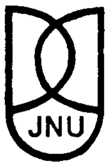
STATE AND THE INDIGENOUS SYSTEMS OF MEDICINE DURING POST-INDEPENDENCE: A CRITICAL ANALYSIS

Dissertation submitted to the Jawaharlal Nehru University
in partial fulfillment of the requirements
for the award of the degree of

MASTER OF PHILOSOPHY

LEKHA. D. BHAT

Centre of Social Medicine and Community Health
School of Social Sciences
Jawaharlal Nehru University
New Delhi
India
2008



CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
New Delhi - 110 067

Date:24./07/2008

Certificate

This dissertation entitled ***"State and the Indigenous Systems of Medicine during Post-Independence: A Critical Analysis***" is submitted in partial fulfillment of the degree of ***Master of Philosophy*** of this University. This dissertation has not been submitted for any other degree of this University or any other University and is my original work.

Lekha D Bhat

We recommend that this dissertation be placed before the examiners for evaluation.

Prof. Mohan Rao
Chairperson

Prof. K R. Nayar
Supervisor

Chairperson
Centre of Social Medicine &
Community Health, SSS
Jawaharlal Nehru University
New Delhi-110067

Acknowledgements

The last one year has been eventful for me in many ways. It has been difficult stressful time and I feel blessed and grateful to have the support and love of so many people.

I thank Prof. K R Nayar for his patience and for encouraging me to select this area of study. Discussions with him were very brief and informative. Sir, you always have encouraging words to say. Whenever I have lost the direction in the study you have brought me back. The care and faith you have expressed in my work gave me a lot of strength. Sir, thank you so much for allowing me to associate with you in this research work.

I am indebted to teachers of this Centre who have provided different insights during the dissertation presentation rounds which have helped me to sharpen my ideas and concepts. I thank Mr. Dinesh and Mr. Durai Pande for all their help in the library. My study would have been incomplete without materials which I collected from National Medical Library, Nehru Memorial Library and Library of Parliament of India. I appreciate the patience which staffs of these libraries have shown to trace old committee reports and parliamentary debates.

I am indebted to Dr. Madulika Banerjee of Delhi University. Madam, discussions with you have given more conceptual clarity. Mathew Chetta, it is you who invited me to explore this area, discussions with you have enriched my work. Thank you so much for the patience which you have shown.

In JNU, I would like to thank my dearest friends who have been inspiring and supporting me in many ways. Nisha, thank you for being there with me in many of my difficult times, you have supported and cared for me. Varda, you have shown me ways how to be strong in life and that change in my orientation has immensely helped me in this endeavor. I'd like to thank Biju for always patiently listening to all my tensions. Shannu you have been so caring and have given me sisterly affection. Thank you for helping me in proof reading.
My sincere wishes and thanks to Preeti who has helped me with grammatical suggestions. Ipsita and Aparna thank you so much for all your moral support and assistance during ups and downs in this phase. Kumaran you have helped me lot with my subject discussions. Shailendra and Rafi thanks for being good friends. Abhilash, you have taken much effort to read my work many times thank you.

I remain highly obliged to many of my teachers who have nourished and encouraged me throughout my student life. My Jerly Sir has supported me throughout and always tells me that achievements in life come through struggles. Sir, I am happy that I have moved one step forward to meet your expectations about me. Asha Ma'am, thank you so much for being there with me. The unconditional love and care which you have shown to me, words are not enough to express my love and thanks to you.

Hema Chechi, I am obliged to you for your constant motivation.

My Akki and Bavu have been there with me throughout this phase. They have always reaffirmed that I have chosen right path of being into JNU. Akki, thank you for all your love and I am obliged to my Bavu for being my good friend. My love to little Shreya for making me feel relax with her cute voice whenever I am tensed.

Thank you to all members in my family houses especially my Aaayi in Kochi, Praba Mausi and Appapa in Quilon for their prayers and blessings. Nendaabu I have purposefully chosen a date associated with you to submit my work. Appa, Amma and Dileep thank you for making me strong in very different way.

This piece of writing I dedicate to my Aabu and Ammama. Aabu, I am missing your presence in my life. I will always carry with me you and your inspirations in my heart. Ammama, I have not seen more strong women than you. Words are just not enough to tell you what I am feeling, both of you have loved me unconditionally. Nothing would have been possible without both of your love, blessings and prayers. I cherish those sweet memories when three of us were together to gain strength when ever I feel weak.

Lastly, I thank the Lord Almighty for HE is the strength, belief and faith within me, helping me in being a better person.

Lekha D Bhat

CONTENTS

Acknowledgements i

Abbreviations iv

Chapter One

Introduction and Methodological Framework **1**

Chapter Two

Discourses on Indigenous System of Medicine in India: Colonialism, Epistemology and the inner conflicts **22**

Chapter Three

Paradigm Shift in ISM Policies of India: Tracing Trends in the Post-independence era **40**

Chapter Four

Politics of State- ISM Interactions in India **71**

Concluding Chapter

Process of Marginalisation: Allopathisation to Institutionalisation to Commercialisation **104**

Bibliography **109**

Abbreviations

1. AYUSH: Department of Ayurveda, Yoga, Unani, Siddha and Homeopathy
2. AIIMS: All India Institute of Medical Sciences
3. CII: Confederation of Indian Industries
4. EU: European Union
5. ISM: Indigenous System of Medicine
6. MBBS: Bachelor of Medicine and Surgery
7. NHS of UK: National health Services of United Kingdom
8. NRHM: National Rural Health Mission
9. PHC: Primary health Centre
10. UNICEF: United Nation Child Emergency Fund
11. USA: United States of America
12. WHO: World Health Organisation

Chapter One

Introduction and Methodological Framework

Societies have many varieties of healing techniques, explanation of health and illness, and distribution of medical knowledge. These different healing systems are interacting with the social and other forces which ultimately produce different results and changes within the system[1]. Medical practice in a stratified society is also stratified as well as distributed along a continuum such as from folk to religious to secular medicine. The changes in these healing systems definitely have its causes rooted in the social-economic -political spheres. At a certain point of time, a particular medical system is at a superior position in the hierarchy and this superiority is gained not only by that system's own intrinsic advantages (over other systems) but also with the hegemonic forces of the society.

From the ancient time onwards, different healing systems are being practiced in India. There were healthy interactions among the systems and the several of those rulers at that time were the patrons[2]. However, after the independence the policies that the State formulated had an overemphasis on science and technology. In the post-independence period the State was determined to prove to the world that India had the capacity and potential to be a developed country[3]. It could be seem from Banerjee's work (2000) that, until the beginning of the planning period in the 1950s, there was a positive perception about the Indian systems among policy-

---

[1] The idea is given by Jeffery (1988:42) in his work The Politics of health in India.

[2] This observation of Johson is cited by Jeffery (1988: 43). Other scholars like Jaggi (1977) has also given the same observation

[3] Banerjee has elaborated this idea as "the policies that the state formulated in the immediate post-colonial years were really a formalisation of the consensus about science and technology that was arrived at in the course of the anti-colonial movement. The Nehruvian vision of the developmental state was all set to cast India in the mould of mainstream modernity and would brook no obstacle on this path. It was determined to prove a point to the dominant power structures in the international arena that India had the capacity and potential to be as advanced in science and technology as any other 'developed' nation" (2002:30)

makers – that the ISM had long been practiced by people in this country that reflected their faith and belief. Contrary to this it was seen that the development of a health system was majorly based on western medicine. The author emphasised that there are three major reasons for such a situation -1) The policy process of post colonial state, 2) market mechanics during colonial and post-colonial period and 3) new dynamics of international economy.

When the health system was planned, the western medicine became the primary focus undermining the fact that the Indigenous Systems of Medicine (here onwards ISM) catered to the health needs of majority of the rural population of India[4].

Indian health system was mainly structured with western medicine as its basis. At the same time Ayurveda, Siddha, Homeopathy, Yoga and Naturopathy is providing health care to its people. These systems, officially called as "Indian System of Medicine" have received little attention in the public health discourse in India. Both the state policies and medical discourses treated these systems as marginal systems or "unscientific other[5]" and assigned a very peripheral and residual role to it.

Although the richness and diversity of the Indian Medical knowledge was long recognised, over the past two centuries one can observe that there has been decline and degradation of ISM. The British used western medicine as a "science with rationality" and trusted it as a force for modernisation efforts of a Nation

[4] It was acknowledged by Bhore Committee report that ISM was providing services to 90 percent of population during the time of independence. Later works by Khan (2005) has also mentioned about this. National Health Policy of 1983 and National Policy on ISM of 2002 also acknowledged this point.
[5] The term "unscientific others" is used by Abraham to criticise Government's position towards ISM in her work "Indian System of Medicine and Public health care in India" (2005: 187)

which was full of superstition and backwardness. Independent India also continued with these imperialist policies as far as health system was concerned.

State being an influential agency in a society, it becomes important to study the State- ISM interaction across the time period. The State has played a major role in the process of marginalisation[6] of ISM especially during post independence era. In the Indian context, a comparison of budget allocation and infrastructure of western medicine with that of ISM gave clear evidence as to how ISM was marginalised after independence[7]. In the neo-liberal context during 1990s what it can be observed that the State has taken initiatives to promote ISM, especially in the area of drug research and manufacture[8].

Studying State- ISM interaction is important because of the following assumptions- 1) most of the time the State becomes an instrument of the dominant class. 2) After 1990s the State has been subjected to international forces and market economy.

Perspectives and ideological orientation of the Government of India towards ISM in 1950s were entirely different from the 1990s; Indian health system would not be a complete service provider unless and until it recognises ISM and integrates it properly into the mainstream. It is because of the simple reason that ISM provides service to rural India. Urban people also rely upon ISM when western medical treatment fails to give appropriate result. It is important to understand what role the State visualised for ISM in the post-independence period. That means how the State placed ISM in the Indian health system. The reason for the neglect of ISM

---

[6] From the works of Abraham (2005), Banerjee (2002, 2000), Khan (2005) it is clear that ISM was not treated at par with western medicine. Indian health system is structured in a hierarchical order where western medicine is at the top. I have used the term "marginalisation" in this context.

[7] See Abraham (2005) for details in her work on place of ISM in public health care in India the resource spread and infrastructure of ISM is documented

[8] Banerjee (2002, 2000) are the important works which studies Ayurveda Pharmaceutical industry and its link with globalisation etc.

was not only clinical of nature; there could be hegemonic forces involved in this process of marginalisation. This work tries to explore these forces.

1.1. Contextualisation of the Study

Let us consider some of the works that have studied about ISM in the Indian context. Public health in its broadest sense includes not only the services which are based on western medicine but also on ISM. One aspect of Public health is about people having choices- choice of healing system.

Abraham (2005) while analysing the role of ISM in public health care of India observed that the State policies and programmes did not reflect any intention of utilising the ISM in extending public health care facilities for the masses of India. She observed that in its encounter with western medicine the character of medical pluralism have changed from a non- hierarchical to a hegemonic and hierarchical one (2005: 210).With evidence she showed how infrastructure- wise, ISM has been placed at the bottom of this hierarchical structure. In the work one of her focus was to document the resource spread and the infrastructure of ISM. Abraham further argued that the cause of ISM was taken up by nationalist movement as a weapon against cultural hegemony of the imperial power, but soon class interests and a development discourse based on modern science dominated over the issue of ISM (2005: 211). She emphasised on some of the current issues of ISM like it becoming cosmetic care supplier (from alternative care) and issues related to globalisation of ISM. She concluded that the change within ISM was not generated within ISM, but was driven by narrow political interests and dictates of global market.

In the area of Politics of Medicine, the works of scholars like Jeffery (1988), Ramasubban (1982), Banerjee (2000, 2002, 2004), Bala (1991, 1982,), Sivaramakrishnan (2006), Khan (2005) and Brass (1972) are important. However,

most of these works remained primarily confined to the nineteenth century and focused on colonial medical interventions and their socio-political implications.

Jeffery (1988) studied the interaction of State and indigenous medicine prior to 1947. The author identified the class elitism of the earlier practices as one of the causes for the degeneration of ISM. Due attention was given by him to the impact of British rule on ISM, followed by identifying various problems that developed within ISM. His observations earmarked that Ayurveda was usually associated with Hinduism and Sanskrit so the practice was usually dominated by the upper caste Hindus. According to the scholar the main three reasons for the decline of ISM during the British were: disunity which was developed within ISM practitioners; the active policy of the State that wanted to supplant ISM with western medicine at appropriate time; and the perception of the ISM clientele that ISM treatments were less effective and were time consuming than the western medicine. The elite nature of ISM was explained by him with Ayurveda as an example. The practice of Ayurveda had strong linkages with rigid and highly divisive caste system of India. Further he observed a gender bias in the practice as well as treatments. He observed that the indigenous medical practitioners were separated on the basis of religious, linguistic and theoretical differences (1988: 57). The scholar explained as how the colonial power made an impact on ISM practitioners' identity. For example he mentioned about how the Bombay Registration Act of 1912 excluded indigenous practitioners from registration process.

While understanding the status of ISM in neo-liberal regime, the works of Banerjee (2004, 2000) could be considered ass important. Banerjee (2004, 2002, and 2000) identified that the Government of India's position towards the ISM was entirely different during 1970s and 1990s. With proper examples of growth of the pharmaceutical industry, the scholar established the linkage between the

international market and the Indian Government's initiatives. According to her there is a paradigm shift where the post independence period saw a complete marginalisation of the ISM and from the 1990s with the growth of international forces, the Government started promoting ISM especially Ayurveda. She argued that this step was not because of the realisation of intrinsic value of ISM but was merely to exploit and avail the international opportunities available to ISM (2002). "Pharmaceuticalisation" of ISM occurred in which the ISM is treated as a bag with recipe for cosmetics and health supplements. The epistemological bases of these systems are completely neglected and in the pharmaceutical industry the packaging, marketing, etc. is modeled upon that of western medicine. This again would help the western medicine to reinforce its hegemony and superiority. She probed the hegemony of western medicine in detail (2002). The rationality behind considering western medicine as a yard stick is questioned by the scholar. The issue of mass production of drugs was also highlighted. The concept of professionalistion was also studied by her where she wrote that with the introduction of division of labour ISM became further weak. The changes that occurred to ISM in the context of globalisation were also explained by the scholar. According to her, traditional knowledge is moulded as per the parameters developed by western medicine. She concluded that with the patenting laws etc. traditional knowledge is drifting away from India to trans-national pharmaceutical companies.

Bala (1982) studied the State- ISM interaction where the focus was on ancient, medieval and colonial period. She took the case of Ayurveda as an example. It was a historical work where the position of Ayurveda during ancient, medieval time was studied followed by a section on colonial and post colonial era. The scholar argued that Ayurveda stagnated and degenerated after independence not because of the State's neglect but because of the shift of clientele base to bio-medicine. She confirmed that despite State support, Ayurveda failed to

mainstream itself to country's health system. She argued that in the modern period the close link between Ayurveda and Unani was due to the fact that they shared identical governing assumptions. The scholar concluded that it was because of lack of scientific nature that Ayurveda became stagnated and lost its clientele base.

Sivaramakrishnan (2006) while concurring with Jeffery (1988) explained how ISM practitioners attempted to develop their status as a self- conscious and corporate identity. Her study focused on colonial Punjab of 1850-1945. In Punjab language-based interest were predominant and produced representations that were divisive in nature. She observed that the introduction of western medicine into India was entirely different from introduction of the same in the west. In India it was used as a tool of social control (2006: 2). When the practitioners of ISM faced identity crisis and their reputation was degraded they started looking for the alternatives to revive ISM. She identified the link between medicine and Hinduism in which there were attempts by the west educated class to use indigenous knowledge of Ayurveda for the revival of Hinduism (2006: 7). She documented the evidence where the vaids tried to project Ayurveda as having a "different" scientific base and that scientific base laid down claim for a Hindu nation. The Punjab vaids tried to link Ayurveda with Aryans and later with Sanskrit tradition. According t her that was an attempt to use ISM as a tool for a "Hindu- nation –in making". She observed that the print media was the main tool used to spread the idea and later that idea was condemned by the Sikh vaids.

The role of State in the marginalisation process is very important for the present degraded status of ISM. Khan (2006) in his work studied about the State –ISM interaction during the first half of the twentieth century. The main argument put forward by the scholar was that though one could see "peripheral level co-existence" of various medical systems the interplay of power, domination and

hegemony could not be undermined. His methodology was similar to that of Bala (1982). According to him in the nationalist discourse of India, there were three major streams: conformity, defiance and a quest for alternative (2006:2786). From the Government documents and assembly proceedings the scholar showed that the State and the powerful strata wanted conformity with western medicine. The stream of defiance was very weak and therefore the State did not promote it. Finally in the quest for alternative, the scholar mainly examined Gandhi's concept of alternative health care and naturopathy. He argued that in the 1990s the international economic institutions like the World Bank and the International Monetary Fund played an important role in shaping the health policies of the developing countries. He concluded that the power, domination and hegemony were pivotal in shaping the health system of a country whereas people's needs or interests were totally neglected.

Due to the neglect of State there developed various problems and tensions between ISM practitioners. That led to problems in the Ayurveda education. Brass (1972) in his work mainly focused on the politics of ayurveda education in India. He argued that in the revival movements the focus of ISM practitioners was to achieve the status and recognition which were at par with that of western medicine. It was done through institutionalisation and professionalisation. The revitalisation movements of Ayurveda in turn created an elite group in ISM which influenced State decision. He argued that the revitalisation movement was used as a political instrument and although such initiatives succeeded in establishing large number of institutions it failed to develop a uniform standard. Later, the strategy shifted to link Ayurveda with nationalism. According to him, the education of ISM became so irrelevant that it produced experts who were neither trained well in ISM nor in western medicine. The pay scales of western medical practitioners and that of ISM and that led to further conflicts and splits. Brass observed that there were wide spread dissatisfaction among ISM practitioners and students

during that time, as their identity was threatened and questioned (1972: 354). He gave the evidence that government's shift to Shudda[9] practice of Ayurveda and Unani was due to the lobby pressure of ISM practitioners from Shudda stream (1972: 360). Rather than objective reasons, power and political interests were the motives behind changes in the educational practices of Ayurveda.

The introduction of western medicine into the Indian health system and its impact was widely studied area, whereas ISM and its history received comparatively less attention from the scholars. Among these, works of Panikkar (1992), Jaggi (1977) and Kumar (2001) and Bala (1991) are very important.

Panikkar (1992) in his study on revitalisation movement in Keralam mentioned about the impact of colonial rule on Ayurveda and the strategies that ISM practitioners used. The interventions of the British led to a degraded status of Ayurveda and the practitioners of the system faced an identity crisis. Number of reformists of Ayurveda had then decided to "modernise and professionalise" Ayurveda. With the example of Ayurvedic tradition of Keralam, the scholar explained the elite orientation of Ayurveda Practice. He argued that in an attempt to revitalise Ayurveda as a medical system, the result was the marginalisation and elimination of the lower caste practitioners from the system. He observed that the quest for revitalisation of indigenous medicine reflected not only a struggle between colonisers and the colonised, but also between different classes within the colonial society (1992: 307). During the initial period of colonial rule in India, the indigenous system of medicine came under severe strain. Exposed to western intellectual and cultural forces, Indian intellectuals imbibed a world view, critical of traditional, cultural and social practices. He observed that the agenda used by ISM practitioners for change was selective rejection and reform rather than

[9] Shudda practice- where the practitioners want to keep the theoretical part of their medical system apart from the influences of the western medicine

westernisation (1992:284). In that process the lower caste practitioners were eliminated from the scene.

Kumar (2001) also identified the highly divisive and rigid caste system of India as a reason for the stagnation of ISM. This is because the questions like "how" and "why" were not allowed in the society. People started blindly following the readymade formula and there was lack of research or further learning which would have enriched the medical system. The mental work and manual work were separated. Similarly western medical discourse occupied an extremely important role in colonial India and it helped the State to ensure complete dominance. The western medical practitioners were interested in the pharmacology base of the ISM and had little faith in the diagnostic methods of ISM. According to his observation, in such a situation of hegemony a cultural interaction and exchange was rather impossible.

Jaggi (1977) in his work on medicine in India explained that when the British came to India, Ayurveda and other ISM were in a state of stagnation. During the British rule, there was no official encouragement to the ISM and that further catalysed the revitalisation movements especially in Ayurveda and Unani. He gave the evidence that the Unani revitalisation movement by Hakim Ajmal Khan in Delhi in the 1890s not only attempted to modernise Unani but also tried to eliminate the lower strata practitioners of Unani, wherein Ajmal Khan claimed that the illiterate practitioners were the main cause for the disintegrated status of Unani. According to him, Unani till the Mughal era enjoyed State patronage. Later the British disinterest excluded ISM practitioners from the purview of the Bombay Registration Act of 1912. He argued that the British allowed the practice of ISM only because it was not possible to substitute it with western medicine in the whole country due to resource constraints (1977: 341).

In her work on Imperialism and Medicine in Bengal, Bala (1991) attempted to assess the impact of State on ISM in nineteenth and twentieth century. She examined the trend of State policies and professionalisation of different systems during the mentioned period. The author suggested that the history of indigenous medicine was one of "accommodation and change and was associated with invasion and changes in rulers". She divided the period under consideration into two phases: an initial phase, 1800-1860; and a later phase, 1860 to the 1920s. As per the observations made by her it was the second phase (1860-1920s) that marked the separation of the two systems of medicine and the gradual withdrawal of state support. Cognitive shift from the humoural theory of disease to the germ theory of disease, industrialisation of medicine (mass production of drugs. standardisation and quality control over drugs) and increasing professionalisation of medicine in general had profound impact on ISM status of that time. The state increasingly favoured doctors trained in western medicine for employment in the state sector. She observed that in 1936, the Medical Council of India threatened practitioners of western medicine with derecognition if they continued to associate themselves with ISM. According to the author, the reason why the ISM movements did not succeed in the face of the challenges posed by the new paradigm of western medicine backed by state power was that the consensus regarding the theory of disease and the efficacy of therapeutics which existed broke down among ISM practitioners.

Sociological focus on ISM is mainly through micro level studies. The changes that occurred to ISM due to ISM-western medicine interaction are the focus of many of these studies. Studies by Naraindas (2006), Langford (1999), May and Sirur (1998), Mizrachi et al (2005), and Sujata (2007) are some of the important works from this perspective.

Naraindas (2006) in his work on evidence and efficacy in biomedicine and Ayurvedic medicine studied the problems which both systems faced due to co-option of specific technologies and materials from each other. It was a primary ethnographic work in South India. He observed that the educated class was not happy with the diagnostic techniques of ISM, because the diagnostic methods of Ayurveda are not "evidence" based. He observed that at the same time the patients wanted to avoid side effects of western medicine. Because of these two reasons treatment was clubbed. The patients used the diagnostic methods of western medicine followed by medication from Ayurveda. Naraindas argued that such a club of two different systems would bring problems to both the systems because such practices are against the epistemological basis of both the medical systems.

Langford (1999) in his work mainly highlighted the differences between western medicine and ISM where he took the case of Ayurveda as an example. The argument which Naraindas (2006) gave about the epistemological differences between two systems was more clearly explained by Langford (1999) in this work. According to him western medicine views the person as solid and bounded whereas Ayurveda views body as fluid and penetrable with special relation to natural environment. The Ayurveda's focus is prevention where as western medicine focuses on cure. He concluded that the standardization and professional association have made the practice of Ayurveda an institutionalised affair.

When two medical systems were mixed up there developed epistemological issues. For example, May and Sirur (1998) in their study of practitioners of NHS of UK studied the use of homeopathy in western medical practice. This work is similar to the one by Naraindas (2006). The main reason according to May and Sirur (1998) for mixing the two systems, was to avoid the iatrogenic effects of western medicine. The diseases for which the western medicines had no treatment

to offer, homeopathy was able to give treatments and in most of the case it was effective too. But those treatment modalities were rejected by the western medicine. He opined that interaction between western medicine and homeopathy result in protecting the interests of the powerful western medicine as a social institution.

It could be derived from the above mentioned studies that when any of the ISM interacted with western medicine it was dominated by western medicine and therefore western medicine reaffirmed its hegemony. Mizrachi et. al. (2005) supported this argument. Mizrachi et. al. (2005) in their attempt had put forward ideas about interaction between western and indigenous medicine. It was argued that when one medical system try to use treatment/ diagnostic methods of the other system, epistemological and ethical issues emerged. It was observed by them that there were no interactions happening between western medicine and Ayurveda, on the other hand the process is completely dominated by western medicine with which the epistemic base of Ayurveda got affected. The concept of "spatial marginalisation[10]" which is about allotting locations for different departments in a hospital was also mentioned in this study.

The argument given by Mizrachi et. al. (2005) is supported by the work of Carlos (2005) in which he argued that each medical system developed from different linguistic, historical, social and political background and had distinct scientific-philosophical base. He concluded that one medical system functioned as a social institution and tried to control another system by labeling them as "unscientific". This is similar to the views of Mizrachi et.al. (2005)

---

[10] The concept of "spatial marginalisation" was put forward by Shuval (1999). This is cited by Mizrachi et.al. (20005: 37). Spatial marginalisation is explained as the process in which in the corporate type of hospitals, the ISM department is allotted location outside the main building or in the end of the corridor. This is another way in which the western medicine maintains its hegemony and power

Efforts of Nisula (2006) were directed at understanding the usage of western medicine instruments by Ayurveda practitioners in Mysore. The work was an attempt to understand the impact of western medicine on the practice of Ayurveda. The observation revealed that people generally turned to Ayurveda when western medicine failed. Here Ayurveda practitioners used western medicine instruments for diagnosis irrespective of whether they required or not. That was to gain popularity because the patients had faith in the vaid only if he used western instrument for diagnosis. One can observe a western medical hegemony over ISM in many of the above mentioned studies.

The interaction process was studied by other scholars like Sujata (2008, 2007). In her work on South India's Siddha medicine she studied how eye treatment practices of pure practitioners differed from that of the college educated practitioners. The Siddha system interacted with other systems especially with the western medicine leading to the changes in treatment practices. In her another work on medical pluralism in India she examined people's perception about medical knowledge and the interaction pattern between professional and folk practitioners in Tamil Nadu (2007).

Anthropologists studied ISM mainly from two perspectives- 1) magico- religious rituals and practices related to health and medicine along with the practices of Shamans. 2) The ethnocentric view like Castairs (1955) and Marriot (1965) where the scholars studied the health practices of Indians and introduction of western medicine in India. Both the works examined the process of introduction of western medicine in rural India and analysed the problems, inhibitions of people to go for western medical treatment. They observed that the western medical practitioners were not able to develop faith in rural people whereas in the case of the ISM practitioners, they were close to the community and had cultural links as well. Therefore the ISM practitioners were preferred over western medical

practitioners. The treatment always involved some religious aspects and that boosted the confidence of the patient. Similarly treatment was not an individual matter with the patient but it was a family effort.

From the above reviewed studies one could identify some common themes. In the colonial period western medicine was used as a tool for social control and it was due to the introduction of western medicine in India that the marginalisation process of ISM gained momentum. In the 1990s a new trend of commercialisation of ISM is observed. Besides the State interventions in the colonial period there existed contradictions and tensions within ISM. The practitioners apart from the theoretical orientations were divided on the basis of caste, class and religion etc. Then one could see that western medicine – ISM interactions were dominated by western medicine, which can be termed as "allopathisation". Thus it could be concluded that ISM in post independence era is facing threat of marginalisation, allopathisation and commercialisation.

1.2 Research Problem

Since the colonial period, the Indian health system has been dominated by "scientific rationality" inherent in the western tradition. Within this discourses, ISM has been marginalised as "unscientific" and ascribed a lower position in the hierarchical structure of the Indian health system. It is evident from the survey of literature that, even after independence, the State has favoured western medicine over ISM and made it marginalised. Apart from the State's intervention and the advantage of western medicine over ISM, the inner contradictions of ISM and its practitioners could be also responsible for its decline in the post independent period. While considering the dimensions of political interests, national ideology and international forces etc. the complexity of marginalisation of ISM becomes much more widened.

Against this background, it deserves particular importance to explore the process of marginalisation of ISM, which was satisfying the medical needs of our population at different levels[11]. Despite its large clientele base as acknowledged by various committees, the government apathy, problems developed within ISM and the interest of western medicine as a system had played a major role in its marginalisation. Among these the State has pivotal role which would be highlighted in the present study.

There is a need for the existence of different systems of medicine because of its clientele demand, and also because of a strong faith and belief that many of these system treatments do not have side effects. Each medical system has its own diagnostic, treatment methods based on its epistemological root. In this context, the attempts of the State to "allopathise[12]" ISM also deserve due attention.

What is important here is the shift in intervention of State within the context of a neo-liberal regime after the 1990s. Health system, since 1990s has changed its patterns and modalities. ISM once on the periphery is moving towards the centre by rediscovering the possibility of "going herbal", in which the direction and momentum is defined by market forces[13].

Who decided western medicine as "science" and what is the role of this science as far as India is concerned? India had a well developed science and medicine basis of its own long before arrival of the British in India. Suddenly with the introduction of western medicine how such centuries old medical systems lost its

---

[11] This fact that ISM had clientele demand is explained by Usman Committee (1923) and Bhore Committee (1948). Bhore committee acknowledged the fact that ISM exercised not merely over the illiterate masses but over considerable sections of the intelligentsia. It also recognized that ISM treatment was cheap. Similarly Usman Committee Report mentioned that in 1920s ISM catered health needs of 90 percent of the population. Later the National Health Policy (1983) and The National Policy on ISM & H (2002) also mentioned about the ISM utilisation of the country.

[12] In this study the term "allopathisation" is used to mention the process in which ISM is using western medical concept/ methods/ techniques in its practice/ education/research.

[13] Banerjee (2002, 2000)

role and importance in the society? Was this a natural, gradual process (because of the intrinsic superiority of the western medicine) or was it a deliberate attempt in which ISM was marginalised to meet certain social, political and economic interests of certain groups? Does it have anything to do with the international forces and market economy? These are the questions to be probed in this work.

In the light of the above, the present study tries to analyse the shifts in the State-ISM interactions in the post independent period.

1.3 Research Questions

1. What are the major discourses on ISM during colonial era in terms of the impact of colonial rule on ISM and the internal contradictions of ISM.
2. What are the major policy shifts of ISM during post independent India?
3. What are the forces leading to this shift?
4. Why there is sudden Government attention to ISM especially in the 1990s?
5. How the interventions of the State could be improved to the development of ISM without loosing its fundamental nature?

1.4. Broad Objective

To understand the nature of State- ISM interaction during post independence period and to place this trend in the broader political, economic and social context of India.

1.5. Specific Objectives

1. To understand the discourses on ISM since the colonial period
2. To explore the paradigm shift in National perspective, policies and programmes towards ISM during the post independence period

3. To place this paradigm shift in a broader context to identify political and economic forces which led to such changes
4. To examine the interaction between international forces and market with ISM during post 1990s in India
5. To critically analyse the process of marginalisation of ISM in India over the period

1.6. Boundary of the Study

ISM within the Indian health system and within the Indian society has many issues- 1) hierarchy within ISM i.e. there is an argument that Ayurveda dominates over other systems within ISM. 2) Another issue highlighted is the elite nature of ISM and the argument that ISM treatments are costlier than western medical treatments 3) Brahmanical nature of Ayurveda is another issue. There are other important questions: - what is the problem if ISM is being modeled on western medicine; and what is the rate of utilization of ISM by Indian masses. The focus given by me, to these issues is very limited because these issues are not the central point of this study but when literature related to these issues has something to do with ISM-State interaction, it will be mentioned.

However, the present study does not intend to initiate a discussion in any of the above mentioned issues, because it falls beyond the scope of my research. It is also not my objective to compare the relative efficiency of different system of medicine practiced in the country. If in any of the chapter, though any mention about the above raised issues is presented, that is merely to understand ISM-State interaction and to place it in the social and political context.

1.7. Methodology

To understand the process by which indigenous medicine is being located in the Indian health system three aspects becomes important – the policy processes and milestones during the post independence period, the market mechanics during the

1990s, and the contradictions and problems located within ISM. Policy and programme shifts of ISM in general with respect to India was analysed with an attempt to locate it in the broader socio-political context.

We followed a systematic literature review for understanding the interaction between State and ISM in post independence period and then interaction between ISM and international forces during 1990s. The study aimed at identifying policy and perspective shifts; and places the same in the wider social context with framework of "coexistence". While documenting or dealing with the "coexistence" of varied practices, role of power, domination and hegemony was not ignored.

1.8. Sources of Literature

The study was completely based on published literature. Primary literature was used to chalk out general trends and shifts in Government policies and programmes. Various committee reports on health, committee reports specifically on ISM, five years plans, annual reports of Ministry of Health &Family Welfare, Parliamentary proceedings and debates became the main source of literature.
Relevant articles, books, and unpublished works was the supplementary data sources; help of authentic internet data (especially Government of India websites) base was also be utilised.

1.9. Scope of the Study

Understanding better the historical roots of the pattern of emergence of ISM as part of Indian health system and highlighting the marginalised situation faced by it may help the Government to overcome these inadequacies.

The study of ISM becomes more important in the context of NRHM, because the mission document has visualised revitalisation of local health traditions and

mainstream of AYUSH into public health system as important. How this revitalisation will be done is the important question. This study provides some insights into the failures of previous interventions of the State. Similarly in India, non-communicable disease rates are increasing where for many of these diseases ISM have a viable solution. Therefore, protecting ISM and developing ISM without affecting its fundamental nature becomes important.

1.10. Usage of Terminology

I have generally used the term "western medicine" to represent what is called as biomedicine and allopathic medicine in India. This is controversial because, Leslie (1972) used the term "cosmopolitan medicine" to denote the same. I do not think there is an ideal and single solution so I have simply chosen to use the term "western medicine" in my study.

Same is the case with Indigenous Systems of Medicine where there are different terminologies like- traditional medicines, alternative medicine and complementary medicine. The Indian Government now uses the term "Indian System of Medicine" to represent this category. But since I am not convinced with the usage of the term (for eg- Unani is not of Indian origin) I prefer to use the term Indigenous Systems of Medicine. Further in this study, the term Indigenous system of medicine includes Homeopathy since the State has treated this system along with Ayurveda, Unani etc. and policy developments for these groups are discussed together. Now onwards, Indigenous system of medicine will be denoted in this study as ISM, which will include Homeopathy also.

1.11. A note on Chapterisation

The second chapter includes the debates over the term ISM, and the impact of colonial rule on the ISM. The problems which existed within the ISM are summarised.

The third chapter examines the policy shifts of ISM at national level. The State-ISM interaction is probed using various committee reports, planning commission documents, parliamentary debates and annual reports as main data sources. This chapter is factual in nature where the whole focus is to chalk out the policy and programmes shifts as far as ISM is concerned.

The fourth chapter places the policy shifts and trends in a broader socio- political context. The various Nationalist agenda, political forces and economical factors that led to the policy shifts are analysed. The role of international forces and the international market in the same is also be analysed here.

The last chapter includes concluding remarks arguments which is followed by a discussion on changes that are needed in the State interventions to improve development of ISM without losing its fundamental nature.

1.12. Limitations of the Study

The content of the study is strictly restricted given the paucity of sources. Especially in the case of parliamentary debates it was difficult to locate all of them. It was not possible to locate all debates on ISM which occurred during post-independence period (because cross reference from articles or details from libraries are not available).

TH-15462

Chapter Two

Discourses on Indigenous System of Medicine in India: Colonialism, Epistemology and the inner conflicts

History is always a continuum and while attempting to explain changes during the post independence era in India, a brief description of colonial rule-ISM interaction becomes important. This chapter briefly mentions about the discourses on ISM, since the colonial time. In this chapter the key concept of ISM and debates on defining ISM comprise the first section. In the second section each of ISM is explained, with the objective of distinguishing about the epistemological base of ISM with that of western medicine. In the third section impact of colonial rule on ISM is studied. The problems which were developed within ISM are analysed in the last section of this chapter. Therefore attempt in this chapter is restricted to give a frame of reference which will be useful to understand State-ISM interaction during the post- independence period.

2.1.1. Debate over the term Indigenous Systems of Medicine

In India, Allopathic Medicine has been referred as western medicine, modern medicine and scientific medicine[1]. From the terminology itself we can see a deliberate attempt to project allopathy as the only system that has proved itself as "scientific"[2]. All other medical systems has been collectively represented by the term Indigenous System of Medicine as each one of these so called "ISM" do not have an independent existence. Further, the term "medicine" in "Indigenous Systems of Medicine" seems to be based on the biomedical framework because systems like Ayurveda etc. never had a terminology "medicine". Ayurveda, Yoga

[1] Such contradiction of various terminologies is highlighted by Leslie (1972), Jeffrey (1988:12).

[2] Similar argument is given by Leslie where he mentioned that the term "scientific medicine" is misleading. It encourages the assumption that all aspects of allopathy is somehow derived from science. This spontaneously leads to next assumption that all medical systems other than western medicine are "unscientific" (1972: 7).

, Naturopathy etc. are more associated with way of life rather than "curative" focused system for which the term "medicine" is more appropriate.

Within the term "Indigenous Systems of Medicine" debates and confusions exists among scholars. Terms such as traditional medicine, Indian system of medicine, alternative medicine, and complementary medicine are used interchangeably. An attempt is made in this study to reflect upon the various definitions by different scholars and thus arrive at a definition of Indigenous System of Medicine, which is used throughout this study.

Pahari in her work has cited definition by Kennett and Jalota (2005: 32). According to them, traditional medicine is a sort of antique treatment based on both supernatural and natural cure. It is deeply rooted in the culture, convictions, and the climate of a particular country where it emerged. It is passed from one generation to another through written as well as oral means. Unlike other traditional systems, Indian traditional medicine does not mean a single system of cure. It consists of different types of natural, empirical and therapeutic system of cure i.e. Ayurveda, Unani, Siddha, Yoga, tantric and folk medicine.

Rather than giving an abstract definition many scholars have made attempts to classify the medical systems into broad categories. For example, Dunn (1972) has classified the medical systems into three stratums with reference to their geographical and cultural settings. Allopathy and Homeopathy are entitled to "cosmopolitan medicine" because they have worldwide scope. Next, Ayurveda, Unani and Yoga are classified as "regional medicine" because they have application or scope in a particular region. Tantric and folk medicine are

classified as "local medicine" because their application is in a very limited locally defined geographical area[3].

Leslie (1972) has called South Asian Medical practices as "Great- traditions" because they have maintained their individual character although they were in contact with each other. He preferred the term "cosmopolitan medicine" to denote allopathy rather than "modern medicine" or "scientific medicine". He has used framework of "co-existence" in many of his works[4].

Banerjee (2000) has mentioned "Indigenous System of Medicine" as a bureaucratic convenient term that includes Ayurveda, Unani, Siddha and Naturopathy. Further she has explained how Indigenous medicine is differentiated from folk medicine. First, these systems have a textual tradition[5]; second it has allowed plurality and third the development of each system and has been influenced by each other. That means while maintaining distinct identity these systems interact and incorporate diagnostic methods, pharmacology of each other.

Officially Government of India has been using the term "Indian System of Medicine & Homeopathy" to represent Ayurveda, Naturopathy, Siddha, Unani, Yoga and Homeopathy. In the Government terminology one can observe many shifts during post-independence period. For example in the sixth plan document instead of indigenous system of medicine "traditional medicine" has been used. In the eighth plan period the term "Indian System of Medicine" has been introduced.

---

[3] Dunn (1972) has considered health as a dynamic entity and he defined a medical system "as the pattern of social institutions cultural traditions that evolves a deliberate behavior to enhance health, whether or not the outcome of the particular items of behavior is" (1972:135)

[4] See Introduction by Charles Leslie in Asian Medical Systems: A Comparative Study ed. By Charles Leslie, University of California Press, London, 1972. He argues that the term "modern medicine" creates an impression that traditional practitioners are conservative and rejects opportunities of acquiring knowledge. His framework of co-existence is challenged by Khan (2005).

[5] Textuality means well documented , authentic evidence exists. It does not rely on oral tradition. Plurality here means diversity of practice with respect to geography, topography.

2.1.2. Operational definition of Indigenous Systems of Medicine

Since this study is primarily examining ISM interaction with the State, it is convenient to adopt the same definition as that of Government of India. Under the term Indian System of Medicine, Government of India recognises Ayurveda, Unani, Siddha, Naturopathy and Yoga as valid medical systems. Homeopathy[6], a distinct system from ISM, is also recognised by the Government as a valid medical system. In this study, homeopathy is also discussed as Indigenous system of medicine because State policies and medical discourses have treated it as a marginal system.

I prefer to use the term Indigenous Systems of Medicine rather than Indian Systems of Medicine because it is not clear what criteria (e.g. origin and development) has the State used to select "Indian System of Medicine" as its official terminology. In earlier committee reports the term used was Indigenous System of Medicine[7]. Later in 1990s the State started using the term Indian System of Medicine where it has projected Unani (which is not of Indian origin) also as a system with Indian origin. Here onwards, in this study, the term Indigenous systems of Medicine include Ayurveda, Unani, Naturopathy, Yoga, Siddha and Homeopathy.

2.2. Brief Overview of ISM

In this section, the focus is to briefly explain about each of the indigenous medical system. This is to develop a brief understanding about principles, concept of body and health, concept of diagnosis and treatment of each of this system. This section however does not intend to give clinical details of each of this ISM. The focus is to understand how each of ISM has its own epistemological base, doctrine and

---

[6] Homeopathy a distinct system came to India during colonial times and has its own distinct history of development in India. Jaggi (1977) has elaborated the development establishment of homeopathy in India

[7] See for example Bhore Committee Report (1948) Mudaliar Committee Report (1962)

principles which is entirely different from that of western medicine. Since the epistemological bases of all the systems are entirely different from that of western medicine therefore the State's attempt of "allopathising" becomes futile.

2.2.1. AYURVEDA[8]

Life in Ayurveda is conceived as the union of body, senses, mind and soul. The living man is a conglomeration of three humours (Vata, Pitta and Kapha), seven basic tissues (Rasa, Rakta, Mansa, Meda, Asthi, Majja and Shukra) and the waste products of the body such as urine and sweat. Thus the total body matrix comprises of the humours, the tissues and the waste products of the body. Health or sickness depends on the presence or absence of a balanced state of the total body matrix including the balance between its different constituents. Both the intrinsic and extrinsic factors can cause disturbance in the natural equilibrium giving rise to disease. In Ayurveda diagnosis of the patient is always done of the patient as a whole. The physician takes a careful note of the patient's internal physiological characteristics and mental disposition.

2.2.2. YOGA[9]

Yoga philosophy is the art and science of living in tune with the Brahmand- the Universe. Yoga has its origins in the Vedas, the oldest record of Indian culture. It was systematized by the great Indian sage Patanjali in the Yoga Sutra as a special Darshana. Yoga today is no longer restricted to a privileged minority of hermits; it has taken its place in our every day lives and has undergone a world wide awakening and acceptance in the last few decades.

Yoga is not a religion; it is a philosophy of life based on certain psychological factors and it aims at the development of a perfect balance between the body and the mind. According to Yoga, most of the diseases mental, psychosomatic and

---

[8] Details of this section are from website of Government of India, AYUSH website topic titled "about Ayurveda" accessed as http://indianmedicine.nic.in/ayurveda.asp on 23.01.08

[9] Details of this section are from website of Government of India, AYUSH website topic titled "about Yoga" accessed as http://indianmedicine.nic.in/yoga.asp on 23.01.08

physical originate in mind through wrong way of thinking, living and eating which is caused by attachment. The basic approach of Yoga is to correct the life style by cultivating a rational positive and spiritual attitude towards all life situations. All the systems of medicine at their best aim at curing the disease whereas Yoga aims at preventing the disease and promoting health by reconditioning the psycho-physiological mechanism of the individual.

2.2.3. NATUROPATHY[10]

Nature Cure believes that all the diseases arise due to accumulation of morbid matter in the body and if scope is given for its removal, it provides cure or relief. It also believes that the human body possesses inherent self constructing and self healing powers. The fundamental difference in Nature Cure with other systems is that its theory and practice are based on holistic viewpoint whereas the latter's approach is specific. Nature Cure does not believe in the specific cause of disease and its specific treatment but takes into account the totality of factors responsible for diseases such as one's un-natural habits in living, thinking, working, sleeping, relaxation, sexual indulgence etc. and also considers the environmental factors involved which on the whole disturbs the normal functioning of the body and lead it to a morbid, weak and toxic state. For treatment it primarily stresses on correcting all the factors involved and allowing the body to recover itself. Naturopathy is a system of healing science stimulating the body's inherent power to regain health with the help of five great elements of nature – Earth, Water, Air, Fire and Ether. Naturopathy is a call to "Return to Nature" and to resort to simple way of living in harmony with the self, society and environment. Nature Cure movement gained momentum in India when Mahatma Gandhi, became much interested in this system and included it in his programmes. He has also

[10] Details of this section are from website of Government of India, AYUSH website topic titled "about Naturopathy" accessed as http://indianmedicine.nic.in/naturopathy.asp on 23.01.08

established a Nature Cure Hospital in Uruli Kanchan, District. Poona, Maharashtra which is still functioning.

2.2.4. UNANI

Unani System of Medicine originated in Greece and is based on the teachings of Hippocrates and Gallen and it developed into an elaborate Medical System by Arabs, like Rhazes, Avicenna, Al-Zahravi and Ibne-Nafis. Unani treatment is mainly dependent on the temperament (Mizaj) of the patient, hereditary condition and effects, different complaints, signs and symptoms of the body, external observation, examination of the pulse (Nubz), urine and stool, etc. Unani medicine is also known as Tibb[11]. Though the threads which comprise Unani healing can be traced all the way back to Claudius Galenus of Pergamum, who lived in the second century of the Christian Era, the basic knowledge of Unani medicine as a healing system was developed by Hakim Ibn Sina (known as Avicenna in the west) in his medical encyclopedia. Unani medicine is very close to Ayurveda. Both are based on theory of the presence of the elements (in Unani, they are considered to be fire, water, earth and air) in the human body. (The elements, attributed to the philosopher Empedocles, determined the way of thinking in medieval Europe.) According to followers of Unani medicine, these elements are present in different fluids and their balance leads to health and their imbalance leads to illness. The base used in Unani medicine is often honey. Honey is considered by some to have healing properties and hence is used in food and medicines practiced in the Islamic world. Real pearls and metal are also used in the making of Unani medicine based on the kind of ailment it is aimed to heal.

[11] Details of this section are from website of Government of India, AYUSH website topic titled "about Unani" accessed as http://indianmedicine.nic.in/unani.asp on 23.01.08.

2.2.5. SIDDHA[12]

Siddha literature is in Tamil and it is practiced largely in Tamil speaking part of India. According to tradition, the origin of Siddha system of medicine is attributed to the great Siddha Ayastiyar. Some of his works are still standard books of medicine and are in daily use among the Siddha Medical practitioners. The principles and doctrines of this system, both fundamental and applied, have a close similarity to Ayurveda. According to this system the human body is the replica of the universe and so are the food and drugs irrespective of their origin. Like Ayurveda, this system believes that all objects in the universe including human body are composed of five basic elements namely, earth, water, fire, air and sky. The food, which the human body takes and the drugs it uses are all, made of these five elements. The proportion of the elements present in the drugs vary and their preponderance or otherwise is responsible for certain actions and therapeutic results.

Naturopathic practitioners prefer not to use invasive surgery, or most synthetic drugs, preferring natural remedies, for instance relatively unprocessed or whole medications, such as herbs and foods

2.2.6. HOMEOPATHY

Hahnemann is the founder of Homeopathy and this medical system was developed in Germany. Homeopathic practitioners contend that an ill person can be treated using a substance that can produce, in a healthy person, symptoms similar to those of the illness. According to homeopaths, serial dilution, with shaking between each dilution, removes the toxic effects of the remedy while the qualities of the substance are retained by the diluents (water, sugar, or alcohol). The end product is often so diluted that it is indistinguishable from pure water, sugar or alcohol. Practitioners select treatments according to a patient consultation

---

[12] Details of this section are from website of Government of India, AYUSH website topic titled "about Siddha "accessed as http://indianmedicine.nic.in/siddha.asp on 23.01.08

that explores the physical and psychological state of the patient, both of which are considered important to selecting the remedy

2.3. Impact of the Colonial Rule on ISM

The British came to India, with western medicine. Till then medical pluralism existed in India, but one can observe that this was non-hierarchical in nature. This trend slowly shifted to a hierarchical one, in which western medicine slowly moved towards the top of the hierarchical structure. The following work gives evidence for this shift.

Abraham (2005) observed that the colonial rule and introduction of western medicine, hegemony developed by western practitioners and finally the problems within ISM were various reasons for marginalisation of ISM in the initial periods. Abraham argued that the reason for the neglect of ISM was historical as well as political (2005: 188). In early 20th century, vast State patronage to western medicine and development of medical profession shaped a discourse that privileged "scientific" medicine and led to the hegemony of allopathic medicine[13].

Gupta (1972) observed that the first two decades of the nineteenth century, did not witness any significant change in the attitude of the British to ISM. The British Government infact did not intervene in the matters related to the traditional system[14].Further he gave evidence that it was very usual to employ ISM practitioners as health workers. He wrote that the withdrawal of the support of English to Ayurveda education was a clever British policy to maintain control over the population.

---

[13] Abraham (2005) further elaborated this point as the colonial health policies were based on western medicine and were aimed to meet the interest of the colonial power. In this process ISM met a set of mixed responses which finally led to the hegemony of western medicine.

The British Government introduced western medicine in India to protect themselves especially their cantonment areas and higher civil servants. Later during the spread of epidemics in India, western medicine got more attention and patronage from the State. Along with this medical reason, there were political and social reasons for promoting western medicine. This was to project western medicine as scientific and ISM as "unscientific". Similarly attempts were made to project that the British systems were modern whereas Indians systems were conservative[15].

The history of colonial rule- ISM interaction according to Gupta (1972), started when in 1824 a Sanskrit college was established in Calcutta. The friendly coexistence of the two medical systems, however, did not last very long. Clear demarcation of British rule against ISM can be traced back to 1835 with the abolition of the Sanskrit College in Calcutta. This was due to the British policy where the higher education became west oriented with English as medium of instruction especially after the introduction of Macaulay's reforms in 1835. In the late 19th century huge funds were earmarked to give scholarships for students of western medicine. The students who studied western medicine had much better chances of achieving a good position than ISM practitioners.

Panikkar (1992) also traced impact of colonial rule on ISM. He wrote that neglect by the State coupled with humiliation experienced by the practitioners led to the formation of All India Ayurvedic Congress in 1907. This professional body challenged "unscientific" status ascribed to ISM, which they argued was unfair and politically motivated. Another evidence for colonial neglect recorded by Panikkar (1992) is about the discrimination which the British showed for the registration of medical practitioners. The Medical Registration Act of 1912 and 1919 restricted the use of the title "doctor" to western medical practitioners.

---

[15] Work of Ramasubban (1982) on introduction of western medicine in India during colonial rule gives an elaborate account of this history.

Further he recorded colonial history of ISM that in 1928 when Indian Medical Association was formed, prominent nationalist leaders called for the inclusion of ISM, but General Medical Council in London disagreed to recognize Indian medical degrees if ISM is also included within the purview of the Indian Medical Association. By 1930s this position changed and in 1938, indigenous practitioners were registered in Bombay on a separate register.

Jeffery (1988) identified two lines of arguments which were common – loss of British patronage led to the decline of ISM; destruction of village economy and localised commercialisation led to the decline of ISM status. He had the view that one reason for State tolerance towards ISM was that, the State reached out only to a very small section of the population. But the medical bureaucrats were hostile to ISM and most of the administrative doctors equated ISM with quackery. His argument is that initially there was State/ Princely patronage to ISM which later changed and a middle class market developed which ultimately led towards efforts of institutionalisation.

Jaggi (1977) observed that when the British came to India Ayurveda was in a state of stagnation. Later there was no official encouragement or support to Ayurveda and as a result in the beginning of the twentieth century many pioneers started working for the revival of Ayurveda and Unani. He documented the evidence where the western medical practitioners developed an interest in Ayurveda especially in its pharmacology (like Dr. R N Chopra). He observed that between 1921 and 1947 a number of committees were set up at Provincial level to examine the ISM status but the outcome of such initiatives were insignificant. According to him Unani medicine till Sultanate- Mughal period enjoyed State patronage and after that the British rulers showed no interest. It was in the later quarter of the nineteenth century, that a few educated Indians started initiatives for the revival of ISM, especially in Ayurveda and Unani.

According to the British, Ayurveda and Unani were based on outdated ancient theories but the government allowed the practice as it was impossible to substitute ISM with western medicine in the whole country because of the financial and other resource constraints. The British though allowed the practice of ISM they were totally against it and were absolutely unwilling to spend any money for the development of these medical systems. The main reason highlighted was the deductive and speculative nature of ISM which did not have any scientific evidence for the diagnosis and prognosis. The same reason was pointed out when the Bombay Medical Registration Act excluded ISM practitioners from the registration.

Kaviraj Gananath Sen in 1923[16] pointed out two reasons for the declining status of ISM. The first one was the lack of recognition and support by the State; and the second reason was the establishment of western medicine as the official system and this system enjoyed the monopoly of the State patronage. According to his observations, for the good brains of the country there were two options: one was to opt for western medical education which would have given pay and recognition another was to opt for stagnated ISM courses which unofficially gave them a label of "quacks" and banned their entry to State services. These conditions also led to further stagnation and deterioration of ISM as a viable medical system.

The role of western medicine in the process of ISM marginalisation during colonial period is studied by Kumar (2001). The western medicine played an important role in the colonisation of India, where it served the State and helped to ensure complete domination and later it became a tool of social control. The western medical practitioners who studied ISM practices and its pharmacology started interpreting everything with the help of their own training and principles. The western medicine was a tool where it was used for persuasion (by pointing

[16] Cited by O P Jaggi (1977:341)

out about "unscientific" nature of ISM) and for coercion (by pointing out the inferiority of ISM)

Western medicine was initially used for the benefit of Europeans and was later forcefully imposed, as a cultural agency for western expansion. The State, after the establishment of western medicine developed the limited number of hospitals and dispensaries as the nucleus of health care system and thus western medicine gradually became the officially preferred system and in the process it also established superiority over other ISM. According to Kumar (2001) there are evidences that the Bombay Medical Registration Act was not only intended to control quacks but also to supplant ISM with western medicine at the "appropriate time". The other reason which the officials pointed out for the lack of support to ISM was that these medical systems cannot establish cause- effect relationship.

2.4. Problems which developed within ISM (Divisive Trends of class, religion and caste)

As we have mentioned earlier (in the introduction pp.1) there are evidences about the fruitful interactions between various ISM[17], especially between Ayurveda and Unani which led to the enrichment of pharmacopia and the improvement of the diagnostic skills. Infact Basham (1972) appreciated the fact about the indigenous practitioners' interest and ability to incorporate knowledge from other systems with which they came into contact. But in the later time, this meaningful and enriching interaction disappeared and along with the introduction of western medicine this state reached its peak.

After the formation of All India Ayurvedic Congress in 1907, there emerged two groups within Ayurveda namely Shudda Ayurveda and Modernists. Suddha

[17] In her work Banerjee(2000) has included this as a feature of ISM. Interaction and incorporation from each other especially in diagnostic methods and pharmacology is appreciated by her.

Ayurveda practitioners were not ready to incorporate western medical elements into their practice where as the modernists tried to develop institutionalised training, research, manufacture and marketing of drugs.[18]

Panikkar (1992) observed that in Keralam, Ayurveda practice was not the monopoly of the upper castes. He took revival movement as an example and showed how class elitism played a politics to eliminate lower caste practitioners. According to him the revival movement which was initiated by P S Variar had two objectives- one was obviously regaining the old privilege of Ayurveda and the second was abandoning the practice of Ayurveda by the lower caste people. In the colonial time when the Indian medicine faced problems related to recognition the Indian intellectual group adopted two fold strategy- selective rejection and reforms. Panikkar in his analysis explained that the revival movement aimed to include "scientific methods" in practice, education, research and marketing of the drugs and thus made the Ayurveda practices of lower caste people "unscientific" and thereby tried to abolish the medical practitioners of the lower castes. The movement underlined its elitist character as it sought to replace popular practices that were seen outside the scientific system. The author also identified a revivalist tendency which was supported by the landed aristocracy. This revival world remained within the literate group who knew Sanskrit and English. Thus professionalisation efforts of the revival movement declared and deemed the untrained from the lower castes as those who "spoil" Ayurveda. As mentioned earlier he drew attention to the fact that the Ayurveda and other ISM was not only used to develop hegemony of coloniser over the colonized but also used to develop hegemony of different classes.

[18] Initiatives of Vaidyarathnam P S Variar is much studied one in the stream of modernist practitioners. Variyar ofcourse had an interest for the revival of Ayurveda. For this he incorporated western medical aspect in the training / treatment modalities. Similarly he initiated publication trend in Kerala Ayurveda. Marketing , mass manufacturing of drugs etc. was also given due importance. See the work of K N Panikkar in 1992 for further details.

To understand about the class elitism of ISM during colonial period the work of Jeffrey (1988) is important. Class elitism in practice of Ayurveda and Unani (during the colonial time and especially during 1850-1920s) is well studied and can be considered as a major problem which made ISM weak during colonial period. He tried to identify reason by which ISM study became a monopoly of upper castes. He analysed it as follows: classic texts of Ayurveda did not keep any restriction on who might study medicine. But the education involved staying in the house of the teacher and it might have been to avoid difficulties in eating arrangement that the (related to the caste system in India) teacher preferred students from the same caste. According to him, this could be one of the reasons for ISM monopoly of certain higher castes in India. Further he explained that ISM was separated by linguistic, theoretical and religious differences. The politics became more communally based in the 1930s when vaids and hakims[19] found it difficult to work together[20].

In his work Jeffery (1988) has cited Chattopadhyaya (1977) where the argument was about the Brahmanic control of Ayurveda. In the 1930s one can note communally based disputes between vaids and hakims and disunity among ISM practitioners.[21] Chattopadhyaya (1977) is also cited by Bala (1982) in her work where it is mentioned that lowering of scientific- standards of ISM was because of religious- orthodoxy. Later the lack of empirical demonstration and materialism of ISM were pointed out as other important reasons.

Kumar (2001) wrote that the highly divisive caste system which is peculiar to South Asia played an important role in the degraded status of ISM. The caste system separated theory from the practice and mental work from manual work.

---

[19] Vaid- is Ayurvedic practitioners and hakkim is Unani practitioner

[20] Gender bias in ISM is also clearly visible as Jeffery (1988) put it, that women had no access to education and practice in these systems and their access to treatment was also limited. The weakness of ISM as a group was partly due to internal divisions.

The scholar identified there were no "how and why" involved in any activity; questioning and enquiry were deemed as negative qualities. There was no research and ISM was not moving ahead along with the changing social and cultural situations and this finally led to the stagnation of ISM.

Jaggi (1977) studied status of ISM in the colonial era where he drew attention to the functioning of the provincial level subcommittee of ISM. The provincial level the sub committee on ISM education reported the dissatisfaction regarding the concurrent scheme of training and there was lack of faith in the type of training provided. The sub committee also observed lack of objectivity in ISM practice as the main problem.

According to Mahatma Gandhi, [22] besides the lack of State support there were prevailing problems within ISM. The hakims and vaids were blindly following the formulae without investigation or questioning. There was no enthusiasm within the practitioners for observation and research and so the practice of ISM also became stagnated. Another problem which he pointed out is quackery. There was no distinction between the trained practitioners and quacks.

Work of Sivaramakrishnan (2006) is similar to that one by Panikkar (1992). She in her work, about ISM in colonial Punjab observed how the ISM practitioners attempted to develop a self- conscious, corporate identity. In Punjab, she recorded evidence of language- based interests which produced representations that were divisive. The western educated Indian elite made attempts to use "scientific" base for the revival of Hinduism. The argument by her is that indigenous practitioners used ISM for political process mainly to protect language interests and to help the process of the development of a Hindu nation. In her analysis she wrote that the

[22] Cited by O P Jaggi (1977: 343,344) in Ganshi's own words " I regret to have to record my opinion, based on considerable experience, that our hakkims and vaids do not exhibit that research spirit....they follow formlue without question....the profession has largely fallen into disrepute"

Hindu Vaids of Punjab argued for ISM as a Hindu science and claimed for linkages with Aryans of ancient times. Those attempts to project Ayurveda as a Hindu Brahmanical Science were criticised by Sikh Vaids. The role which the western medicine played in colonial India is also briefly mentioned by the author. She explained that the introduction of western medicine in India was distinct from the introduction of the same in the west, because in India it was introduced as a medium of social control. According to her observations, the capacity of the western medicine to handle epidemic like plague also played an important role in elevating its status within a short span of time.

Although the Ayurveda Texts were essentially secular in nature, the revivalist movements which began in 1890s tried to project it as part of Hindu Nationalism, in which attempts were made to link Ayurveda with Aryans of ancient time. Similar efforts in Unani were made by Hakim Ajmal Khan in 1889 in Delhi. He declared that unqualified practitioners had to be eliminated from the practice with which he meant elimination of the illiterate practitioners. His attempts did not please the practitioners in Luknow, where a more traditionalist school of Unani existed, and therefore they resisted and criticised the efforts of Ajmal Khan.

The above literature gives an overall idea about the problems which developed within ISM during the colonial time. The practitioners were divided at caste, linguistic and religious basis. Theoretical orientation was also different which led to development of pure and modernist streams. The confusion whether to make ISM modern or to remain as pure also persisted. What these internal divisions contributed to ISM is nothing but, made the system further weak.

2.5. Conclusion

This chapter was an attempt to give a broad framework to examine ISM- State interaction during the post independence period. Firstly, one can see that there

exists confusion over the term Indigenous System of Medicine and thus marginalisation and sidelining starts from this level onwards.

Secondly, a brief description about each of ISM, helped to explain the differences between various medical system in terms of principles and doctrines etc. It is evident that, since each medical system has different set of principles and different concepts of body and disease, the "allopathisation" and "marginalisation" efforts are futile.

Thirdly the impact of colonial rule on ISM was examined. From the late medieval period onwards ISM was in a state of stagnation. Initially the British did not ban the practice of ISM. First, they had a non- judgmental attitude towards ISM. Later from 1835 onwards the British made it clear that the State patronage can not be given to ISM and the reason pointed out was the base on the "out-dated" ancient theories. They did not ban the practice because of financial constraints for establishing a health system based on western medicine through out the country. For them western medicine was a weapon for social control. Technology was always a powerful tool which the coloniser used against the colonised.

Fourthly, there were problems within ISM like the split among the practitioners based on theoretical orientation, caste, religion and language. As narrated earlier there emerged two groups- modernists and pure practitioners (both in Ayurveda and Unani). Modernists through revival movements tried to bring western medical elements into their practice. There are evidences of these movements' attempts were to eliminate lower caste practitioners from the mainstream. Religious divide between Hindu (Ayurveda) and Muslim (Unani) was also predominant during the colonial time. There were attempts to project Ayurveda as a Hindu science and use Ayurveda as an instrument for making of a Hindu nation. We can conclude that in the colonial time the non- supportive attitude of the government coupled with tensions and contradictions which developed within ISM led to the degradation of ISM.

Chapter Three

Paradigm Shift in ISM Policies of India: Tracing Trends in the Post-independence Era

There is unanimous agreement among the scholars that, ISM and western medicine was not supported and promoted by the State at the same level[1]. History of ISM in the post independence period has received less attention from social scientists. The general neglect of research on ISM by scholars was followed by the general neglect of these systems by the State. It is clear from the previous chapter that ISM was under strain and pressure, and in 1947 it is in this context the Government of India assumed the responsibility of the State. This chapter will trace the historical milestones, institutional developments, and policy trends related to ISM by the Government of India during the post independence period.

After independence till the later 1950s one can see a complete neglect and marginalisation of ISM – in terms of infrastructure, institutional developments, and budgetary allocation. During this period though various committees were set up by the State many of the findings and recommendations of those committees were contradicting and confusing with each other.

What stuck to us is the fact that from 1960s onwards Government suddenly recognised the importance of ISM and started setting up institutions especially research institutions. Another trend observed during this period was the setting up of committees to study the educational aspects of Shudda practice of ISM which eventually led to the elimination of "integrated approach". During this period

[1] This aspect is highlighted by scholars like Banerjee (2002), Abraham (2005) and Khan (2006). Khan (2006) have specifically studied State-ISM interaction. Khan (2006) has studied the period prior to independence.

budgetary allocation also increased. The State slowly started identifying the opportunities in international economy and in international market in the 1980s.

After 1990s in the neo-liberal regime there is a boom for ISM in the international market. Here one can observe the Government taking more initiatives for promotion of ISM. A separate department was set up and complete attention has shifted to exports of Ayurveda and Unani products. Medical tourism promotion, patenting etc. are the recent trends that could be observed.

In this chapter, the main focus is to identify historical milestones; consolidate various committee recommendations and identify the pattern of ISM institutional development. The attention is to identify the type and nature of shifts and to understand the evidence for the shift. The reasons for these decisions and their consequences are discussed in the next chapter.

3.1. Provincial Committees Prior to Independence

To begin the discussion, two provincial committees set up prior to independence are important; it was with the establishment of these two committees, that the trend of setting up of committees to study ISM related issues started.

Committee on Indigenous Systems of Medicine, with Muhammad Usman as Chairman[2] submitted its report in 1923, and the task assigned to the committee was 1) answer the question whether ISM was scientific or not 2) to study whether ISM was "eligible[3]" to be included as a viable medical system in India's health system. The report argued that from the point of view of Science ISM was strictly logical and scientific but from the point of view of Arts it was not self- sufficient

[2] The Report of the Committee on The Indigenous Systems of Medicine, Chairman Muhammad Usman, 1923. The methodology used by the committee is questionnaire based survey. This is a provincial committee appointed by Government of Madras Province.

[3] The term "eligible" is no where defined in Usman Committee Reports (1923)

especially in the area like surgery (1923:1). To overcome this problem the committee suggested taking the help of western medicine and the surgery method.

In the analysis by us, the contradictions within the committee's observation were evident. It means that, if the committee considered ISM as a Science, then why it recommended the use of western medicine without exploring the opportunities within ISM. Whether the existence of surgery technique is a prime concern or criterion to become an "eligible" medical system is another question to be debated. The committee also did not give attention to the fact that there were surgery methods in Ayurveda in ancient time. The issue here is why the committee did not suggest an approach to develop surgery method in ISM in line with its ancient surgical practices. Committee also identified another problem that valuable learning of ISM was either in Sanskrit or in Urdu. Thus the authentic knowledge became inaccessible to many of the practitioners. But it did not suggest methods to tackle this problem. Another suggestion of the committee was to use western diagnostic methods by ISM practitioners. It also tried to project ISM as part of a single medical system where each ISM would constitute a single school of thought and practice. One can understand approach of reductionism which the committee used to study ISM and its related issues.

The Indigenous Medicine Enquiry Committee of Punjab Government set up in 1938 was the second important provincial setup which examined the ISM status of that period. It was entrusted with the task of comparing various provinces and understand what they did to improve the education and the practice of ISM. The committee identified the "static nature"[4] of ISM as its main problem. Further, to

---

[4] Static nature is not defined in this committee report (1938)

overcome this problem the committee suggested the use of advanced scientific innovations which would not disturb the basic principles of ISM[5].

One can observe some very positive suggestions from this committee. For example, developing a registration mechanism for ISM practitioners was a feasible and viable recommendation; with this recommendation the committee aimed to restrict and tackle the problem of quacks. Direction to the ISM practitioners that they were allowed to practice only the system in which they were trained and should avoid practicing western medicine was another positive suggestion from this committee. Here one can observe a "biomedical modeling" in education related suggestions. For instance, the curriculum suggested by the committee was exactly a replica of the MBBS course.

3.2. Health Ministers' Conference and ISM in 1946

Jaggi in his work on the historical changes of ISM in India mentioned about this Conference (1977:342). The first Health Ministers Conference held in 1946, passed a resolution which supported the development of ISM in the country. The Conference indicated the need to grant facilities for encouraging research[6] in the ISM. Establishment of new colleges and schools was also the focus. Absorbing practitioners of ISM in the health services of the country was also mentioned. It is also important to note that the Conference's focus was restricted to Ayurveda and Unani[7].The conference strongly called for absorbing well trained Ayurveda & Unani practitioners into Country's health system.

---

[5] Report of the Indigenous Medicine Enquiry Committee, Chairman Col. C G Jolly, Punjab Government 1938. The methodology followed was personal visit by the members of the committee to various Tibba and Ayurveda colleges across the country. They also studied the other provincial governmnet's committee recommendations.

[6] It is observed by Banerjee (2002) the conference resolved to make provisions "for research in and the application of scientific method for the investigation of the indigenous systems..., for starting colleges and schools for training for diploma and degree courses in indigenous systems of medicine and for postgraduate courses in Indian Medicine for graduates in Western Medicine.

[7] Resolution No 11, adopted by the Central Provincial Health Ministers' Conference at New Delhi. (cited by Jaggi, June 1977 pp. 342)

3.3. Complete Neglect and Allopathisation efforts of the State (From Independence till late 1950s)

3.3.1. Visualisation of ISM role by the two main committees

After independence, the Indian health system was planned mainly based on the recommendations made by Health Survey and Development Committee[8] later popularly came to be known as Bhore Committee (1948). Though the committee acknowledged the fact that ISM not only served the illiterate of the country but also the intelligentsia and the treatment by ISM was cheap, did not give considerable importance to ISM while it formulated the recommendations[9].
As per the words of the committee:

> "We are not in a position to assess the real value of these systems of medical treatment as practiced today. No system of medicine which is static in conception and does not keep pace with the discoveries of scientific workers can hope to give the best available ministration to those who seek its aid[10]".

The important point raised by the committee was that public health system in India could be developed only through scientific methods and ISM did not have any role to play there. The committee completely neglected the huge role which the ISM could have played in Indian health system. ISM would have helped to reach all people in terms of health services because of its practitioners strength; people's faith, accessibility and availability of ISM was also high during this period[11]. In short Bhore Committee report completely bypassed the role which ISM would have played and thus laid the foundation for the official, clearly

---

[8] Report of Health Survey and Development Committee, Chairman Sir Joseph Bhore, 1948, . The observations and recommendations of this committee on ISM became very important, which to a great extent determined the future of ISM in the country's health service system.

[9] It is interesting to note that the Bhore committee report devoted only three pages of huge four volume report for the discussion on ISM

[10] See Bhore Committee report (1948:455)

[11] It is mentioned by Banerjee (2002) that the attitude and omission on the part of the Bhore Committee provoked a great deal of public criticism, including that in the presidential address of the All-India Medical Conference held at Madurai in 1946

demarcated beginning of the marginalisation of ISM. The only recommendation made by the committee was to set up a Chair of History in AIIMS, one of the objectives being the study of ISM.

A subcommittee for Health was set up by Indian National Congress which later popularly came to be known as Sokhey Committee[12]. The committee gave importance to preventive, curative aspects of health care along with focus on medical care. The scarcity of resources was projected as one of the major hurdle for giving equal importance to all medical systems.
As per the report:

> "there exists confusion over ISM and this not only produces considerable dissipation of effort and funds, but is also to side track the medical development of the country"[13].

Unlike the previous committees which tried to check whether ISM was "scientific" or not this committee analysed status of ISM from the practice point of view and identified that there was no unanimity in practices or methods of ISM across time and place. The committee did not ignore the huge manpower base of ISM thus decided to reduce their role to "health workers". These health workers along with other selected persons from the villages would be given training in primary first aid etc. In this approach ISM practitioners were recognised as having some role in the health system but the role was humiliating which questioned their professional identity. Apart from the utilitarian aspect there was no attempt on the

---

[12] Indian National Congress (here onwards INC) played an important role in the development of India's economy and the planning of social sector after the independence. For this purpose, INC set up a National Planning Committee, to study situations that were prevalent in various social sectors.

[13] Report of the National Planning Committee, which was set up by INC in which various subcommittees (here health , Chairman Sokhey) were there to study the problems pertaining to various social issues. Pp. 42

part of the committee to support and develop ISM as an independent and important medical system which would be at par with the western medicine[14]

3.3.2. The Committees set up specifically to examine ISM status (Till late 1950s)

The Government of India, appointed a committee under the Chairmanship of Col. Ramnath Chopra to examine the question of development of Ayurveda in all its aspects[15]. After this, marginalisation of another nature became visible where problem projected was of whole ISM but the query was mainly restricted to Ayurveda. The committee submitted its report in 1948 and recommended the establishment of special research institutions. According to the committee the aim of the new institutions was to clear ISM from the centuries of doubtful value, and to give scientific meaning and significance to these systems so they could be accepted by science (cited by Borkar 1961:228).

The analysis of this report by us showed that the committee mainly argued for harmonisation of western medicine and Ayurveda for rendering medical relief. It acknowledged that this synthesis of western medicine and ISM was time consuming, but declared that it was not an impossible task. The committee forgot the basic fact that both western medicine and Ayurveda have different doctrines and principles of practice and thus synthesis was not a viable solution. The

[14] Report of the National Planning Committee, which was set up by INC in which various subcommittees (here health , Chairman Sokhey) were there to study the problems pertaining to various social issues. Pp. 40-51, 58-59, 170-175

[15] Banerjee (2002) has documented the Chopra Committee's position on ISM. She argues that this was a crucial committee that marked important points of departure from colonial policy, while continuing much of the spirit of the approach of the state and, remained a point of reference for many subsequent investigations. According to her, In its report, it is possible to delineate three main arguments. They are: (1) those of integration in teaching/education of traditional medical systems; (2) those of standardisation and rationalisation of research and production parameters, primarily to serve modern needs of commercial production and (3) those of hastening specialisation in the traditional medical systems, with an emphasis on learning the techniques involved in that, from the biomedical system.

positive aspect of the recommendation was that it did not project western medicine as superior one.

For example it is mentioned in the report:

> "curricula of medical education should be in such a way that whatever is weak in one system should be supplemented by the strong points of the other[16]".

The committee also suggested the appointment of a Deputy Director of Health Services under Health Ministry to handle the activities related to ISM. Other important recommendations were – to establish a Central Research Institute, compilation of Materia-Medica for Ayurveda, and providing same facilities for Ayurveda and Western Medicine to develop and supply drugs. What one can observe here is although the committee did not consider Ayurveda as an inferior system (as other committees usually have done), it did fail to acknowledge and consider the fact that integration/ synthesis of Ayurveda and Western Medicine would lead to confusions because both have different doctrines and principles of practice.

The Government of India responded to the recommendations of Chopra committee immediately[17]. The government explained that the fact that the complete integration between western medicine and ISM was not possible

It is said:

> "integration of different systems of medicine is impracticable, as the theories and principles of modern medicine are different from the theories and principles enunciated by Ayurveda and Unani[18]."

---

[16] Chopra Committee cited by Borkar in his book "Health in Independent India", Ministry of Health, GoI, New Delhi, 1961, Pp. 230

[17] Cited in Report of the Committee to assess and evaluate the present status of Ayurvedic system of medicine, Chairman K N Udupa 1960 , Pp. 8

[18] Cited in Report of the Committee to assess and evaluate the present status of Ayurvedic system of medicine, Chairman K N Udupa 1960 , Pp. 5

The prejudice of Government of India towards ISM became more visible, when it mentioned and directed the Provincial Governments to use modern scientific medicine as the basis for the development of the National Health Services in the country.[19]

Next initiative from Government of India came when it set up another committee headed by Dr. C G Pandit, in the year of 1949, with the main task to follow up the recommendations of the Chopra Committee. This committee recommended the establishment of Central Research Institute in Indigenous Medicine at Jamnagar. The committee explained that the inclusion of instructions of Ayurveda into Western Medicine was not immediately feasible. The positive outcome of this committee was the establishment of the Central Research Institute of ISM at Jamnagar in 1952. The period also witnessed the establishment of similar institutes at Varanasi and Trivandrum.

The committee recommendation was that in the training programme of a doctor in any of the school of ISM it would be necessary to incorporate in the curriculum that amount of teaching of modern medicine which was considered necessary by the Health Survey and Development Committee for the training of a basic doctor[20]. Here also one can see that the western medicine was taken as a standard or yardstick and ISM compared with such a standard. ISM viewed as a kind of supplementing mechanism to western medical services. This was mainly because of the fact that the western medicine could not be spread so fast to the whole country due to financial constraints.

---

[19] Ibid Pp. 5

[20] Cited in Report of the Committee appointed by Government of India to Study the Type of Training In pharmacology imparted in different parts of the country to students undergoing the training of 4 and ½ years in Ayurvedic and Unani Colleges , Chairman Dr. H B N Swift, Ministry of Health , Government of India, 1956 (Pp. 33)

In 1954, Government of India appointed another committee headed by Dr. H B N Swift to study the type of training in Ayurvedic and Unani Colleges[21]. It envisaged the role of ISM as one which supplements the western medicine. The committee considered the training of ISM in comparison with western medicine. This showed the committee did not have a clear vision or understanding that ISM methods and doctrine was entirely different from that of western medicine. The committee advised that wherever possible an attempt should be made to familiarize ISM students with western medicine so that they could prescribe the same. Is this not affecting the identity of the ISM practitioners as well as the identity of the ISM as such is the question to be examined.

Report continued as follows:

> "In the medical wards of these ISM institutions, the patients are treated with Ayurvedic and Unani medicine so these students do not get a chance to learn modern therapeutics"[22].

Since, the students did not get opportunity to know about modern drugs their training was considered as degraded by this committee. What the committee could have effectively done was to make an effort to understand about pharmacopoeia of each ISM separately and see how to inculcate the best from it to the students within the framework and doctrine of ISM.

The Committee under the Chairmanship of D T Dave was established in 1954 with the task of studying the need and possibility of establishing standards with respect to education and regulation of ISM practice. In its subsequent report

---

[21] This committee has reviewed the previous committee recommendations. The methodology followed by the committee is visits to various educational institutions. Questionnaire was circulated among the expert groups in the colleges.

[22] Report of the Committee appointed by Government of India to Study the type of Training In pharmacology imparted in different parts of the country to students undergoing the training of 4 and ½ years in Ayurvedic and Unani Colleges , Chairman Dr. H B N Swift, 1956, Pp.. 4

submitted in 1956[23], though the committee first accepted the fact that Ayurveda has its own doctrine, all its suggestions related to education and training in Ayurveda was coupled with that of western medicine. Suggestions like 5 and ½ year course and inclusion of Physics, Chemistry and Biology in ISM training showed this bias. Committee also submitted a model syllabus for what it called "integrated course". It strongly recommended for continuation of integrated course of ISM with the western medical components. The committee drew attention to the need of registration of practitioners. To substantiate this suggestion the committee gave the evidence that from ancient times there were practices where practitioners registered with the State as this helped in avoiding quacks[24]. What one can observe is the committee's attempt to utilise manpower of Ayurveda to reach out to rural areas where western medical practitioners were not interested to render their service[25].

The Committee which was established by the Government of India, with Dr. K N Udupa as its Chairman submitted its report in 1960. The committee studied recommendations of the past committees' and then pointed out observations. The task entrusted to this committee was to study the status of Ayurveda institutions in particular and assess and evaluate status of ISM in general. One can see the attitude of Government to equate ISM with Ayurveda. It was mentioned by this committee that Ayurveda as a part of post-graduate study of MBBS did not improve the status of ISM[26]. It was mentioned in the report that various State Governments have shown high enthusiasm for the development of ISM but this

[23] Interim Report of the Committee Appointed by the Government of India To Study and Report on the Question of Establishing Uniform Standards in respect of Education & Practice of Vaids, Hakkims and Homeopaths, Chairman D T Dave, 1956

[24] Bala (1982) has mentioned about Dave Committee report. She observed that the committee suggested for 5and ½ years education and one year internship in rural area.

[25] We can observe that all the members of the committee were health ministers of various Indian States and there was no representation of practitioners or experts of ISM

[26]Bala (1982) has mentioned about Udupa committee report ; according to her the committee suggested that the drug preparation is not meeting the standards to be acceptable to modern minded people so there is a need for change in mode of production

statement of the committee was not justified with any data. Recommendations were formulated in such a way which incorporated the components of western medicine into Ayurveda education. At the same time it gave prominence to principles of Ayurveda. Further, since ISM renders medical relief to masses in India, it suggested establishment of Central Council of Indian Medicine. Another positive recommendation was to give more emphasis to aspects of Ayurveda through out the under graduate course. The concept of division of labour– which was not prevalent in ISM was also brought into picture first time by this committee.

It suggested that:

> "Preparation of Medicine and practice should be separated if the status of Ayurvedic Practitioner's has to be improved"[27].

To achieve the above mentioned objective of division of labour, the committee also recommended for special courses like B. Pharm (Ayurveda).

As far as the area of research is considered this committee did not make objective of research clear but it suggested cooperation between western medicine and Ayurveda. Recommendations such as 1) considering Ayurvedic treatment for the purpose of reimbursement of medical charges 2) pay scale of Ayurvedic practitioners should be at par with western medicine practitioners, 3) Ayurvedic practitioners should be given the same privilege as allopathic doctor to issue medical certificates etc. were also included in the report. One can see that this committee recognised the intrinsic value of Ayurveda as a viable medical system and it did not delve into a comparison of Ayurveda methods with that of western medicine. However, when it came to the recommendation part especially with regard to the matter of education it modeled ISM upon western medical education.

---

[27] Report of the Committee to Assess and Evaluate the Present Status of Ayurvedic System of Medicine, Chairman K N Udupa, 1960. Pp. 45

A positive outcome of the establishment of this committee was the constitution of a council of Ayurvedic Research. This apex organization had number of sub-committees on education, research and other matters.

3.3.3. Other Government documents of late 1950s which mentioned about ISM

In his work Borkar (1961)[28] reviewed the overall development of ISM till the time, in a systematic manner. In a forward to this work the then Prime Minister Jawaharlal Nehru, had mentioned the need for optimum health for all and had pointed out scarcity of resources as the main hurdle. According to him, the focus was on science and modern scientific methods to improve our standards[29].

As far as health as a social sector is considered the report suggested providing basic training in scientific methods for all who specializes in Ayurveda, Unani or Homeopathy. This report identified a major distinction between Ayurveda and western medicine explained as follows: Ayurveda had an "approach to life" rather than an "approach to disease" where as the western medicine had a disease oriented approach. The report mentioned that Ayurveda had great scientific tradition based on its epistemological root; but the recommendation was to develop "proved[30]" valuable drugs and incorporate this to modern medicine. Indirectly the report suggested an utilitarian method where ISM should be used to

[28] Borkar (1961), this work was the useful one to understand about the India's health service system where he had examined ISM. See G Borkar, "Health In Independent India" , Ministry of Health, GoI, New Delhi, 1961, V- XIV , 226-236. Here the author has tried to make his recommendation on ISM in tune with the forward message by Nehru where Nehru has stressed importance of modern & scientific methods as base and build upon this where Ayurveda , Unani etc. will become branches

[29] In Jawarharlal Nehru's words (from Borkar 1961: XII-XII) " There is much controversy about the place of Ayurvda...It would be wrong to ignore the accumulation of this past knowledge. ...But in many directions modern science ...has made wonderful discoveries...We can not expect to improve our standards unless we take advantage of scientific methods....There should be basic training in scientific method....It is the scientific approach that is important" .

[30] The term "proved" not explained in the report Borkar (1961)

supplement western medical treatment and ultimately help the growth and development of western medicine.

Borkar (1961) gave another argument about the non-uniformity of ISM education. The recommendation was to construct a base consisting of "modern and scientific methods" to include Ayurveda, Unani etc. as specialisations in the undergraduate course. This means ISM rather than separate medical system with separate epistemology and principles would be included as part of western medical system. The history of ISM College's conversion to western medicine is also documented in his work. The School of Indian Medicine which was established in 1945 in Madras was converted later to College of Integrated Medicine. In 1950s it was fully converted to a college which imparted education and training in western medicine.

It can be concluded that this period (independence till late 1950s) was characterised by the attempts at "integration". The long term objective of the Government was to have one system of medicine (here western medicine) where each ISM would be included as a separate specialisation (after MBBS course). The era also witnessed conversion of ISM medical colleges into western medicine colleges.

3.4 First Paradigm shift: attempts to promote Shudda methods and Institutionalisation of 1960s to 1990s

In this period the first important Committee as far as ISM was concerned was Mudaliar committee. The committee suggested for the abolition of the integrated approach to ISM education. Following this plea, the subsequent committees started paying more attention to develop shuddha curriculum for each of the ISM. During this period for the first time attention was given to Unani, Yoga, and Homeopathy. This was a shift from the policy of equating ISM with Ayurveda.

Special attention was paid for the development of institutions and as a result the concept of institutionalisation and division of labour etc. became more explicit. A number of apex bodies and training institutes were established and the State started paying attention to ISM research. In research the focus was clinical research leaving literary textual research apart.

3.4.1. Mudaliar Committee's call for the abolition of integrated approach to ISM education

Health Survey and Planning Committee with Lakshman Swami Mudaliar as the Chairman in 1962 recommended to the State that the integrated training and education of ISM has to be abolished[31]. Also as it suggested that ISM students should be given chance to study from original texts and later shift to the courses followed in the MBBS. In post graduate courses in western medicine, ISM could be offered as a subject in the line similar to gynecology etc[32]. What one can observe here was the difference in doctrine and basic principles of ISM with that of western medicine. Therefore including ISM as a post graduate subject in the western medical training was not a good option. Following the trend set by previous committees, this committee also focused on the point that preventive dimensions were missing in ISM. In the report this argument was nowhere substantiated with evidence or literature. In the long term the committee visualised to make western medicine as a base and each ISM could become merely post-graduate subjects of western medicine. i.e. a person who completed his MBBS, later at post graduate level could opt for any of the ISM as his specialisation area. What the committee basically did was to call for the abolition of integrated training but it wanted to take the best of both of the systems. Unfortunately it could not suggest practically how to reach this goal.

---

[31] Bala (1982) has elaborated this point further. She has observed that the committee called for abolition of integrated system of training. Plea was that education of Ayurveda need original textual knowledge.

[32] The recommendations of Mudaliar committee (1962) is consolidated by Jaggi in detail (1977:313 to 317)

The report continued:

> "to us the idea of a concurrent development and maintenance of different system of medicine for all times is unacceptable"[33].

The committee failed to acknowledge the fact that health system was not only clinical in nature but rooted in the social – cultural context. One can understand that promoting one medical system (here western medicine) to meet the needs of complete society was not a practical solution. Committee took special interest to highlight the role which western medicine played in improving health status of the masses. It stated that India cannot stand out in the international effort on ensuring "Health for All" goal. According to the Committee, ISM which had centuries old history and tradition would be merely converted into a specialisation like gynecology, ophthalmology etc. Nowhere in the report, the committee explicitly mentioned about the weakness of ISM or evidence on which committee gave the above mentioned recommendations.

3.4.2. Committees which examined education of ISM during this period

In the beginning of 1960s one can see another shift wherein the Union government started appointing Committees to study the status and problems of ISM other than Ayurveda. Till this time, ISM was somewhat considered akin to Ayurveda.

In 1963-64 the first committee with this focus was constituted under the Chairmanship of Abdul Hameed. The committee was assigned the task of developing a curriculum for Shuddha Unani Education. Till this time, all the efforts of the State were to integrate ISM and western medicine, or to place ISM as a branch of western medicine. A sudden shift in the State perspective was visible here as in the form of direction which the State gave to this committee. The State has directed the committee to develop a curriculum for Unani education

[33] Report of the Health Survey and Planning Committee, Chairman L Mudaliar, 1962. Pp. 35

which should not include any subject of modern medicine or allied sciences in any form or language[34]. The degradation and mixing up was so high and complete separation of ISM education from western medicine was difficult at this point.

Therefore the objective was again reframed as:

> "Curriculum and syllabus of studies formulated by the committee should as far as possible be based up on the theory and practice of Unani system only"[35].

This Committee (1964) strongly criticised State's prior policies where ISM was equated with Ayurveda. The report continued to explain how Unani is different from Ayurveda. The committee succeeded in explaining and convincing the fact that what is good for ayurveda is not good for Unani and other ISM. The Committee also succeeded in giving evidence from past works and ancient texts that Unani had branches like surgery and gynecology. This fact was never acknowledged by the Government and one can observe that in many cases the Government used this as a weapon to project ISM as inferior. The committee also analysed that ISM practitioners were trained in such a way that they fed the needs of western medicine. The committee suggested a 6 and ½ year course for Unani education and unfortunately it could not come up with a proper curriculum for the same. The committee demanded the State to equate pay, power and privilege of Unani practitioners at par with their western counter parts.

In 1962 another committee was set up by the Government which was headed by M Vyas. It favoured promotion of the course in "pure" Ayurveda and stated that Ayurveda had to be developed by an intense study of the classical medical literature including its materia medica and pharmacy. But at practical level it

[34] Shudha Unani education Committee (1963-64) , the committee members in the first meeting itself, the concerned members of the committee made it clear that such a demarcation was not possible. The committee substantiated its position with the following reason. The prior State interventions had already deteriorated status of Unani medicine.

[35] Report of the Shuddha Unani Education Committee, Chairman Abdul Hameed, 1964, Pp..3

suggested dissection of corpse and use of equipments of western medicine practice. To justify its recommendations in favour of the practical aspects of Ayurveda the committee argued that since many western medicine drugs produce side- effects, it was essential for the Ayurvedic physicians to deal with such cases which in turn would necessitate the requirement of the possession of knowledge of western medicine.

3.4.3. State's Attention to Yoga and Homeopathy

One can observe that for the first time after Independence, State's attention was paid to Yoga in 1961, when it appointed a Committee on Evaluation of Therapeutical Claims of Yogic Practices, with Dr. B K Anand as its Convener. It came up with the conclusion that since very few Yoga centers maintained records, the committee could not evaluate its therapeutic claims. This committee identified the lack of trained staff as the reason for the condition of lack of record maintenance. The blame of not maintaining records was conveniently placed on the Yoga centers. When the State never extended financial support to these centers, how these centers could manage administrative matters like maintaining the records is the issue. This committee acknowledged the role that Yoga could play in prevention of diseases and maintainenance of positive health.

The issue of Homeopathic practitioners during this time is mentioned by Jeffery (1988:45). He observed that By 1960s the homeopaths merely used the correspondence training as a route to registration. He has documented that it was Melkote Committee set up to recommend measures for Improvement of Indian System of Medicine, which for the first time paid special attention to Homeopathy and Naturopathy. The Committee suggested for a Shudda approach in Homeopathy education. According to this always might be supplemented by the western medicine wherever there was a missing gap of knowledge or practice

3.4.4. Various Institutions' Positions on ISM education

The Annual Meeting of the Central Council of Health held in 1963 endorsed the proposals of the committee and decided to incorporate "pure" Ayurvedic courses in all colleges of Indigenous Medicine. The Central Council of Ayurvedic Research declared that the aim of Ayurvedic Education was to make available proficient Vaids-cum-basic doctors to relief the medical problems of the masses. This terminology itself is confusing as to who is this Vaida-cum- basic doctor. It suggested for a 6 and ½ year course with pre-professional courses including Sanskrit, Physics, Chemistry and Botany[36].The duration of MBBS degree is 5 and ½ years and it is important for us to note that these Ayurvedic practitioners even after spending 6 and ½ years for education don't get privileges and pay at par with western medical doctor.

3.5. Trend of Institutionalisation in 1970s; shift from education to drug research

Jaggi mentioned about the constitution of the Central Council for Research in Indian Medicine and Homeopathy in 1969 to initiate aid and develop scientific research in different system of indigenous medicine (1977:317). In this, drug research and clinical research was given more focus than the literary research[37]. The efforts of identifying and codifying ancient literature were sidelined. Later one can see that this apex body was later bifurcated into four Councils for the sake of effective implementation of various programmes. Under this, Ayurveda and Siddha were brought under one Council i. e, Central Council for Research in Ayurveda and Siddha.

[36] For further details see Report of Curriculum And Syllabus For Ayurvedic Education formulated by The Central Council of Ayurvedic Research,1962

[37] The trend of Institutionalisation is further elaborated by Abraham (2005)

The establishment of Central Council of Indian Medicine in New Delhi for ensuring uniform standards of education and the registration of the practitioners of ISM is mentioned by Jaggi (1977:317)

This period also witnessed a change where ISM was recognised for the purpose of medical reimbursement under Central Services rule of 1944. Treatment facilities of Ayurveda, Siddha and Homeopathy have been provided to Central and State Government Employees.

Some of the changes which the Government introduced during this period, in favour of ISM are documented by Banerjee (2002). She mentioned that in the Drug and Cosmetic Act of 1940 the definition of "drug" excluded substances and medicines prepared as per Ayurveda / Unani system of medicine. When amended in 1964 it included ISM medicines with certain conditions (ingredients must be listed out, machine production etc.)[38]. The Good Manufacturing Practices were also explained for ISM drugs in the amended version of the Drugs & Cosmetic Act.

One could trace mainly two areas of institutional development[39] from 1970s onwards; the first area is the promotion of research in ISM especially in Ayurveda and the second area is the attempt to regulate education and practice of ISM as a viable medical system. In both the attempts more focus was on Ayurveda where as the developments and initiatives of the Government were very little for other systems like Unani, Naturopathy and Yoga.

Abraham (2005) documented the history of establishment of various institutions for promotion of research; This include Rashtriya Ayurvedic Vidyapeeth, Delhi

[38] Banerjee (2002) argued that such amendment of the Act intended to get hold in local as well as international market

[39] Abraham (2005) has argued that Government has tried to legitimize its actions by institutionalising.

(1988); National Institute of Ayurveda, Jaipur (1978); National Institute of Homeopathy, Calcutta (1975); National Institute of Unani Medicine, Bangalore (1987); National Institute of Naturopathy Pune (1987) ; Gujarat Ayurveda University ; and Banaras Hindu University College at Varanasi. Similarly National Institute of Research in Yoga was established in Delhi.

For the development of educational and professional practices, the following apex bodies were established: Central Council of Indian Medicine in 1971 and Central Council of Homeopathy in 1973. The above two were the main apex bodies which were entrusted with the responsibility of educational and professional standards of ISM.

The Central Council for Research in Ayurveda and Siddha was established in 1978. The institution mentioned in its objective that it aimed to organise these systems on "scientific lines". From the experiments of the State one can understand that the meaning of scientific lines was nothing but following the research methods set by western medicine[40].

Central Council for Research in Yoga and Naturopathy was established in 1978 with a view of providing better opportunities for all-round development of Yoga and Naturopathy independently according to their own doctrines and fundamental principles. The emphasis was on clinical research and literary research was completely neglected[41].

---

[40] See the official website of Central Council for Research in Ayurveda for further details. The title was "aims of objectives of the institute", accessed as http://www.ccras.nic.in/aims.htm on 23.01.08

[41] See the official website of Central Council for Research in Yoga and Naturopathy, for further details. The title was "aims of objectives of the institute", accessed as http://www.ccryn.org/english/amis&objective.php on 23.01.08

Central Council for Research in Unani Medicine was established in 1979 to initiate aid and develop scientific research. Drug standardisation was given prime importance. Development of agro techniques for cultivation of Unani medicinal plants was also highlighted. Evidently we understood the objective was to exploit the commercial opportunities of drugs and this obviously would result in the commodification of the system[42].

Central Council for Research in Homeopathy is the apex body which supervises aid and coordinate research in Homeopathy.

The National Institute of Ayurveda at Jaipur is the apex body which formulates examples of highest order of education and research practices in Ayurveda. This institute was set up in 1976[43]. A similar Institute for Homeopathy is established in Calcutta.

The National Institute of Naturopathy is established in Pune. The institute mentioned its objective as developing Naturopathy as a system of medicine and way of life. High emphasis was on clinical research, since 1986 when it was established[44].

3.6. Gradual and slow move towards commercialisation of ISM

In 1982, one could observe that the State started focusing on identifying opportunities in international economy for the sale of ISM drugs. Passing of Amended Drugs and Cosmetics Act for regulating import/export of ISM was one important measure. This was followed in 1983 by setting up of the Indian

---

[42] See the official website of Central Council for Research in Unani Medicine, for further details. The title was "aims of objectives of the institute", accessed as http://indianmedicine.nic.in/html/council/ccrum.htm on 23.01.08

[43] Details are from the official website of Government of India, http://www.niam.com/ accessed on 23.01.08

[44] The details are from Government official website of the Institute accessed as http://punenin.org/about.htm on 23.01.08

Medicine Pharmaceutical Corporation Ltd. in Mohan, Almora District., Uttaranchal.

In 1986, the Second World Conference on Yoga and Ayurveda was held at Banaras Hindu University. All these efforts- 1) institutionalisation 2) amendment of Acts for promoting exports constituted the initial efforts of the State for the commodification of ISM.

National Health Policy, 1983, had referred to our rich, centuries - old heritage of medical and health sciences. The Policy outlined that although vast infrastructure was available in the ISM for addressing health care of our people, they were under utilised. The Policy suggested that it was necessary to initiate measures to enable each of these various systems of medicine and health care to develop in accordance with its genius. Simultaneously, it also suggested that planned efforts should be made to integrate their services, at the appropriate levels, within specified areas of responsibility and functioning in the over all health care delivery systems, specially in regard to the preventive, promotive and public health objectives. The Policy emphasised the need for a meaningful phased integration of ISM with the western medicine. The recommendation itself seemed to be confusing because at one point it has mentioned about the ISM development with its own genius while at some other part of the document it suggested phased integration of ISM with western medicine.

3.7. Second Paradigm shift: Institutionalisation to Allopathisation; New approach to Marginalisation of ISM by Commercialising in 1990s

With the wave of neo-liberalism one can see two important developments. One is the establishment of a separate department named AYUSH for ISM. After the independence, it took more than four decades for the State to recognise the fact

that ISM cannot be developed along with western medicine. As mentioned earlier by Banerjee (2000) it is not because the State identified the intrinsic value of ISM that it established AYUSH but because it identified the market opportunity of ISM especially of Ayurvedic drugs, Yogic practices etc. in the international market. The latest development is the introduction of National Policy on Indian System of Medicine and Homeopathy in 2002.

3.7.1 Formation of AYUSH and There After

In 1995 all activities of ISM and Homeopathy were brought under a separate department known as Department of AYUSH. Under the department there are four Central Research Apex Bodies; Central Council for Research in Ayurveda and Siddha; Central Council for Research in Unani Medicine; Central Council for Research in Homeopathy; Central Council for Research in Yoga and Naturopathy. Their objective is to guide, develop, coordinate and fund "scientific research". These Councils mainly conduct clinical studies, medico botanical surveys and publication work. Drug standardisation is another important area of research of these Councils[45].

Abraham documented evidence about the attempts to integrate outcomes of such research into health programmes of the Government (2005:196). Best Examples in this line is the inclusion of AYUSH 64 for the treatment of Malaria. Central Council for Research in Ayurveda and Siddha also evolved anti-epileptic drug known as AYUSH-56, AYUSH-55 for obesity, AYUSH AC-2 and AC-4 for anti-fertility treatment.

In the various reports of the Council, it has highlighted the possibilities of commercial exploitation of drugs of ISM. It has explicitly mentioned commercial exploitation of the demand of ISM drugs as one of its important objectives.

[45] See website of Government of India for further details. Accessed as http://indianmedicine.nic.in/index.asp on 23.04.08

Concepts like patenting, royalty etc. have come to forefront which marks an era of commodification of medicine[46].

There are two Pharmacopoeia Committees for regulation / standardisation of drugs. One is for Ayurveda and another for Homeopathy. Now the drugs of ISM have been brought under the purview of Drugs and Cosmetic Act of 1940. A drug control cell for ISM was set up in 1992 to assist the drug Controller of India to deal with issues of ISM drugs.

In 1997, the Government implemented a Central Scheme in 33 organizations for the development of agro-techniques of important medicinal plants which is mainly for the commercial production. Recently Non-Governmental Organizations are also into the cultivation of medicinal plants.

3.7.2 Commercialisation of ISM for the international market

The year 1998 was marked by the maiden participation of Ayurveda along with other systems in the India International Trade Fair. In the same year the country witnessed implementation of Central Scheme in 32 laboratories for developing pharmacopoeia standards of Medicinal Plants/ ISM Formulations[47].

Another trend which started during this period was the establishment of ISM departments (especially Ayurveda departments) in hospitals which mainly provide western medical services. The establishment of specialty clinic of Ayurveda in Central Government Hospital (Safdarjung Hospital) New Delhi in 1998 was another major milestone. In private hospitals the same pattern was observed. One

---

[46] Government of India (1994), Ayurveda –Science of Life A Profile and Focus on research and Development, Central Council for Research in Ayurveda and Siddha, Ministry of Health & Family Welfare, New Delhi

[47] Accessed Online from the website of Newspaper "The Hindu" accessed as http://thehindu/Ayurvedic Milestones.htm on 25.02.08

can conclude that this was the effort to attract people who could afford to pay for ISM treatment which became costlier.

The participation in the Mystique India (Exhibition cum fair on Indian Traditions) in 1997-99 was another step where ISM was taken into the International market followed by Introduction of Vanaspati Van Scheme for large scale cultivation of Medicinal Plants[48].

The ISM presence abroad can be traced out from this period onwards. The West was in search of Alternative and Complementary medicine. This was because Western medicine failed to provide treatment for certain ailments (like asthma, arthritis) and another reason was that ISM did not have side effects. Inauguration of Ayurveda conference in New York, USA by the Prime Minister of India in 2000 was an important event linked to this trend. As mentioned earlier ISM doctrine and principles were neglected and ISM was considered as something equivalent to cosmetic care, food supplements etc. The following initiatives of the State justify this particular observation.

The changes in the twenty first century start with the Gazette Notification for the constitution of Medicinal Plant Board under AYUSH. In the same year (2000) AYUSH came out with the publication of second volume of Ayurvedic Pharmacopoeia. The State drug testing laboratories and Pharmacies were given central assistance; this was done because for exports the West demanded certain standards of the drugs. In 2001, the third volume of Ayurvedic Pharmacopoeia was published. In the same year, India participated and made a presentation on ISM in the World Health Assembly in Geneva. Presentation on evidence based support was made by the Department of AYUSH before House of Lords, U.K in 2001 followed by the Participation of Department in "Made in India" exhibition

[48] Accessed Online from the website of Newspaper "The Hindu" article titled as "AYUSH milestones" accessed as http://thehindu/Ayurvedic Milestones.htm on 25.02.08

organised by Confederation of Indian Industries (CII) in South Africa are other two important developments[49].

In the official website of AYUSH under the title "salient achievements[50]" the following statements are given:

1. AYUSH has recruited Ayurveda experts to US medical education institutes to give them exposure to ISM. It is also mentioned that further efforts will be made to popularise Ayurveda in the USA.
2. India also has held dialogue with European Union and has succeeded in making EU authorities convinced about the quality and standards of Ayurveda drugs.
3. India is represented in the International Regulatory Cooperation on Herbal Medicines (IRCH) network set up under the aegis of WHO. This forum came into being in 2005 on the recommendations of Eleventh International Conference of Drug Regulatory Authorities (CDRA) and is presently made up of 16 countries.
4. The Department of AYUSH in collaboration with Indian Embassy in Hungary has organised an International Conference-cum-Exhibition on Ayurveda in Budapest from 28-30 September, 2007

Nowhere in these achievements has, it explained how the above mentioned efforts would help to bring ISM into the public health arena of the country. Also it is never highlighted what AYUSH has done for intrinsic development of ISM. All the present developments points out to the fact that ISM is not developing now within its doctrine and framework but it is molded in such a way that it meets the requirements of the international market.

---

[49] Accessed Online from the website of Newspaper "The Hindu" accessed as http://thehindu/Ayurvedic Milestones.htm on 25.02.08

[50] Details are codified from the official website of AYUSH, Government of India which was titled "achievements" accessed as http://indianmedicine.nic.in/index.asp on 25.02.08

3.7.3. National Policy on Indigenous System of Medicine and Homeopathy 2002

Government of India, in 2002 came up with National Policy on Indian Systems of Medicine and Homeopathy which identified that the interest in Complementary and Alternative Medicine or Traditional Medicine is rapidly growing worldwide. It then acknowledged the fact that ISM is providing services to a large number of people of the country. The ISM remedies for non- communicable diseases like diabetes has special mentioning in the document. Further the report acknowledged that though the Government set up an independent Department in 1995 (to give focus to the issues related to ISM), it has not been able to play a significant role in health care delivery services (2002:3).

In medical education of ISM, the policy identified an important problem that there has been a mushroom growth of sub-standard colleges causing erosion to the standards of education and harm to medical training and practice. The document narrated about ISM growth as an industry, mentioned about Intellectual Property Rights and then explained the possibilities of medical tourism. Role of medical tourism is projected as a good opportunity to earn foreign exchange. The document explained that evidence of safety and efficacy in the same line of western medicine is demanded by the consumers. To satisfy the consumers clinical and drug research is encouraged. The objectives mentioned in the policy are very broad which starts with including ISM in the public health arena of the country. Encouraging export and finally commercialising ISM in the international market are also objective as per the policy document. It suggested strategies to improve all aspects of ISM from education to drug standardisation and quality control. Private hospitals and specialist hospitals would be encouraged to set up ISM departments. While the policy accepted the fact that only 2% of the health budget is spend on ISM, it suggested for increasing this to 10% of the total health budget.

3.7.4. Placing ISM as per NRHM Vision

The mission seeks to revitalise local health traditions and mainstream AYUSH infrastructure including manpower and drugs to strengthen the Public Health System at all levels. The strategy which is mentioned in the document (2005) is to include AYUSH medications in the drug kit provided at village levels to ASHA. Another suggestion is to provide two rooms at the CHC level for AYUSH practitioner and pharmacist under the Indian Public Health Standards (IPHS) model. At the same time, single Doctor PHCs shall be upgraded to two Doctor PHCs by inducting AYUSH practitioner at that level.

One can observe that the institutional development which is suggested in NRHM would result in creating a subordinate layer of service providers who have lost their professional identity. In NRHM there is a proposal to appoint ISM practitioners to fill the vacancies in rural Primary Health Centers (PHC) because western medicine practitioners are not willing to serve in rural areas. In these PHCs, Ayurveda practitioner will be providing pulse polio by which the practitioners will be loosing the identity and ISM as a viable medical system will be loosing its epistemic base. This is not professionalisation of ISM happening but is allopathisation.

3.8 Conclusion

This chapter was an attempt to explore the paradigm shift in National perspective, policies and programmes towards ISM during the post independence period.

The period from independence till late 1950s is identified by us as a period of complete neglect, marginalisation and allopathisation of ISM. During this period the State appointed a number of committees to examine the status of ISM. These committees considered ISM as non-scientific because of the absence of surgery and proved value of drugs. These committees did not make an attempt to see

whether surgery was present in ancient times, as well as to see whether surgery was an essential criterion for a scientific label. The focal point was education and training of ISM. All the committees mainly suggested integration of ISM with western medicine at different levels. The recommendations of various committees were contradictory to each other. The main activity of the State was to establish committees and at the same time budget allocation and infrastructural development was so poor. ISM was equated to Ayurveda, and other systems like Siddha and Unani did not receive any attention.

The first paradigm shift is observed from 1960s which lasted till late 1980s. The period is characterised by shift from allopathisation to Shudda method (in education); institutionlisation led to another minor shift where focus moved slowly from education to drug research. With the Mudaliar committee which called for the abolition of integrated practice one can see appointment of number of committees to study the possibility of converting each of the ISM education into respective Shudda stream. This was the period when State started paying attention to ISM other than Ayurveda. A number of Institutions were also set up for the promotion of research and education practices. Focus slowly shifted from education of ISM to research in drugs and the setting up of apex national level bodies. Budget allocation also marginally increased. One can observe that issue of ISM practitioners were not addresses by any of these committees. Their identity crisis, pay and privilege matters were not addressed by the Government. The State never promoted or suggested the formation of professional bodies to promote unity among the practitioners.

In the neo-liberal regime we identified the second paradigm shift where one can see 1) institutionalisation to Allopathisation and 2) a new approach to marginalisation of ISM by commercialising it. The separate department of AYUSH was established. From the initiatives of the Government it is evident that

the sudden interest in ISM is because of the opportunities in the International Market. In the National Policy on ISM also, "exploitation" of international opportunities is the thrust area than utilising ISM in public health. Leaving education and practice of ISM apart, now the attention of the State is on drugs, medicinal plants and pharmaceutical industry of ISM. All these trends show the attempt of the State to commercialise ISM with special focus on the international market. It is evident that with the commercialisation of ISM the system is again marginalised but in a different way.

Chapter Four

Politics of State- ISM Interactions in India

In the previous chapter an attempt was made to trace the trends and the changes of the ISM within India's health system. From independence till late 1950s marginalisation and allopathisation was the feature of ISM. Later in 1960s institutionalisation coupled with attempt to promote Shudda practices of ISM became the focus. And in 1990s allopathisation again gained momentum where the marginalisation of ISM is done in a different way, by commercialising it.

This chapter primarily tries to place this paradigm shift in the State-ISM interaction in the broader social, economic and political context of India. It reflects the causes and the reasons for which the State ignored ISM, marginalised it and attempted to model it on biomedicine. First the political dimensions- like National Movement's position, Nehru- Gandhi discourses and etc. is studied. In order to explore the variegated dimensions of marginalisation this chapter reviews the position of planning commission, analyse the Parliamentary questions and understands the role of various international organisations.

4.1. Political Developments of Pre-Independence Period which laid foundation for Marginalisation of ISM

The political situation of pre-independence and the hostile attitude towards the colonial rule led to the growth and development of strong people's movements. In this National Movement was important one. National Movement took up many social issues and health and ISM was one among its agenda. Later in the post-independence era, the important and powerful political positions were occupied by the leaders of National Movement. So it is important in this study to reflect on National movement's position on ISM.

4.1.1. ISM and the National Movement

While mobilising people for idea of an independent Nation the National Movement tried to address various social problems, and health issues also gained attention from the leaders. One of the important characteristic of the Indian National Movement was that majority of its leaders belonged to upper caste and upper class strata of the society and they had acquired western education and some western traits in their thoughts and actions[1].

An important feature of health policies, programmes in India is that they originated during the national movement against colonial rule. Dr. B C Roy in his Presidential Address at the All India Medical Conference at Lahore in 1929 addressed the issue of ISM and questioned as to where ISM should be placed in Independent India's Health system.

In his own words:

> "Should we restrict the membership of Indian Medical Association to such persons only who follow the Western System of Medicine? It is not for us to cut off from the past systems but it is necessary to resuscitate them and to develop them. If we desire to do so, we can not keep out the Vaid and Hakim. We can not ignore them… if we regard medicine as an art of healing, who is there so bold to say that the art is the exclusive achievement of one system?[2]".

If the political leaders had such supporting position towards ISM then what happened when it came to the planning level is the question which remained unanswered.

The interest of National Movement in ISM was studied by The All India Ayurvedic Congress. This professional body in 1907 had challenged the "unscientific" status ascribed to them, which they argued, was unfair and

[1] Abraham has mentioned that the cause of ISM was taken up by nationalist movement as a weapon against cultural hegemony of the imperial power, but soon class interests and a development discourse based on modern science dominated over the issue of ISM (2005: 211)

[2] Cited by Banerji ((1985:14)

politically motivated[3].Jeffery (1988) also mentioned about the position of this professional body towards National Movement. This professional body recognised that ISM has only a rhetorical value for Nationalist movement and did not embody any genuine concern for their development. Rather than ISM, western medicine with its sophisticated technology could be used as a weapon in the hands of the oppressing class to further oppress the already oppressed[4].

We should also understand about the difference of opinion among the leaders of National Movement during this period. By the 1920s two groups- traditionalists and modernists were evolved in Congress. Finally the group which supported the spread of Western scientific medicine (like Dr. Ansari) rose to senior positions. Policies were focused on gaining power and removing the British and there were no agreed- upon programmme for social and economic change beyond this. So there was no long term planning and this naturally could have affected ISM status also.

4.1.2. Discourses between Nehru and Gandhi on ISM

Main developmental discourse of the time was between two important leaders-Nehru and Gandhi. Nehru wanted a development model which has more entanglement towards western development and growth. He gave more importance to modernisation, industrialisation and growth which is in accordance with scientific development. Where as on the other side, Gandhi's idea was to enhance village economies and promote agrarian oriented economical development. Regarding the health system, Nehru preferred western medicine to

[3] This is mentioned by Panikkar but his main focus was revitalisation movement and its class elite nature (1972: 287)

[4] This observations made by Ayurvedic Congress is mentioned by Roger Jeffrey (1988) in his work The Politics of health in India, Introduction part. The same observation is given by Abraham (2005: 189)

be the base of Indian Health system, whereas Gandhi's focus was on Alternative Medicine- especially Naturopathy, etc[5].

The politics within Congress and its impact on ISM is explained by Banerjee (2002, 2000) where she observed that after independence there were conflicts within the Congress between the powerful lobbies representing traditional and modern medicine. What emerged then was a compromise; a public health system based on both western medicine and the ISM but structured in a particular hierarchical order.

One can see that after Independence, Nehru's model was the one which gained more attention and power and thus it was used to plan the framework for overall socio- economic development of the country. Nehru's interest in scientific development was mainly to show the world that India can also be a developed nation. Investment in heavy industries, large dams etc. is the best example of this approach.

Again, according to the vision of Nehru, all development should be in line with the scientific proof. At least, in the area of ISM what Nehru meant by "scientific level"[6] is nothing but, imitating western medicine. Thus in the area of health system, due attention was given to the western medicine, which was already approved as most "scientific" whereas ISM was considered as "unscientific" and attempts to "allopathise" ISM started.

---

[5] Khan has mentioned about the importance of studying Nehru- Gandhi position on various social issues (2006: 2987)

[6] See the forward message by Nehru for further details in G. Borkar, "Health in Independent India", 1961, V- XIV

4.2. Contextualising State –ISM Interaction during Post Independence Period

4.2.1. Who Placed ISM within Indian Health System and for Whom

How the State considered the Health Sector is an important issue to be studied. i.e. health as a service sector or a product breed of the industry. The State started interfering into health sector with a specific agenda. An important reason for this was the realisation that health is an investment rather than expenditure. The benefits of health gained by an individual ultimately accrue to the benefit of the entire nation. From this realization the health sector was given prominence among the other social sectors.

In the early times of post independence era, the State projected health care (which was predominantly western medicine based) as a service sector, but the same technology based health care was an instrument to ensure social control by the ruling elite[7]. Presently, the attention and the efforts of the State are subjected to meet the demands and interests of the market forces.

Health system comprises a sub-system of social system. Health of an individual is not a personalised matter and health practices of a community are deeply embedded in the ecological, social, economic and political systems[8]. Banerjee (1985) argued that in India, ISM was a part of people's health culture and neglecting ISM while planning for Indian health system was not a simple decision. Political forces played a vital role in decisions concerning resource allocation. Choice of technology and the degree to which health system were made available and accessible to the different segments of the society are other

---

[7] This point is elaborately explained by Banerjee (1985, 1979). He argues that the health sector with its curative tertiary service orientation was to meet interests of the elite group of the country. He argues that medical systems were used as a weapon for social control. The characteristics and elite orientation of Indian Health care system is explained.

[8] D Banerji (1985: 3)

examples in which the political system interfered in the development of health system system[9]. The scholar concluded that the decision to marginalise ISM and use western medicine for health services had roots in the political system of that time.

This process, where political system took deliberate positions on the issues of, about health system is explained by Banerjee (1985) as follows: technology was always a potent force in the hands of the exploiting class. In India, thus western medicine was used as a political weapon by the colonialists to strengthen the oppressing classes and to weaken the oppressed. Not only the people were denied the access to western medicine, but these decisions also led to the decay of ISM. According to him, this western and privilege class orientation of the health services has been actively promoted by the post colonial leadership of India.

Work by Frankenberg (1981) also showed the close linkage between capitalism, ruling class ideology and western medicine in the Indian context. According to him, ruling class was always an educated minority group who gave over emphasis to "scientific evidence". This scientific evidence was to eliminate various elements of the society which were not favouring power preservation. In the case of health, western medicine was the instrument that helped the ruling elite to reach this goal of power preservation.

About the post-liberalisation era also Frankenberg (1981) has made observations linking medicine with the capitalist interests. According to him, in the 1990s when market forces gained power ISM was promoted as per market interests. The commodification and commercialisation of medicine also did not help ISM to regain its previous privilege and status, but again degraded its status. He observed the elite orientation of the market because the ISM products were developed and

---

[9] Ibid

shaped in such a way that, it met the standards set by this elite group of consumers.

Knowledge is always a powerful instrument which one class uses to dominate over the other. John (2007) in his work titled "Politics of Knowledge" has explained how the power of knowledge is used by one group to control another group. According to him the knowledge was always preserved by the powerful and was outside the purview of the poor who had no say in it. The socially, politically and economically powerful used the knowledge to subjugate and control lives of the less powerful. People developed their own medical knowledge through centuries; and now what the powerful is to completely destroy and bring the powerless in tune with western medicine so that complete control over them can be ensured effectively. He observed that the western medicine has number of limitations- like the side effects. But this can never be evaluated so easily unless it displays some symptoms of dysfunction in the body. From the period of Renaissance onwards, western medicine became more individualistic and profit-cure- oriented.

John (2007) wrote that around the 1940s when more and more countries were becoming independent from the clutches of the colonial power, there were hopes that a more people- centered health system based on ISM would be designed to serve the needs of the majority. If one apply this assumption to the Indian context, one can see that it went totally wrong because the ruling classes deliberately chose a healthcare system which continued to be elitist, class –based and do not serve the needs of the majority. The political system of India was shaped in such a way that power was always with a minority of oligarchy. The scholar concluded that in such a context western medicine was a tool to ensure the power rests with the ruling elite.

4.2.2. Nehru Ministry's Decisions regarding ISM

Khan (2006) in his work on State- ISM interaction identified that in the time period of 1940s the attention given to ISM and all the attempts for its "revival" was, however not inspired by any intention to replace or supersede western medicine. Western medicine came to hold a central position in the nationalist discourse and the ISM was assigned a subordinate role. This was confirmed by the attitude of the Ministry and its efforts to evolve a so called "uniform policy" based on "modern scientific methods". The government also gave different level of patronage to these two broad categories- western medicine and ISM.

In 1950 when Jawaharlal Nehru heard about the efforts of some of the State Governments to popularise ISM utilisation he wrote a "Note to Chief Ministers" stating that he felt unhappy when modern medicine was condemned and other systems were praised. According to him, the proper approach was that ISM should be modernised and up to date it; this should be done with the help of western medicine[10].

When one study the Indian Health system which was shaped by Nehru's policies one could see that the above mentioned "uniform policy" was based on the scale of measurement of western medicine. This uniform policy was discriminatory to ISM and this led to a dominant position assigned to western medicine. This approach was not different from that followed by the British where they used western medicine as a technological weapon to control powerless, weak strata of the society.

The initiatives of the Post-independent India were not completely free from that of the imperial power. For example, Jeffery (1988) in his work mentioned that the British "privately" believed that their attempts to place ISM on scientific lines at

[10] Selected works of Jawaharlal Nehru, April- July, 1950, part 2 pp. 287-289

par with western medicine would destroy the system completely. That was another or rather indirect approaches used by British to destroy ISM and finally tired remove ISM from Indian health system. Jeffery (1988) links this with the policies of Nehruvian Government that Nehru too was never convinced about the value of ISM. In many cases he did not explicitly mentioned it but he argued for making ISM "scientific"[11]

Why the State, in the post-independent era did not completely ban the practice of ISM is an important question to be examined. As per the analysis by Khan (2006) it appeared that the unmet needs of the rural people, what he called as "pressure from below" as well as Government's financial constraints were the major reasons. Mortality rates etc. were very high in rural areas where as the western medical services were available mainly in urban areas. Thus moved with the urgency and the financial constraints, the State had no option but to fall back on the ISM to fill this gap. The allopathic system was too expensive as well as not available to rural masses[12].

4.2.3. Institutionalisation and initial Commercialisation Efforts of India –its link with interests of the West in Alternative Medicine

In the early phase of modernisation of Indian society, two features of ISM were notable – standardisation and slow gradual commercialisation of medicines. The State developed various legal measures like Drugs and Cosmetic Act Amendment to include ISM drugs into the drug list but all these initiatives were just meant to protect the interests of the marketing companies rather than to provide ISM services to the masses of India. This has to be linked to the fact that the State was so much interested in standardising ISM drugs the same enthusiasm was not

11 Khan (2006) has also given the same argument. He argues that the stream which was holding idea of western medicine dominated health system was more powerful in the Assemblies.

12 Abraham also has analysed this issue. She has given another reason for not banning ISM practice. There were practitioners and supporters who were politically powerful. This coupled with ISM providing health care to masses of India ensured that ISM not banned in India (2005:190)

shown to make ISM education curricula uniform throughout the country or to protect the interests of ISM practitioners. Though we assume that, the State was genuinely interested in the revival of ISM, the question to be debated is why is the State always focused upon standardisation and clinical trials and ignored education, training, and welfare of ISM practitioners?

The developments in India in 1970s can be linked to the developments in the West where in the developed countries focus shifted from western medicine to Complementary and Alternative Medicine. This link is elaborated by Saks (1998) where he observed that in the beginning of post modern era 1970s onwards the West there was a search of an alternative medicine. There developed a plurality of culture in the West and they were interested to go beyond the western medicine's discourse. The scholar considered this shift as a causal factor for the West's growing interests in ISM of India. It was the same period the Indian Government started appointing various committees to examine possibilities of "Shudda" education in ISM. Same is the period witnessed that Yoga and Naturopathy started gaining some attention. Drug research was also gaining pace during 1970s. We can link these developments in India, to the growing interest of the West in Complementary and Alternative Medicine.

Discussions in this section basically show that, the authority and hegemony of western medicine over ISM though was initiated by the colonial state was extended by the main stream national leaders and the State with far more extensive and profound implications. The national elites while projecting their efforts as revival or modernisation of ISM modeled ISM on western medicine. Though ISM was projected as non- scientific and even when its efficacy was questioned, in the 1970s with the growing market demand one can see how the State changed its position and started commercialising and commodifying ISM.

4.2.4. Planning Commission and Its Position on ISM

It is mentioned by Jeffery the health planning has stressed preventive and public health programmes with a rural bias (1988: 143). He observed that the planning Commission in its report has stressed need to focus on rural areas with emphasis on prevention (1977: 142). What one can understand here rural India though had good resources (as far as ISM is concerned) in terms of practitioners but their service was never integrated properly into the Indian health system. ISM which specifically focuses on prevention aspect did not receive any attention from the Indian planners. Here an attempt is made to see what position the Planning Commission of India took on ISM in each of its five year plans.

In the first five year plan, its focus was on research so that ISM could become part of an Integrated System of Medicine. There was special mention about herbs. The Commission identified that the training and education across the country was not uniform. In case of Homeopathy the recommendation was to set up a Central Council for Homeopathic Medicine. The plan report also called for the government consideration of natural cure as a way of life rather than as a system of treatment. But all this positive recommendations had no effect on budget outlays. Plan outlay for ISM was Rs. 37 .5 lakhs, where as total budget allocation for health was approximately Rs. 65 crores[13].

In the second five year plan attention focus was only Ayurveda; it left out all other ISM and the outlay for ISM was Rs. 1 crore for the Central plan and suggested for outlay of Rs.5 crores for the State plans. Total outlay for health in this plan was Rs. 140.8 crores[14].

---

[13] Government of India (1951), First Five Year Plan Document, Planning Commission of India , New Delhi, chapter on health

[14] Government of India (1956), Second Five Year Plan Document, Planning Commission of India , New Delhi, chapter on health

The Third five year plan acknowledged the failure of the approach of an integrated system of medicine. It suggested for the establishment of various statutory bodies and creation of various bureaucratic positions within Ministry of Health for the promotion of ISM. In this document one can trace an attempt to include natural cure as a technique in western medicine. For ISM plan allocation was Rs. 9.8 crores where as total budget for Health was Rs. 225.9 crores[15]

In the fourth five year plan while total of Rs. 433.53 crores was allotted to Health the ISM got only Rs. 15.83 crores of this huge allocation[16]. There was direction for The Indian Council for Medical Research to conduct research in crude drugs. Classification of Indian medicinal plants was another thrust area. Clinical research was the focus where it was directed to get scientific evidence for the chemical and pharmacological properties of medicinal plants.

In the sixth five year plan instead of the term "Indigenous System of Medicine" a new term "Traditional Medicine" was used. The plan suggested developing drugs in ISM. An attempt to integrate ISM to the health system of the Country was also observed[17].

The idea of popularisation appears during the seventh plan period onwards. Another major shift was to see how the service of the huge manpower of ISM practitioners could be used in the country's health system[18]. In the review of achievements (of the sixth plan period) the document note down that the Indian Systems of Medicine had been given due importance during the Sixth Plan. The policy acknowledged that ISM popular in the country and there are about 4.5

[15] Government of India (1961), Third Five Year Plan Document, Planning Commission of India , New Delhi, chapter on health

[16] Government of India (1969), Fourth Five Year Plan Document, Planning Commission of India , New Delhi, chapter on health

[17] Government of India (1974), Fifth Five Year Plan Document, Planning Commission of India , New Delhi, chapter on health

[18] Government of India (1985), Seventh Five Year Plan Document, Planning Commission of India , New Delhi, chapter on health

lakhs practitioners of these systems who are working in rural areas. The report claimed that teaching and training programmes for Ayurveda, Siddha, Unani Naturopathy, Yoga and Homoeopathy have been augmented and streamlined. There is mention about establishment of separate councils of education and research for the various systems of medicine. In the seventh plan period the direction of the Commission was to have efforts to dovetail the functioning of these systems and integrate their services at appropriate levels into the overall health care delivery system, particularly the national health programmes and the programme of primary health care.

In the eighth five year plan again one can observe change in the terminology- from "traditional system" to "Indian System of Medicine and Homeopathy". The document acknowledged the fact that ISM practitioners were close to the community (not only in geographical proximity but also in terms of cultural and social ethos). The plan document stated that they could play a significant role in the health delivery system. The highlights of the plan include giving importance to manpower training, integrating various ISM, bringing them to the health system of the country etc. Drugs, herbs and their export potential were also mentioned in the plan document and for this promotion of research was also emphasised.[19]

The ninth plan document devoted one whole chapter on ISM and its related issues. Huge manpower of ISM practitioners and their service in remote areas of the country was documented by the Commission. For the first time, the Planning Commission approached the ISM as an entity with a potential to be utilised in primary, secondary and tertiary levels of health system. It also called for research in ISM so that ISM drugs could be utilised in National Health Programmes. The patenting aspect, export opportunities, international market chances were also

[19] Government of India (1992), Eighth Five Year Plan Document, Planning Commission of India, New Delhi, chapter on health

highlighted by the Commission. For the West oriented market due to its stringent standardisation and efficacy norms the Commission gave special emphasis for standardisation and quality assurance. Commodification of ISM was seen seen as a main goal in this five year plan period. It has mentioned that drugs have to be developed, tested "scientifically" and thus could be patented and utilized to exploit the opportunities in the international market. It also mentioned that the potential contribution of drugs and formulation of ISM to meet global demands would be fully exploited. Outlay of this plan period for ISM was Rs. 266.35 crores[20]. There is no mention about the welfare and protection of ISM practitioners in any of the plan documents till the ninth plan.

The tenth five year plan document observed, that India is undergoing a demographic and life style transition where by communicable diseases will come down and non-communicable diseases will increase. It identified the role of ISM as a preventive as well as a curative mechanism. 62 billion US $ is the global market of herbal products as per the calculations of the Planning Commission. Food supplements and cosmetic care products of ISM were identified as the products with great marketability. Promotion of health tourism, encouraging "Good Manufacturing Practices" and quality – standard assurance was the thrust areas of the tenth plan[21]. Therefore, one can see that in the tenth plan period, full thrust was given to export, development of cosmetic care- food supplement and to quality assurance- standardisation as per the demand of the western market. The ISM has been converted from a viable medical system to cosmetic and food supplement provider. This is nothing but further degradation of the status of ISM. In the tenth plan document, the Planning Commission acknowledged that ISM do have a preventive focus, while in most of the early committee reports, main draw

---

[20] Government of India (1997), Ninth Five Year Plan Document, Planning Commission of India , New Delhi, chapter on health
[21] Government of India (2002), Tenth Five Year Plan Document, Planning Commission of India , New Delhi, chapter on health

back pointed out was its absence. From time to time ISM is presented as per the interests of the market and various classes of people.

4.2.5. Power relations within ISM practitioners during the post independence period

After independence though western medicine was given importance and the patronage gradually shifted from ISM to the western medicine, these western medicinal services were not accessible to all. Thus ISM was practiced by people with less competence and knowledge because the demand was high. This led to the decay of the ISM as a medical system and it was even some times equated with quackery, superstition etc. One can see how the identity of authentic vaids and hakkims were confused with that of quacks and impostors.

During the post independence period, Leslie (1972) identified two reasons for the tension development within ISM. The decline in the "elite" position of vaids and hakkims along with the internal divisions was pointed out as the first reason. Decline in the ISM clientele was pointed out as supplementary reason.

There are other scholars who pointed out that ISM decline was mainly due to its lack of professionalisation and "scientific élan". Bala (1982) specially focused on Ayurveda- ISM interaction. Though her work focused history prior to independence, briefly she explained about developments of post independence period. She argued that the Ayurvedic scholars could not effectively assimilate knowledge from other sources to Ayurvedic corpus. The scholar identified the decline in the clientele demand as one of the important reason for Ayurveda not flourishing in the modern period. According to her in the modern period the close link between Ayurveda and Unani was because they shared identical governing assumptions. The scholar concluded that it was because of lack of scientific nature that the Ayurveda became stagnated and lost its clientele base.

Work by Brass (1972) is an interesting one in which he studied about Ayurvedic movement in India and linked it to political system in an interesting way. According to him, ISM practitioners to achieve status and recognition initiated the process of institutionalisation and professionalisation within ISM. This process in turn created an elite group of ISM who used the revival movement as a political instrument to influence State decisions. But this revival movement was just a partial success because of the internal divisions within the group as modernists and traditionalists. Though they established large number of institutions they failed to develop a uniform education pattern. The integrated education in ISM produced practitioners who were neither good in western medicine nor in ISM. One could observe lot of strikes by the ISM students during 1940s-1960s, and this finally led to the abolishment of integrated courses of ISM. All this showed wide spread dissatisfaction that prevailed among ISM practitioners[22].

As far as professional bodies were considered the following debates and power sharing observed. Among the practitioners of Ayurveda there emerged two apex bodies. 1) Ayurvedic Congress which back up Shudda tradition 2) Council of State Boards & Faculties of Indian System of Medicine (established in 1952) which supported integrated method in ISM. From the time of Dave Committee onwards the Ayurvedic Congress was more powerful and thus they influenced State decisions and this was a major reason for the shift in the State's attention to Shudda curricula and practice from 1970s onwards. Same way, many committees were set up during 1950-1975.[23] The tensions and differences of opinion which

[22]Abraham has argued that the discourses of Ayurveda. According to her the period which extended up to the 1960s is marked with intense debate within Ayurveda, between purists and modernists which led to radical attempt at integrating western medicine with Ayurveda in the medical colleges. (2005:189)

[23] Brass has mentioned that the conflict between the groups of Ayurveda was a major obstacle to the establishment of educational uniformity and professional standards. Although both the groups agreed to have professional standards for practice, the standards of one group would disqualify the practitioners of the other. (1972:359)

developed within ISM, especially in the powerful Ayurveda lobby influenced the State decisions[24].

4.3 Contextualising ISM Commercialisation, Commodification etc. in the Neo-liberal Regime

This section is a kind of complex analysis of both causes and consequences of changes which happened in ISM after the 1990s. The pattern of changes happened in this era was discussed in the previous chapter and here this is an attempt to link that changes to market forces, international economy etc. Commercialisation, commodification of ISM and moulding ISM as per the interests of the market are the main consequences of such State decision. ISM has degraded from being a viable medical system to a cosmetic care industry. All the drugs and the methods like Panchakarma are now widely used in the West as well as in India to support the therapies of western medicine. All these changes give a picture that ISM cannot and need not exist independently but it should supplement and support the growth of western medicine.

4.3.1. International Market for ISM

Banerjee argued that the new motive for the expansion of the health system was the business world's recognition of the fact that the health system was itself an "industry"[25] (1985:5). According to him, the health industry is now regarded as a thriving social service with virtually endless potential for swelling the Gross National Product. The medical establishments thus not only created a new set of health needs but also determined to see how these needs are met Banerjee (1985:6). It is in this context one has to see the changes that happened to the ISM

---

[24] See Brass (1972) for example, appointment of Dave Committee (in 1955) was influenced by this power games between purists and modernists.

[25] Though he made this comment generally about Indian Health System, it is very well applicable to ISM . Recent works of Frankenberg (1981), Banerjee (2004, 2002, 2000) also give evidences in the case of ISM

in the post liberalisation period. ISM was promoted from 1990s onwards by establishing AYUSH and then started focus on exports and on commodification. One could observe a sudden increase in the Government's budget allocation to ISM and started promoting ISM. As mentioned earlier in this work, it is not because the Government realised the intrinsic value of the ISM as viable medical system but because the State identified commercial- market opportunities of the ISM. There is a realisation that along with China, India can claim a big share in this growing "herbal" market.

Regarding marketability of ISM, Khan (2006) has put his argument in an interesting way as follows; the Government in the recent years is promoting the ISM because of the promises attached with the new "gold rush" i.e., the competition for patents and commodification of indigenous knowledge. The State started encouraging recently the promotion in this respect shows how this would again exclude the masses and serve the needs of the market and other vested interests[26].

Saks (1998) identified another change where the interests of the West especially that of European Union, United States of America and Australia developed in favor of traditional/ complementary medicines of India. Identifying this opportunity the State and Market responded positively. According to him, this led to another negative development as far as ISM is concerned (when it was placed within Indian health system). The growing interests of the West in ISM motivated Indian drug manufacturers to focus on drug production. One can see that the State established AYUSH and other Central Research Councils during the same period. This might be to meet the interests and demands of these Indian companies.

---

[26] Khan (2006) has mentioned about growing global networking of "traditional" and "complementary" systems. He examines the situation and argued that the Government is paying more attention to this system because of threat and fear about patents. He concludes that how these developments will help people to benefit from the Indian health system is the question to be debated

Although many of these companies are facing problems in the export of the ISM drugs (because of stringent standards set by the developed countries) food supplements and cosmetic products are extensively exported. Another important development in this area is the growth of medical tourism and health resorts in India which totally changed the concept of health care (Saks 1981). Therefore the health needs are created by the market and these needs are met by the market. The end result of this game is the shrinking presence of ISM in the Indian Health system. According to him Saks (1981) ISM treatment has become expensive and thus inaccessible to the masses. But the more problematic fact is that ISM's viability and credibility as a medical system has been threatened.

Another important change which led to the growth of local market of ISM in India might be the shift in the epidemiological profile of India; non-communicable diseases like diabetes, cardiac problems, arthritis etc. are increasingly prevalent among certain classes. It is generally observed that people have more faith in the ISM when the ailment is chronic as well as non-communicable in nature. So this shift might be an important reason for the development and growth of a local market for ISM within India.

In his recent work Alter (2005) has identified another major problem that when a medical system which was regional becomes trans-national, it created whole lot of issues because such regional medical systems had close linkages with lifestyle, food habits and climate of that particular place. He argued that the efficacy tests as prescribed by these developed countries and as explained by western medicine would not help ISM to be proven to be effective or ineffective.

If one examines the writings of Banerjee (2002), she explained about interest shown by Government of India in the possibilities of going herbal. She argued that this interest is determined by the parameters defined by the dominant

economies of the world. According to her the so called modernisation efforts of ISM (with standardisation, pharmacueticalisation and commercialisation) created a situation known as "pharmacuetic episteme" which means a situation focusing on retaining ISM's usefulness as a mere supplier of new pharmaceuticals and dismissing its world view on health, body and disease. The parameters of legitimacy were always decided by the western medical research models. She reiterated that the same parameters could possibly be elicited from within ISM but this path is never tried[27].

Another issue which is highlighted in writings of Banerjee (2004, 2002) is about mass production of ISM drugs. As per the conventional ISM practice there is no such mass production involved. The market projected this mass production as a need. It is clear that those mass production policies always help big pharmaceuticals to establish their hold on the market and eliminate small groups which are involved in the practice. There is no attempt by the State to decentralise the production, as to facilitate the preparation of drugs in accordance with classical text principles (Banerjee 2002). The mass production has another problem; though they are cheap their quality is always compromised. The quality compromise comes from two factors profit motive and the violation of the preparatory measures.

One can observe the introduction of component of professionalisation to ISM which was not there earlier. The introduction of division of labor could further weaken the ISM as a system as every thing would be interdependent. This would again help western medicine to reaffirm its superiority over ISM.

---

[27] This argument is supported by the work of Abraham (2005) where she writes that the urban better off use the ISM services in search of alternative medicine or because they are harmless. She further explains that ISM in earlier times met need of cultural nationalism, now it is serving the interest of private companies and in broad sense serves the globalisation demands.

Work by Banerjee (2002) drew the attention to the issue of the clinical trials and efficacy of ISM. Why the efficacy demonstration has to be done within the western medical framework is the question. One can say that the Good Manufacture Practices prescribed by AYUSH is for global market while Amendment to Drugs & Cosmetic Act is for local market. Banerjee (2002, 2004) identified that three processes - standardisation, commercialisation and pharmacueticalisation[28] together have degraded the status of ISM. It has created a situation where the medicine prepared according to the old classical texts of Ayurveda has become more expensive. She has highlighted the problems associated with mass production of ISM drugs. The medicines which are mass produced are cheap but the results did not meet the best standards. Another impact of these changes is that the presence of ISM in the private market has expanded whereas its presence in public health system has shrunk.[29]

In 2001 one could see AYUSH and Confederation of Indian Industries (CII) joining hands for the "growth" of ISM. These two bodies collaborated and organised a Conference with a bigger initiative of CII thereby giving a new direction to the Government's activities. As mentioned earlier a Medicinal Plant Board was established in 2001 and this was to ensure the sustainable availability of medicinal plants for mass production of drugs mainly for various private pharmacy industries. One can see clear effort on the part of the State to meet the interests and demands of Industry.

[28] Pharmmacueticalisation is the process whereby the western medicine practitioners use the pharmacology of ISM to create new pharmaceutical products. Here ISM complements western medicine therapy, which again helps western medicine to gain dominant position in the hierarchical arrangement.

[29] The findings of Abraham (2005) are also similar in nature. Work by Carlos (2005) gives another interesting insight that various medical systems and its treatment modalities have close linkages with the climatic and cultural conditions of that region. According to him mere ISM drug intake may not help the patients unless they follow the dietary instructions.

4.3.2. Globalisation and ISM

Bagchi (1994) argued that in the globalisation phase India trades with the advanced market economies on unequal terms and this globalisation process is deliberately chosen by a subset of the ruling class. For India, Globalisation was imposed from outside and this created many problems in economic as well as social sector of India. According to him transnationalisation is happening i.e. transnational agencies direct command over the production and distribution is increasing. In this context placing ISM in the background of globalisation and analysing the same is very important.

Bagchi (1994) further explained this phenomenon as follows: what is happening to ISM especially to Ayurveda in the context of globalisation is an interesting question to be probed. As per the patenting laws, process or product or both are patentable. With the huge potential of capital, research and development facilities, the transnational companies are patenting faster than Indian firms and thus our knowledge and our medicinal plants are becoming alien to us and drugs are becoming more expensive. Small manufacturers are being eliminated from the market and the companies with huge capital potential are gaining total control of the market .Therefore ISM from a medical system is being converted completely as food supplements and cosmetic products provider. These food supplements and cosmetic products definitely are not purchased by the masses who can not even meet minimum daily calorie intake.

Banerjee (2004, 2002) gave another interesting observation about ISM in the context of globalisation. With the neo-liberal policies when the State withdrew from almost all social sectors, ISM faced an opposite trend. Till this time ISM had a lower budgetary allocation. With the globalisation this budget increased. She further argued that this increased support is to exploit the market opportunities associated with ISM products with focus on Ayurveda.

There are other works which give insight about globalisation related problems of ISM. For example, Abraham (2005) identified that there are markets for specific ISM commodities both local and global. Medical tourism and the creation of large personnel base of private ISM practitioners led to development of an unregulated private sector of ISM. These services are more concentrates in urban developed areas. Abraham noted down that according to WHO projection global herbal market projection is US $ 62 billion which will become US $ 5 trillion by 2050(2005: 208). She concluded that both market and the Government of India have identified medicinal plants as potential area of export.

In the neo-liberal regime, one can see ISM became a market commodity. The market itself created demand and sold out the products. With the concept of patenting, medical tourism etc. the ISM status is further degraded. Rather than developing ISM with out loosing its fundamental character what the State is interested is to help the market to exploit possibilities of promoting a herbal world.

4.4. Analysis of Parliamentary Questions

Analysis of the Parliamentary debates gives two broad trends- 1) prior to the 1980s the main discussions were around the limitations of ISM. 2) After 1980s the discussions were more focused on export and international opportunities. In this era after 1980s mainly three types of questions were raised in the Parliament- 1) commodification and commercialisation related, 2) infrastructure and fund utilization related 3) about education and ISM practitioners' identity related issues. Within this itself, commercialisation, export, foreign exhibition, promotion of Yoga as a commodity etc. are recurrent.

Trend 1: Prior to 1980s ISM projected as Non- Scientific and plea for allopathisation

There was an effort to project that ISM had some limitations when compared to western medicine. Nowhere in these discussions the efficacy of ISM explicitly questioned but always argued that ISM should be modeled upon biomedicine. Discussions especially prior to 1980s broadly fall in this category. For example, from the discussions on "The united Provinces Indian Medicine Bill" in the early 1940s, it is clear that the goal was to "modernise" ISM by considering western medicine as an ideal model.

The then Minister of Health said:

> "raise the ISM and bring it up in line with the scientific knowledge of the western system of medicine[30]"

The optimism which was highlighted there was that within a couple of years ISM would also be modernised and brought in line with "scientific development" as of western medicine.

One has to understand these discussions from a broader perspective because the State never made any attempts to understand issues like utilisation rate of ISM or its survival despite the decades of negligence.

As the discussions in the Parliament on Bhore report puts it:

> "since the health services facilities of western medicine is limited let the ISM exists and later as we "develop and modernise" our society, we will replace ISM completely with western medicine".[31]

The reason pointed out was again the "scientificity" of western medicine. How the State defined "science was never explicitly mentioned in the debates.

---

[30] Khan (2006: 2788)
[31] Indian Parliament Question -321 on 21. 02.50

Trend 2: After 1980s ISM commercialisation, focus on exports; education and infrastructure also gaining some attention

Debates after 1980 mainly fall into three broad categories- 1) discussions on commodification and commercialisation 2) on infrastructure and fund utilisation 3) education and identity of practitioners. A new position of the State was visible here because in these debates nowhere it projected ISM as non-scientific.

Trend 2.1. Debates on Commodification and Commercialisation of ISM[32]

The queries on export and commodification were mainly to know which countries were interested in ISM, what were the exports rate and how India could "exploit" the market opportunities (for example Q No 2799 of 13.03.1992, Q No 3883 of 28.04.1995, Q No 22.03.1990) Many of the responses of the Government (for example Q No. 17.12.1992, Q No 9504 of 08.05.1992) to such questions made it clear that the countries which export ISM drugs, ISM cosmetics and therapies like Yoga and Naturopathy demand clinical data in line with western medicine. One can link this to the Government establishing Central Councils on Research for each of the ISM. These apex bodies are mainly established to promote export and meet the needs of the market. Moulding ISM in accordance with as the market demands and later on sidelining ISM from the mainstream of Indian health system was also one of the major outcomes.

The European Union market was identified as "extreme focus" group for export promotion by the Health Minister (Q No 9504 of 8.5.1992, Q No *25 of 24.02.1997). Again, the plea was that (in Q No 832 of 29.02.2000) though these countries did not acknowledge ISM as a viable medical system (as such or not scientific) our opportunities to sell cosmetic products food supplements etc. should be well exploited. This approach reveals the elitist attitude of identifying

[32]Indian Parliament Questions --Q No. 3036 of 10.12.1991, Q No. 2799 of13.03.1992, Q No. 3883 of 24.04.1995, Q No @@1105 of 22.03.1990, Q No 3643 of 17.12.1992, Q No 9504 of 8.05.1992, Q No. 4133 of 20.04.2005, Q No 5520 of 29.08.2001, Q No 832 of 29.02.2000, Q No. 3785 of 18.04.2000

market opportunities anywhere and selling the product is even though this process is antithetical to the very philosophy of ISM. Though the intrinsic value of ISM is not recognised the approach is to let the market forces gain whatever they demand.

The State, not even in a single debate said that an attempt would be made to convince these western countries about differences between ISM and western medicine and clinical triai etc. Again many questions pertaining to patents, sending ISM practitioners aboard to give lectures to MBBS students' etc. were also debated over.

In all the debates which probed about the Government efforts for commodification (see Q No. 5698 of 02.05.2000 for example) the reply mainly mentioned the establishment of AYUSH, Central Council for Research, and many other National laboratories for ISM. From the debates on clinical trials (Q No 832 of 29.02.2000) one can observe that these trials were done in places where mainly Scheduled Caste population lived. This means that the poor who do not benefit from the advancements in science and technology were again being treated as guinea pigs for the clinical trials.

One can see that all these debates which mentioned about export started after 1990s. It is surprising to note that there is not much debate after 1995 which mentioned about issues like- including ISM in National Health Programmes. All discussions were around issues such as exploitation of the export potential of ISM and on meeting the standards prescribed by the EU, USA etc. for the exports. This as mentioned earlier shows the interests of the State to meet the demands of the market forces.

Trend 2.2. Debates on Infrastructure and fund utilisation[33]

The analysis of Parliamentary debates showed that there were a few questions related to infrastructure of ISM as well as on attempts to mainstream ISM in the Indian health system (Q No 303 of 7.03.1997, Q No 1516 of 09.08.1995, Q No 1569 of 15.05.1985). According to the replies, ISM is less scientific so it cannot be given an important role in public health unless ISM itself becomes "modern and scientific". One can observe a dual stand of the Government on the issue. As mentioned in the previous trends (P. No 104-105) in the questions related to exports the Government claimed that ISM is a medical system which has thousand of years' proven knowledge base. But, when it came to utilise ISM in Indian health system the Government chose another position that ISM is not scientific.

In some of the questions (see Q No 303 of 07.03.1997 for details) the State did confess that ISM is marginalized even after independence. To the query related to infrastructure of ISM, the Central Government took the stand that Health is a state subject. Resource scarcity is projected as main reason for the lack of proper ISM infrastructure but never any promise was given to increase the ISM budget provision. In a debate on comparison of ISM dispensaries (Q No 1516 of 9.08.1995) with that of western medicine it was shown that only 20 percent of total dispensaries are having ISM facilities.

Major fund allotment is for research and standardisation procedure rather than for infrastructural development at the primary level of health care. Again it was made

[33] Indian Parliament Questions— Q No. 269 of 1.12.1998, Q No. 303 of 7.03.1997, Q No 1516 of 9.08. 1995, Q No *509 of 09.09.1996, Q No. 3397 of 16.12.1996, Q no. 45 of 19.11.1997, Q No. *25 of 24.02.1997, Q No. *122 of 03.11.1997, Q No. 1250 of 21.05.1990, Q No. 1569 of 15.05.1985, Q No. 2520 of 18.03.1997, Q No. 4934 of 02.05.1985, Q No. *561 of 26.08.1991, Q No. 3273 of 19.08.1991, Q No *74 of 26.11.1991 Q No. 5698 of 02.05.2000 Q No 536 of 13.05.1997, Q No. 1746 of 11.03.1997

clear that State does not have any plan to open new colleges of ISM in recent future.

The only two queries which asked about the State neglect of ISM (Q No 5698 of 02.05.2000, Q No 4637 of 25.04.2000) are not answered clearly because the Government claimed that there was no discrimination shown against ISM.

In almost all the replies (See Q No 617 of 09.05.2000, Q No 5698 of 02.05.2000) the common theme was the establishment of AYUSH and Central Council for Research. But for whom these institutions stand for is a pertinent issue here, which has to be studied by the scholars. The queries related to integration of ISM into the Indian health system were vaguely answered or left out as a matter under state's subject.

Trend 2.3 Debates on ISM education and practitioners' identity[34]

The third set of debates related to education of ISM and practitioners professional identity revealed that ISM practitioners do not enjoy same pay, privilege and other benefits as their western medicine counter parts(Q No 5665 of 12.05.1997, Q No *82 of 03.03.1992). The reason for such discrimination was not highlighted in the discussions. The Centre made it clear that, it has no intention to direct the State Governments to make the pay of these two groups the same.

In these discussions there was a suggestion to use ISM practitioner's service to supervise spray squads of Malaria Programme (See Q No 5665 of 12.05.1997 for details). Such suggestions from the State again degrade the status of ISM and are humiliating ISM practitioners who like their MBBS counterparts spend 4-6 years for education and training. There was a suggestion (to Q No 536 of 13.05.1997)

[34] Indian Parliament questions- Q No *82 of 3.03.1992, Q No. 3397 of 16.12.1996, Q No. 5665 of 12.05.1997, Q No. 1569 of 15.05.1985, Q No 3274 & 3383 of 19.08.1991, Q No. 843 of 14.07.1992, Q No.3379 of 18.03.1993, Q No. 8944 of 16.05.1996, Q No. 6657 of 09.05.2000, Q No. 536 of 13.05.1997

to create a sub-cadre of ISM in the existing CHS, but the objective of this initiative was not mentioned.

Analysis of Parliamentary debates showed that in the post independence period ISM was used by the State as it wanted. Sometimes, it was projected as unscientific and not modern and thus State was so "concerned" about the masses of India and thus did not develop ISM infrastructure and did not mainstream ISM into the Indian health system. But when the State identified market opportunities and commercialisation options of ISM in the western countries, the same ISM became most important traditional asset of India which has a scientific base and has advantages like lack of side effects etc.

4.5. Role of International Organisations in the Commercialisation of ISM

In this section I would like to highlight how various policies and decisions of international bodies like World Health Organization (here onwards WHO), European Union (here onwards EU), United Nations Child Emergency Fund (here onwards UNICEF) and Alma-Ata Declaration influenced decisions of the Indian Government regarding ISM. Again, since EU, United Kingdom (here onwards UK) and United States of America (here onwards USA) together comprise major export zones of ISM products, their positions is also reviewed.[35]

Banerjee (2002) has documented how Alma- Ata declaration positioned ISM. In 1979 WHO and UNICEF came out with the Alma-Ata declaration with the goal of providing health care for all by the year 2000. It acknowledged the role of traditional medical practices in providing primary health care to 80 percent of the world's population. Their low cost, accessibility, and people's faith in them made

[35] Khan has observed that in the light of the growing global networking of "traditional" and "complementary" health systems on one side and growing hegemony of WB, IMF such analysis becomes important (2006:2786)

them eligible to be taken into this public health policy statement. But it was made clear that this absorption would be based on the following of norms and standards of western medical system. Following this, in 1980s there was continuous though marginal support for research in ISM. But this research was in tune with the hegemonic validation process as laid down by the western medicine.

With the advent of globalisation, ISM's position was not the same as that of the domestic industries of India which were shrinking when the international ISM industries were expanding. In many sectors the State withdrew from social sectors but in the case of ISM the State has come forward to support (Banerjee 2002). But the force of international bodies is so much that the State as well as the Indian Industries could not withstand the pressure of developing ISM drugs along with the efficacy parameters established by the western medicine. In the capitalist production ISM especially Ayurveda has became the mirror image of western medicine.

From the work of John (2007) it is evident that in UK, USA and other countries of EU, there is a positive attitude towards Complementary and Alternative Medicines. This opportunity is identified by the pharmaceutical giants and thus they have pressurised the Governments of those countries to develop policies which support them in two ways- first is to retain superiority of western medicine and second is to develop ISM drugs in line with western medicine standards. This second attempt is to make the market entry easier. Consumers belong to "modern" group who are the clients of western medicine practitioners. It was these radical changes in the west which transformed the status of ISM even in India but this transformation was also to degrade its status further.

In 2001, the WHO developed a policy document on Traditional Medicine and which accepted the Chinese pattern of research on ISM as the valid one. This is

because the Chinese pattern is shaped within the framework of the western medicine. This allowed the WHO to promote the hegemony of western medicine. Therefore, when one country adapts to the dictates of "scientific methods", the chances of its success in the market is more.

The EU similarly has passed strict norms for the ISM drugs which cause great difficulty for business in that continent. The Hunt Commission set up by the EU declared Ayurveda as "unscientific" and allowed only food supplements and cosmetics to be imported by the member countries. All this led the Indian firms to develop the food supplements and the cosmetic products which deteriorated the status of ISM.

In the USA, the National Center for Complementary and Alternative Medicine is the Government agency dealing with the ISM related issues. The Centre has also issued policy documents similar to that of the EU. With all these "selling" has become more important for the Indian firms rather than considering the ISM in accordance with the philosophy and principles of the particular system. One can safely conclude here that, the new policies of the Government of India are driven by the external demands rather than an internal drive to strengthen these medical systems.

4.8 Conclusion

This chapter was an attempt to place the paradigmatic shift in the State polices towards ISM of post independence period in a broader political and economic framework. The basic arguments were as follows: The colonial Government gave importance to western medicine to control the masses and after the independence the ruling elite gave the same or even more emphasis to western medicine and marginalised ISM. The State clearly marginalised ISM by mentioning it as "non-

scientific". The various committee formations etc. were due to the pressure from ISM practitioners like the Ayurvedic Congress.

In the 1940s one could observe how the National Movement considered ISM and it assigned a rhetorical role for it without much support. After independence Nehru- Gandhi discourse gained momentum and finally Nehruvian model gained prominence. The subsequent Government promoted policies which were strictly science based.

In the 1970s, the State started paying attention to ISM because of Alma- Ata declaration but nothing much was done to ensure ISM existence at least at the primary level. Around the same time there started a wave for search of Alternative and Complementary Medicine in the West. Therefore the State gave importance to pure stream ISM. One can observe that till this time the same ISM was "unscientific" and now it became "our heritage and pride".

In the 1990s with the wave of liberalization and globalisation ISM also became a commodity. Process of commercialisation, pharmacueticalisation, standardisation, clinical trials and patents etc. became part of ISM. The Indian Companies influenced the State and developed various parameters and policies which suited their interests. Rather than considering ISM as a viable medical system it has been degraded to a pharmaceutical store. In 1990s one could see new approach to marginalise ISM, this is by commercialising.

Further World Trade Organization, TRIPS etc. make the ISM more inaccessible to the people of the country as it becomes a "cosmetic" science. One could see that the position of Planning Commission towards ISM was also not very supportive. Similarly debates in the Parliament were focused on commercialisation, commodification opportunities of ISM. Issues like identity

crisis of ISM practitioners, proper integration of ISM in public health etc. are least probed.

The "allopathisation" has created lot of tensions within the ISM because it affects the epistemic base of ISM. And the final point here is that the medicine, though indigenous or western, is the preserve of the elite, to meet their needs as well as help them to preserve the power with them. In the post independence era, if it is political reasons which marginalised ISM in the first three decades, from 1990s onwards it is economic and commercial reasons which were the predominant cause for the deteriorating status of the ISM.

Concluding Chapter

Process of Marginalisation: Allopathisation to Institutionalisation to Commercialisation

This research work was an attempt to study State- ISM interaction during post independence period. We started with the basic assumption that State did not treat ISM at par with western medicine and this led to the development of a health system which was hierarchically arranged where western medicine was at the top. In the present study this unequal State patronage/ support is termed as marginalisation of ISM. We pre-assumed that rather than the advantage of western medicine, there existed other reasons which led to such State decisions. This needed further exploration because the State usually represent dominant group, and after 1990s in the neo-liberal regime the State has subjected itself to the international force. This work was an attempt to see "how ISM was marginalised, what is the role that the State Played, how this process occurred and finally what are the reasons for such State decisions."

Stagnation and neglect of ISM in colonial era:

One can see that from the colonial period onwards ISM was sidelined. From the literature it is clear that ISM especially Ayurveda and Unani was in a state of stagnation. The British did not ban the practice mainly because of financial constants associated with developing a health system in the whole country. In this period one can see the development of modernists and purists groups within ISM. The State decision and neglect during this period led to tensions within ISM where class, caste and religion based groups developed. There were mainly three reasons for decline of ISM in this era. First was the political and social motive of the British to ensure power and control, second were the advantages which the western medicine had and third were the internal tensions of ISM.

Post Independence era marginalisation: in the form of neglect coupled with Allopathisation

In the post independence period this marginalisation has taken different forms. From the time of independence till late 1950s one can see trend where ISM is marginalised with two methods. 1) Complete neglect in terms of fund allotment and no attention was given to the infrastructural development. 2) All the attempts were directed towards allopathisation. The reason for the neglect was pointed out as the "unscientific" nature of ISM. This argument led to the establishment of number of committees which examined the issue and recommended for modeling ISM on western medicine. The focus of many of the committees was the ISM education and focus of the Government was to "make ISM scientific" and developed "integrated course" approach of education. All systems other than Ayurveda were completely marginalised.

In this research work an attempt is made to link this development with broader political scenario that existed during that time. The National Movement's position was such that it gave rhetorical value to ISM. Similarly in Nehru- Gandhi discourse what one can see is that Nehruvian model which was based on "scientific rationality" was prominent and all policies of the State during this time was based on this "science base" development and the policies towards ISM also were not an exception. In this period the Planning Commission's views, debates in the Parliament etc. substantiate this argument.

Post-Independence era in 1960s to 1990s Marginalisation: Attempts to promote Shudda Systems and Institutionalisation

During this period one can see second form of marginalisation where the State made an attempt to promote Shudda system of ISM. The marginalisation is in a new sense because attempts were compartmentalised, where focus mainly was

only on drug research. Initially though the focus was on education within short span of time shifted to drug research. It was reported by many committees that the previous Government interventions had degraded ISM to such a level that separating it completely from the influence of western medicine became difficult. The attention slowly shifted from education to drug research. Among ISM the medical systems other than Ayurveda started receiving the State attention during this period. A number of Institutes and Research Apex bodies were also established during this period.

In this study we have tried to link the developments of this period to the growing interest of the West in Complementary and Alternative Medicine. The West wanted pure form of alternative medicine and that might be one of the reasons for the State promoting Shudda system of ISM in this period. Another reason for the promotion of Shudda method was the pressure of the ISM professional groups. It was in this period strong discourses developed between Shudda and modernist groups in Ayurveda and their pressure also influenced policy decisions.

Neo-liberal regime: New form of Marginalisation by Commercialising ISM; Back to allopathisation

Post 1990s saw the formation of a separate department AYUSH and a National Policy on ISM as main developments. The State's present focus is on drugs. Especially drug research, clinical trials, research on medicinal plants receives due attention. Standardisation is another thrust area. All these are planned based on the yardstick and guidelines developed based on western medicine. Medical tourism, patenting etc. have changed the nature of the ISM where it became a marketable commodity in India. In the developed countries due to stringent norms ISM is represented as cosmetic care and food supplement provider.

Contextualising the changes of ISM during this post liberalisation period was done in the study. In this commercialisation process it is the market forces and their interests that are protected. Standardisation, efficacy validation etc. are the demands of the developed countries and ISM is moulded as per the interest of the market and other international forces. The role of international organisations in this process also can not be undermined. Power hegemony of the market and that of western medicine are evident here.

Some Reflections for Public Health:

How a public health researcher is concerned about the marginalisation of ISM is an important question. Firstly, Public health also includes an aspect of choices- choice to opt for the medical system in which the person feels comfortable and confident. So there is a demand in the society for the existence of different medical systems (what is called as medical pluralism). Medical pluralism is a fact and it is up to the State to decide how these various resources are to be best used to serve the health needs of its citizen. What one can summarise from the above findings is that the State policies and programmes do not reflect any intention of utilising the services of ISM in extending the public health care in India. State interventions have led to overall degradation of ISM, be it in the case of drugs (degraded to cosmetic care and food supplement) or practitioners (their identity is questioned and are not well trained). And these issues were developed because of the structural issues- like political motives, market forces, nationalist ideology etc. Therefore addressing these issues and properly placing ISM within Indian health system becomes important.

Secondly, in India the shift in the epidemiological profile is visible; non-communicable diseases like diabetes, cardiac problems, arthritis etc. are increasingly prevalent among certain groups. It is generally observed that people have more faith in the ISM when the ailment is chronic as well as non-

communicable in nature. ISM if it is protected and developed without loosing its fundamental nature can meet these surging demands.

Thirdly, it is well documented that Indian health system is not accessible and affordable to the whole population. If the objective of the State is to make basic health available to all in an affordable and comfortable manner, then the best alternative is to mobilise resources of ISM. This has to be done in such a way that the fundamental nature of ISM is not affected. There is no need of comparison between western medicine and ISM. Rather than political interests and market pressures, the utilisation rate and demand etc. should be the basic criteria to promote/ not promote a particular medical system.

Fourthly, due to the commercialisation the very nature of ISM has changed. ISM treatment and drugs have become expensive and it will become inaccessible for common men if this trend continues.

Medical pluralism is a reality in India. Rather than realising its strength, the colonial and post-colonial period witnessed uni-focal attention on western medicine which led to the marginalisation of ISM. The importance given to the ISM during post- liberalisation period was largely due to commercial interests which could further erode the epistemic base of ISM in India and denigrate it to "second class" cosmetic medical science.

Bibliography

1. Abraham, Leena (2005): *Indian System of Medicine and Public health care in India*, in Gangolli, Leena et.al. (ed.) Review of Health Care in India, CEHAT, Mumbai
2. Alter, Joseph (2005): *Asian Medicine & Globalization*, University of Pennsylvania Press, New York, USA
3. Arseculeratne, S N(2002): *Interactions between Traditional Medicine and "western" Medicine in Srilanka,* Social Scientist, Vol 30, No 5/6 (May – June 2002) pp. 4-17
4. Bagchi, Amiya Kumar (1994): *Globalising India: The Fantasy and The Reality*, Social Scientist, Vol 22, No 7-8 July-Aug, pp. 343-354
5. Bala, Poonam (1991): *Imperialism and Medicine: A Socio-historical perspective*, Sage Publications, New Delhi
6. Bala , Poonam (1982): *The State And Indigenous medicine: Some explorations on the Interaction between Ayurveda and the Indian State* M Phil Dissertation, Unpublished, JNU, New Delhi
7. Banerjee, Madulika (2004): *Local Knowledge for world market-globalising Ayurveda*, Economic and Political Weekly, Jan 3.
8. Banerjee , Madulika (2002): *Public Policy and Ayurveda- modernising a great tradition*, Economic and Political weekly , March.
9. Banerjee, Madulika (2000): *Whither Indigenous Medicine*, Economic and Political Weekly, July.
10. Banerji, D (1985) :*Health and Family Planning Services In India – An epidemiological, Socio-cultural and Political Analysis and a perspective,* Lok Pakash, New Delhi
11. Banerji, D (1979): *Place of the Indigenous and Western Systems of Medicine in the health services of India*, International Journal of Health Services, Vol 9 (3), pp.511-519

12. Basham, A L (1972): *Practice of Medicine in Ancient and Medieval India* in Leslie, Charles (ed) Asian Medical Systems: A Comparative Study, University of California Press, London
13. Borkar, G for Government of India (1961): "*Health in Independent India*", Ministry of Health, New Delhi, pp. V- XIV , 226-236
14. Brass, Paul (1972): *The politics of Ayurvedic Education: A case Study of Revivalism and modernization in India*, in Rudolph, Susane and Rudolph, Lloyd (ed.) Education and Politics in India- studies in organization, society and policy, Delhi
15. Carlos, Leguizamon(2005): *Dichotomies in western biomedicine and ayurveda: health- illness and body- mind,* Economic and Political weekly, July, pp. 20-24
16. Castairs G M (1955): "*Medicine and faith in rural Rajasthan* in Paul B D (ed.) Health culture and community , Russell sage foundation , New York
17. Croizier , Ralph (1970): *Medicine, Modernisation and cultural crisis in China and India*, Comparative Studies in Society and History, Vol 12 No. 3, pp. 275-291
18. Dalal, Ajit K(2005): *Integrating traditional Health Services within Primary Health Care*, Journal of Health Management, 7;249
19. Dunn, Frederick L (1972): *Traditional Asian Medicine and Cosmopolitan Medicine as Adaptive Systems*, in Leslie, Charles (ed) Asian Medical Systems: A Comparative Study, University of California Press, London
20. Frankenberg, R (1981) : *Allopathic medicine, profession and capitalist ideology in India*, Social Science & Medicine 15A, pp. 115-125
21. Government of India, (2006-07): *Annual Report,* Ministry of Health & Family Welfare, New Delhi
22. Government of India (2006) : *Annual Report* , Department of AYUSH, Ministry of Health and Family Welfare , New Delhi

23. Government of India (2005) : *Annual Report*, Department of AYUSH, Ministry of Health and Family Welfare , New Delhi
24. Government of India (2005) : *National Rural Health Mission policy document* , Ministry of Health and Family Welfare, New Delhi
25. Government of India (2002) : *Tenth Five Year Plan Document*, Planning Commission of India, New Delhi, Vol 2, Chapter on Health
26. Government of India, (2002): *ISM & H National Policy Document,* Ministry of Health & Family Welfare, New Delhi
27. Government of India (1997): *Bird's eye view on Indigenous Medicine in India*, Handout published by Ministry of Health, New Delhi
28. Government of India (1997) : *Ninth Five Year Plan Document*, Planning Commission of India, New Delhi, Vol 2, Chapter on Health
29. Government of India, (1994): *Annual Report,* Ministry of Health & Family Welfare, New Delhi
30. Government of India (1994): *Ayurveda –Science of Life A Profile and Focus on research and Development*, Central Council for Research in Ayurveda and Siddha, Ministry of Health & Family Welfare, New Delhi
31. Government of India (1992) : *Eighth Five Year Plan Document*, Planning Commission of India, New Delhi, Chapter on Health
32. Government of India (1985) : *Seventh Five Year Plan Document*, Planning Commission of India, New Delhi, Chapter on Health
33. Government of India (1984) : *National Health Policy* document , Ministry of Health & Family Welfare, New Delhi
34. Government of India (1974) : *Fifth Five Year Plan Document*, Planning Commission of India, New Delhi, Chapter on Health
35. Government of India (1969) : *Fourth Five Year Plan Document*, Planning Commission of India, New Delhi, Chapter on Health
36. Government of India (1964) : *Report of the Shuddha Unani Education Committee*, (Chairman Abdul Hameed), Ministry of Health, New Delhi

37. Government of India (1962) : *Report of the Committee on Evaluation of Therapeutical Claims of Yogic Practices*, (Convener Dr. B K Anand), Ministry of Education, Ministry of Health, New Delhi
38. Government of India (1962) : *Report of Curriculum And Syllabus For Ayurvedic Education formulated by The Central Council of Ayurvedic Research*, Ministry of Health, New Delhi
39. Government of India (1962) : *Report of the Health Survey and Planning Committee*, Chairman (L Mudaliar) , Ministry of Health, New Delhi
40. Government of India (1961) : *Third Five Year Plan Document*, Planning Commission of India, New Delhi, Chapter on Health
41. Government of India (1960) : *Report of the Committee to Assess and Evaluate the Present Status of Ayurvedic System of Medicine*, (Chairman K N Udupa), Ministry of Health, New Delhi
42. Government of India (1956): *Interim Report of the Committee Appointed by the Government of India To Study and Report on the Question of Establishing Uniform Standards in respect of Education & Practice of Vaidyas, Hakims and Homeopaths*, (Chairman D T Dave), Ministry of Health, New Delhi
43. Government of India (1956) : *Report of the Committee appointed by Government of India to Study the Type of Training In pharmacology imparted in different parts of the country to students undergoing the training of 4 and ½ years in Ayurvedic and Unani Colleges* , (Chairman Dr. H B N Swift), Ministry of Health , New Delhi
44. Government of India (1956) : *Second Five Year Plan Document*, Planning Commission of India, New Delhi, Chapter on Health
45. Government of India (1951) : *First Five Year Plan Document*, Planning Commission of India, New Delhi, Chapter on Health
46. Government of India (1948): *Report of Health Survey and Development Committee*, (Chairman Sir Joseph Bhore), New Delhi, pp. 455- 457

47. Government of Karnataka (1978): *Report of the Committee to recommend measures for improvement of Indian Systems of Medicine Including Homeopathy and Naturopathy in The State of Karnataka*, (Chairman Dr. G S Melkote), Bangalore

48. Government of Madras (1923), : *Report of the Committee on The Indigenous Systems of Medicine* (Chairman: Muhammad Usman), Office of the Committee on Indigenous system of Medicine ,Madras

49. Government of Punjab (1938) : *Report of the Indigenous Medicine Enquiry Committee,* (Chairman Col. C G Jolly), Government Press, Lahore

50. Gupta, Brahmananda (1972): *Indigenous Medicine in Nineteenth and Twentieth Century Bengal* in Leslie, Charles (ed) Asian Medical Systems: A Comparative Study, University of California Press, London

51. Jaggi, O P (1977) : *Medicine in India : Modern Period* in Chattopadhyaya, D P (ed.) History of Science - Philosophy and culture in Indian Civilisation , Oxford University Press, pp. 311-344

52. Jeffery , Roger(1988) : *The Politics of Health in India*, University of California Press, London

53. Jeffery, Roger (1979): *Recognizing India's doctors: The institutionalization of medical dependency* , Modern Asian Studies,13 (2), pp.301-326

54. John, Hari M (2007): *Politics of Knowledge*, written for CETIM, Geneva, accessed online as http://cetim.title/tvw/kk34 on 23.02.08

55. Khan, Shamshad (2006): *Systems of medicine and nationalist discourse in India: Towards "new horizons" in medical anthropology and history*, Social Science and Medicine,62, pp. 2786-2797

56. Khare, R S (1996): *Dava, Daktar and Dua: Anthropology of practiced medicine in India*, Social Science and Medicine, Vol 43, No 5 pp .837-848

57. Kumar , Deepak (2001): *"Introduction "* in Kumar, Deepak(ed.) Disease and Medicine in India A historical Overview, Indian History Congress, Tulika

58. Kumar, Deepak (1997): *Unequal contenders, uneven ground; medical encounters in British India 1820-1920,* in Andrew & Bridie Western Medicine as contested knowledge" Manchester University Press

59. Langford, Jean (1999): *Medical mimesis: healing signs of a cosmopolitan "quack"*, American Ethnologist, 26 (11), pp. 26-46

60. Langford, Jean (1995) :*Ayurvedic Interiors: Person, Space and Episteme in three medical practices,* Cultural Anthropology, Vol 10 No. 3, pp. 330-366

61. Larson, Gerals James(1987): *Ayurveda and the Hindu Philosophical Systems*, Philosophy East and West, Vol 37, No 3 , Jul, pp.245-259

62. Leslie ,Charles (ed.) (1972) : *Asian Medical Systems: A Comparative Study* University of California Press, London

63. May, Carl and Sirur, Deepak (1998) :*Art, science, and placebo: incorporating homeopathy in general practice,* Sociology of Health and Illness, Vol 20 No 2 , pp. 168-190

64. Marriot M, (1965): *"Western Medicine in village Northern India"* in B D Paul (ed.) Health Culture and Community , Russellsage foundation , New York

65. Misarachi, Nissim et.al (2005): *Boundary at work: alternative medicine in biomedical settings*, Sociology of health & Illness, Vol 27 No 1 pp. 20-43

66. Naraindas, Harish *(2006): Of spineless babies and folic acid; evidence and efficacy in biomedicine and ayurvedic medicine,* Social Science and Medicine, No.62, pp. 2658-2669

67. Nath, Vijay(2001) : *From "Brahmanism" to "Hinduism": Negotiating the myth of the great tradition*, Social Scientist, Vol 29 No 3, Mar -April, pp 19-50

68. Nehru, Jawaharlal (1950) : Selected works of Jawaharlal Nehru, April-July, Orient Longman, Vol 14 part 2 P. no 287-289

69. Nisula, Tapio (2006): *In the Presence of Biomedicine: Ayurveda, Medical Integration and health Seeking in Mysore, South India*, Anthropology & Medicine, Vol 13 No 3, Dec, pp. 207-224

70. Pahari, Subrata (2005): *Travails of traditional medicine*, in Palit, Chittabrata et.al. (ed.) History of Medicine in India – The Medical Encounter, Kalpaz Publications, Delhi

71. Panikkar, K N (1992) : *Indigenous medicine and cultural hegemony- a study of the revitalization movement of Keralam,* in book Studies in History, Sage Publication , New Delhi, 1992 , P.No 282-308

72. Report of The National Planning Committee, Which was set up by INC in which various subcommittees were set up to look into problems pertaining various social issues. (Chairman Sokhey), P. No.40-51, 58-59, 170-175

73. Saks ,Mike (1998): *Medicine & Complementary medicine: challenge & change*, in Scambler , Graham and Higgs, Pauls (ed.) Modernity, Medicine & Health towards 2000, Routledge, London

74. Sarkar, P K (2004): *A Rational drug policy*, Indian Journal of Medical Ethics, Jan-Mar, 12 (1).

75. Sivaramakrishnan, Kavita (2006): *Old Potions, New Bottles- Recasting Indigenous Medicine in Colonial Punjab1850-1945*, Orient Longman, New Delhi

76. Sujata, V (2008): Paper presented in Seminar on Politics of Medical Pluralism in India , JNU, unpublished work

77. Sujata, V (2007): *Pluralism in Indian Medicine: Medical lore and a genre of medical knowledge,* Contributions to Indian Sociology (n.s), 41,2, pp. 169-202

78. Zimmermann, Francis (1978): *From Classic texts to learned Practice: Methodological remarks on the study of Indian medicine*, Social science and Medicine, Vol 12, pp. 97-103

Websites

1. http://indianmedicine.nic.in/index.asp
2. http://thehindu/Ayurvedic Milestones.htm
3. http://www.ccras.nic.in
4. www.ccryn.org
5. www.ccrum.nic.in
6. www.ccrhindia.org
7. http://nia.nic.in
8. http://nih.nic.in/
9. http://www.ccras.nic.in/aims.htm
10. http://www.ccryn.org/english/amis&objective.php
11. http://indianmedicine.nic.in/html/council/ccrum.htm
12. http://www.niam.com/
13. http://punenin.org/about.htm

Questions Addressed in the Parliament

1. Government of India (2005): Parliament Questions Q No. 4133 of 20.04.2005
2. Government of India (2001): Parliament Questions Q No 5520 of 29.08.2001
3. Government of India (2000): Parliament Questions Q No. No. 5698 of 02.05.2000, Q No 832 of 29.02.2000, Q No. 3785 of 18.04.2000, Q No. 6657 of 09.05.2000
4. Government of India (1998): Parliament Questions Q No. 269 of 1.12.1998

5. Government of India (1997): Parliament Questions Q No. 303 of 7.03.1997, Q No. 45 of 19.11.1997, Q No. *25 of 24.02.1997, Q No. *122 of 03.11.1997, Q No 536 of 13.05.1997, Q No. 1746 of 11.03.1997,Q No 2520 of 18.03.1997, Q No. 536 of 13.05.1997, Q No. 5665 of 12.05.1997
6. Government of India (1996) : Parliament Questions Q No *509 of 09.09.1996, Q No. 3397 of 16.12.1996, Q No. 3397 of 16.12.1996, Q No. 8944 of 16.05.1996
7. Government of India (1995): Parliament Questions Q No. 3883 of 24.04.1995, Q No 1516 of 9.08. 1995
8. Government of India (1993) : Parliament Questions Q No.3379 of 18.03.1993
9. Government of India (1992) : Parliament Questions Q No. 2799 of13.03.1992, Q No 9504 of 8.05.1992, Q No *82 of 3.03.1992, Q No. 843 of 14.07.1992,
10. Government of India (1991): Parliament Questions Q No. 6657 of 09.05.2000, Q No. *561 of 26.08.1991, Q No. 3273 of 19.08.1991, Q No *74 of 26.11.1991, Q No 3274 & 3383 of 19.08.1991
11. Government of India (1990): Parliament Questions Q No @@1105 of 22.03.1990, Q No. 1250 of 21.05.1990
12. Government of India (1985) : Parliament Questions Q No. 1569 of 15.05.1985, Q No. 4934 of 02.05.1985, Q No. 1569 of 15.05.1985
13. Government of India (1950): Parliament Question Q No. 321 on 21.02.1950