreaming AYUSH In State PIP-Tamil Nadu

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	28	28	28	
AYUSH Hospitals	292	292	292	
Beds	3225	3225	3225	Relocated disp. not mentioned.
Dispensaries	533	533	533	
Registered Medical Practitioner	27223	27223	27223	
Drug Manufacturing Units	571	571	571	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs 1712.00 lakhs			No activity mentioned in particular.
Total NRHM budget	Rs 43315.6Lakhs	Rs 46819.5lakhs	Rs 67837.06 lakhs	
Total AYUSH under NRHM PIP			Rs 1052.97lakhs	
%of AYUSH in total NRHM			1.55%	
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC /DHs Level	Strengthening of ISM wings in DH in 30 districts as referral hospitals	* 200 PHCs proposed for celecation. AYUSH services will be extended to another 150 PHCs due to the growing public demand. Support to human resource, drugs, equipments and furniture has been budgeted. The grants for establishing 359 herbal gardens are proposed.	Manpower proposed Asst. MO - 2 Asst. MO (Y&N) - 2 per HUD Pharmacist - 1 MHW - 3	There are 1917 - PHCs out of which 479 PHCs have ISM wings.
Colocation by diversion or new recruitment				

Subject	2007-2008	2008-2009	2009-2010	Comments
Training of AYUSH doctors		Under the RCH Programme, a kit of 50 siddha and Ayurveda drugs have identified. Training of 8683 VHNS and 3886 supervisors is planned.	Training to ISM doctors is booked under NRHM training budget head	
Drug provisions			Budget for Medicine proposed	
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities		ISM kits were developed for the treatment of Chikungunya epidemic during 2006.Each kit cost Rs.2175. These drugs were supplied to all PHCs during 2006-2007for the treatment of Chikungunya cases and have yielded good results.	Establishment of outpost Dispensaries of ISM in cities. (40) Establishment of Maternity centres in ISM in various allopathy hospitals. Publication of AYUSH books.	AYUSH strengthening strategies may be more detailed, particularly for RKS formation for AYUSH institutes, mainstreaming planning, availability of drugs issue, specific activities in NCDs control etc

10.Mainstreaming AYUSH In State PIP-West Bengal

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	17	17	17	
AYUSH Hospitals	17	17	17	
Beds	1099	1099	1099	
Dispensaries	1518	1518	1518	
Registered Medical Practitioner	47715	47715	47715	
Drug Manufacturing Units	708	708	708	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs 190.28 lakhs			
Total NRHM budget	Rs 54019.7 lakhs	Rs 60385.3 lakhs	Rs 81812.44 lakhs	
Total AYUSH under NRHM PIP	Rs 27 lakhs	Rs 100 lakhs		.
% of AYUSH in total NRHM	0.04%	0.16%		
NRHM Component				
AYUSH Dept. Component		Rs 100 lakhs		
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC/DHs Level				Not highlighted in the PIP. Colocations not started.
Colocation by diversion or new recruitment				
Training of AYUSH doctors				No activity proposed over the years.
Drug provisions				
Integration with ASHA/ANMs				

Subject	2007-2008	2008-2009	2009-2010	Comments
NRHM PIP-Additional Activities				
State specific innovative activities		Rogi Kalyan Samitis would be formed in 2 (two) Ayurveda and 4 (four) Homoeopathy Medical College & Hospitals of the Govt. and these Samitis would also be allotted funds @ Rs. 3.00 lakh per Medical College & Hospital in the first year under this programme.		

Master chart for large Non high focus States.

Mainstreaming AYUSH & Revitalizing Local health traditions in State PIPs 2007-10												
Non High Focus large States												
S.no.	**Mainstream-ing strategies**	**Andhra Pradesh**	**Goa**	**Gujarat**	**Haryana**	**Karnataka**	**Kerala**	**Maharash-tra**	**Punjab**	**Tamilnadu**	**West Ben-gal**	**Total**
1	AYUSH Com-ponent in the PIPs	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	All have planned
2	Colocations in the Institutions / Total no. of Institutions(as per the NRHM Quarterly State Data Sheets 31/12/08)											
a)	District Hospi-tals	39/19	0 /2	0 /23	0/20	19/24	0/10	23/23	0/20	27/27	0/15	108/183
b)	CHC	0/167	0 /5	0 /273	0/86	58/254	0/107	105/407	0/126	131/236	178/346	472/2007
c)	PHC	0/1570	10 /19	554/1073	0/411	0/1679	0/909	491/1800	0/484	320/1181	368/922	1743/10048
3	Total AYUSH Doctors ap-pointed	0	0	554	0	669	74	125	98	0	0	1520
4	Total AYUSH Paramedics ap-pointed	0	0	0	0	0	0	34	0	0	0	34
5	Training of AYUSH Doctors											
a)	SBA	N	N	N	N	Y	N	NA	N	N	N	Very few have planned.
b)	IMNCI	N	N	N	N	Y	N	NA	N	N	N	Only Karna-taka

Mainstreaming AYUSH & Revitalizing Local health traditions in State PIPs 2007-10												
Non High Focus large States												
S.no.	**Mainstream-ing strategies**	**Andhra Pradesh**	**Goa**	**Gujarat**	**Haryana**	**Karnataka**	**Kerala**	**Maharash-tra**	**Punjab**	**Tamilnadu**	**West Ben-gal**	**Total**
c)	NHP	Y	N	Y	N	Y	N		Y	Y	N	Planned
d)	Any other / CME/Public health /AYUSH/ LHT NRHM etc.	N	N	N	Y	Y	N	NA	N	N	N	
	Integration with ASHA /ANM	Y	N	Y	N	N	N	N	Y	N	N	Only three states hav done so.
7	Drugs & Equip-ments Procure-ment	N	Y	Y	Y	Y	Y	Y	Y	N	N	Planned but with unclear budget plans
8	**Additional activities**											
a)	Specialty ser-vices/wings	N	N	N	N	N	N	Y	Y	Y	N	
	School Health Programme	N	Y	Y	N	N	N	N	Y	N	N	
	Tribal health linkages	N	N	N	N	N	N	N	N	N	N	None of the states have planned
b)	IEC&BCC	Y	Y	N	N	N	N	N	Y	Y	N	
c)	LHT Promotion	N	N	N	N	N	N	N		Y	N	
i)	Herbal Gardens in facilities	N	N	N	N	N	N	N	N	Y	N	
ii)	Village level	N	N	N	N	N	N	N	N	N	N	None of the states have planned

Mainstreaming AYUSH & Revitalizing Local health traditions in State PIPs 2007-10												
Non High Focus large States												
S.no.	**Mainstream-ing strategies**	**Andhra Pradesh**	**Goa**	**Gujarat**	**Haryana**	**Karnataka**	**Kerala**	**Maharash-tra**	**Punjab**	**Tamilnadu**	**West Ben-gal**	**Total**
d)	Outreach activi-ties											
i)	MMU	N	N	Y		N	N	N	N	N	N	
ii)	AYUSH health Melas	N	Y	Y	Y	N	N	N	N	N	N	
iii)	Call Centres for AYUSH	N	N	N	N	N	N	N	N	N	N	None of the states have planned
e)	Management Strengthening	Y	Y	Y	Y	N	Y	N	Y	Y	Y	
f)	Technical Strengthening	N	Y	Y	Y	N	Y	N	Y	Y	Y	
	Total AYUSH budgets in the PIPs (07-10)	7992.14 lakhs***	681.55 lakhs*	3524 lakhs***	115.3 Lakhs**	1032.42 lakhs*	4357 lakhs***	309.6 lakhs**	4312.80 lakhs*	1052.97 lakhs*	127 lakhs**	
	% of AYUSH budget in NRHM	4%	43%?	2.2%	3%	1.3%	5.5%	0.2%	17.19%	1.55%	0.1%	

*indicates financial data available for one year

** indicates financial data available for two years*** indicates financial data available for all three years

Annexure - I

State wise PIPs & Master Charts

d) Non High Focus Small States & Union Territories

1.Mainstreaming AYUSH In State PIP-ANDAMAN &NICOBAR

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	4	4	4	
AYUSH Hospitals	30	30	30	
Beds	9	9	9	
Dispensaries	0	0	0	
Registered Medical Practitioner	0	0	0	No practitioners in the UT
Drug Manufacturing Units	0	0	0	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)				
Total NRHM budget	Rs. 609.1 lakhs	Rs.1083.2 lakhs	Rs.2419.25 lakhs	
Total AYUSH under NRHM PIP	Rs.89lakhs	Rs.295lakhs		
% of AYUSH in total NRHM	14.6%	27.23%		
NRHM Component			Rs.252.20 lakhs	
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC/DHs Level	Integration of the AYUSH treatment facilities al all levels.	All AYUSH institutions will be strengthened with necessary infrastructure like building, equipment, manpower etc	Proposed to start 9 Ayurveda dispensaries and 9 homeopathy dispensaries in all the left out PHCs.	
Colocation by diversion or new recruitment		Strengthening of AYUSH Dispensaries with provision of storage equipments.		
Training of AYUSH doctors	Training of AYUSH doctors in Primary Health Care and National Disease Control Programmes.		Training of doctors in AYUSH and NHP=10 Training of paramedics in AYUSH and NHP=10	

Subject	2007-2008	2008-2009	2009-2010	Comments
Drug provisions		Making provision for AYUSH Drugs at all levels.		Since there are adequate funds under the State Budget of Andaman & Nicobar Islands under AYUSH for the drug procurement, therefore under NRHM this year the provision is not kept for the Drug Procurement.
Integration with ASHA/ANMs			Training of ASHAs in Mainstreaming AYUSH=50	
NRHM PIP-Additional Activities				
State specific innovative activities		The School Health programmes are planned to be strengthened with Yoga & Naturopathy classes and also the Weighing Machines and Height Recorders are also planned to be installed this year. AYUSH doctors to be involved in all National level Programme health care such as in the areas of IMR,MMR,JSY, TB, Malaria Control, Filaria, and other communicable diseases etc 2 day state level workshop was organized in Homeopathy for Healthy Mother and Happy Child. One Health Mela also organized.	Proposed to start two new Yoga Centers one each at District Hospital Establishment of Rogi Kalyan Samiti for AYUSH DH. Establishment of State Resource Centre (AYUSH). Awareness Programme and IEC campaigns on strengths of AYUSH systems of Medicine.	

2. Mainstreaming AYUSH in State PIP-Chandigarh

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	2	2	2	
AYUSH Hospitals	145	145	145	
Beds	11	11	11	
Dispensaries	297	297	297	Relocated disp. not mentioned
Registered Medical Practitioner	2	2	2	
Drug Manufacturing Units	1	1	1	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs.17 lakhs			
Total NRHM budget	Rs.734.9 lakhs	Rs.776.5 lakhs	Rs.1141.375 lakhs	
Total AYUSH under NRHM PIP	Rs.208 lakhs		Rs.39.73lakhs	
% of AYUSH in total NRHM	28.3%		3.4%	
NRHM Component	Rs.20 lakhs			
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC/DHs Level	The availability of AYUSH Centers at the CHC level in sector 22 and manimajra at first instance.		Setting up of Two Homeopathic Dispensaries, One Unani Dispensary, Yoga Centers	
Colocation by diversion or new recruitment		The AYUSH dispensaries may be opened in the 10 Allopathic dispensaries.		
Training of AYUSH doctors			Training of Allopathic and AYUSH Doctors=50	
Drug provisions			The medicines will be provided as per the existing budget available with the Directorate of AYUSH	

Subject	2007-2008	2008-2009	2009-2010	Comments
Integration with ASHA/ANMs				No activity proposed under this head.
NRHM PIP-Additional Activities				
State specific innovative activities		Planning for integrating AYUSH SYSTEMS in to the mainstream is at a initial phase (Rs.910 lakhs provided)	Exhibition of AYUSH Medicine Training of Teachers and students of Schools for promoting Yoga/Naturopathy, Ayurveda and Homoeopathic Medicines	

3. Mainstreaming AYUSH In State PIP-Dadar & Nagar Haveli

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	0	0	0	
AYUSH Hospitals	0	0	0	
Beds	0	0	0	
Dispensaries	4	4	4	
Registered Medical Practitioner	0	0	0	
Drug Manufacturing Units	22	22	22	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)				
Total NRHM budget	Rs.377.8	Rs 400.2	Rs 572.125lakhs	
Total AYUSH under NRHM PIP	Rs 59lakhs	Rs 13.2lakhs		For contractual appointment of AYUSH doctors.
% of AYUSH in total NRHM	15.6%	3.2%		
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC/DHs Level				
Colocation by diversion or new recruitment				
Training of AYUSH doctors				
Drug provisions		Provision of generic drugs both AYUSH and allopathic at village/SC/PHC/CHClevel for common ailments.		
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities				

4. Mainstreaming AYUSH In State PIP-Daman & Diu

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	0	0	0	
AYUSH Hospitals	0	0	0	
Beds	0	0	0	
Dispensaries	1	1	1	
Registered Medical Practitioner	0	0	0	
Drug Manufacturing Units	12	12	12	Weak AYUSH infrastructure except these.
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)				
Total NRHM budget	Rs 343.5 lakhs	Rs 356.9 lakhs	Rs 533.3 lakhs	
Total AYUSH under NRHM PIP	Rs 48lakhs	Rs 136 lakhs		No activity proposed
% of AYUSH in total NRHM	13.97%	38%		
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC/DHs Level	Provision of 4 AYUSH doctors at 3 PHCs and 1 CHC			
Colocation by diversion or new recruitment	1 AYUSH specialist and one AYUSH MO at CHC			Only colocations started.
Training of AYUSH doctors				No activity proposed
Drug provisions				No activity proposed
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities				No activity proposed

5. Mainstreaming AYUSH In State PIP-Delhi

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges	5	5	5	
AYUSH Hospitals	20	20	20	
Beds	1094	1094	1094	
Dispensaries	277	277	277	Colocated dispensaries not highlighted
Registered Medical Practitioner	7862	7862	7862	
Drug Manufacturing Units	69	69	69	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs 163.52lakhs			
Total NRHM budget	Rs 7920.5 lakhs	Rs 8521.1 lakhs	Rs 14307.44 lakhs	
Total AYUSH under NRHM PIP	Rs 12 lakhs	Rs 2 lakhs	Rs 178.00 lakhs	
% of AYUSH in total NRHM	0.15%	0.02%	1.2%	
NRHM Component				
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/ CHC /DHs Level	In PIP 2007-08 only one district had proposed additional AYUSH Units. They had not been able to carry this out.	Services to be provided in PUHC		No activity proposed
Colocation by diversion or new recruitment			Computerization and co-location of AYUSH dispensaries (Five dispensaries in a year)	This year co-locations are planned.

Subject	2007-2008	2008-2009	2009-2010	Comments
Training of AYUSH doctors		Re-orientation training programme (ROTP):	Training of AYUSH TOT for sensitization of AYUSH &Allopathic doctors. Training & Development programme for AYUSH doctors and Paramedics in Emergency care & disaster management.	
Drug provisions		Supply of Essential Drugs to AYUSH dispensaries: Rs 7.75 Lakh for ISM dispensaries & 6.25 Lakh to Homoeopathic dispensaries	Supply of essential drugs to dispensaries	
Integration with ASHA/ANMs	The AYUSH drugs will be added after her modular training dealing with AYUSH is completed. ASHA will receive the drug kit upon completion of her training.		ASHA s to be given AYUSH training	
NRHM PIP-Additional Activities				
State specific innovative activities		Ksharasutra Campaign: Rs 1 Lakh Up-gradation of AYUSH college: Rs 11.80 to NHMC & H For this a budget of 2 lakhs per district and 2 lakh at the State level is proposed to initiate a ground level hand holding and exploring methods of bringing the systems together in a synergistic mode.	1 To develop State level resource centre 2 National Campaigns of AYUSH Homoeopathy for Healthy Mother and Happy Child Unani for the treatment of Skin Diseases Ayurveda for Geriatric Care Yoga for Mental Health and Life style diseases.	Various activities proposed this year.

Subject	2007-2008	2008-2009	2009-2010	Comments
			3 Quality assurance and Drugs standardization of AYUSH. 4 Development of training modules and IEC material designing and printing. 5 AYUSH in Schools 6 Development of PPP modules to mainstream AYUSH by supporting NGO 7 Co-ordination at state level with all the Districts.	

6. Mainstreaming AYUSH In State PIP-Lakshwadeep

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges				
AYUSH Hospitals				
Beds				
Dispensaries	3			
Registered Medical Practitioner				AYUSH infrastructure very weak.
Drug Manufacturing Units				
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs 17Lakhs			
Total NRHM budget	Rs 224.5	Rs 248.1	Rs 3.40	
Total AYUSH under NRHM PIP	0.24cr?		0.20cr?	
% of AYUSH in total NRHM				NA
NRHM Component				ROP not received
AYUSH Dept. Component				
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC/DHs Level				NA
Colocation by diversion or new recruitment				
Training of AYUSH doctors				
Drug provisions				
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities				NA

7. Mainstreaming AYUSH in State PIP-Puducherry

Subject	2007-2008	2008-2009	2009-2010	Comments
Existing AYUSH infrastructure				
AYUSH colleges				No college in the UT
AYUSH Hospitals	1	1	1	
Beds	10	10	10	
Dispensaries	39	39	39	
Registered Medical Practitioner				
Drug Manufacturing Units	41	41	41	
Budgets				
Total AYUSH budget (from the Dept. of AYUSH MOHFW)	Rs 17lakhs			
Total NRHM budget	Rs 998.2 lakhs	Rs 1038.6 lakhs	Rs 4918.70lakhs	
Total AYUSH under NRHM PIP			Rs 1294.78lakhs	
% of AYUSH in total NRHM			8.81%	Substantial budget proposed this year.
NRHM Component			103.44 lakhs	
AYUSH Dept. Component			1191.34 lakhs	
NRHM PIP-Main strategies				
Mainstreaming at PHC/CHC/DHs Level		Co-locating of AYUSH doctors and services will be completed in 24 PHCs. AYUSH facilities have been provided in 24 PHCs & 3 CHCs.	AYUSH Services at PHC and CHC s Provision of rooms for AYUSH doctors and Pharmacy. separate building for accommodating ISM&H units, within the campus of CHC and PHC (34 Centers). Construction of ISM&H Hospital at Puducherry to establish 16 ISM&H Units for the integration of ISM&H & Allopathy, in the PHC's/CHC's where the AYUSH facilities are not available.	The activities under AYUSH could not be carried over as the allocations under the human resources component had to be received from the Govt. of India and the matter has been taken up for the necessary approvals from them.

Subject	2007-2008	2008-2009	2009-2010	Comments
Colocation by diversion or new recruitment			No. of AYUSH dispensaries re-located to PHCs nil	
Training of AYUSH doctors				
Drug provisions		Supply of Essential Drugs to Rural & Backward Area Dispensaries		
Integration with ASHA/ANMs				
NRHM PIP-Additional Activities				
State specific innovative activities			Establishment of Panchkarma Special Therapy Unit in Karaikal, Mahe & Yanam region Establishment of Thokkanam & Varma Special Therapy(Siddha) Establishment of Naturopathy & Yoga Unit Establishment of Unani Clinic in Karaikal region. Starting of Integrated AYUSH Pharmacist course	The AYUSH facilities of Ayurveda, Siddha and Homeopathy are well integrated with Allopathy system of medicine. The availability of AYUSH services in health centers is as follows: Ayurveda in 30% of CHCs / PHCs, Siddha in 26% of CHCs / PHCs and Homeopathy in two Health Centres. This year activities are much more planned and proposed with proper budgets.

Master chart for Small non high focus & UT

Mainstreaming AYUSH & Revitalizing Local health traditions in State PIPs 2007-10									
Non High Focus States- Small & UT									
S.no.	**Mainstreaming strategies**	**A & N Islands**	**Chandigarh**	**D & N Haveli**	**Daman & Diu**	**Delhi**	**Lakshadweep**	**Pondicherry**	**Total**
1	AYUSH Component in the PIPs	Y	Y	Y	Y	Y	N	N	
2	Colocations in the Institutions / Total no. of Institutions(as per the NRHM Quarterly State Data Sheets 31/12/08)								
a)	District Hospitals	3/3	0/1	0/1	1/2	0/9	1/2	4/5	9/23
b)	CHC	4/4	2/2	2/1	1/1	0/0	2/3	4/4	15/15
c)	PHC	0/20	0/0	1/6	2/3	0/8	0/4	24/39	27/80
3	Total AYUSH Doctors appointed	0	4	7	1	0	0	24	36
4	Total AYUSH Paramedics appointed	0	4	0	0	0	0	0	4
5	Training of AYUSH								
a)	SBA	N	N	N	N	N	N	N	
b)	IMNCI	N	N	N	N	N	N	N	
c)	NHP	y	N	N	N	Y	N	Y	
d)	Any other /CME/Public health /AYUSH/ LHT NRHM etc.	Y	Y	N	N	Y	N	Y	
	Integration with ASHA /ANM	Y	N	NNNN	N	Y	N	N	3 UT s have Planned
7	Drugs & Equipments Procurement	Y	y	N	N	Y	N	Y	4UTs have planned

Mainstreaming AYUSH & Revitalizing Local health traditions in State PIPs 2007-10									
Non High Focus States- Small & UT									
S.no.	**Mainstreaming strategies**	**A & N Islands**	**Chandigarh**	**D & N Haveli**	**Daman & Diu**	**Delhi**	**Lakshadweep**	**Pondicherry**	**Total**
8	**Additional activities**								
a)	Specialty services/ wings	y	N	N	N	Y	N	Y	3 UTs have planned in at least one of the FY.
	School Health Pro-gramme	Y	N	N	N	N	N	N	Only one has planned in at least one of the FY.
	Tribal health linkages	N	N	N	N	N	N	N	
b)	IEC&BCC	Y	Y	N	N	N	N	N	2 UTs have planned.
c)	LHT Promotion	N	N	N	N	N	N	N	
i)	Herbal Gardens in facilities	N	N	N	N	N	N	N	
ii)	Village level	N	N	N	N	N	N	N	
d)	Outreach activities								
i)	MMU	N	N	N	N	N	N	N	
ii)	AYUSH health Melas	Yyy	Y	N	N	N	N	N	
iii)	Call Centres for AYUSH	N	N	N	N	N	N	N	
e)	Management Strengthening	N	N	N	N	N	N	N	

Mainstreaming AYUSH & Revitalizing Local health traditions in State PIPs 2007-10									
Non High Focus States- Small & UT									
S.no.	**Mainstreaming strategies**	**A & N Islands**	**Chandigarh**	**D & N Haveli**	**Daman & Diu**	**Delhi**	**Lakshadweep**	**Pondicherry**	**Total**
f)	Technical Strengthen-ing	Y	N	N	N	N	N	N	
	Total AYUSH budgets in the PIPs (07-10)	384 lakhs**	247.73 lakhs**	72.2 lakhs**	184 lakhs **	210 lakhs ***	NA	1294.78 Lakhs*	
	% of AYUSH budget in NRHM	22.7%	13.2%	9.2%	26.2%	1%	NA	8.81%	

*indicates financial data available for one year

** indicates financial data available for two years*** indicates financial data available for all three years

Annexure - 11

NRHM guidelines for Mainstreaming of AYUSH & Revitalizing LHT

Annexure 1

Ministry of Health and Family Welfare

Dated the 12th August, 2005

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.

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)

D.O No 10(2)/2008-NRHM

Dear

The broad framework for preparation of NRHM District Health Action Plan provided for submission of State PIPs with Part A on RCH, Part B on NRHM Mission Flexible Pool, Part C on Immunization, Part D on Disease Control Programmes and Part E on Inter-sectoral convergence. The same shall be followed this year. While analyzing the PIPs, it was found that there were overlaps specifically with regard to the RCH Flexible Pool and the Mission Flexible Pool. Perhaps due to the under budgeting for JSY many State PIPs provided for RCH interventions under the Mission Flexible Pool. To resolve this, higher allocation for JSY 2008-09 has been factored while working out the tentative allocation for the RCH Flexible Pool. Therefore, in the year 2008-09 States would be expected to project all their requirements for RCH under the RCH Flexible Pool including JSY as a component of MH.

2. As has been clarified earlier, NRHM is a programme for health system improvement. This means that activities which are essential for health system improvement but cannot be funded from any other programme can be funded from the NRHM flexi pool. It may be noted that RCH Flexible pool provides support for certain activities ***a list of which is annexed with this letter,*** will continue to be funded from the same pool and will be part of RCH-II PIP.

3. Every programme has provision for engagement of human resource. While they may continue to do so as per approvals of plans, it must be ensured that human resources are now for the entire health system and not for a particular programme alone. In planning human resources therefore an assessment must be made of the requirement in the light of convergence within the health sector. It has to be ensured that Nurses, ANMs and Lab Technicians have new job responsibilities given to them so that they are available for the entire range of programmes rather than limited to the source of programme funding. This would call for changes in the systems of pre-service and in-service training and skill development as well.

4. Various programmes have come out with clear operation manual and monitoring manual of State PIPs. States must kindly follow the broad framework provided under them. There must be an effort to ensure that there is a clear classification of items of expenditure specific to the programme.

5. States should endeavour to mainstream AYUSH and necessarily present a detailed plan for intersectoral convergence as part of the PIP. Due attention to programmes like disease surveillance programmes is required to ensure that systems

get established. Similarly, strengthening of Monitoring and Evaluation activities need to be specifically factored in each of the sections of PIP.

With kind regards,

G.C. Chaturvedi,

AS and Mission Director, NRHM

Enclosure: As Stated

To All Principal / Health Secretaries of all States

Government of India

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Secretary to Government of India
Department of Health & Family Welfare
Ministry of Health & Family Welfare
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Tel : 23061863 Fax : 23061252

S. JALAJA
Secretary to Government of India
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DO.No.4(1)/2009-NRHM.I(Pt.I)
Dated the May 15, 2009

As you are aware, co-location and mainstreaming of Ayush are important goals under the NRHM. Many State Governments have come forward in their Programme Implementation Plans with requests for assistance to Ayush under the NRHM. Nearly 5000 Ayush doctors and 1000 Ayush paramedics have been appointed on contract under NRHM in the States. The provision of medicines is made by the Department of Ayush. The approvals are through the PIPs and these are based on the resource envelope of the States under the NRHM and prioritization determined by them. NRHM promotes decentralized planning and the States are free to prioritize within the resource envelope provided to them.

2. The intent of co-location and mainstreaming of Ayush is to increase the choice to patients in health care. It is also an effort to increase the human resource availability in the Primary and Community Health Centres (PHCs/CHCs) for improved public health performance. Many State Governments have also been utilizing the services of Ayush doctors after adequate training for the management of National Health programmes and for public health activities. This has been done in States keeping in view the demand from the local communities and the need for service provision.

3. NRHM support is for co-location and mainstreaming at Primary Health Centres and Community Health Centres. Support for Sub District and District Hospitals and higher level institutions are provided by the Department of Ayush.

4. To enable achievement of the NRHM goal on co-location and mainstreaming of Ayush more effectively the following may kindly be assigned top most priority:

i) Co-location of Ayush at PHCs and CHCs should be done in a manner that the public health system gains from the provision of additional human resource and people get choice in treatment. Coordination with Ayush Department for timely availability of drugs needs to be ensured;

ii) The intent of co-location and mainstreaming is not to disturb a well functioning Ayush dispensary. Such dispensaries can continue to be funded from the Department of Ayush;

iii) The Indian Public Health Standards provide for Ayush personnel at PHCs, CHCs. The States have to prioritize the need and coverage of Ayush facilities based on their resource envelope and their willingness to provide support for salaries after the end of the Mission. States are also encouraged to multi-skill Pharmacists and other paramedics to ensure even better convergence and coordination;

iv) The training programme of ASHAs and ANMs should necessarily have Ayush related component as well to ensure that Village Health and Nutrition Days provide for dispensation of Ayush drugs as per need;

v) Just as Ayush doctors are trained to manage National Health programmes, the States may undertake short duration training/ orientation of Allopathic doctors in Ayush systems as well;

vi) The District Hospitals and Community Health Centres should facilitate the provision of special services like Panchkarma/Khshar Sutra etc. in their premises. Efforts to co-locate Ayush may also be made at secondary and tertiary level facilities in the States. Wherever co-location has taken place it must be ensured that Ayush doctors are represented on Rogi Kalyan Samitis;

vii) Efforts to integrate Ayush in preventive health care and promotion of cultivation of medicinal plants in health facility premises may also be encouraged.

5. We seek your full support in mainstreaming and co-locating Ayush under the National Rural Health Mission.

With regards,

Yours sincerely,

(NARESH DAYAL) (S. JALAJA)

Annexure - III

AYUSH PIP guidelines
by
Department of AYUSH

Department of AYUSH

Subject: Issues to be looked into for preparation of Programme Implementation Plan (PIP) – 2009-10.

1. Promotion of the AYUSH stream of health care is to be done on a holistic basis, for which required support (i) under NRHM for the field level activities, like staff, training and IEC (ii) Schemes of the Department of AYUSH for providing required forward and backward linkages for provision of health care, training, IEC as well as education, research, publicity, etc. and (iii) the State Government need to be pooled together.
2. In the past 3 years, as a part of Mainstreaming of AYUSH, the States had undertaken action for collocating AYUSH facilities in the Primary Health Centers (PHCs), Community Health Centers (CHCs), along with allopathic streams. However, it is also necessary to strengthen the AYUSH dispensaries & hospitals other then the DHs/PHCs/CHCs under AYUSH Dept. for achieving for complete mainstreaming and providing quality AYUSH health care facilities to the people in the rural areas. Therefore, preparation of a separate PIP for this Department is necessary. The Programme Implementation Plan (PIP) for any state for a financial year should be in two parts. namely:- part – (A) (i) under which NRHM flexipool (Health) (ii) NRHM (AYUSH) and Part- (B) Schemes of Department of AYUSH. Details **given in annexure I and II** may be referred to in this regard.

Part A (i)

NRHM Flexipool under the Health Department would indicate appointment of AYUSH medical officers, alongwith Pharmacist/ paramedical staff and Attendant (both recurring of new expenditure) (ii) Training of the officers and staff; and (iii) IEC component for holding Health Mela. Training of ANMs on AYUSH may also be taken up under RCH/NRHM flexipool as the AYSUH wing of the State training institutions should also be reflected.

Part- A (ii) - NRHM AYUSH

Assistance available under NRHM flexipool may be supplemented by assistance under existing scheme of AYUSH which provide for (a) repair, renovation/additions for collating AYUSH facilities in PHCs/CHCs/DHs (b) procurement of furniture, equipment, medicine and consumables both for proposed and existing units.

Part- 'B' AYUSH Sector

Requirement for strengthening colleges in the AYUSH stream for development of institutes as Centre for Excellence, organization of "AROGYA" fair, additional IEC activities component, strengthening of laboratories, quality control, cultivation & processing of medicinal plants (by cultivation/forest of Govt. lands). AYUSH industry-cluster scheme projects on PPP may be projected in part-B of the PIP. In all the schemes proposed, the State Govt. share may be clearly indicated.

The National campaigns initiated by the Department on (1) Mother and child care in Homoeopathy (2) Geriatric care for Ayurveda, for skin disorders, yoga for mental health may be kept in view while planning expansion of AYUSH streams for optimizing use of available resource.

Points to be noted under Mainstreaming of AYUSH under NRHM –Part A (i), (ii) of the PIP

- The role of newly appointed doctors & staff under NRHM flexipool should be made clear.
- In no doctor PHC they should primarily do AYUSH work but in addition provide some essential basic allopathic treatment after getting required training and as per prevailing legal provisions in the State. They will in addition manage the PHC.
- In a one doctor PHC (allopathic doctor) they will practice essentially their own system with cross referrals.
- In both cases they may participate in national programmes like anti Malaria/DOTS etc. of the training.
- The officers and staff of the allopathic stream may also be given exposure and training for providing AYUSH health care facilities (NRHM flexipool).
- AYUSH medical personnel may also be given training for supporting allopathic system as per need, (part A (ii) – AYUSH NRHM).

- Training Programme in AYUSH streams may be organized for the field workers like ANM/ASHA and Anganwadi workers.
- One officer may be nominated for coordinating all AYUSH related matters at the state level.
- The AYUSH officer should be included in the all Committees set up under NRHM at the State, District and below district levels.
- Specific attention should be given for supplying quality drugs. AYUSH drugs could be procured from with the help of IMPCL and Tamil Nadu, Medicinal supplies corporations, OUSHADHI and HLL (Hindustan Latex Ltd.) of Kerala.

New features under AYUSH NRHM*

- GOI will consider sanctioning a PMU* (Programme Management Unit) for AYUSH set up on the pattern of NRHM 50% cost to be borne by the State Govt. PMU to comprise of an MBA, Fin. Manager, Accountant, computer personnel.
- The existing panel of the states Health Department if any could be utilized to save time.
- Support to be provided to AYUSH rural dispensaries/hospitals* will be taken up in phases building component will be on the 85:15 ratio (85 % GOI: 15 % State).
- Funds to be provided for the dispensaries and Hospitals other than PHCs/CHCs/DHs may be utilized through Rogi Kalyan Samitis* (RKS) may on similar line as NRHM. Fund to be placed with RKS may be reflected in part A (ii) of the PIP.

Points to be taken care of on part -B

- Strengthening and improving quality of AYUSH education set up by availing Rs. 2.00 Crores for graduates & Rs. 3.00 Crores for PG institutions under the existence scheme of the Department of AYUSH.
- All State Governments should start facilities for nursing education in the existing colleges (no need for additional land). In the absence of a nursing council, affiliation could be provided by the university.
- Paramedical education should be given priority through certificate courses.
- All sanctioned /vacant posts should be filled on priority by the State Governments.
- Scope for medicinal plantations in Government and private land with assistance available under the Schemes of National Medicinal Plants Board/National mission of medicinal plantation may be indicated.
- Possible location for setting up AYUSH industrial clusters (for which IL&FS is engaged by GOI), for supporting forward and backward linkage for medicinal plants cultivation projects may be indicated.
- Organization of AROGYA fair under Department of AYUSH may be included for spreading awareness about benefits of AYUSH stream of medicine.

Public Private Partnership*

- The state may explore possibility of partnership with credible, well established non-Govt. institutions especially in running AYUSH dispensaries, AYUSH hospitals, AYUSH specialties, existing Govt. institutions. The staff component be met by the partner or State Govt. Govt. of India will provide assistance for alternation/renovation/ additions of buildings, medicines/consumables/furniture and equipments. Each proposal should not be more than of Rs. 1.00 Crores.
- Enhancing AYUSH Provision to at least 10% of the total Health budget in the State budget from 2009 may be given top priority.
- Position of pending UCs and action taken for liquidating the pending UCs may be indicated. While pending utilization certificate for equipment and consumables may be submitted immediately, for construction related components, (i) status of construction, (ii) location of units for which fund was sanctioned may be indicated along with the proposal for new sanction. (along with the locations).

* These components are under process and guidelines will be circulated as soon as these are finanlized.

Part A-1: NRHM Mission flexipool from Department of Health

Sl. No.	Component		Continuing from previous year (08-09) (X)		New during 2009-10 (Y)		Cumulative for 2009-10 (X+Y)	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Manpower	Unit	Physical	Financial	Physical	Financial	Physical	Financial
1.1.1	AYUSH doctors	PHCs						
1.1.2		CHCs						
1.1.3		DHs						
1.2.1	Para-medics	PHCs						
1.2.2		CHCs						
1.2.3		DHs						
1.3.1	Multi Purpose worker	PHCs						
1.3.2		CHCs						
1.3.3		DHs						

Sl. No.	Component	For 2009-10	
2	Training under NRHM	Physical	Financial
2.1	For AYUSH Doctors		
2.2	For Paramedics		
3	Information education and coordination (IEC), Organization of health fair.		

Part A-2: NRHM components from Department of AYUSH

(Amount in Lakhs of Rs.)

Sl. No.	Components		Units continuing		New 2009-10		2009-10	
1	Creation of Facilities (one time)		Unit	Amount	Unit	Amount	Unit	Amount
1.1.1	Addition,	PHCs @ 3						
1.1.2	Alteration,	CHCs @ 5						
1.1.3	Construction	DHs @ 10						
1.2.1	Equipments, machinery & Furniture	PHCs @ 3						
1.2.2		CHCs @ 10						
1.2.3		DHs @ 15						
1.3.1	Medicines	PHCs @ 3						
1.3.2		CHCs @ 5						
1.3.3		DHs @ 7						

2	Essential Drugs	For AYUSH Dispensaries @ 0.25	For existing units		New Units in 2009-10		Total for 2009-10	
			Unit	Amount	Unit	Amount	Unit	Amount

Part B: Schemes of Department of AYUSH

1. Upgradation of AYUSH Educational Institutions – UG & PG Colleges and Model Colleges, add on component of AYUSH Pharmacy and Nursing course in existing AYUSH Colleges.
2. Establishment of AYUSH College/University in the States where these are not existing.
3. Centre of Excellence.
4. Cultivation of Medicinal Plants (assistance from National Medicinal Plants Board) www.nmpb.nic.in
5. State level Mission on Medicinal Plants (assistance from National Medicinal Plants Board).
6. ROTP programme for Teachers and CME programme for Practitioners
7. Enforcement Mechanism of Quality control of Drugs
8. State level and regional level Campaigns on Geriatric Care, Ksharasutra, Homoeopathy for Mother and Child Health, Quality control of Drugs (@ Rs. 05.00 Lakhs)
9. Industrial Cluster (@ Rs. 10.00 Crores)
10. Central Sector Scheme of Public Health Initiatives
11. Central Sector Scheme of Local Health Traditions
12. Arogya Fair (Mela) (@ Rs. 35.00 Lakhs)
13. Digitization/ Printing of Books and Manuscripts.

Annexure - IV

Indian Public Health Standards
for
AYUSH & Local Health Traditions

Indian Public Health Standards on AYUSH & Local Health Traditions

The Indian Public Health Standards [IPHS] outlines the following guidelines regarding the AYUSH systems and Local Health Traditions at various levels of the Primary Health Care.The Standards set for each level are as follows:

Sub centre (SC)

Minimum Requirement for Delivery of the Services at SC:

Curative Services:

- Provide treatment as per AYUSH as per the local need.
- ANMs and MPW(M) be trained in AYUSH.

Promotion of Medicinal Herbs

- Locally available medicinal herbs/plants should be grown around the sub -centre

Primary Health Centre (PHC)

Minimum Requirement for Delivery of the Services at PHC:

Curative Services:

- AYUSH services as per local preference.
- One Medical Officer [AYUSH],as per the AYUSH system prevalent in the area.
- Training of pharmacist on AYUSH component with standard modules.
- Training of AYUSH doctor in imparting health services related to National Health and Family Welfare programme.
- The AYUSH doctor at PHC shall attend patients for system-specific AYUSH based preventive, promotive and curative health care and take up public health education activities including awareness generation about the uses of medicinal plants and local health practices.
- The signboard of the PHC should mention AYUSH facilities.
- Sufficient space with the storage cabins for AYUSH drugs be provided.
- Infrastructure for AYUSH doctor: Based on the specialty being practiced, appropriate arrangements should be made for the provision of a doctor's room and a dispensing room cum drug storage.
- For drug dispensing, the present pharmacist may be trained or Rogi Kalyan Samiti (RKS) may provide an AYUSH pharmacist.
- Drugs required for the AYUSH doctor should be available in addition to all other facilities. The list of suggested drugs including AYUSH drugs is given in the annexure.
- Wherever possible, the MO will conduct field investigations to delineate local health problems for planning changes in the strategy of the effective delivery of Health and Family welfare services. He/she will coordinate and facilitate the functioning of AYUSH doctor in the PHC.

Promotion of Medicinal Herbs

- Locally available medicinal herbs/plants should be grown around the PHC

Community Health Centre (CHC)

Minimum Requirement for Delivery of the Services at CHC:

Curative Services:

- One AYUSH specialist[Post Graduate in AYUSH]
- One AYUSH General Duty Medical Officer[Graduate in AYUSH] are recommended in the IPHS for CHC.
- AYUSH Drugs will be as per the list in the annexure.
- One Pharmacist – AYUSH
- Pharmacy cum store for AYUSH 6.4X3.2Mtrs
- Space for 2 AYUSH doctors Room 3.2 X 3.2 X2

31-50 Bedded Hospital

Minimum Requirement for Delivery of the Services:

Consultation services:

Two AYUSH Physicians are recommended.

- One AYUSH specialist[Post Graduate in AYUSH].
- One AYUSH General Duty Medical Officer[Graduate in AYUSH].
- Provided there is no AYUSH hospital / dispensary in the district headquarter.
- One AYUSH Pharmacist.

51-100 Bedded Hospital

Minimum Requirement for Delivery of the Services:

Consultation services:

Two AYUSH Physicians are recommended.

- One AYUSH specialist[Post Graduate in AYUSH].
- One AYUSH General Duty Medical Officer [Graduate in AYUSH]. Provided there is no AYUSH hospital/dispensary in the district headquarter.
- One AYUSH Pharmacist.

101-200 Bedded Hospital

Minimum Requirement for Delivery of the Services:

Consultation services:

Two AYUSH Physicians are recommended.

- One AYUSH specialist[Post Graduate in AYUSH].
- One AYUSH General Duty Medical Officer [Graduate in AYUSH]. Provided there is no AYUSH hospital/dispensary in the district headquarter.
- One AYUSH Pharmacist.

201-300 Bedded Hospital

Minimum Requirement for Delivery of the Services:

Consultation services:

Two AYUSH Physicians are recommended.

- One AYUSH specialist[Post Graduate in AYUSH].
- One AYUSH General Duty Medical Officer [Graduate in AYUSH]. Provided there is no AYUSH hospital/dispensary in the district headquarter.
- One AYUSH Pharmacist.

301-500 Bedded Hospital

Minimum Requirement for Delivery of the Services:

Consultation services:

Four AYUSH Physicians are recommended.

- 2 AYUSH specialists [Post Graduate in AYUSH].
- 2 GDMOs [Graduate in AYUSH].
- Two AYUSH Pharmacist

List of AYUSH Drugs to be Used by AYUSH Doctor Posted at PHC (As per the List Provided by the Department of AYUSH, Ministry of Health & Family Welfare, Government of India):

List of Ayurvedic Medicines for PHCs:

1. Sanjivani Vati
2. Godanti Mishran
3. AYUSH-64
4. Lakshmi Vilas Rasa (Naradeeya)
5. Khadiradi Vati
6. Shilajatwadi Louh
7. Swas Kuthara rasa
8. Nagarjunabhra rasa
9. Sarpagandha Mishran
10. Punarnnavadi Mandura
11. Karpura rasa
12. Kutajaghan Vati
13. Kamadudha rasa
14. Laghu Sutasekhar rasa
15. Arogyavardhini Vati
16. Shankha Vati
17. Lashunadi Vati
18. Kankayana Vati
19. Agnitundi Vati
20. Vidangadi louh
21. Brahmi Vati
22. Sirashooladi Vajra rasa

23. Chandrakant rasa
24. Smritisagara rasa
25. Kaishora guggulu
26. Simhanad guggulu
27. Yograj guggulu
28. Gokshuradi guggulu
29. Gandhak Rasayan
30. Rajapravartini Vati
31. Triphala guggulu
32. Saptamrit Louh
33. Kanchanara guggulu
34. AYUSH Ghutti
35. Talisadi Churna
36. Panchanimba Churna
37. Avipattikara Churna
38. Hingvashtaka Churna
39. Eladi Churna
40. Swadishta Virechan Churna
41. Pushyanuga Churna
42. Dasanasamskara Churna
43. Triphala Churna
44. Balachaturbhadra Churna
45. Trikatu Churna
46. Sringyadi Churna
47. Gojihwadi kwath Churna
48. Phalatrikadi kwath Churna
49. 54.Maharasnadi kwath Churna
50. Pashnabhedadi kwath Churna
51. Dasamoola Kwath Churna
52. Eranda paka
53. Haridrakhanda
54. Supari pak
55. Soubhagya Shunthi
56. Brahma Rasayana
57. Balarasayana
58. Chitraka Hareetaki
59. Amritarishta
60. Vasarishta
61. Arjunarishta
62. Lohasava
63. Chandanasava
64. Khadirarishta
65. Kutajarishta
66. Rohitakarishta
67. Ark ajwain
68. Abhayarishta
69. Saraswatarishta
70. Balarishta
71. Punarnnavasav
72. Lodhrasava
73. Ashokarishta
74. Ashwagandharishta
75. Kumaryasava
76. Dasamoolarishta
77. Ark Shatapushpa (Sounf)
78. Drakshasava
79. Aravindasava
80. Vishagarbha Taila
81. Pinda Taila
82. Eranda Taila
83. Kushtarakshasa Taila
84. Jatyadi Taila/Ghrita
85. Anu Taila
86. Shuddha Sphatika
87. Shuddha Tankan
88. Shankha Bhasma
89. Abhraka Bhasma
90. Shuddha Gairika
91. Jahar mohra Pishti
92. Ashwagandha Churna
93. Amrita (Giloy) Churna
94. Shatavari Churna
95. Mulethi Churna
96. Amla Churna
97. Nagkesar Churna
98. Punanrnava Churna
99. Dadimashtak Churna
100. Chandraprabha Vati.

List of Unani Medicines for PHCs:

1. Arq-e-Ajeeb
2. Arq-e-Gulab
3. Arq-e-Kasni
4. Arq-e-Mako
5. Barshasha
6. Dawaul Kurkum Kabir
7. Dawaul Misk Motadil Sada
8. Habb-e-Aftimoon
9. Habb-e-Bawasir Damiya
10. Habb-e-Bukhar
11. Habb-e-Dabba-e-Atfal
12. Habb-e-Gule Pista
13. Habb-e-Hamal
14. Habb-e-Hilteet
15. Habb-e-Hindi Qabiz
16. Habb-e-Hindi Sual
17. Habb-e-Hindi Zeeqi
18. Habb-e-Jadwar
19. Habb-e-Jawahir
20. Habb-e-Jund
21. Habb-e-Kabid Naushadri
22. Habb-e-karanjwa
23. Habb-e-Khubsul Hadeed
24. Habb-e-Mubarak
25. Habb-e-Mudirr
26. Habb-e-Mumsik
27. Habb-e-Musaffi
28. Habb-e-Nazfuddam
29. Habb-e-Nazla
30. Habb-e-Nishat
31. Habb-e-Raal
32. Habb-e-Rasaut
33. Habb-e-Shaheeqa
34. Habb-e-Shifa
35. Habb-e-Surfa
36. Habb-e-Tabashir
37. Habb-e-Tankar
38. Habb-e-Tursh Mushtahi
39. Itrifal Shahatra
40. Itrifal Ustukhuddus
41. Itrifal Zamani
42. Jawahir Mohra
43. Jawarish Jalinoos
44. Jawarish Kamooni
45. Jawarish Mastagi
46. Jawarish Tamar Hindi
47. Khamira Gaozaban Sada
48. Khamira Marwareed
49. Kushta Marjan Sada
50. Laooq Katan
51. Laooq Khiyarshanbari
52. Laooq Sapistan
53. Majoon Arad Khurma
54. Majoon Dabeedulward
55. Majoon Falasifa
56. Majoon Jograj Gugal
57. Majoon Kundur
58. Majoon Mochras
59. Majoon Muqawwi-e-Reham
60. Majoon Nankhwah
61. Majoon Panbadana
62. Majoon Piyaz
63. Majoon Seer Alwikhani
64. Majoon Suhag Sonth
65. Majoon Suranjan
66. Majoon Ushba
67. Marham Hina
68. Marham Kafoor
69. Marham Kharish
70. Marham Quba
71. Marham Ral Safaid
72. Qurs Aqaqia
73. Qurs Dawaul Shifa
74. Qurs Deedan
75. Qurs Ghafis
76. Qurs Gulnar
77. Qurs Habis

78. Qurs Kafoor
79. Qurs Mulaiyin
80. Qurs Sartan Kafoori
81. Qurs Zaranbad
82. Qurs Ziabetus Khaas
83. Qurs Ziabetus Sada
84. Qurs-e-Afsanteen
85. Qurs-e-Sartan
86. Qutoor-e-Ramad
87. Raughan Baiza-e-Murgh
88. Raughan Bars
89. Raughan Kahu
90. Raughan Kamila
91. Raughan Qaranful
92. Raughan Surkh
93. Raughan Turb
94. Roghan Luboob Saba
95. Roghan Malkangni
96. Roghan Qust
97. Safoof Amla
98. Safoof Chutki
99. Safoof Dama Haldiwala
100. Safoof Habis
101. Safoof Muqliyasa
102. Safoof Mustehkam Dandan
103. Safoof Naushadar
104. Safoof Sailan
105. Safoof Teen
106. Sharbat Anjabar
107. Sharbat Buzoori Motadil
108. Sharbat Faulad
109. Sharbat Khaksi
110. Sharbat Sadar
111. Sharbat Toot Siyah
112. Sharbat Zufa
113. Sunoon Mukhrij-e-Rutoobat
114. Tiryaq Nazla
115. Tiryaq pechish
116. Zuroor-e-Qula

List of Siddha Medicines for PHCs:

1. Amai otu parpam -For diarrhoea in children a nd indigestion
2. Amukkarac curanam-For general debility, insomnia, Hyper acidity.
3. **Anna petic centuram-For anaemia**
4. Antat Tailam - For febrile convulsions
5. Atotataik kuti nir - cough and cold
6. Aya Kantac centuram- aneamia
7. Canku parpam - anti allergic
8. Canta cantirotayam - fevers and jaundice
9. Cilacattu Parpam - Urinary infection, white discharge
10. Civanar Amirtam - anti allergic, bronchial asthma
11. Comput Tinir - indigestion, loss of appetite
12. Cuvacakkutori mathirai- asthma and cough
13. Elatic curanam - allergy, fe ver in primary complex
14. Incic Curanam - indigestion, flatulence
15. Iraca Kanti Meluku - skin infections, venereal infections.
16. Kantaka Racayanam - skin diseases and urinary infections.
17. Kapa Curak Kutinir - fevers
18. Karappan Tailam - eczema
19. Kasturik karuppu - fever, cough, allergic bronchitis
20. Korocanai mattirai - sinus, fits.
21. Kunkiliya Vennay - external application for piles and scalds
22. Manturati Ataik Kutinir- anaemia
23. Mattan Tailam - ulcers and diabetic carbuncle
24. Mayanat Tailam - swelling, inflammation
25. Murukkan Vitai Mattirai- intestinal worms
26. Nantukkal Parpam - diuretic
27. Nellikkai Ilakam - tonic
28. Neruncik Kutinir - diuretic
29. Nilavakaic Curanam - constipation
30. Nila Vempuk Kutinir - fever
31. Omat Tinir - indigestion
32. Parankip pattaic Curanam - skin diseases
33. Pattuk karuppu - DUB, painful menstruation

34. Tayirc Cuntic Curanam- diarrhea, used as ORS
35. Terran kottai Ilakam - tonic, used in bleeding piles
36. Tiripalaic Curanam - styptic and tonic
37. Visnu Cakkaram - pleurisy

Patent & Proprietary Drug

1. 777 Oil - for Psoriasis

List of Homeopathy Medicines for PHCs:

S.No	Name of Medicine	Potency
1	Abrotanum	30
2	Abrotanum	200
3	Absinthium	Q
4	Aconite Nap.	6
5	Aconite Nap.	30
6	Aconite Nap.	200
7	Aconite Nap.	1M
8	Actea Racemosa	30
9	Actea Racemosa	200
10	Aesculus Hip	30
11	Aesculus Hip	200
12	Aesculus Hip	1M
13	Agaricus musca.	30
14	Agaricus musca	200
15	Allium cepa	6
16	Allium cepa	30
17	Allium cepa	200
18	Aloe soc.	6
19	Aloe soc.	30
20	Aloe soc.	200
21	Alumina	30
22	Alumina	200
23	Ammon Carb	30
24	Ammon Carb	200
25	Ammon Mur	30
26	Ammon Mur	200
27	Ammon Phos	30
28	Ammon phos	200
29	Anacardium Ori.	30
30	Anacardium Ori.	200
31	Anacardium Ori.	!M
32	Angustura vera	Q
33	Anthracinum	200
34	Anthracinum	1M
35	Antim Crud	30
36	Antim Crud	200
37	Antim Crud	!M
38	Name of Medicine	Potency
39	Antimonium Tart	3X
40	Antimonium Tart	6
41	Antimonium Tart	30
42	Antimonium Tart	200
43	Apis mel	30
44	Apis mel	200
45	Apocynum Can	Q
46	Apocynum Can	30
47	Arg. Met	30
48	Arg Met.	200
49	Arg. Nit.	30
50	Arg. Nit.	200
51	Arnica Mont.	Q
52	Arnica Mont	30
53	Arnica Mont	200
54	Arnica Mont	!M
55	Arsenicum Alb.	6
56	Arsenicum Alb.	30
57	Arsenicum Alb.	200
58	Arsenicum Alb.	1M
59	Aurum Met.	30
60	Aurum Met.	200
61	Bacillinum	200
62	Bacillinum	1M
63	Badiaga	30
64	Badiaga	200
65	Baptisia Tinct.	Q
66	Baptisia Tinct	30
67	Baryta Carb.	30
68	Baryta Carb.	200
69	Baryta Carb.	1M
70	Baryta Mur.	3X

71 Belladonna 30
72 Belladonna 200
73 Belladonna 1M
74 Bellis Perennis Q
75 Bellis Perennis 30
76 Benzoic Acid 30
77 Benzoic Acid 200
78 Berberis Vulgaris Q
79 Berberis Vulgaris 30
80 Berberis Vulgaris 200
81 Blatta Orientalis Q
82 Blatta Orientalis 30
83 Blumea Odorata Q
84 Borax 30
85 Bovista 30
86 Bromium 30
87 Bryonia Alba 3X
88 Bryonia Alba 6
89 Bryonia Alba 30
90 Bryonia Alba 200
91 Bryonia Alba 1M
92 Bufo rana 30
93 Carbo veg 30
94 Carbo veg 200
95 Cactus G. Q
96 Cactus G. 30
97 Calcarea Carb 30
98 Calcarea Carb 200
99 Calcarea Carb 1M
100 Calcarea Fluor 30
101 Calcarea Fluor 200
102 Calcarea Fluor 1M
103 Calcarea Phos 30
104 Calcarea Phos 200
105 Calcarea Phos 1M
106 Calendula Off. Q
107 Calendula Off 30
108 Calendula Off 200
109 Camphora 6
110 Camphora 200
111 Cannabis Indica 6
112 Cannabis Indica 30
113 Cantharis Q
114 Cantharis 30
115 Cantharis 200
116 Capsicum 30
117 Capsicum 200
118 Carbo Animalis 30
119 Carbo Animalis 200
120 Carbolic Acid 30
121 Carbolic Acid 200
122 Carduus Mar Q
123 Carduus Mar 6
124 Carduus Mar 30
125 Carcinosinum 200
126 Carcinosinum !M
127 Cassia sophera Q
128 Caulophyllum 30
129 Caulophyllum 200
130 Causticum 30
131 Causticum 200
132 Causticum !M
133 Cedron 30
134 Cedron 200
135 Cephalendra Indica Q
136 Chamomilla 6
137 Chamomilla 30
138 Chamomilla 200
139 Chamomilla !M
140 Chelidonium Q
141 Chelidonium 30
142 Chin Off. Q
143 Chin Off 6
144 Chin Off 30
145 Chin Off 200
146 Chininum Ars 3X
147 Chininum Sulph 6
148 Cicuta Virosa 30

149 Cicuta Virosa 200
150 Cina Q
151 Cina 3X
152 Cina 6
153 Cina 30
154 Cina 200
155 Coca 200
156 Cocculus Indicus 6
157 Cocculus Indicus 30
158 Coffea Cruda 30
159 Coffea Cruda 200
160 Colchicum 30
161 Colchicum 200
162 Colocynthis 6
163 Colocynthis 30
164 Colocynthis 200
165 Crataegus Oxy Q
166 Crataegus Oxy 3X
167 Crataegus Oxy 30
168 Crataegus Oxy 200
169 Crotalus Horridus 200
170 Croton Tig. 6
171 Croton Tig. 30
172 Condurango 30
173 Condurango 200
174 Cuprum met. 30
175 Cuprum met. 200
176 Cynodon Dactylon Q
177 Cynodon Dactylon 3X
178 Cynodon Dactylon 30
179 Digitalis Q
180 Digitalis 30
181 Digitalis 200
182 Dioscorea 30
183 Dioscorea 200
184 Diphtherinum 200
185 Drosera 30
186 Drosera 200
187 Dulcamara 30
188 Dulcamara 200
189 Echinacea Q
190 Echinacea 30
191 Equisetum 30
192 Equisetum 200
193 Eupatorium Perf. 3X
194 Eupatorium Perf. 30
195 Eupatorium Perf. 200
196 Euphrasia Q
197 Euphrasia 30
198 Euphrasia 200
199 Ferrum Met. 200
200 Flouric Acid 200
201 Formica Rufa 6
202 Formica Rufa 30
203 Gelsimium 3X
204 Gelsimium 6
205 Gelsimium 30
206 Gelsimium 200
207 Gelsimium 1M
208 Gentiana Chirata 6
209 Glonoine 30
210 Glonoine 200
211 Graphites 30
212 Graphites 200
213 Graphites 1M
214 Guaiacum 6
215 Guaiacum 200
216 Hamamelis Vir Q
217 Hamamelis Vir 6
218 Hamamelis Vir 200
219 Helleborus 6
220 Helleborus 30
221 Hepar Sulph 6
222 Hepar Sulph 30
223 Hepar Sulph 200
224 Hepar Sulph 1M
225 Hippozaenium 6
226 Hydrastis Q

227 Hydrocotyle As. Q
228 Hydrocotyle As. 3X
229 Hyocyamus 200
230 Hypericum Q
231 Hypericum 30
232 Hypericum 200
233 Hypericum 1m
234 Ignatia 30
235 Ignatia 200
236 Ignatia 1m
237 Iodium 30
238 Iodium 200
239 Iodium 1m
240 Ipecacuanha Q
241 Ipecacuanha 3X
242 Ipecacuanha 6
243 Ipecacuanha 30
244 Ipecacuanha 200
245 Iris Tenax 6
246 Iris Veriscolor 30
247 Iris Veriscolor 200
248 Jonosia Ashoka Q
249 Justicia Adhatoda Q
250 Kali Bromatum 3X
251 Kali Carb 30
252 Kali Carb 200
253 Kali Carb 1M
254 Kali Cyanatum 30
255 Kali Cyanatum 200
256 Kali Iod 30
257 Kali Iopd 200
258 Kali Mur 30
259 Kali Mur 200
260 Kali Sulph 30
261 Kalmia Latifolium 30
262 Kalmia Latifolium 200
263 Kalmia Latifolium 1M
264 Kreosotum Q
265 Kreosotum 30
266 Kreosotum 200
267 Lac Defloratum 30
268 Lac Defloratum 200
269 Lac Defloratum 1M
270 Lac Can 30
271 Lac Can 200
272 Lachesis 30
273 Lachesis 200
274 Lachesis 1M
275 Lapis Albus 3X
276 Lapis Albus 30
277 Ledum Pal 30
278 Ledum Pal 200
279 Ledum Pal 1M
280 Lillium Tig. 30
281 Lillium Tig. 200
282 Lillium Tig. 1M
283 Lobella inflata Q
284 Lobella inflata 30
285 Lycopodium 30
286 Lycopodium 200
287 Lycopodium 1M
288 Lyssin 200
289 Lyssin 1M
290 Mag.Carb 30
291 Mag.Carb 200
292 Mag Phos 30
293 Mag Phos 200
294 Mag Phos 1M
295 Medorrhinum 200
296 Medorrhinum 1M
297 Merc Cor 6
298 Merc Cor 30
299 Merc Cor 200
300 Merc Sol 6
301 Merc Sol 30
302 Merc Sol 200
303 Merc Sol 1m
304 Mezerium 30

305 Mezerium 200
306 Millefolium Q
307 Millefolium 30
308 Muriatic Acid 30
309 Muriatic Acid 200
310 Murex 30
311 Murex 200
312 Mygale 30
313 Naja Tri 30
314 Naja Tri 200
315 Natrum Ars 30
316 Natrum Ars 200
317 Natrum Carb 30
318 Natrum Carb 200
319 Natrum Carb 1M
320 Natrum Mur 6
321 Natrum Mur 30
322 Natrum Mur 200
323 Natrum Mur 1M
324 Natrum Phos 30
325 Natrum Sulph 30
326 Natrum Sulph 200
327 Natrum Sulph 1M
328 Nitric Acid 30
329 Nitric Acid 200
330 Nitric Acid 1M
331 Nux Vomica 6
332 Nux Vomica 30
333 Nux Vomica 200
334 Nux Vomica 1M
335 Nyctenthus Arbor Q
336 Ocimum Sanctum Q
337 Oleander 6
338 Petroleum 30
339 Petroleum 200
340 Petroleum 1M
341 Phosphoric Acid Q
342 Phosphoric Acid 30
343 Phosphoric Acid 200
344 Phosphoric Acid 1M
345 Phosphorus 30
346 Phosphorus 200
347 Phosphorus 1M
348 Physostigma 30
349 Physostigma 200
350 Plantago Major Q
351 Plantago Major 6
352 Plantago Major 30
353 Platina 200
354 Platina 1M
355 Plumbum Met 200
356 Plumbum Met 1M
357 Podophyllum 6
358 Podophyllum 30
359 Podophyllum 200
360 Prunus Spinosa 6
361 Psorinum 200
362 Psorinum 1M
363 Pulsatilla 30
364 Pulsatilla 200
365 Pulsatilla 1M
366 Pyrogenium 200
367 Pyrogenium 1M
368 Ranunculus bulbosus 30
369 Ranunculus bulbosus 200
370 Ranunculus repens 6
371 Ranunculus repens 30
372 Ratanhia 6
373 Ratanhia 30
374 Rauwolfia serpentina Q
375 Rauwolfia serpentina 6
376 Rauwolfia serpentina 30
377 Rhododendron 30
378 Rhododendron 200
379 Rhus tox 3X
380 Rhus tox 6
381 Rhus tox 30
382 Rhus tox 200

383 Rhus tox 1M
384 Robinia 6
385 Robinia 30
386 Rumex crispus 6
387 Rumex crispus 30
388 Ruta gr 30
389 Ruta gr 200
390 Sabal serreulata Q
391 Sabal serreulata 6
392 Sabina 3X
393 Sabina 6
394 Sabina 30
395 Sang.can 30
396 Sang.can 200
397 Sarsaprilla 6
398 Sarsaprilla 30
399 Secalecor 30
400 Secalecor 200
401 Selenium 30
402 Selenium 200
403 Senecio aureus 6
404 Sepia 30
405 Sepia 200
406 Sepia 1M
407 Silicea 30
408 Silicea 200
409 Silicea 1M
410 Spigellia 30
411 Spongia tosta 6
412 Spongia tosta 30
413 Spongia tosta 200
414 Stannum 30
415 Stannum 200
416 Staphisagria 30
417 Staphisagria 200
418 Staphisagria 1M
419 Sticta pulmonaria 6
420 Sticta pulmonaria 30
421 Stramonium 30
422 Stramonium 200
423 Sulphur 30
424 Sulphur 200
425 Sulphur 1M
426 Sulphuric acid 6
427 Sulphuric acid 30
428 Syphilinum 200
429 Syphilinum 1M
430 Tabacum 30
431 Tabacum 200
432 Tarentula cubensis 6
433 Tarentula cubensis 30
434 Tellurium 6
435 Tellurium 30
436 Terebinthina 6
437 Terebinthina 30
438 Terminalia arjuna Q
439 Terminalia arjuna 3X
440 Terminalia arjuna 6
441 Thuja occidentalis Q
442 Thuja occidentalis 30
443 Thuja occidentalis 200
444 Thuja occidentalis 1M
445 Thyroidinum 200
446 Thyroidinum 1M
447 Tuberculinum bov 200
448 Uran.Nit 3X
449 Urtica urens Q
450 Urtica urens 6
451 Ustilago 6
452 Verat alb 6
453 Viburnan opulus 6
454 Viburnan opulus 30
455 Viburnan opulus 200
456 Vipera tor 200
457 Vipera tor 1M
458 Verat viride 30
459 Verat viride 200
460 Viscum album 6

461 Wyethia 6
462 Wyethia 30
463 Wyethia 200
464 Zinc met 200
465 Zinc met 1M
466 Zink phos 200
467 Zink phos 1M
468 Globules 20 no.
469 Sugar of milk
470 Glass Piles 5 ml
471 Glass Piles 10 ml
472 Butter Paper
473 Blank Sticker 1/2*3/2 inch

Ointments

474 Aesculus Hip
475 Arnica
476 Calendula
477 Cantharis
478 Hamamelis Vir
479 Rhus tox
480 Twelve Biochemic Medicines 6x & 12x
481 Cineraria Eye Drop
482 Euphrasia Eye Drop
483 Mullein Oil (Ear Drop)

Annexure - V

Department of AYUSH

Schemes/Initiatives/Campaigns for Strengthening the Mainstreaming strategy

Department of AYUSH schemes/initiatives to strengthen Mainstreaming Strategy

There are a number of bodies, Institutes and various Schemes, projects and campaigns under the Dept of AYUSH which are contributing to strengthen the mainstreaming activities of AYUSH and Local Health Traditions, which are mentioned here. The details of each of these can be obtained from the Dept. of AYUSH website given in the Bibliography section.

I. Centrally Sponsored schemes:

1. Centrally sponsored schemes on Quality Control of ASUH drugs.
2. Centrally sponsored schemes on Hospitals and Dispensaries.
3. Centrally sponsored scheme of National Mission on Medicinal Plants

II. Central Sector Schemes:

1. Central Sector Scheme for supporting Reorientation training, Continued Medical Education, Education Exposure Programmes of AYUSH.
2. Central Sector Scheme for Up gradation of Centers of Excellence
3. Central Sector Scheme for Public Health Initiatives.
4. Central Sector Scheme for Revitalization of Local Health Traditions, Midwifery practices etc.
5. Central Sector Scheme for promotion of IEC in AYUSH.
6. Central Sector Scheme for Exchange programme /Seminar/Conference/Workshops on AYUSH

III. National Campaigns paign

2. Geriatric Care Campaign
3. Homeopathy campaign on Mother & child care.

IV. National Institutes of AYUSH

V. National Research Councils

VI. National Regulatory Bodies for AYUSH education & Qualifications

VII. National Resource Centre for Homeopathy

Annexure - VI

AYUSH & LHT

Innovations & Initiatives

AYURVEDGRAM

Establishment of Ayurved Gram to meet the objective of AYURVEDA 'Swasthasya *Swatha Rakshnam / Aturashya Vikarprashnam.*

Back Ground

In view of its extremely rich and unique Bio-cultural-diversity, the government has resolved to develop Chhattisgarh as **Herbal State**. Through the state led initiatives on situ conservation, ex situ cultivation and propagation, capacity building of local communities on herbal produce.

The indigenous communities of the State use as many as 327 medicinal herbal species grown in the forest without any systematic environmental planning out of which 42 herbal plants being considered endangered species. According to the tribal herbalists more than 75% of the rare herbs have been wiped out.[21]. There are at least 23 Minor Forest Produce (MFP) and another 32 types of roots and herbs that are the largest source of income, After agriculture.

Traditional practitioners and faith healers such as the Baigas, Gunias and Tantriks were the main providers of health care in the past. These healing systems included the knowledge and use of herbs for curing diseases. There is a resident knowledge base in the villages, among the local dais (midwives) they have traditional knowledge of maternity care during pregnancy and childbirth. The indigenous knowledge system, local innovations and practices of tribal herbalists hold the key to sustainable development and the transformation of Chhattisgarh into an herbal State of India.

Ayurvedic system of medicine is practice since ancient period and this knowledge is transmitted from generation to generation. Communities which are close to nature and hilly areas are familiar with the medicinal plants and are using this knowledge to treat minor illness effectively. These medicinal plants are available locally and do not require any expense the only thing require is knowledge about the same. This way the minor illness can be treated effectively with the help of the knowledge of medicinal plants and preventive practices can be established by practicing Ayurvedic principles without any expense. Community which are economically poor and for whom health care services are not easily accessible bringing Ayurveda into practice could be an economic and easiest way to prevent and treat some of the illness and live quality healthy life.

Chattisgarh is a state where 80% of the population is in Villages. It is very mu ch possible to live according to the Ayurvedic concepts and all herbal medicines are available in huge quantity in these villages. It is being observed that more urban people are going for the Ayurvedic Treatment rather than any other, for this to give them regular information and suggestion this concept of Ayurved gram is being prepared.

Project objectives

1. To ensure the health for each person of the *Ayurved Gram and* Teaching them the basics of good health according to Ayurvedic principals and promotion and treatment of common ailments.
2. Giving information about the *Rutucharya* (seasonal routine) and Din charya (daily routine) to all residents of Ayurved gram.
3. Taking information about food habits and daily routine of Ayurved gram villagers and imparting correct Knowledge and activities.
4. Impart knowledge on the importance of the available Ayurvedic herbs and drugs in the villages and Encouraging them for their production and use.
5. Imparting skills of Treating common ailments with the home remedies and available Ayurvedic Drugs.
6. Encouraging farmers to cultivate rather than to replace the existing crops with Ayurvedic plants in the form or kitchen garden.
7. Creating awareness in order to prevent the diseases prevalent in that area like TB, malaria, Dengue & water borne disease and its treatment and cure.
8. Successful coordination and integration of the all-national health program in Ayurvedgram.
9. To promote wider application of community knowledge, practices and innovation related to biodiversity with their approval and participation.

1 Ethno-Medicinal Practices and Sustainable Development: Sensitive Issues of Economic Transformation in Chhattisgarh, Pati R N (not dated)

Priority Areas in the Ayurved gram

- Health for All
- Healthy Childhood
- Good Motherhood
- Healthy Ageing
- Healthy society

Issues under Concern for Implementation of Ayurved gram

1. Within the selected block one village is selected where Ayurvedic dispensary already exists and doctor and staff is in place. The programme is already implemented to improvise the results more human resource is utilized
2. Collaboration of existing Health program with Ayurvedgram in order to ensure improved health status benefits.
3. Adequate base line data on Health status wellbeing, burden of disease, socioeconomic cultural strata, and NGO's involved in the health sector of the village.

Out Put

- Community participation of the Villagers for improving the health status of the individual
- Health seeking behavior of the population shall be modified
- Improving the doctor patient relationship for seeking better health care as patient friendly AYUSH Clinics
- Enhancing the preventive aspect of medicine by the concepts of Swasthavritta
- Popularization of the herbal medicines among the residents of the Village
- Increasing the socio economic status of the villagers by cultivation of herbs.
- Better utilization of Ayurvedic systems of medicine at the Village level.
- Reducing the morbidity status of the villagers in Communicable and Non Communicable Disease
- Increasing the life expectancy of the people of the selected villages.

Phase	Activity			Time frame
	State	District	Village	
Phase I	Scrutinizing the village proposals and identifying the villages Releasing funds to the District Ayurveda officer for Ayurvedgram Monitoring strategy prepared and introduced	Identifying the villages suitable for Ayurvedgram Preparation of work plan Formulation of committee for monitoring Ayurvedgram Provision of monetary assistance for different sectors of Ayurvedgram	Collection of Data regarding the existing Ayurvedic impact\ as well as baseline Formulating a basic policy of Ayurvedgram Documenting all Health Practices and Lacunae to be rectified through Ayurveda Domains of the Disorders to be selected and priority selected Developing a training program for the grass root level Activist based on Ayurvedic preventive, promotive and curative principles	First quarter of the year

Phase	Activity			Time frame
	State	District	Village	
Phase II	Motivating nearby villages to under take the project of Ayurvedgram- Setting up	Annual program of Health melas (Health camps organized for particular village. Allocation of Money for various programme components.	Imparting training to the grass root level activists Awareness and health camps in school's Organizing regular Health check up and treatment camps Continuous education and campaign based on Ayurvedic preventive and promotive principles	Second & third quarter of the year
Phase III	Review of the initiative and funds flow patterns to prepare a course correction Improving programme contents through ongoing, monitoring research and evaluation	Assessing the health status and disease prevalence of the village as a comparison to the baseline Facilitating local or institutional marketing of herbal produce Annual report on Ayurvedgram presented to the Directorate	Motivating cultivators to grow Medicinal plants Training Women groups through Mittanin(ASHA) and CHW for home remedies for common illness Providing understanding between the farmer & Vanoshadi and Laghu vanopaj sangh to sell the local produce	Fourth quarter of the year

Key stakeholders at state level and their role:

- State government of Chhattisgarh
- Director AYUSH
- State Health Resource centre Chattisgarh
- District Ayurveda Officer
- CEO Vanoshadi Board

Key stake holders at district level and their role:

- District Ayurveda Officer
- Ayurved medical officer
- Member of Vanoushadi board

Key Stakeholders at village level and their role

- Ayurveda medical officer 1
- The Villagers in Ayurveda gram 1
- The Herbal Farmer, Collector of herbal medicine 2
- Dais in the Ayurveda gram 1
- Mittanin in Ayurveda gram 1
- SHG Groups 1
- The Traditional Healers 1
- Member of vanoshadi board 1
- Other civil Societies 2

Indicators of monitoring

- Awareness camps organized
- Health melas organized
- Admission in Ayurvedic dispensary programme
- Schools health check up camp\ awareness camps held
- Yoga camps organized
- No of herbal cultivation and kitchen garden

Concept Note of AYUSH Deep Samiti

Back Ground

The Government of Chhattisgarh has also given equal status and fairer chance of development of AYUSH to its full potential in providing health care. Mainstreaming AYUSH institutions and practitioners with modern systems of medicine in Chhattisgarh has been major priority, so that people have access to complementary systems of care. Utilizing human resources of AYUSH in the national health programmes, with the ultimate aim of enhancing the outreach of AYUSH health care in an accessible, acceptable, affordable, and quality manner is visualized. The department of AYUSH has reasserted on mainstreaming component with constant efforts and activities in coordination with modern system of medicine coordination.

The State of Chhattisgarh has a large cadre of AYUSH health care institutions; they are widely distributed in the State with a strong health care network. The Current Institutions under the AYUSH systems are Seven Ayurvedic District Hospitals and 692 dispensaries. As a major initiative under mainstreaming, the AYUSH health care institutions need to be well equipped to look after and manage various AYUSH facilities in a systematic manner. The State has assessed and identified by setting up of facility management committee in the same line of Jeevan Deep Scheme as already operational in the States for ensuring reform based hospital management in all the AYUSH facilities. This Scheme is visualized for setting up quality criteria of AYUSH facilities, training of functionaries on facility development as well as efficient management and steady up gradation of the institutions.

Objectives

- To create and enhance the facilities in the AYUSH District Hospitals and Dispensaries
- Ensure compliance to minimum standards for facility and hospital care in the AYUSH institutions.
- Enhancing the Standard of provision of services AYUSH health care institutions as per the recommended standards
- Improving the Community participation and awareness through the AYUSH institutions
- Provision of AYUSH health care facility to common masses
- Existing infrastructure and facilities of the AYUSH systems shall be upgraded by the Current improvement in information and technology
- Maintaining minimum standards of Quality of equipments, building and conveyance facilities in the AYUSH network
- Improving the Discipline and duty consciousness of the Physicians and subordinates in the AYUSH health care system
- Introducing transparency and creating the modes for generation of resource through fee, donations and other means for the improvement of facilities of AYUSH health care institutions
- Modernization and continuous facility enhancement of them AYUSH health care and specialized and therapy centers.
- Ensure subsidized provision of medicines, food and drinking water to the patients and the attendants.
- Improving the outreach camps and service through health camps by AYUSH
- Ensure the implementation of the national health programmes through the AYUSH health facilities.

Output

- Gap filling of the AYUSH Human Resource.
- Need based planning of the AYUSH facilities
- Enhancing Quality of services to meet customer expectations
- Improving work environment for optimal performance.
- Strong monitoring system for enhancing the services to be patient friendly
- Setting verifiable benchmarks.
- Accreditation of AYUSH Service provision units like Hospitals and AYUSH Specialized service centres
- Evaluation of performance through exit surveys
- Identifying the gaps and identifying the resource pools like grants, external financial assistance and borrowings to performance

Activities

- To ensure discipline and monitor accountability of the AYUSH physicians
- Levy user charges in consultation with People's representatives.
- Ambulance services for emergency.
- Provide free treatment to BPL patients
- Arrange for good quality diet, Panchakarma and other specialized health services and AYUSH medicines.
- Proper maintenance of Hospital, Wards, Beds, Equipments, cleanliness of premises.
- Recurrent capacity building of AYUSH physicians and paramedics
- Up gradation of health care facilities by efficient resource allocation in the supply side
- Effective implementation and monitoring of National Health programmes.
- Formation of AYUSH Deep Samiti under the society's registration act and the governing body formed at the district level and the AYUSH Dispensaries are placed under the jurisdiction of District level Samiti and the village level operational Samiti are formed.

Constitution of AYUSH Deep Samiti

The Samiti has been formed at

- District Ayurved Offices
- District Ayurveda Hospitals
- No block level and village level Samiti in the AYUSH Deep Samiti

Institution	No.	Constituted
District Ayurveda Offices	16	12
Dist. Ayurveda Hospital	6	6
Ayurveda College Hospital	1	1

General Body Member of AYUSH Deep Samiti

For effective functioning the AYUSH Deep Samiti has two bodies for effective functioning

- General Body
- Executive Body

Members of General Body

I/C Minister of the District	Chairman
MLAs of District President of Swasthya Samiti Zila Panchayat Mayor of Municipal Corp. Chief Medical Officer Municipal corporation/ Municipality District Ayurved Officer Two AYUSH physicians appointed by District Ayurveda Officer Municipal Commissioner CEO Zila Panchayat Ex. Eng. PWD & PHE	Member
District Collector	Member Secretary

Permanent Members

Donors who have donated more than 2,00,000 lakh cash.

Annual Members

- Two Donors (donated 10,000 Rs) Nominated by Chairman
- Two social workers/NGO/Reputed Organizations/ Reputed Clubs nominated by chairman

Powers and Responsibilities of General Body of AYUSHdeep Samiti

1	The General Body shall meet at least once in a year. However the Committee or 1/3rd members on request can call meetings of AYUSH Deep Samiti
2	The newly constituted AYUSH Deep Samiti shall hold its meeting within 3 months and shall elect its office bearers.
3	The Executive Committee can call the special meeting of the old AYUSH Deep Samiti General Body and this body can amend objectives, membership, change in rules & regulations or it can approve the removal of the left out members from the list.

4	The quorum of the General Body shall be 1/3rd of the members.
5	The General Body shall take the policy decisions and it will be implemented by Executive Committee under rule 10 of the constitution of AYUSH Deep Samiti.
6	General Body can authorize the Executive Committee for implementation of functions, it can delegate financial powers to members of Executive Committee and also approve financial proposals that are beyond the powers of the Executive Committee.
7	The General Body shall review the financial account at least once in a financial year, review income & expenditure statements and shall approve the budget for the next year.
8	General Body shall have powers to appoint chartered accountant and can constitute sub committees for specific purposes such as new construction & commercial use of land.

Members of Executive Committee

Formation of this committee is essential for the execution and implementation of day to day activities

• Collector	Chairman
• President of Swasthya Samiti Zila Panchayat (Vice Chairman) • Ex. Eng. PWD & PHE • Chief Medical Officer • Two Social Workers/donars • Five AYUSH physicians nominated by District Ayurveda Officer • Municipal Commissioner • CEO Zila Panchayat	Member
• District Ayurved Officer /Deputy director AYUSH	Member Secretary

Powers and Responsibilities of Executive Committee

1	The Executive Committee will meet at least once in three months. The quorum will be of 50% members. The presence of the Chairman will be essential.
2	Executive Committee will perform its day to day functions with existing manpower.
3	Executive Committee will implement the decisions taken by General body and will function within its powers invested by General Body.
4	Executive Committee can delegate its financial powers to the Member secretary.
5	Executive Committee shall have the authority of raising the funds for the activities approved by General Body. e.g. New construction, equipments purchase, modern investigation facilities, development of pancha karma and Kshara sutra unit. It shall have the authority to take loan from Banks.
6	The Executive Committee can appoint cleanliness staff, AYUSH Para medical staff, Security guard and part time employees on contract.
7	Executive Committee will levy user charges from the patients and facilities given to their relatives.
8	Executive Committee can purchase equipment, drugs, furniture's, Pathological reagents, X-ray films in consultation with three members of the Executive Committee for quality purchase by following the norms of Chhattisgarh Store Purchase rules and amendments.
9.	AYUSH Deep Samiti will bare the charges of maintenance of the infrastructure which demands small scale investment.
10	Installation of modern equipments essential for provision of Panchakarma and Ksharasutra services and appointing technical staffs for the operation of the Special Equipments
11	Campaigning the achievements and developments future plans for the Creation of staunch faith of the general public in AYUSH Systems of medicine
12	Enhancing the performance appraisal strategy for all the category of AYUSH Staffs and felicitation of the AYUSH health care providers who have been working remarkably well.
13	Establishment of AYUSH Deep Sub Committee at Hospital and Dispensary level in the first executive committee meeting for effective facilitation of daily activities

Members of AYUSH Deep Sub Committee

Formation of this committee is essential for the execution and implementation of day to day activities at dispensaries level.

• President of Gram Panchayat/Sarpanch	Chairman
• President of Swasthya Samiti Zila Panchayat (ViceChairman) • Ex. Eng. PWD & PHE • Representative of Zila panchayat/ Nagri nikay • One Social Workers/donors • AYUSH physicians of the Dispensaries	Member

Powers and Responsibilities of AYUSH Deep Subcommittee

1	The SubCommittee will meet at least once in Three months. The quorum will be of 50% members. The presence of the Chairman will be essential, in unavoidable circumstances in the absence of Chairman, vice chairman can conduct the meeting
2	The SubCommittee will perform its day to day functions with existing manpower.
3	The SubCommittee will implement the decisions taken by the members
4	The SbCommittee can appoint staff on contract for maintaining cleanliness
5	The SubCommittee shall have the authority of raising the funds for the activities approved by the members.e.g. Small scale repair of the building, maintainance of equipments, maintaining herbal gardens.
6	Initiatives taken for provision of clean drinking water for the patients
7	Installation of modern equipments essential for provision of Panchakarma and Ksharasutra services and appointing technical staffs for the operation of the Special Equipments Executive Committee will levy user charges from the patients and facilities given to their relatives.
8	For quality purchase the Sub Committee shall make it mandatory to follow norms of Chhattisgarh Store Purchase rules and amendments.
9.	AYUSH Deep Samiti will bare the charges of maintenance of the infrastructure which demands small scale investment.
10	The Accounts of the subcommittee shall be audited annually and the report duely submitted to the executive committee.
11	Utilization certificate, accounts, audit report and the plans for the next year will be submitted to the subcommittee for appraisal.
12	The subcommittee account will be created in Nationalized bank or post office and account shall be operated by the secretary.
13	From the available fund not more than Rs.2000 can be spent at a time after approval of the members.

Impact

The AYUSH Deep Samiti has been formed at the district level covering 14 Districts with the other districts on the verge of completion of registration. The recommended meeting of the functionaries are held at districts and Villages by the committee. Training of functionaries complete in 14 Districts with the assessment of the lacunae and difficulties faced by the operational committee. AYUSH Hospitals and dispensaries have started using funds for renovations of buildings, repair and maintenance of equipments and to install newer and better equipment, and furniture which in turn is enhancing the out reach of AYUSH services to the common masses.

Monitoring and Evaluation

The monitoring of the Subcommittee of AYUSH Deep Samiti is done by the executive committee of the AYUSH Deep Samiti and the monitoring of the Executive Committee is done by the Governing body members and the overall monitoring and evaluation is delegated by the AYUSH Member of District Health Society.

Jan Jagran Vikas Samiti

A) Programme Areas and Area of Operation

Area of Operation

The work of JAGRAN is focussed on the lives of the less fortunate spread over 103 villages in the seven development blocks i.e. Girva, Sarada, Salumber, Dhariyawad, Jha dol and Gogunda of Udaipur district and Aspur block of Dungerpur District with a population of about 2.4 million people. The whole area is mainly inhabited by the tribes; Bhills, Meenas, and Gerasias.

JAGRAN has provided traditional health care in the district of Udaipur in Rajasthan and more activities are extended to Alwar, Banswara, Dungarpur, Jodhpur, Bikaner, Jaisalmer, Barmer and Jaipur districts. Trainings and promotion of traditional health products and services are also done in other States of India like Himachal Pradesh, Haryana, Chhatisgarh, Jharkhand, Madhya Pradesh, Bihar, Uttranchal and Gujarat.

B) Integrated Rural Development

JJVS is intimately connected with all aspects of rural village management and development issues. Our unique breadth of experience on the ground gives us the qualifications to ensure that any regional development project is appropriately contextualized for maximum effectiveness.

- Rural Water management and Drought Relief
- Education
  - Literacy (Shiksadan)
  - NFE (Non-Formal Education)
- Rehabilitation
- Rights of Ownership
- Drought Relief Protest
- Mines labour protection
- Village Democracy
- Microenterprises

Traditional Health Systems

Traditional health systems are customarily described in contrast to “modern” or allopathic medicine, which focuses on direct curative intervention. We see the role of traditional healers as complimentary to modern medicine. Traditional health systems are holistic by nature, comprising:

- Emphasis on health as a normative condition
- Integration of lifestyle and environmental factors
- Non-invasive healing and hygiene practices
- Indigenous knowledge traditions (e.g., guru-student method)

We conceived the idea of promoting Traditional Health Systems as a viable alternative to costly and scarce allopathic treatment. We provided the term “guni” as a uniting title for these traditional healers, and are actively working with the government to obtain official recognition for traditional health systems.

Gunis: Revitalizing the role of village healers

Gunis are distributed in practically every rural village in India. Generally, these “non degree holder” doctors possess remarkable competencies in solving typical rural health problems, including bone setting, skin diseases, asthma, snake bites, sciatica and chronic pains. To establish traditional healing as a viable public health alternative, our first challenge was to identify and document traditional practitioners across the country. To date, JJVS has interviewed and registered about 600 Gunis. This is the largest and most authoritative listing of traditional healers in existence. The next project we undertook was to survey and record the remedies in use by the gunis. This resulted in a remarkable compendium of folk medicine, which we published as the Guni Pharmacopoeia in 1998. The book

contains 80 herbal remedies that have been used by traditional healers for centuries. This is the most comprehensive catalogue of non-Ayurvedic traditional health knowledge assembled and forms the basis of much of our research and training activities. In 1999, we published a taxonomic record of medicinal plants in the Udaipur region, listing descriptions and applications for over 300 species.

To complete the programme, we have established certification, training, knowledge exchange, and public awareness processes that combine to position the Guni movement as a dynamic and important health alternative.

Principle Activities

- **Training Programmes:** Gunis are selected to receive 30 days of structured training in three phases of 10 days duration. Training programs specifically for women Gunis are also arranged.
- **Study and Knowledge Exchange:** Annual education tours are organized in order to enhance the Guni's skill and knowledge and expose them to the varied cultural, social, ethical and traditional health programmes of remote Indian villages and towns.
- **Certification and standards**: JJVS is developing a formal Guni certification process that will facilitate the integration of Gunis into the mainstream health system.
- **Research and development:** Traditional health is a dynamic tradition. JJVS is active in working with healers and botanical specialists to provide solutions for contraception, women's health, tuberculosis, etc
- **Botanical conservation:** Preserving plant germplasm is a key issue. We support seed- saving, perm culture, and creation of herbal gardens to ensure reliable local supplies of medicinal plants.
- **Curative Camps:** JJVS organized 12 state level and 160 local level curative camps where about 50,000 patients have been treated by Gunis for various ailments
- **State level Ethno-Veterinary (Sammelan):** This programme was organized in 1999 at Udaipur in which 137 veterinary Gunis from various states of India participated. They exchanged their formulations used in the treatment of livestock diseases of their region.
- **Newsletter (Gaon Ka Guni):** JJVS promotes an active dialogue amongst the Guni community by publishing a quarterly magazine, featuring Guni profiles, medicinal formulations, and current issues.
- **Exhibitions and Seminars:** TRIFED Fair organized by Government of India (2700 visitors attended); National level seminar organized by JJVS attracted 150 participants from nine states.
- **Health Centres:** JJVS has established 23 traditional health centres in 9 districts of Rajasthan.
- **Create National Guni Forum:** JJVS organises a national level forum to promote awareness and advocacy of common issues.

Foundation for Revitalization of Local Health Traditions

Mission

"To revitalize Indian medical heritage".

The Vision of FRLHT is to enhance the quality of medical relief and healthcare in rural and urban India and globally by creative application of our rich medical practices, action oriented research, education, training and Community services based on India's Traditional Health Sciences.

Vision

To demonstrate the contemporary relevance of Indian Medical Heritage in providing Medical relief, in extending Education, training and imparting creative Community services by designing and implementing innovative programmes related to

A. High quality medical practices and research in Indian systems of medicine,

B. Conservation of the natural resources used by Indian systems of medicine

C. Revitalisation of social processes for transmission of our medical heritage, on a size and scale that will have societal impact.

The institutional agenda of the Foundation for Revitalisation of Local Health Traditions (FRLHT) is derived from its vision: "enhancing the quality of **medical relief and healthcare** in rural and urban India and globally by creative application of our rich medical practices, action oriented research, **education, training and Community services** based on India's Traditional Health Sciences" and thus revitalize Indian medical heritage".

FRLHT has identified three thrust areas to fulfill this vision. These are:

i) Demonstrating contemporary relevance of theory and practice of Indian Systems of Medicine [D]

ii) Conserving natural resources used by Indian Systems of Medicine [C]

iii) Revitalisation of social processes (institutional, oral and commercial) for transmission of traditional knowledge of health care for its wider use and application [R]

All the current programmes and projects of FRLHT can be covered under these three thrust areas.

The following paragraphs cover briefly the scope of activities being carried out as well as those envisaged, under the three thrust areas mentioned above. In operational terms FRLHT has articulated specific programmes and sub-programmes under each of the thrust areas. For instance, under the first thrust area viz., "Demonstrating contemporary relevance of theory and practice of Indian systems of medicine", FRLHT engages in major programmes such as assessment and documentation of local health practices prevalent in different rural and urban communities. It also has a major programme related to interpretation of traditional medical theories and practices with the use of scientific laboratory tools. Other programmes under this thrust area include creation of traditional knowledge databases and development of methodologies for trans-disciplinary medical research.

In the second thrust area viz.."Conserving natural resources used by Indian Systems of Medicine", FRLHT concentrates on research programmes involving studies related to: inventorising medicinal plants in different forest types; threat assessment; saving species on the verge of extinction and sustainable harvest. Under this thrust area, FRLHT also undertakes other important programmes related to efforts towards development of databases and establishment of a bio-cultural herbarium and raw-drug repository of the plants of India.,

The third thrust area deals with the "Revitalisation of social processes" (institutional, oral and commercial) for transmission of traditional knowledge of health care and the main programmes under this thrust area are; building decentralized associations of folk healers and self-help women groups, home herbal gardens and promoting community-owned enterprises. A major initiative under this thrust area for influencing institutional processes is the development of a research hospital, pharmacy and a post-graduate training institute and University affiliated PhD degree programs.

The Ministry of Science & Technology recognizes FRLHT as a scientific and industrial research organization. The Ministry of Environment and Forests and the

Ministry of Health have designated FRLHT as a National Center of Excellence for medicinal plants, traditional knowledge and Ayurvedic Geriatrics respectively.

FRLHT is a registered Public Trust and Charitable Society, which started its activities in March 1993.

Annexure - VII

LEGAL PROVISIONS

Sub group on Mainstreaming AYUSH, Working Group on Access to Health Systems including AYUSH, Planning Commission

Q. Can Qualified AYUSH practitioners be utilized for delivery of National Health Programme?

Recognized AYUSH training courses provide basic knowledge to under-graduates regarding anatomy & physiology/biochemistry in addition toclinical 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/contraindication etc. of the medicines he prescribes to patient. These judgments basicallydefine what is medical negligence. It is the considered view of a study carried out by National Law School, Bangalore that these judgments 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 VIII below). 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.

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. Mukhthiar 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 andCosmetics 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 Vaids 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 Vaids/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'.

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Annexure - VIII

Schedules for Recognized AYUSH Qualifications

The Indian Medicine Central Council Act, 1970
Chapter III: Recognition of Medical Qualifications

14. Recognition of medical qualifications granted by certain medical institutions in India

(1) The medical qualifications granted by any University, Board or other medical institutions in India which are included in the Second Schedule shall be recognised medical qualifications for the purposes of this Act.

(2) Any University, Board or other medical institution in India which grants a medical qualification not included in the Second Schedule may apply to the Central Government to have any such qualification recognised, and the Central Government, after consulting the Central Council, may, by notification in the Official Gazette, amend the Second Schedule so as to include such qualification therein, and any such notification may also direct that an entry shall be made in the last column of the Second Schedule against such medical qualification declaring that it shall be recognised medical qualification only when granted after a specified date.

15. Recognition of medical qualifications granted by certain medical institutions whose qualifications are not included in Second Schedule

The medical qualifications included in the Third Schedule granted to a citizen of India before the 15th day of August, 1947, by any medical institution in any area which was comprised before that date within India as defined in the Government of India Act, 1935, shall also be recognised medical qualifications for the purposes of this Act.

16. Recognition of medical qualifications granted by medical institutions in countries with which there is a scheme of reciprocity

(1) The medical qualifications granted by medical institutions outside India which are included in the Fourth Schedule shall be recognised medical qualifications for the purposes of this Act.

(2) The Central Council may enter into negotiations with the authority in any State or country outside India, which, by law of such State or country is entrusted with the maintenance of a Register of practitioners of Indian medicine, for the settling of a scheme of reciprocity for the recognition of medical qualifications in Indian medicine, and in pursuance of any such scheme, the Central Government may, by notification in the Official Gazette, amend the Fourth Schedule so as to include therein any medical qualification which the Central Council has decided should be recognised, and any such notification may also direct that an entry shall be made in the last column of the Fourth Schedule against such medical qualification declaring that it shall be recognised medical qualification only when granted after a specified date.

17. Rights of persons possessing qualifications included in Second, Third and Fourth Schedules to be enrolled

(1) Subject to the other provisions contained in this Act, any medical qualification included in the Second, Third or Fourth Schedule shall be sufficient qualification for enrolment on any State Register of Indian Medicine.

(2) Save as provided in section 28, no person other than a practitioner of Indian medicine who possesses a recognised medical qualification and is enrolled on a State Register or the Central Register of Indian Medicine, -

(a) shall hold office as Vaid, Siddha, Hakim or physician or any other office (by whatever designation called) in Government or in any institution maintained by a local or other authority;

(b) shall practice Indian medicine in any State;

(c) shall be entitled to sign or authenticate a medical or fitness certificate or any other certificate required by any law to be signed or authenticated by a duly qualified medical practitioner;

(d) shall be entitled to give evidence at any inquest or in any court of law as an expert under section 45 of the Indian Evidence Act, 1872 (1 of 1872) on any matter relating to Indian medicine.

(3) Nothing contained in sub-section (2) shall affect, -

(a) the right of a practitioner of Indian Medicine enrolled on a State Register of Indian Medicine to practise Indian medicine in any State merely on the ground that, on the commencement of this Act, he does not possess a recognised medical qualification;

(b) the privileges (including the right to practise 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;

(c) the right of a person to practise Indian medicine in a State in which, on the commencement of this Act, a State Register of Indian Medicine is not maintained if, on such commencement, he has been practising Indian medicine for not less than five years;

(d) the rights conferred by or under the Indian Medical Council Act, 1956 (102 of 1956) [including the right to practise medicine as defined in clause (f) of section 2 of the said Act], on persons possessing any qualifications included in the Schedules to the said Act.

(4) Any person who acts in contravention of any provision of sub-section (2) shall be punished with imprisonment for a term which may extend to one year, or with fine which may extend to one thousand rupees, or with both.

18. Power to require information as to courses of study and examination

Every University, Board or medical institution in India which grants a recognised medical qualification shall furnish such information as the Central Council may, from time to time, require as to the courses of study and examinations to be undergone in order to obtain such qualification, as to the ages at which such courses of study and examinations are required to be undergone and such qualification is conferred and generally as to the requisites for obtaining such qualification.

19. Inspectors at examinations

(1) The Central Council shall appoint such number of medical inspectors as it may deem requisite to inspect any medical college, hospital or other institution where education in Indian medicine is given, or to attend any examination held by any University, Board or medical institution for the purpose of recommending to the Central Government recognition of medical qualifications granted by that University, Board or medical institution.

(2) The medical inspectors shall not interfere with the conduct of any training or examination, but shall report to the Central Council on the adequacy of the standards of education including staff, equipment, accommodation, training and other facilities prescribed for giving education in Indian medicine or on the sufficiency of every examination which they attend.

(3) The Central Council shall forward a copy of any such report to the University, Board or medical institution concerned, and shall also forward a copy with the remarks of the University, Board or medical institution thereon, to the Central Government.

20. Visitors at examinations

(1) The Central Council may appoint such number of visitors as it may deem requisite to inspect any medical college, hospital or other institution where education in Indian medicine is given or to attend any examination for the purpose of granting recognised medical qualifications.

(2) Any person, whether he is a member of the Central Council or not, may be appointed as a visitor under this section but a person who is appointed as an inspector under Section 19 for any inspection or examination shall not be appointed as a visitor for the same inspection or examination.

(3) The visitors shall not interfere with the conduct of any training or examination, but shall report to the President of the Central Council on the adequacy of the standards of education including staff, equipment, accommodation, training and other facilities prescribed for giving education in Indian medicine or on the sufficiency of every examination which they attend.

(4) The report of a visitor shall be treated as confidential unless in any particular case the President of the Central Council otherwise directs:

Provided that if the Central Government requires a copy of the report of a visitor, the Central Council shall furnish the same.

21. Withdrawal of recognition

(1) When upon report by the inspector or the visitor, it appears to the Central Council

(a) that the courses of study and examination to be undergone in, or the proficiency required from candidates at any examination held by, any University, Board or medical institution, or

(b) that the staff, equipment, accommodation, training and other facilities for instruction and training provided in such University, Board or medical institution or in any college or other institution affiliated to the University.

do not conform to the standard prescribed by the Central Council the Central Council shall make a representation to that effect to the Central Government.

(2) After considering such representation, the Central Government may send it to the Government of the State in which the University, Board or medical institution is situated and the State Government shall forward it along with such remarks as it may choose to make to the University, Board or medical institution, with an intimation of the period within which the University, Board or medical institution may submit its explanation to the State Government.

(3) On the receipt of the explanation or, where no explanation is submitted within the period fixed, then, on the expiry of that period, the State Government shall make its recommendations to the Central Government.

(4) The Central Government, after making such further inquiry, if any, as it may think fit, may, by notification in the Official Gazette, direct that an entry shall be made in the appropriate Schedule against the said medical qualification declaring that it shall be a recognised medical qualification only when granted before a specified date, or that the said medical qualification if granted to students of a specified college or institution affiliated to any University shall be recognised medical qualification only when granted before a specified date or, as the case may be, that the said medical qualification shall be recognised medical qualification in relation to a specified college or institution affiliated to any University only when granted after a specified date.

22. Minimum standards of education in Indian medicine

(1) The Central Council may prescribe the minimum standards of education in Indian medicine,required for granting recognised medical qualifications by Universities, Boards or medical institutions in India.

(2) Copies of the draft regulations and of all subsequent amendments thereof shall be furnished by the Central Council to all State Governments and the Central Council shall, before submitting the regulations or any amendment thereof, as the case may be, to the Central Government for sanction, take into consideration the comments of any State Government received within three months from the furnishing of the copies as aforesaid.

(3) Each of the committees referred to in clauses (a), (b) and (c) of sub-section (1) of Section 9 shall, from time to time, report to the Central Council on the efficacy of the regulations and may recommend to the Central Council such amendments thereof as it may think fit.

The Homoeopathy Central Council Act
Chapter - III: Recognition of Medical Qualifications

Recognition of medical qualifications granted by certain medical in situations in India.

13. (1) The medical qualifications granted by any University, Board or other medical institution in India which are included in the Second Schedule shall be recognized medical qualifications for the purposes of this Act

(2) Any University, Board or other medical institution in India which grants a medical qualification not included in the Second Schedule may apply to the Central Government to have any such qualification recognized, and the Central Government after consulting the Central Council, may, by notification in the Official Gazette, amend the Second Schedule so as to include such qualification therein and any such notification may also direct that an entry shall be made in the last column of the Second Schedule against such medical qualification only when granted after a specified date.

Recognition of Medical qualifications granted by medical institutions in States or countries outside India.

14. (1) The medical qualifications granted by medical institutions outside India which are included in the Third Schedule shall be recognized medical qualifications for the purposes of this Act.

(2) (a) The Central Council may enter into negotiations with the authority in any Sate or country outside India, which by the law of such State or country is entrusted with the maintenance of a Register of practitioners of Homeopathy for setting of a scheme of reciprocity for the recognition of medical qualifications in Homoeopathy and in pursuance of any such scheme, the General Government may, by notification in the Official Gazette, amend the Third Schedule so as to include therein any medical qualification which the Central Council has decided should be recognized medical qualification only when granted after a specified date.

(b) Where the Council has refused to recommend any medical qualification which has been proposed for recognition by any authority referred to in clause (a) and that authority applies to the central Government in this behalf, the Central Government, after considering such application and after obtaining from the Council a report, if any, as to the reasons for any such refusal , may, by notification in the Official Gazette, declare that such qualification shall be a recognized medical qualification and the provisions of clause (a) shall apply accordingly.

Rights of persons possessing qualifications included in Second or the Third Schedule to be enrolled.

15. (1) Subject to the other provisions contained in this Act, any medical qualification included in the Second or the Third Schedule shall be sufficient qualification for enrolment on any Sate Register of Homoeopathy.

(2) No person, other than a practitioner of Homeopathy who possess a recognized medical qualification and is enrolled on a State Register or the Central Register of Homoeopathy.

(a) shall hold office as Homoeopathic physician or any other office (by whatever designation called) in Government or in any institution maintained by a local or other authority;

(b) shall practise Homoeopathy in any State;

(c) shall be entitled to sign or authenticate a medial or fitness certificate or any other certificate required by an law to be signed or authenticated by a duly qualified medical practitioner;

(d) shall be entitled to sign or authenticate a medial or fitness certificate or any other certificate required by an law to be signed or authenticated by a duly qualified medical practitioner;

1 of 1872

(3) Nothing contained in sub-section (2) shall affect:

(a) the right of a practitioner of Homoeopathy enrolled on a State Register of Homoeopathy to practise Homoeopathy in any State merely on the ground that, one the commencement of this Act, he does not possess a recognized medical qualification;

(b) the privileges (including the right to practise Homoeopathy) conferred by or under any law relating to registration of practitioners of Homoeopathy for the time being in force in any State, on a Practitiner of Homoeopathy enrolled on a State Register of Homoeopathy;

(c) the right of a person to practise Homoeopathy in a State in which, on the commencement of this Act, a State Register of Homoeopathy is not maintained if, on such commencement, he has been pra ctising Homoeopathy for not less than five years.

(d) Nothing contained in sub-section (2) shall affect:

(4) Any person who acts in contravention of any provision of sub-section (2) shall be punished with imprisonment for a term which may extend to one year, or with fine which may extend to one thousand rupees or with both.

Power to require information as to courses to study and examination.

16. Every University, Board of medical institution in India which grants a recognized medical qualification shall furnish such information as the Central Council may, from time to time, require as to the courses of study and examination to be undergone in order to obtain such qualifications, as to the ages at which such courses of study and examinations are required to be undergone and such qualification is conferred and generally as to the requisite for obtaining such qualification.

Inspectors at examinations.

17 (1) The Central Council shall appoint such number of medical inspectors as it may deem requisite to inspect any medical college, hospital or other institution where education in Homoeopathy is given, or to attend any examination held by any examination held by any University, Board or medical institution for the purpose of recommending to the Central Government recognition of medical qualifications granted by that University, Board of medical institution.

(2) The medical inspectors shall not interfere with the conduct of any training or examination but shall report to the Central Council on the adequacy of the standards of education including staff, equipment, accommodation, training and other facilities prescribed for giving education in Homoeopathy, as the case may be, on the sufficiency of every examination which they attend.

(3) The Central Council shall forward a copy of any such report to the University, Board or medical institution concerned, and shall also forward a copy with the remarks of the University or medical institution thereon, to the Central Government.

Visitors at Examinations.

18. (1) The Central Council may appoint such number of visitors as it may deem requisite to inspect any medical college, hospital or other institution where education in Homoeopathy is given or to attend any examination for the purpose of granting recognized medical qualification.

(2) Any person, whether he is a member of the Central Council or not may be appointed as a visitor under this section but a person who is appointed as an inspector under section 17 for any inspection or examination shall not be appointed as a visitor for the same inspection or examination.

(3) The visitors shall not interfere with the conduct of any training or examination but shall report to the President of the Central Council on the adequacy of the standards of education including staff, equipment, accommodation, training and other facilities prescribed for giving education in Homoeopathy or on the sufficiency of every examination which they attend.

(4) The report of a visitor shall be treated as confidential unless in any particular case the President of the Central Council otherwise directs:

Provided that if the Central Government requires a copy of the report of a visitor, the Central Council shall furnish the same.

Withdrawal of recognition

19. (1) When upon report by the inspector or the visitor it appears to the Central Council

(a) that the courses of study and examination to be undergone in or the proficiency required from candidates at any examination held by any University, Board or medical institution, or

(b) that the staff, equipment, accommodation, training and other facilities for instruction and training provided in such University, Board of medical institution or in any college or other institution affiliated to the University.

Do not conform to the standard prescribed by the Central Council, the Central Council shall make a representation to that effect to the Central Government.

(2) After considering such representation, the Central Government may send it to the Government may send it to the Government of the State in which the University, Board or medical institution is situated and the State Government shall forward it alongwith such remarks as it may choose to make to the University, Board or medical institution with an intimation of the period within which the University, Board or medical institutional may submit its explanation to the State Government.

(3) On the receipt of the explanation or where no explanation is submitted within the period fixed then on the expiry of that period the State Government shall make its recommendations to the Central Government.

(4) The Central Government after making such further inquiry, if any, as it may think fit, may, by notification in the Official Gazette, direct that an entry shall be made in the Second Schedule against the said medical qualification declaring that it shall be a recognized medical qualification only when granted before a specified date or that the said medical qualification if granted to students of a specified college or institution affiliated to any University shall be recognized medical qualification only when granted before a specified date or as the case may be, that the said medical qualification shall be recognized medical qualification in relation to a specified college or institution affiliated to any University only when granted after a specified date.

Minimum standard of education in Homoeopathy.

20. (1) The Central Council may prescribed the minimum standards of education in Homoeopathy required for granting recognized medical qualifications by Universities, Board or medical institutions in India.

(2) Copies of the draft regulations and of all subsequent amendments thereof shall be furnished by the Central Council to all State Governments and the Central Council shall, before submitting the regulations or any amendment thereof as the case may be, to the consideration the comments of any State Government received within three months from the furnishing of the copies as aforesaid.

Annexure - IX

National Mission on Medicinal Plants

सत्यमेव जयते

CENTRALLY SPONSORED SCHEME OF NATIONAL MISSION ON MEDICINAL PLANTS

OPERATIONAL GUIDELINES

National Medicinal Plants Board
Department of Ayurveda, Yoga & Naturopathy,
Unani, Siddha & Homoeopathy (AYUSH)
Ministry of Health & Family Welfare
Government of India

The National Medicinal Plants Board (NMPB), has been implementing a Central Sector Scheme of "Setting up Medicinal Plants Board" during the 10th Plan. During the 11th Plan, however, the Central Sector Scheme has been modified to give sharper focus on promotional activities like resource documentation, in-situ conservation, research and development, ex-situ conservation of rare and endangered species, support to Joint Forest Management Committees for value addition/warehousing, capacity building and training of primary collectors and forest dwellers in good collection and sustainable harvesting practices etc. The scheme, renamed as the "Central Sector Scheme of Conservation, Development and Sustainable Management" has been approved with an 11th outlay of Rs. 321.30 crores. However, the component relating to commercial cultivation has been taken out of the pre-revised Central Sector Scheme and formulated into a new scheme which seeks to integrate cultivation with pre and post harvest activities, like, development of nurseries for quality planting material, cultivation of species in demand by the ASU industry, support for post harvest management, marketing, improvement of marketing infrastructure, organic/GAP certification, quality assurance and crop insurance. These components have been incorporated in a new Centrally Sponsored Scheme of National Mission on Medicinal Plants.

4. NATIONAL MISSION ON MEDICINAL PLANTS

4.1 The Centrally Sponsored Scheme of "National Mission on Medicinal Plants" has been approved with a total outlay of Rs. 630 crores for implementation during the 11th Plan. During the 11th Plan, the Central Government's contribution will be 100%. During the 12th Plan, however, the State Government's contribution is proposed to be suitably enhanced, based on the mid-term review of the scheme. The scheme is proposed to be implemented in a mission mode to organically link different components under the scheme and thus give a strategic push to the Sector during the 11th Plan

5 MISSION OBJECTIVES

5.1 Support cultivation of medicinal plants which is the key to integrity, quality, efficacy and safety of the AYUSH systems of medicines by integrating medicinal plants in the farming systems, offer an option of crop diversification and enhance incomes of farmers.

5.2 Cultivation following the Good Agricultural and Collection Practices (GACPs) to promote standardization and quality assurance and thereby enhance acceptability of the AYUSH systems globally and increase exports of value added items like herbal extracts, phyto-chemicals, dietary supplements, cosmeceuticals and AYUSH products.

5.3 Support setting up processing zones/clusters through convergence of cultivation, warehousing, value addition and marketing and development of infrastructure for entrepreneurs to set up units in such zones/clusters.

5.4 Implement and support certification mechanism for quality standards, Good Agriculture Practices (GAP), Good Collection Practices (GCP), and Good Storage Practices (GSP).

5.5 Adopt a Mission mode approach and promote partnership, convergence and synergy among stake holders involved in R&D, processing and marketing in public as well as private sector at national, regional, state and sub state level.

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