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Integrating *Sowa Rigpa* into the Public Healthcare system in Ladakh

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Abstract: This study attempts to examine Sowa Rigpa, a traditional medicinal system practised in the Himalayan regions of India and its integration in the public healthcare system. Drawing from semi-structured interviews with the practitioners, educators and administrators of Sowa Rigpa Institutes of Ladakh, the study brings to the fore the transition of Sowa Rigpa from a traditional medicinal system to a recognised and institutionalised healthcare system post its recognition in 2010 by the Government of India. This study also highlights how the stakeholders, including the Amchis and the administrators, have navigated the changes and challenges, and their social, cultural and political implications. Findings indicate the multifaceted nature of integration, where Sowa Rigpa and its institutionalisation can be seen as not just a mere inclusion in the mainstream healthcare system, but a process that has reinforced the legitimacy of its practitioners and their holistic approach to healthcare.

Keywords: *Sowa Rigpa, Himalayan Medicine, Traditional Medicine, Healthcare.*

Introduction

Traditional medicine (TM) forms an important part of the healthcare delivery system. According to the World Health Organisation (WHO), TM and complementary medicine (CM) have historically been indispensable to communities and households (Traditional Medicine,2024). One hundred seventy countries reported using traditional medicine. As per the WHO report, based on a 2012 study, almost half the population in developed countries use some form of Traditional and Complementary Medicine (T & CM) (United States, 42%; Australia, 48%; France, 49%; Canada, 70%). WHO (n.d.) defines traditional medicine as 'the total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous

to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.' Many countries worldwide incorporate and recognise different forms of T&CM as a valuable source of healthcare. Countries like Chile and some African Countries reportedly rely heavily on traditional medicine (Langwick, 2011). Recognition from the developed nations and adaptation have led TM to become a global healthcare solution.

The demand for traditional medicine has grown because patients seek more holistic, compassionate, and personalised healthcare. Traditional medicine becomes the first choice for rural and remote areas as it provides both affordability and cultural acceptability (World Health Organisation, n.d). In 2018, the Declaration of Astana by the WHO on Primary Healthcare highlighted and acknowledged the role of traditional medicine in healthcare delivery. WHO's Traditional Medicine Program started in 1976 and is operational in numerous countries to develop specific standards and benchmarks for the training and practice of traditional medicine. WHO has implemented the Traditional Medicine Strategy (2014-2023), which focuses on developing norms, standards, and technical documents based on reliable information and data to support member states. A new strategy for traditional medicine will be developed per the 2025-2034 timeline.

Traditional medical systems use plants, animal products, spiritual and manual therapies, exercises, etc., to treat and prevent illness and disease based on traditional knowledge and beliefs. They include, but are not limited to, plant and animal-based medicines, mental therapies, techniques, and exercises to diagnose, prevent, and treat illnesses or maintain well-being (World Health Organisation, n.d.). As Besch (2006) writes, 'medical systems are embedded in cultural, social, political, and economic surroundings of the societies in which they are practised. They cannot be considered uncoupled from these parameters, including their geographical and climatic settings, as further influences.' Countries with TM as a practice are usually associated with the dependency of a large population on these medical practices. Thus, the importance of these practices is significantly increased in day-to-day life or for illnesses that do not require extensive treatment. Access to TM and Complementary Medicine (CM) in many countries supports the goal of providing healthcare access for all. The advantages of TM over the biomedicine model are its ease of accessibility, cost, and belief system. Accessibility and cost are some of the parameters that result in the popularity

of these medical systems.

Payyappallimana (2009) classifies traditional medical knowledge into four types: codified medical systems, folk systems, allied disciplines, and new knowledge systems. Codified medical systems or great traditions have existed for a long time, spanning 3-4 millennia. He cites Ayurveda, Chinese Traditional Medicine, Siddha, and Unani with the characteristics of these systems, such as different worldviews, conceptual and theoretical frameworks, and elaborate literature. Furthermore, he reiterates that these systems also have a unique understanding of physiology, pathogenesis, pharmacology, and pharmaceuticals, which differs from Western biomedicine. If we consider the definition and characteristics of such codified medical systems, Sowa Rigpa, as a medical system, falls into this category, except for being a great tradition. Payyappallimana, while defining the codified medical system, uses the terminology of the great tradition, which, in an anthropological sense, can be used to define the broader aspects of a culture practised by the population. However, this case also talks about the extent and scope of these medical systems in terms of population coverage. Sowa-Rigpa, although rich in tradition, history, and all the characteristics that define the codified medical systems, lacks coverage (at least initially, limited to Tibet and India). This starts a fascinating debate on classifying medical systems like Sowa Rigpa in the great tradition of medical knowledge and systems.

Sowa Rigpa as a System of Medicine

Sowa Rigpa is a traditional system of medicine that originated in the trans-Himalayan region, particularly in Tibet and India, and later expanded to other countries, including Bhutan, Nepal, Mongolia, and some parts of the former Soviet Union. Sowa Rigpa flourished in the Tibetan plateau and in the Himalayan region since the remoteness of these locations adds to the harshness of the climate due to accessibility problems of these regions and the availability of medical facilities, especially in the wintertime. The use of natural remedies and natural ingredients available locally becomes imperative.

This system of medicine is deeply rooted in Buddhist philosophy and plays a crucial role in the cultural and social life of the society in which it is practised. Sowa-Rigpa provides a unique synthesis of medical knowledge and cultural practice, thus acting as an agent of cultural solidarity. Traditionally, the origin of this system is said to be from the Medicine Buddha,

and the teaching of the Medicine Buddha forms the basis of this medical system. Historically, the earliest medical texts in Tibet originate from the Bon tradition (an animistic and shamanistic pre-Buddhist religion) practised in the regions of Shang Shung in southwestern Tibet. The texts, namely *Sojay Kyi Do Ghu, Sorig Chegyud Daser, and Sojay Nadbum,* are said to have been written by the first Bon master and cultural founder, *Tonpa Shenrab Miwoche* (Gonpo, 2005).

The *Rgyud-bzi* (Gyüshi) is the fundamental text of this medical system, a collection of mantras, medical knowledge, the use of medicinal substances, human anatomy, and physiology. The *Rgyud-bzi* consists of four books or four tantras, namely *Tsa Gyue* (The Root Tantra), *Shed Gyue* (The Explanatory Tantra), *Man Nyag Gyue* (The Oral Instruction Tantra), and *Chima Gyue* (The Subsequent Tantra).

The root tantra has six chapters, mainly consisting of the basic principles of health and diseases, methods of diagnosis, and therapeutic uses of different substances. This text also contains mantras for the medicine Buddha and serves as a foundational text to the system of medicine. The Explanatory Tantra, the second Tantra, arranges medical knowledge systematically and is highly theoretical. In contrast, the first Tantra emphasises introducing the medical system and the importance of metaphors to incorporate concepts like time, space, teacher, auspiciousness, etc. The first section of the second Tantra is characterised by its focus on the human body, tracing the human growth stages from birth to death and its relation to anatomy, physiology, and the five elements (*Jungwa Nga or Panch Tatva).* The second section discusses the classification of diseases and their prevention, followed by the description of various medicinal substances, their use, their properties, such as taste, and the types of medical equipment and drug interactions. The second Tantra is considered the most essential as it incorporates philosophical traditions and physician ethics and integrates the theory and practice of these ethics and philosophy by providing the tools for practising medicine.

The Third, or the Oral Tantra, applies the theoretical concept of the second Tantra. The book consists of 92 chapters and focuses on diagnosing diseases, their classification, pattern of diseases, and their relation to the three energies, signs, and symptoms of particular diseases. The fourth or subsequent Tantra discusses the theoretical principles behind primary techniques like

compounding medicines, external therapies, etc. This Tantra is also essential because it contains information about the types of medicine and the administration of different medications and treatments. This book acts as a summary of all the medicinal knowledge.

Objectives

This study intends to explore the integration of Sowa-Rigpa, as a traditional medical system, into the healthcare landscape of Ladakh and India's public healthcare infrastructure by documenting and analysing how Sowa-Rigpa practitioners (Amchi) are being integrated into the healthcare system following its official recognition in 2010. India has recognised Sowa Rigpa under the Ministry of AYUSH. We are trying to understand how this system is recognised, institutionalised, and legitimised under this framework. The transition from a traditional medical system came with the issues of identity, authority, and state regulations. This study highlights how Amchis navigated these changes while considering modern governance's socio-political implications. Lastly, we attempt to contribute to the larger discussion in medical anthropology by applying theories of medical pluralism, governmentality, and epistemic politics in understanding Sowa Rigpa.

Methodology

This study draws from multi-site ethnographic work that includes semi-structured interviews with the Sowa Rigpa practitioners, which is supplemented by observation and analysis of various policy documents from the Ministry of AYUSH(MOA), Government of India and reports from the institutionalised medical infrastructure of Sowa Rigpa. Ethnographic fieldwork was conducted between 2023 and 2024 in Leh, the capital of Ladakh, India and nearby villages, such as Choglamasar, Basgo, Nyoma, and Nimoo. The data were collected through semi-structured interviews with practising Amchi (traditional and institutionalised), patients, educators, and the administration of Sowa Rigpa Institutes. The interviews were recorded with consent and were transcribed, coded, and thematically analysed.

We analysed relevant policy documents and reports from various credible published sources like the National Rural Health Mission (NRHM) district health plan, the Ministry of AYUSH, the National Institute of Sowa Rigpa Research (NISR) annual reports, the Syllabus from the Central Institute of

Buddhist Studies (CIBS), the National Eligibility cum Entrance Test (NEET) entrance exam conducted by National Testing Agency (NTA), press releases and institutional reports from the Sonam Nurboo Memorial (SNM) Hospital and NISR. The analysis is grounded in the existing scholarship in Sowa Rigpa, drawing from studies like Craig (2012), Kloos (2016), Blaikie (2019), Adams (2002), Pordié (2008), Pordié & Blaikie (2014), and Schrempf (2015). These studies provide a background by citing relevant works on the commercialisation, commodification, and governance of Sowa Rigpa.

Theoretical framework

This study uses multiple frameworks to assess the integration of Sowa Rigpa in Ladakh's public healthcare system. The idea behind using multiple theoretical frameworks is that no single lens can adequately explain the complexity and nuances of a traditional medical system incorporated in the pluralistic landscape.

Medical pluralism, developed by Charles Leslie (1976) and further enriched by Arthur Kleinman (1978), attempts to understand the co-existence of multiple medical systems in a shared space. In the case of Sowa Rigpa in Ladakh, even before its official recognition, it existed in the region within the same shared social and institutional space along with biomedicine, making it a truly pluralistic landscape. This pluralism is fundamental to understanding the public health system of Ladakh, where the health-seeking behaviour is motivated by the social and cultural values and growing ideas of modernism. Medical pluralism is used to understand the background of Sowa Rigpa or Amchi medicine in the policy context, where we discuss the co-presence and policy treatment of multiple systems along with their interactions.

The recognition and standardisation of Sowa Rigpa practices bring forward the idea and concept of Biopower, as proposed by Michel Foucault (1973). Sowa Rigpa is being codified; the interactions of the state (in this case, the Government of India and the Ministry of AYUSH) exercise control over the population through standardisation and regulation (NEET as an entrance exam and biomedical standardisation). This lens becomes useful to understand the national policies for its codification and legalisation. This theory shapes the analysis section of this study, where there are interactions and interventions at a state level for regulation and practitioner licensing.

This study also deals with the shifting social values of Sowa Rigpa practice and practitioners, which can be understood through the lens of cultural capital (Bourdieu, 1986). The institutionalisation of Sowa Rigpa changed the core practice of this system in Ladakh; the criteria for legitimate knowledge shifted from lineage-based tradition to formal degrees, affecting who could practice and where. The positive side to this legitimisation was that opportunities were given to every student to pursue this profession even without the presence of a long Amchi lineage; this is also evident from the high ratio of female students in institutions (Fieldnotes personal communication, Mathur, 2023), breaking the earlier patriarchal ceiling of knowledge transfer.

Sowa Rigpa is a complex system that involves various dynamics and heterogeneous networks. This study also discusses the assemblage of actors, Amchi practitioners, bureaus, suppliers, clinics at home, institutions, and medicine (material entities). To understand how this system can be integrated and negotiated at the ground level, the study has used data from policy documents and ethnographic fieldwork. We also deployed Latour's (2005) Actor-Network Theory (ANT) while discussing the policy and pathways for integration section.

These theoretical lenses bring out the multi-layered understanding of a traditional system when it is undergoing the process of modernisation, professionalisation and legitimisation. Modern Ladakh today is an interesting mix of contested identities and conflicting interests, and yet it comes together to integrate Sowa Rigpa alongside biomedicine at multiple levels. The different perspectives have been leveraged to elucidate diverse aspects ranging from the National policies to interactions of different actors at the ground level.

The traditional role of the Ladakhi Amchi

Sowa Rigpa practitioners, known as Amchis, have always been integral to the Ladakh society. Before 1960, Sowa Rigpa healthcare facilities were primarily in Ladakh. The development of Sowa-Rigpa has been significantly shaped by its interactions with Indian *Ayurveda*, Chinese medicine, and indigenous Himalayan practices, resulting in a syncretic medical system that is both comprehensive and adaptable (Gyatso, 2015). Ladakh remains heavily dependent on Amchis to this day. Amchi, in a typical village setting,

is responsible for treating patients and acts as the most learned and resourceful person in the community. An Amchi typically enjoys a high status, which is evident because Amchi is derived from the Mongolian word *Am-rjai*, meaning 'superior to all.'

Historically, every village had its own Amchi. Amchis are considered the representatives of Medicine Buddha (*San-gyas-Smanla*) and traditionally did not charge for their services. An Amchi requires years of training in both theoretical and practical learning. Traditionally, the Amchis attain their training through *rgyud pa*, which means learning within their own family or transmitting knowledge within one's lineage.

> *My father expired when I was a kid, I was 16 at that time, but ever since I was a small child, I was supposed to learn Gyüshi by heart...*
>
> *I used to sit and observe when my father was seeing patients; it was a way of learning…*
>
> *— An Amchi in CIBS, Leh (July 2024)*

Once the training is completed, the Amchis take an examination before the whole community and an expert Amchi. The ceremony is called *'rtsa mkrid.'* The patient-doctor relationship is an important aspect of understanding the role and status of an Amchi in society. Though Amchis never charged any fee from the patients, the relationship was bound by reciprocity, and people who could not afford to pay the Amchi would exchange their services for the Amchi household, either by maintaining their land or providing free labour.

With the advent of modern medicine in Ladakh, the traditional roles of Amchi have changed. The Amchis who were traditionally trained in the household are slowly being replaced by institutionally trained Amchis and Amchi clinics. Amchis are losing their family traditions, but they are still left with family names. Traditional Amchis in Ladakh are associated with the Ladakh Amchi Sabha (LAS), which was formed in 1978 (Blaikie, 2009).

Institutional Framework and Recognition

The recognition of Sowa Rigpa is a complex interplay of politics, survival strategies and conflicting interests. Tibetan Medicine and Sowa Rigpa are

two crucial actors that have played their parts in the institutionalisation and recognition of this medical system. The institutionalisation of Sowa Rigpa can be understood historically as the establishment of Men-Tsee-Khang in Lhasa, Tibet, by the 13th Dalai Lama (Men-Tsee-Khang, n.d.). However, this study has limited its scope to the interaction of Sowa Rigpa within the Indian context, specifically Ladakh. The development of Sowa-Rigpa has been significantly shaped by its interactions with Indian *Ayurveda*, Chinese Medicine, and indigenous Himalayan practices, resulting in a syncretic medical system that is both comprehensive and adaptable (Gyatso, 2015). It becomes imperative to understand the growth and history of a traditional medical system; placing it in a historical context not only helps us understand the cultural significance of the system but also the underlying political movements that helped shape the present face of the system.

The push towards recognition in India started in the late 1990s. There was a conscious effort to recognise Sowa Rigpa as the lost form of Ayurveda. In the early 2000s, practitioners sought legal recognition (Kloos, 2016). The Government of India officially recognised Sowa Rigpa as an Indian system of Medicine under the Ministry of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH). This recognition and integration provide a great opportunity to understand how a newly recognised system is integrated into a pluralistic system of Medicine.

The integration and recognition of Sowa Rigpa happened in the Indian context through the combined efforts of two agencies of medical practitioners. The first is Men-Tsee-Khang or the Tibetan Medical and Astrology Institute (re-established in 1961in Dharamshala by the 14th Dalai Lama) (Men-Tsee-Khang, n.d.), and the second is Ladakhi Amchi Sabha (Founded in 1978) (Kloos, 2016; Blaikie,2009). In Ladakh, new institutions were formed during 1960-1980. The Central Institute of Buddhist Studies (CIBS) was founded in 1959, and its department of Sowa Rigpa was established in 1989 (Central Institute of Buddhist Studies, n.d.). CIBS also opened a hospital and a dispensary in 2010, which is now a fully functional hospital.

> *People used to go to Tibet to study ever since the 8th Century to study in monasteries…. The Indo-China conflict in the 1960s made it difficult for people to take Buddhist teachings in Tibet…*
>
> *The CIBS was started as a school by Kushok Bakula Rinpoche in 1959; he went to the Prime Minister of India, Pt. Jawaharlal*

Nehru and what started as a centre with a few students, 10-12, is now a centre for learning.

— A Senior Amchi in CIBS, Leh (July 2024)

A Central Council for Tibetan Medicine (CCTM) was established in 2004 to standardise practices and techniques. In 2012, the Sowa Rigpa came under the purview of the Central Council of Indian Medicine (CCIM). The Major function of CCIM is to set minimum standards for the education of medical practices, maintenance of a central registry for practitioners, and establishment of codes and conduct. It also recognises medical qualifications and inspects medical colleges that give medical education. In the case of Sowa Rigpa in India, the National Commission for Indian System of Medicine (NCISM), along with CCIM, regulates and oversees the standardisation of education in colleges offering Sowa Rigpa training. In 2019, the Union Cabinet of India approved the establishment of the National Institute of Sowa Rigpa (NISR) in Leh. It was given an autonomous status under the Ministry of AYUSH (Press Information Bureau, 2019). This institute functions as a research centre to undertake an interdisciplinary education and research program to integrate and facilitate different forms of Medicine.

The recognition of Sowa Rigpa in India was crucial, as Kloos (2016) implies that recognition made "Sowa Rigpa legible to the state" and commoditised it as "inalienable". Tibetan heritage was re-framed as capital, sparking "tensions over ownership and control". The strategy of AYUSH is to recognise traditional systems that are local to a region as part of primary care. One must understand that recognising this system gives it legitimacy, as the Amchis have always yearned for. However, as Blaikie (2019) points out, this also forces them into the biomedical paradigm. The duality of this recognition and integration in biomedicine ultimately interferes with the concept of identity of the traditional medical system.

Different ethnographic works (Adams & Li, 2008; Hofer, 2018; Schrempf, 2015; Saxer, 2016, etc.) have discussed the pressure of state policies and the market to reconfigure Sowa Rigpa. Hofer (2018) has shown how Tibetan medicine practitioners have responded to the changing landscape by adapting to different practices and identities, and calls adaptability the key to the resilience of Tibetan medical knowledge. Adam and Li (2008) have also discussed how the Mentsikhang in Tibet is being reshaped by modernisation policies while aligning itself with biomedicine. This study becomes more

relevant in this context because integration 'masks the marginalisation of traditional practices'.

In India, six institutions are authorised to give a degree in Sowa Rigpa:

1. National Institute of Sowa Rigpa (NISR) in Leh city, Ladakh.
2. Central Institute of Buddhist Studies (CIBS) in Choglamasar, Ladakh.
3. Men-Tsee-Khang (Sowa Rigpa) in Dharmshala, Himachal Pradesh.
4. Central Institute of Higher Tibetan Studies (CIHTS) in Sarnath, Uttar Pradesh.
5. Chagpori Tibetan Medical Institute (CTMI) in Darjeeling, West Bengal.
6. Namgyal Institute of Tibetology (NIT) in Gangtok, Sikkim.

The admission of students in these institutes was under the discretion of the individual institutes, often based on institution or state-level exams. The syllabus and practices were, however, standardised by the NCISM and CCIM, which created a gap in how accessible these institutes were in accepting students. The standard practice of admission in India is through the National Eligibility cum Entrance Test (NEET) conducted by the National Testing Agency (NTA). The entrance test is conducted at two levels: NEET-UG (Undergraduate) and NEET-PG (Postgraduate). A third category was added in 2023 for the 2024-2025 Session - the NEET-SR UG (Sowa Rigpa) for admission to the undergraduate medical degree in Sowa Rigpa, through regulation (5) of the NCISM, which instates the use of National Examinations for the Indian system of Medicine regulations, 2023. The examination was conducted by CIHTS, Uttar Pradesh, for 2024-2025. (National Commission for Indian System of Medicine, 2024).

Introducing NEET for Sowa Rigpa also reaffirms the recognition by the Government of India. The erstwhile institute-level or state-level examination had reportedly led to inconsistencies in student preparedness and academic rigour. Admission through NEET brought parity and increased the credibility of Sowa Rigpa as an Indian system of Medicine. The syllabus also includes subjects that lead to the bio-medicalisation of Sowa Rigpa, like Physics,

Chemistry and Biology; this integration works in synergy with the national policy of integrating Sowa Rigpa in the modern healthcare landscape, which is pluralistic.

The policy of NEET for the governance of the traditional medical systems can be understood through the lenses of 'biopower' and 'governmentality', which explain how modern states regulate population and knowledge systems through institutional and disciplinary mechanisms (Foucault, 1991). This standardisation renders the biomedical orientation of the entrance exam. It makes it more legible and governable by virtue of bureaucratic rationality, which aligns this system with the prevalent and dominant form of medical education (Scott, 1998). As Banerjee (2009) points out, indigenous medical knowledge can only be validated when it shows compliance with the biomedical standards, which is true for Sowa Rigpa and its growing need to present itself scientifically.

> *...The qualifications to become an Amchi are simple: you need to be 12th Pass and know the Bhoti language, but now we are starting to use NEET...*
>
> *On being asked, Do you need the biology subject in 12th grade to be an Amchi doctor? Amchi replies...*
>
> *Biology students are given preference, but it is okay even if you do not have it, officially, we have yet to make it compulsory; NEET will do it in the near future...*
>
> *—Amchi from CIBS, Leh (June 2023)*

This analysis can be further supplemented by the existing studies discussed in the subsequent sections to distinguish cultural and institutional dynamics and how the traditional medical system of Sowa Rigpa can be reshaped according to the rationalities of the modern state.

Ladakhi Amchis in the Public Healthcare System

Ladakh's healthcare landscape was governed by Amchi at the village level. However, the formal integration of Amchi in Ladakh's healthcare happened under the aegis of the former National Rural Health Mission (now National Health Mission) and the government of erstwhile Jammu and Kashmir.

These organisations hired Amchi to work in healthcare services, primarily at the village level for primary healthcare. In 2007, around 40 Amchis were on the government payroll as honorary staff; the Amchis received a stipend of Rs. 300 per month plus Rs. 1500 for herb collection. (NHRM- District Health Action Plan, 2007). This initiative aimed to promote and extend public health outreach to the remote villages in Ladakh. As per the NRHM 2007 report, over 200 Amchis existed in Ladakh, of which 40 were formally linked to the health department.

> *After the Government recognition, we started getting jobs at block-level hospitals, even for small villages. A big village has 100 houses, while a small one has 30-40 houses. We got jobs there as well"*
>
> *—Amchi, CIBS (August, 2024)*

In the popular body of knowledge, it is understood that the integration of Amchi into public healthcare took place after the formal recognition by AYUSH in 2010. However, the Amchis were employed in the PHC along with Unani and Ayurvedic doctors in 2009 (Blaikie, 2009). This was a result of the experiments and efforts of the Ladakh Autonomous Hill Development Council (LAHDC).

An appropriate example of the integration of Sowa Rigpa in Ladakh with a biomedical system is the case of Sonam Nurboo Memorial (SNM) Hospital, Leh, which is the biggest hospital in the region. The hospital has its own AYUSH facility, a Sowa Rigpa OPD, which was opened in 2010. The patients in this department can access both Amchi and allopathic doctors. The fee for the OPD is as nominal as Rs. 20, making it affordable. The CIBS and NISR offer a five-year medical degree course (Bachelor of Sowa Rigpa Medical System), and SNM offers an internship for the final year students.

Apart from the SNM hospital in Leh, the National Institute of Sowa Rigpa in Ladakh has an Out-Patient Department (OPD), dispensary, and several Public Health Clinics (PHC). According to the NHM report (2007), PHCS is recommended to have an Amchi and an allopathic practitioner. NISR hosts several health camps under the Tribal Health Care Research Program (THCRP)- an initiative under the Central Council for Research in Ayurvedic Sciences (CCRAS). Under the THCRP initiative, NISR, during the years

2014-2020, undertook 389 clinical visits to 162 villages of two districts of Ladakh, i.e. Leh and Kargil, catering to at least 18,649 patients (NISR, n.d.). Ladakh has three dedicated Sowa Rigpa dispensaries (Chuchot, Nyoma and Yamcog).

Integrating Sowa Rigpa: A Case Study of SNM Hospital and CIBS

SNM Hospital and CIBS are two early pioneers that ensured the successful integration of Sowa Rigpa practitioners within the biomedical setting.

SNM Hospital Amchi Clinic: SNM Hospital has an OPD of Sowa Rigpa on the hospital premises. This hospital is one of the best examples of integration; nurses do basic processes like blood pressure and vital monitoring, while the Amchi provides treatment and advice; the patients are then directed to the state/hospital-sponsored dispensary. If there is a requirement, Amchi doctors also refer patients to allopathic doctors, thus ensuring a coexistence of the two systems. As per the report of Sonam Norboo Memorial Hospital (n.d.), the influx of patients has increased over the years, from 20-30 in the early 2010s to around 60 patients a day by 2022. When we consider the coexistence of two medical systems in a shared space, it becomes imperative to understand the conditions under which a person is accessing healthcare services. In the SNM hospital, most patients visit an Amchi for chronic conditions like hypertension, arthritis, stomach disorders, etc., where the patients believe that Amchis are better skilled in dealing with chronic conditions. The affordability of medicine has also impacted the patient's inclination towards healthcare access. The SNM model shows the level of integration at both the patient and practitioner levels, where the doctors follow standard practices such as hospital timing, keeping patient records, using medical forms, etc., and all of this is overseen by a dean or hospital administrator, which is a departure from how Amchis operate in a traditional setting.

CIBS Sowa Rigpa Hospital: The Central Institute for Buddhist Studies (CIBS) is a university with a dedicated Sowa Rigpa Department and one of the earliest institutionalised practices of Sowa Rigpa. The Sowa Rigpa department at CIBS has undergone modernisation with respect to its teaching department and hospital. They hired new faculty, set up an herbal garden with several varieties of medicinal plants and a pharmaceutical laboratory.

The department also operates a Sowa Rigpa hospital, which has 10 beds for patients and hosts about 60-70 daily patients for consultation, treatment, and therapies.

> *We have two dedicated medical officers for the hospital, but other teaching faculty also contribute. Now we have labs too… have you seen the new blood collection labs? We got equipment too… (says the Amchi, proudly)*

Our daily intake of patients has grown from 10-20 to 60-70 patients a day…

— Amchi from CIBS, Leh (July 2024)

A few faculty teaching the students for the *Kachupa* degree (Bachelor of Medicine in Sowa Rigpa) also have duties as practising doctors in the hospital's OPD. The CIBS works closely with Ayurvedic Pharmacopoeia, where treatments and therapies are also offered in *Panchakarma* therapy. The pharmacy is well stocked with medicines, and students often go on field trips, health camps and collection of medicinal plants. Some medicines are prepared in collaboration with the Ladakhi Amchi Sabha and NISR, apart from the in-house herbal garden. CIBS is an excellent example of how funding, the right direction and institutionalisation of medicine in a local setting can produce good medicine and doctors, and this is evident from the fact that the majority of the BSMS Graduates in Ladakh are from CIBS, who are absorbed in NHM, SNM Hospital and NISR. In short, CIBS exemplifies how dedicated infrastructure and promotion can mainstream Sowa Rigpa locally.

Institutional Change vs. Identity Politics

The push for Sowa Rigpa recognition and integration results from a complex set of identity issues and contrasting interests. The Ladakhi people consider Sowa Rigpa or "Amchi medicine" as a part of their local cultural heritage and, for the medical lineages, a work of their ancestors and not merely foreign or 'Tibetan'. The Ladakh Amchi Sabha (LAS) focuses on lineage-based doctors who exist in the local Ladakhi culture. LAS considers Tibetan Amchi and Men-Tsee-Khang external actors because Ladakhi Amchi's prime motivation has been to govern the local Amchi according to local laws and cultural norms. The cultural politics of identity exist for the Ladakhi

Amchi because of their need to recognise Sowa Rigpa as an 'Indian System of Medicine'. To understand the agendas of the Amchi practice in Ladakh, we must understand the natural and cultural landscape of the Amchi. Ladakh is a cold desert, and a heavily militarised zone due to its proximity to the National borders of India, China, Tibet and Pakistan. Ladakh remained cut off from the world for a long time, and especially during winters, road connectivity gets adversely affected in the interior parts of the region due to heavy snowfall. Ladakh has historically depended on the local Sowa-Rigpa practitioners; access to allopathic or biomedicine healthcare models was limited to the region's army personnel. In 1974, when Ladakh was opened to tourism, it opened a new chapter of development. As per the Government of India's 2022 vision document for the development of Ladakh, the tourism sector in the region contributes about half of Ladakh's Gross Domestic Product (GDP). It also employs numerous other sectors, such as transport, hospitality, catering services, and the cottage industry. Situating Amchi in this context is essential as the practice of Sowa-Rigpa in the region follows a traditional lineage transmission.

The Amchi, in a typical village setting, enjoys high social status and respect from the people. The lineage-based transmission has both advantages and disadvantages for the next generation practising medicine. While it ensures that the transmission of knowledge and skills remains within one family, on the other hand, the method of practice had mutual reciprocity in kind in the exchange of medical services with no monetary benefit for the local Amchi.

> *... See Amchi in a village was always available, whether it was day or night. Whenever someone calls, Amchi has to go; some patients cannot walk, so for them it is important.*
>
> *And in village, some people also did not use to give money, they would just give you tea and that is it! it is not about money there, there is hardly any money.*
>
> *— Senior Amchi NISR, Leh (July 2024)*

Lack of monetary benefits and the new culture of modern lifestyle left very little motivation for the younger generation to practice the medicine their ancestors have been practising for years. Therefore, the Ladakhi Amchi elite had to face the socio-economic challenges and the loss of traditional and cultural heritage and lineages. In Ladakh, "the medical system faced

economic setbacks because of the opening of new avenues that introduced a modern lifestyle and a capitalist economy" (Kloos & Pordié, 2019). The efforts to recognise Sowa-Rigpa from a Himalayan perspective were motivated by two factors: the loss of heritage and cultural knowledge, and financial motivations. Therefore, it became politically important for the Ladakhi Amchi to frame Sowa Rigpa as a Ladakhi heritage. In a national discourse at the time of recognition of Sowa Rigpa, it was being compared and equated with Tibetan medicine and Ayurveda. This interaction led to conflicting interests in Sowa Rigpa's healthcare policy. The 2010 recognition of Sowa Rigpa gave the Ladakhi Amchi an opportunity to train, teach, and get government jobs in association with AYUSH Colleges (Kloos, 2016). During the interviews with the local Amchi practitioners in an institutional setting, we noticed that Ladakhi Amchis have always lobbied for Sowa Rigpa as an indigenous system under the aegis of AYUSH and connected to Ayurveda. However, the ideas and terminology sounded similar in each interview, and seemed more rehearsed than spontaneous. This idea is not to question the practitioners' integrity but the ideas and motivation required to situate the new system in a public health landscape. The Ladakh Amchi Society's focus was on the practicality of integration: Government Jobs, more funding, basic infrastructure, upholding their distinct cultural values, religious nature and work lineage.

However, in practice, the system's institutionalisation has remained, and the infrastructure development and growth of Amchi medicine in Ladakh have also given Ladakhi doctors the opportunity to obtain the required financial freedom. Many Ladakhi doctors still collaborate and work with the Men-Tsee-Khang; they visit the conference despite their different positionality related to Sowa Rigpa. The conflicting interests of the Tibetan and Ladakhi Amchis created some ideological rivalry. However, they seem to have put aside their differences and worked towards a shared goal of wider acceptance of this medical system. Several researchers (Adams & Li, 2008; Schrempf, 2015; Saxer, 2016; Hofer, 2018) have shown similar dynamics in other Himalayan settings, but legal terminology aside, the institutes locally can integrate into state systems while preserving their core traditions.

Pathways for Deeper Integration: The Way Forward

One can argue that Sowa Rigpa is integrated into the health landscape in

Ladakh and India, with its recognition by AYUSH. However, there are a few needs, barriers, and capabilities to be further explored to sharpen the integration. The Indian government's attempt to integrate Sowa Rigpa into the medical system is influenced by the experience of integration in China and Europe. There is increasing governance by 'formulation regimes' that standardise medicines according to biomedical regulation practices (Schrempf, 2015). These suggestions/gaps arise from the literature and interviews with the Amchi practitioners.

Strengthening the human resources and training: The formal education of Sowa Rigpa in Ladakh is limited to three institutes, and the number of seats in these institutes remains limited, impacting the training of Amchis and internships.

Focus on the practical experience of an Amchi can lead to better healthcare outcomes-

> *The difference in the practice of a traditional Amchi and an Institutional Amchi is that, in the village, we used to get a lot of practical experience, and here in the institute, the focus is more on theory; we do get practical, but the experience gained there is more. Students need more practical training…*
>
> *—Amchi from NISR, Leh (July 2024)*

The newest development in this regard is the new campus of NISR, envisaged to increase the research output of the institute and student intake. The training curriculum should also incorporate public health skills so that the newer Amchis can understand and integrate themselves into the health centre roles (NHSRC, 2009). Means and merit-based scholarships at the central and state levels can increase and incentivise participation.

Institutionalising Amchi positions: The older NHRM strategy called for dedicated Amchi doctors at every PHC, CHC and District hospital. These recommendations can be fulfilled by hiring Amchi at these levels. However, it is important to incorporate the government pay scale instead of a stipend. The Job status would provide legitimacy and impact retention. Many Amchis leave due to financial hardship and job uncertainty.

Proper Drug Supply and Pharmacies: NRHM co-location data shows that the lack of medicines hinders the integration of medicines under AYUSH.

If we add the unavailability of raw materials naturally in the Ladakh area to this equation, it becomes imperative that the government ensures drug formulary at the local level.

> *Earlier, we used to get all the ingredients locally, but now we have to buy some from outside. The raw material, which was previously collected in Ladakh, is now bought from traders from Kashmir and Delhi…*
>
> *—Senior Amchi NISR, Leh (July 2024)*
>
> *The raw material that we purchase from traders is sometimes not good; maintaining the quality becomes difficult, and it affects the efficacy of the medicine.*
>
> *—Pharmacist, Sowa Rigpa pharmacy division, Leh (July 2023)*

A central pharmacy can be set up in Ladakh, at the NISR or SNM hospital. The cultivation of plants has been a joint effort of Ladakhi Amchi Sabha and CIBS, a central location with a larger production scale and decreasing the pressure on the local diaspora, especially when Ladakh does not have a suitable climate for most plant growth.

Outreach activities: Establishing referral links between the allopathic and the Amchi can enhance care. Combining referrals can build trust among the practitioners and an understanding of each other's medical systems. The Amchis have adopted tests like blood pressure, X-rays, and other reports to enhance their diagnosis, exemplifying the integration of traditional medicine. Awareness campaigns of Sowa Rigpa for both patients and healthcare workers need to be enhanced. ASHA and ANM can refer patients to the Amchi for chronic conditions like arthritis, asthma, etc.

Leverage cultural heritage and Medical Tourism: Sowa Rigpa is an intangible heritage of Ladakh, and more emphasis on its recognition as a heritage should be given. The eco-tourism experience in Ladakh could be supplemented with therapies encompassing Sowa Rigpa practices. Many medical tourists are visiting Dharmshala and Men-Tsee-Khang. A similar promotion can work in Ladakh. Leading Amchis of Ladakh get a few patients from abroad, showing the potential of medical tourism in Ladakh.

> *…I have two patients coming from France today. Earlier, I had*

> *a few patients from outside who gave good reviews for me.*
>
> *Proceeds to show me letters and testimony of patients*
>
> *See! They have sent me letters and appreciation; I sometimes give consultation online…*
>
> *—Amchi from NISR, Leh (July 2023)*

The UNESCO intangible heritage nomination can bring about more funding opportunities for research and healthcare services.

Research and Development: The legitimacy of the medicine and its healing capabilities can be further enhanced by clinical trials. It can help in establishing the credibility of the medicine and the trust of allopathic doctors in the Sowa Rigpa system. Interdisciplinary studies can improve the connection between different researchers and the medical infrastructure of Ladakh. Patient satisfaction can be measured and assessed at SNM and CIBS in their OPD, and NISR can combine the data along with their field surveys to assess the community health impact of this system and guide quality improvements.

Conclusion

The positioning and identity of Sowa Rigpa in Ladakh's public healthcare system are relevant in the context of socio-political transformation, and health policy development and implementation. The multiple frameworks like medical pluralism, biopower, cultural capital and actor network theory clearly demonstrate the multifaceted nature of this integration, where Sowa Rigpa and its institutionalisation are not just merely a case of 'inclusion' but the process that has reshaped itself and the legitimacy of its practitioners and their roles.

Medical pluralism in the case of Ladakh is not 'evenly structured' as multiple of these systems exist in the healthcare system, but they are not treated on equal footing in terms of power, resources and legitimacy. Sowa Rigpa, although brought under the purview of the Ministry of AYUSH, does not enjoy the same privileges as biomedicine in terms of funding, human resources, and infrastructure. Also, in a typical hospital setting, the knowledge of an Amchi may be considered lesser vis-à-vis that of a biomedical doctor,

making it a barrier to integration. Foucauldian principles of biopower in this context legitimise or delegitimise a practitioner based on the state control, as the state selectively legitimises medicine, which reinforces the hierarchies of knowledge by privileging biomedical logics like case records, evidence-based trials and deciding what is scientific. This logic disregards how the system was practised within a lineage and the techniques used in lineage-based traditional healing. Policy integration in practice is a product of different actors. In the case of Sowa Rigpa, the different actors are in alliance and in frictions: between the Ladakhi and Tibetan Amchi. Negotiations at the level of government for recognition and legitimisation are all components of the Actor network.

Integration in case of Sowa Rigpa is not limited to being just an administrative act but a different level of contest and adaptation. The legitimation brings along a fair amount of risk. On one hand, it enhances the acceptability and credibility of a traditional medical system, but on the other, it forces the traditional model to reconfigure itself to the norms of the state. It is important to understand what is gained and what is lost in the context and process of recognition.

The policy implications suggested and the way forward discussed highlight the context sensitivity of integration -the local image and the realities of integration into the public healthcare landscape. At the ground level, the cross-disciplinary approach and interaction between the practitioners of biomedicine and Sowa Rigpa is more important, whereas for the promotion and incorporation at the structural level, the top-down approach seems more appropriate.

Overall, Sowa Rigpa is a cultural heritage that needs to be preserved. However, one has to understand that this heritage is a living system that reshapes itself with interactions and a new identity. To integrate Sowa Rigpa into the pluralistic system requires navigating through the structure of powers, keeping in sight its legacy and the local context. Integration of the Sowa Rigpa medical system does not only require incorporating it into the biomedicine model, but also preserving its epistemic richness of the traditional system that manifests its real essence.

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