The Making of 'Local Health Traditions' in India

Revitalisation or Marginalisation?

ARIMA MISHRA, DEVAKI NAMBIAR, HARILAL MADHAVAN

The Indian government's attention to the mainstreaming of traditional systems of medicine and the revitalisation of community-based local health traditions needs to be viewed as a part of its overall mandate of strengthening traditional systems of medicine. An analysis of existing policy documents and reviews reveals that LHTs have an eclectic policy history in India, marked by several decades of neglect by the state, with sporadic attention to the LHT practitioners as community health workers, to an upsurge of seemingly explicit, and yet somehow obtuse interest in revitalisation. Tracing the evolution (and dissolution) of these trajectories chronologically reveals that there is ambiguity and inconsistency around the rationales for the revitalisation of LHTs, potentially leading to fragmented medical pluralism.

Arima Mishra (*arima.mishra@apu.edu.in*) is Professor at the Azim Premji University, Bengaluru. Devaki Nambiar (*devaki.nambiar@gmail.com*) is Program Head—Health Systems and Equity, the George Institute for Global Health, Delhi. Harilal Madhavan (*harilalms@gmail.com*) is Faculty at the Indian Institute of Science Education and Research, Thiruvananthapuram, Kerala.

There has been a distinct resurgence of policy interest both globally and in India in traditional systems of medicine and healing at the turn of the 21st century. The public health potential of traditional systems of medicine and the modalities of their integration into the national health systems have begun to be looked at afresh (Bodeker and Kronenberg 2002; Richter 2003; Wreford 2005). While this renewed policy attention seemingly indicates efforts towards "pluralist" health systems, academics are wary of the nature, extent and scope of pluralism in the larger context of the history and politics of medical and health knowledge. Despite the apparent apolitical connotations of the term, it is argued that pluralism needs to be situated in the context of the larger processes of globalisation, scientisation and commoditisation (Nichter and Lock 2002; Bode 2008; Banerjee 2009). Cant and Sharma (2002) argue that pluralism in such contexts should be labelled as "new medical pluralism" that draws sharper attention to the politics of knowledge, demands for evidence and efficacy, reconfiguring the relations between biomedicine, the state and the consumer/citizen. Located in this context, this article seeks to unpack the upsurge of policy interest, specifically the Indian government's proposed strategies of mainstreaming traditional systems of medicine known as AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) and the revitalisation of local health traditions (LHTs). We specifically turn our attention to the positioning of LHTs in this evolving policy context as an amorphous, marginal category of medical/health knowledge that is historically and epistemologically linked to, and yet distinct from and subservient to the codified and officially recognised systems of traditional medicine (AYUSH) in India.

Anthropological literature on LHTs, or what is often referred to as folk medicine/ethnomedicine/indigenous healing abounds, and yet explicit analysis of policy engagement with such forms of health traditions is lacking. LHTs, as this literature discusses, refer to a range of therapies and healing traditions that include bone setting, home remedies, the dai tradition (traditional midwives), practices of herbalists, *marma chikitsa* (understanding and management through vital points in the body like acupuncture), faith and spiritual healing, among others. As is evident, heterogeneity is a significant feature of LHTs in India. However, despite the heterogeneity, most LHTs exhibit certain broad common characteristics. In a large number of cases, knowledge transmission among these traditions is largely oral. It follows that evidence on efficacy draws on experiential knowledge, rather than codified processes of documentation

(such as laboratory or clinical trials). Further, LHTs are also characterised by their everyday-ness: their practitioners in many cases are undistinguished from the community where these traditions are practised (Lambert 1996). Lastly, the epistemology and therapeutic techniques of LHTs are driven typically by a "cultural logic," interwoven with local ecology (Lambert 1992, 1996; Sujatha 2002; Quack 2012).[1]

In the policy literature, the term LHT finds an explicit reference in 2002 in the first ever National Policy on Indian Systems of Medicine and Homeopathy (ISM/H). Within the larger context of the strategies for strengthening ISM/H, this policy refers to the need for the revitalisation of LHTs which it defines as

> the *undocumented* knowledge possessed by individuals, communities and tribal groups including birth attendants (*dais*), bone setters, herbal healers, poison specialists as well as the knowledge on local grains, cereals, wild fruits, vegetables and locally available medicinal plants possessed by ordinary households. (emphasis added) (Government of India 2002: 14)

The revitalisation agenda is reinforced in subsequent policy and planning documents, including the National Rural Health Mission (NRHM 2005), the Eleventh (2007–2011) and Twelfth (2012–2016) Five Year Plan documents as well as the Draft National Health Policy 2015 (Government of India 2015). In such a context, it is imperative to situate the state's reinvigorated attention to LHTs to ask—how, in earnest, does the state view the revitalisation agenda of such traditions, which was relegated to the realm of the "folk," "traditional" and potentially "unscientific"? What does the revitalisation of LHTs entail? LHTs, as we seek to discuss in this article, witness an eclectic policy history in India. This history is marked with several decades of neglect by the state, with occasional and sporadic attention to the practitioners of such traditions as community health workers, to an upsurge of seemingly explicit, and yet somehow obtuse interest in revitalisation.

The analysis in this article draws from a narrative review of national health policy documents, published policy reviews on India's health policies and peer-reviewed literature on medical pluralism that had a specific focus on non-codified systems of traditional medicine/knowledge. Our emphasis has been on the national scale, and also on the relationship between national and international discourses on LHTs. We used 2002 as a key milestone, the year that the first National Policy on ISM/H was introduced, that explicitly stated the need for a revitalisation of LHTs, within the larger context of strengthening and integrating traditional systems of medicine. The first stage of the review thus focused on mapping health policy documents and discussions, to include national health policies and reports of committees and task forces since 2002 onwards. We noted that the rationale, funding and methodologies for the revitalisation of LHTs (including the usage of the term LHT), received specific mention and were appearing in policy documents in greater frequency during this period. The inclusion of the policy documents followed those specifically on traditional systems of medicine, including non-codified traditions as well as broader health policies and debates (examples include universal health coverage (UHC) and the revitalisation of primary healthcare) to situate the former in the relevant policy and political climate in India.

The second stage of review drew on peer-reviewed literature that reflected on policies towards medical pluralism since India's independence, to be able to situate the current upsurge of policy interest in traditional systems of medicine in a historical context, as well as those that discuss trends in the international policy context. The literature search also included key civil society organisations' reports offering either a counter narrative and/or influencing the mainstream policy on traditional medicine, including LHTs. We identified, sourced and analysed international health policy documents (that is, specifically those of the World Health Organization [WHO], including its traditional medicine strategies, declarations in traditional medicine conferences, the Convention on Biological Diversity [CBD]) that were either contemporaneous to Indian policymaking and/or had policy implications for India with respect to LHTs, indigenous knowledge, and non-allopathic systems of medicine.[2]

The State and Pluralism: LHTs as a 'Residual' Category

Existing policy reviews show that the Indian government's policy towards medical pluralism does not follow a clear or coherent trajectory (Jeffery 1982; Priya 2012; Banerjee 2002; Sujatha and Abraham 2012). Following India's independence, the developmental state's response to traditional medicine has largely been cast in the overall vision of a model of development driven by the logic of scientific temper. The global science of biomedicine defines the contours of this temper (and its scientificity). Yet at the same time, considering the popular appeal of indigenous practitioners, and the elite character—and limited reach—of biomedical services, the state has had to turn its attention to traditional medicine whenever its legitimacy is weakened (Jeffery 1982). This ambiguity is clearly reflected in the history of the Indian state's approach to medical pluralism per se, resulting in a distinct patronage of biomedicine and yet with eventual, formal recognition of six traditional systems of medicine (though subordinate to the former).

The policy debates in the early years of post-independence are marked by a triangular contestation over three models of development in relation to the organisation of health service provision (Priya 2012). These contestations are distinctly reflected in the recommendations of the health committees set up to craft the organisation of health service delivery in India. As Priya (2012) sums up, these approaches/models include the "international standards" development model and is reflected in the Bhore Committee (1943). This perspective underscores the need for scientificity based on modern biomedicine and the "best doctor" (trained in biomedicine) to be the sole provider of health services. The second is the revival of India's ancient canonical traditions model that claims the validity of the traditional systems of medicine as "science" and thus encourages the integration of different systems of medicine in education, research and practice. This integrative approach is reflected in the recommendation of the Chopra R N (1948). It has been fiercely debated through subsequent committees and

related forums, dividing the traditional medicine community along the lines of integrative versus pure Ayurveda. Implicit in this debate are notions of a universal versus cultural specificity of science; where the locus standi of LHTs is, in fact, inarticulate. The third approach is a pluralistic local development model, which echoes the Gandhian perspective and constitutes the recommendation of the Sokhey Committee (Government of India 1948). Offering a grounded approach to development, this committee recommends that

> manpower and services be developed from below; youth in every village be trained in primary health tasks and those that performed well be trained further to become doctors including those who were already practicing indigenous systems of medicine. (Priya 2012: 121)

Subsequent health committees either explicitly or tacitly align themselves with one of these approaches.

Irrespective of the different approaches to health service provision, these strands of debates operate within the landscape of an ideological orientation of the supremacy of biomedicine (Banerjee 2002). This is clear in the first planning document, that is, the First Five Year Plan (1951–56) which submits that scientifically conducted investigations will, in the course of time, decide the value and validity of different medical techniques. Those which can justify their existence could become part of an integrated system of medicine (Planning Commission 1951; Banerjee 2002). Thus, integration has meant casting indigenous systems of medicine in the mould of biomedicine (Banerjee 2002). This gets reflected in concrete policy measures, including financial allocation (lesser when compared to biomedicine), translation (into biomedical norms), and replication (of a centralised, hospital-based health provisioning apparatus). Demands for integration translate into standard modes of establishing legitimacy—professionalisation/institutionalisation of the training of traditional systems of medicine, registration of qualified practitioners (qualified through recognised institutions) and the standardisation of research and practice.

These modes of governance mechanisms align themselves with another instrument of modernity—industrial development—reflected in the large-scale manufacture of pharmaceutical products. As a primary example, issues of standardisation of manufacturing practices and validation of efficacy have always been crucial dimensions of the traditional medicine sector (Banerjee 2002). These norms (which were already set in the pre-independence context) imply that (only) those traditional systems of medicine which subscribe to (or compete with) these parameters of legitimacy get official state recognition, even if marginalised in comparison to biomedicine. These official systems of medicines include AYUSH and very recently in 2010, Sowa Rigpa. Thereby, other aspects and forms of traditional medicine, which are based on experiential knowledge and performative expertise (LHTs/folk medicine), are delegitimised.

Hardiman and Mukharji (2010) sum up the implications of such a hierarchy of legitimacy within the pluralism debate in India. They argue that much of the policy response on different systems of medical and therapeutic knowledge in India follows a tripartite schema with biomedicine at the top of the hierarchy, followed by professionalised/codified systems of medicine like AYUSH and the "residual" category, often known as folk medicine/LHTs/indigenous healing that fall outside the purview of the state. Thus, forms of medicine and healing that are non-institutionalised and are practised largely based on experiential knowledge, handed over through apprentice mode of training, fall outside the officially recognised systems of medicine. This residual category has come to be known through different names such as folk medicine, indigenous healing and LHT and "understood in terms of what they are not—biomedicine" (Hardiman and Mukharji 2010: 15) or other officially recognised systems of medicine (like AYUSH).

Belying the heterogeneity of these therapeutic practices and traditions, in deeming them as an "other" category, the state is in fact relieved of the obligation to expand, elaborate, or operationalise further. In this one taxonomic act, moreover, these practices are not only delegitimised by their now confirmed distance from the state, but also from the traditional medical systems with which they have had historical and epistemological links (Ayurveda, for example). The distinctions between institutionally trained/registered medical practitioners and folk healers have become politically significant only when the former have consciously sought to make the distinction in their quest for scientific legitimacy (Unnikrishnan and Harirammurthi 2012: 283; Priya 2013). In Kerala, for example, both these categories were referred to as *nattu vaidyans* (indigenous medical practitioners) and the department of traditional systems of medicine as *Nattu Cikitsa Vakupu* (indigenous medicine department) till the government renamed it as the Department of Indian Systems of Medicine. Further changing the terminology of the officially recognised systems of medicine from ISM/H (in 1995) to the acronym AYUSH in 2005 witnesses this process of drawing definitive boundaries between select systems of traditional medicine that have state legitimacy and the "others" that fall outside this legitimacy frame.

However, these "others" have continued to survive, though at the margins of the state. Sociological and anthropological research have extensively documented these therapeutic practices, showing how these folk practices/LHTs occupy an eclectic space in the pluralistic therapeutic landscape and continue to challenge linear distinctions between science and culture (religion), tradition and modernity, local and national/global (Lambert 1992, 1996, 2012; Trawick 1987; Lohokare and Davar 2010; Unnikrishnan et al 2010; Chawla 2013; Sujatha 2002; Sax et al 2014).

Community-based Facilitators

Pressed by continued community support, limited reach of biomedicine and select civil society advocacy, the state has turned its attention occasionally to practitioners of folk medicine/indigenous healing to accommodate them in developmental activities. While the suggestion on their involvement as community level health workers goes back to the Sokhey Committee report, this idea got a major boost in the 1970s and 1980s. A number of events both at the national and international

levels fuelled interest in indigenous practitioners. The anti-incumbent, right-wing of the then Janata government's manifesto in 1977 called for an organisation of a cadre of paramedical community health workers that included the trained practitioners of indigenous medicine (Jeffery 1982). The Srivastava Committee's Report of the Group on Medical Education and Manpower Support (Government of India 1974: 26), recommended that indigenous healers potentially could be drawn from the community as "local para-professionals" who are to provide "simple specified medicines for common day-to-day illnesses." Following this, the 1978 manual for community health workers included chapters on various non-allopathic systems of medicines and medicinal plants.

At a global level, this period also witnessed the historic WHO Alma Ata Declaration which reoriented the discourses on health around the notions of comprehensive primary healthcare, health equity and community participation, among others. Several WHO member countries, including India, enthusiastically endorsed this declaration. For the WHO (1978: 63):

> Traditional medical practitioners and birth attendants are found in most societies. They are often part of the local community, culture and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices. With the support of the formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community. Some communities may select them as community health workers. It is therefore well worthwhile exploring the possibilities of engaging them in primary health care and training them accordingly.

It passed additional resolutions supporting the utilisation of indigenous practitioners in government health systems. However, the (re)training of traditional healers is seen as a prerequisite for their potential involvement in community health and development. For example, training of indigenous healers, including birth attendants, has been actively encouraged in international health policy since the mid-1970s. Till the early 1990s, training of traditional midwives was widely supported in developing countries by several international donor organisations, including United Nations Population Fund (UNFPA), the World Bank, United States Agency for International Development (USAID) and United Nations Children's Fund (UNICEF). These training programmes aimed at spreading scientific medicine in order to improve biomedical health service delivery. Traditional medical practitioners are found to be the useful linking factor with the community, seen as inexpensive, immediate "solutions" to the human resource shortage problem (Pigg 1995). Both policy and implementation of development programmes, specifically biomedical solutions to health problems, subsume LHTs under the universalistic rationality of the development model.

Training programmes for midwives distinctly reflect these trends of universalising the discourse of biomedicine and its concomitant evidence-based, safe motherhood practices in a bid to control high maternal and infant mortality in many developing countries. Such programmes have been actively promoted by the WHO and supported by other international agencies throughout the 1970s and 1980s. For example, in 1972, 24 countries had some form of Traditional Birth Attendant (TBA) training and by 1982, 52 countries were providing training programmes for TBAs (Kruske and Barclay 2004). In India too, the training of traditional midwives or dais was an integral part of the safe motherhood and child survival policies and services till it was discontinued in 1996 (Sadgopal 2009). Both the training and the evaluation of the efficacy of this training are framed within the Western biomedical model, disrespecting the knowledge and skills of traditional midwives (Sadgopal 2013; Van Hollen 2003; Pinto 2004).

In 1996–97, international health policies shifted the language in addressing safe motherhood from trained traditional birth attendants to skilled birth attendants. The Safe Motherhood Inter-Agency Group (consisting of organisations like the WHO, UNFPA, UNICEF, Population Council) institutes the following definition: "A skilled attendant refers exclusively to people with midwifery skills (doctors, midwives, nurses) trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer complications" (quoted in Kruske and Barclay 2004: 308). Thus, the presence of a health worker with midwifery skills at birth with relevant medical backup is considered as the most critical intervention for safe motherhood (Kruske and Barclay 2004). This definition of skilled birth attendant distinctly excludes the traditional midwives, reducing them at best as link workers than as primary care providers (Sadgopal 2009). The role of training in safe motherhood practices continues to be relevant in the reproduction of a hierarchy between traditional birth attendants and skilled birth attendants (Price 2014). Pigg (1995) rightly asks how training programmes for indigenous healers could possibly respect indigenous practices and the practitioners when the explicit aim of these programmes is to alter them.

State Collaboration with Healers

Policies towards indigenous healers in many parts of the world during this period show that the policies adopted by many countries are neither sufficient to promote them, nor are they able to provide a level playing platform for them to serve as a complementary system in the national health agenda. The "co-existence or co-option" argument has often concealed the skewed favours that many of the national policies offered to biomedicine. Speaking specifically in the context of mental healthcare in India, Quack (2012) shows how the argument of state collaboration with folk healers has meant the utilisation of these healers, rather than appreciating the positive elements of this body of knowledge and practice. The decision on the time and type of implementation of most international policies concerned with traditional healers, were left to national planners. However, national planners in many countries have sidelined the indigenous practitioners while implementing policies (Pillsbury 1982: 826). Soon after Alma Ata, Pillsbury noted that only 16 countries had included traditional healers in the national policy agenda.

In India, several civil society efforts, though limited to local/regional levels, strive to reclaim the value of the knowledge and skills of indigenous systems, including those of the

traditional midwives and their role in childbirth practices (Bajpai and Sadgopal 1996; Shodhini Collective 1997; Chawla 1994). Though these efforts, along with other similar civil society efforts on indigenous medicine, including the Lok Swasthya Parampara Samvardhan Samiti and the Voluntary Health Association of India, may not have translated into making inroads into the lexicon of the national-level safe motherhood policies and programmes, they certainly have kept the theme of the role of indigenous health services and practitioners in India's health system politically alive.[3] They have consistently sought to draw attention to the need and the viability of a self-reliant model of primary healthcare in Indian society, thus highlighting the need for revitalisation of LHTs.

Returning to the 'Local' and 'Traditional'

Significant developments since the mid-1990s have reoriented the focus on traditional systems of medicine in the national and international policy scenario. Along with macroeconomic changes, a rising burden of non-communicable diseases, the failure of the grand narrative of biomedicine (which could offer control but not cure of several of these diseases along with iatrogenic effects), the maturing influence and institutionalisation of civil society organisations working in development, increasing commercial demand for and viability of herbal medicine, the growing complementary and alternative medicine movement, clamour for UHC and strengthening of primary healthcare bring back the focus on traditional systems of medicine, though in a new avatar. Civil society stakeholders have taken the opportunity afforded to them by their macro-context to develop the coinage of LHTs and advocate its insertion into policy discourses (Karnataka Knowledge Commission 2013). Indeed, these are the voices that populate various task groups focusing on this form of knowledge, set up as part of different task groups and commissions on AYUSH (Planning Commission 2007a, 2007b, 2012a, 2012b; Chandra 2011). Interestingly, these developments witness the marriage of different discourses and actors with a renewed interest in traditional medicine but for different and at times irreconcilable approaches and goals.

It is commonplace to find mention of multiple rationales for the resurgence of attention to traditional medicine in policy documents in India as much as in international policy documents, including the WHO Traditional Medicine Strategies (2002–05, 2014–23). These multiple rationales range from the need to promote pluralism as a value—cost-effectiveness, popular appeal and easier access, usefulness in preventive and promotive health, self-reliance in healthcare, perceived threat of erosion of traditional health knowledge, protection from potential commercial exploitation and biopiracy. At the national level, for example, the National Policy on ISM/H in 2002 states that

> The positive features of the Indian Systems of Medicine, namely, their diversity and flexibility; accessibility; affordability; a broad acceptance by a section of the general public; comparatively low cost; a low level of technological input and growing economic value have great potential to make them providers of health care that the larger sections of our people need. (Government of India 2002: 2)

Further, it adds, "Although new treatments and technologies for dealing with them [lifestyle diseases] are plentiful, nonetheless more and more patients are now looking for simpler, gentler therapies for improving the quality of life and avoiding iatrogenic problems" (Government of India 2002: 2). A few years later, documents begin to talk about a combined strategy to strengthen both AYUSH and LHTs through "mainstreaming AYUSH and revitalization of local health traditions" (Government of India 2014) to strengthen primary healthcare. The multiple rationales for the revitalisation of LHTs have different implications in shaping the debates on pluralism, though these are projected as unproblematic in most of the policy documents. We discuss two broad policy strands that capture the problematic of different rationales and implications on the revitalisation of LHTs.

One set of policy discourses hover around the growing importance of an emerging traditional medicine industry (specifically herbal medicine) and India's role in this global market. There is a growing realisation of the significant economic value of the medicinal plants used today and the great potential of the plant kingdom to provide new drugs in the future. Traditional knowledge-inspired approaches to drug discovery are projected as a cost-effective alternative to emerging global health problems (Patwardhan and Mashelkar 2009). Of the 119 drugs developed from higher plants and in the world market today, it is estimated that 74% were discovered from a pool of traditional herbal medicine (Laird et al 2004). Thus, the importance of traditional medical knowledge for product development has stimulated the resurgence of interest in these forms of knowledge by several actors, including the academia, industry, the state and civil society, forging alliances at different levels. With this growing emphasis with the new possibilities of the herbal medicine sector, the focus of WHO seems to have moved away from traditional medicine to that of herbal medicine (Banerjee 2002).

Signifier of Economic Possibilities

The focus on herbal medicine turns its attention as much to the codified, officially recognised systems of traditional medicine (AYUSH) as to the LHTs, as practitioners of these traditions supposedly possess knowledge on several medicinal plants and their usage. Thus, the argument on the organic links between codified systems of medicine and LHTs (where the latter is sometimes the "progenitor" of the former), are brought back, locating its evident legitimacy in the classic texts of Ayurveda, implying a turnaround of the earlier processes of distanciation of such forms of medicine by the AYUSH systems. It is thus argued that,

> Shepherds, cowherds and those dwelling in the forest areas know medicinal drugs both by name and form or in other words, forest dwelling communities constitute a rich depository of health knowledge. (Government of Karnataka 2013: 1; Shankar 2004)

Thus, the documentation of this knowledge is seen as an immediate priority, resulting in several national and international non-governmental organisations (NGOs), government bodies and academic institutions (pharmacy, botany) involved in the documentation of LHTs. Local medical knowledge thus shifts from being a mere drug development facilitator to a drug

development "originator." Over the past decade or so, biotechnology, pharmaceutical and human healthcare industries have increased their interest in natural products as sources of new biochemical compounds for drug, chemical and agro-products development. The expiry of patents by the second decade of 2000 created a kind of panic around the loss of exclusive rights for many drug brands, causing many pharmaceutical firms to turn attention to local knowledge for new drug sources, that is, bioprospecting. This attention to LHTs (owing to their knowledge on medicinal plants), however, necessarily subsumes these traditions under the codified systems of traditional medicine. The herbal medicine market focuses its attention on traditional systems of medicine (here AYUSH) and only derivatively on LHTs, as the latter cannot operate within a licensed mass marketing frame.

The growing herbal medicine market raises related concerns about the depletion of biodiversity, challenge to sustainable development, and the threat of biopiracy, in turn generating discussions about the protection and conservation of medicinal plants, promotion of herbal gardens, protection of intellectual property rights (IPRs) in knowledge use and dissemination, etc. The threat of commercial exploitation of traditional medical knowledge looms large in multilateral as well as national policy documents. The Twelfth Five Year Plan document (2012–16) reinforces the need for the documentation of traditional knowledge associated with medicinal plants to contest biopiracy and bioprospecting. Several administrative bodies as well as networks have been created to address these concerns, including the National Medicinal Plants Board, State Biodiversity Boards (both in 2000) (India), Medicinal Plants Conservation Network (a network of NGOs, state forest departments, academic institutes) (1993) and the Convention on Biological Diversity (1992) and the World Intellectual Property Organization's (WIPO) Intergovernmental Committee on Intellectual Property and Genetic Resources, Traditional Knowledge and Folklore (2000) at the international level. These concerns draw attention towards the need for the protection of traditional medical knowledge and the conservation of medicinal plants for sustainable use (Unnikrishnan and Suneetha 2012). This is also evident in several discussion forums and documents, including the WHO resolution in the World Health Assembly in 2003 that reinforces the need for sustainable use of traditional medicine, while devising national strategies for integration into mainstream health systems.

A related concern in the international traditional medicine policy literature has been on the question of whether the rights to the use of traditional medical knowledge belong within international IPRs regimes or outside them, because the dominant knowledge protection and reward is not designed to account for or accommodate epistemic narratives other than Western science and technology (Oguamanam 2004).

A growing herbal medicine market and the imperative of sustainability have given LHTs visibility in the policy arena. And yet, this visibility ironically generates further need to establish state legitimacy. Both the potential of LHTs as herbal medicine originator or the threat of loss of LHTs build an argument for the documentation and validation of such knowledge. While a systematic analysis of different models of the documentation of such knowledge is lacking, few studies do note that documentation efforts tend to focus only on the knowledge on medicinal plants (name, usage and ailments) used by the LHT practitioners systematically, excluding other aspects of knowledge or the social context in which such knowledge is produced and practised (Unnikrishnan 2010; Lambert 2012). In India, these documentation efforts are more in the nature of ethnobotanical surveys which get further validated through AYUSH or where possible, through clinical trials.

The herbalisation (demands for herbal medicine) of LHTs, thus, could potentially lead to fragmented knowledge on LHTs, reducing such traditions to knowledge on medicinal plants alone. This may, thus, exclude several other traditions that do not necessarily use herbs as the primary mode of healing. Along with the exclusion of different aspects of local health knowledge, the processes of herbalisation and pharmaceuticalisation tend to exclude the knowledge holders themselves. The focus of this interpretation of LHTs is on its "knowledge" (as possibilities for discovery of drugs, nutritional products) and not on knowledge holders. The practitioners matter to the extent that they provide the information on medicinal plants. This may not result in any formal recognition of healers, neither as legitimate healers nor through any role in formal health system, creating a divide between knowledge that is valued while neglecting the practitioners of such knowledge (Unnikrishnan and Hariramurthi 2012).

Traditional Medical Knowledge and a Return to Primary Healthcare

Another set of parallel discourses focus on the potential of LHTs and its practitioners in strengthening primary healthcare. This view has its antecedents in India's Sokhey Committee Report (1948), other landmark health reports (Indian Council of Social Science Research, 1981, Voluntary Health Association of India, 1991), the Alma Ata Declaration (1978) followed by the Chiang Mai Declaration on "Saving Lives by Saving Plants" (1988), which was revived around 2000—the year that marked the unfulfilled promise of the Alma Ata Declaration for Health for All. In 2002, WHO released its first ever Traditional Medicine Strategy, reiterating the role of traditional medicine in facilitating universal access to healthcare and urging individual countries to formulate traditional medicine policies. This call got reinforced in the Beijing Declaration (2008), which further reasserted the role of "traditional medicine as one of the resources of primary health care services to increase availability and affordability and to contribute to improve health outcomes including those mentioned in the Millennium Development Goals" (WHO 2008: 1). The revival of primary healthcare gained further momentum in India through the People's Health Movement. The Indian People's Health Charter (adopted at the first People's Health Assembly in 2000) makes reference to the need for systematic research and

community-based evaluation of LHTs to reorient the contours of pluralism, to give due space to community-based health knowledge and people-centred healthcare (Narayan 2008).

The revival of primary healthcare focus resonates with the prevailing political and health climate in India, that is, the crumbling rural public health system, high out-of-pocket expenditure and subscription to achieve the Millenium Development Goals (MDG). The erstwhile United Progressive Alliance government's commitment (especially in its first tenure from 2004–09) to focus on health (along with other social sectors) all crystallised into the development of a NRHM. The mission was launched in 2005, and it seeks to strengthen comprehensive primary healthcare through architectural corrections, employing horizontal refurbishments in the financing and design of health services. One of the core principles of the architectural corrections is to bring the community back in public health, thus instituting several community-based health strategies, including recruitment of village level health activists, promoting local level planning and community monitoring.

Revitalisation of LHTs gets positioned in this overarching policy agenda, in effect, to revitalise primary healthcare. The primary healthcare approach focuses on knowledge as much as on the knowledge holders, so as to enable community self-reliance in planning and managing health. De jure, NRHM subscribes to a larger vision of the revitalisation of primary healthcare. However, NRHM provides no operational guidelines for ways to revitalise LHTs, leaving this up to the discretion (and prioritisation) of individual states. A review of NRHM shows that rarely has any Indian state taken initiative to revitalise LHTs; most efforts so far concentrate on mainstreaming the codified systems of medicine in different levels of the health system through co-location of AYUH practitioners (NHSRC 2009; Nambiar et al 2014).

Perhaps, this reticence is due to the fact that the operationalisation of policy on the revitalisation of LHTs raises significant political questions, which have neither been addressed nor resolved. For example, Sadgopal (2009) argues that several dimensions, including caste, class, gender, power and ideology would be implicated in accepting the dai tradition within the healthcare system under the revitalisation agenda. She urges that we unpack the policy intent of revitalisation:

> Do we want to integrate certain woman-friendly non-allopathic practices into existing healthcare structures (hospitals, health centers) to humanize them, making them gender-sensitive and less commercialized? Or would we like to see parallel services for pregnancy and childbirth care based on indigenous healing and midwifery traditions? … Might referral units (usually allopathic) somehow become sensitive to the knowledge and skill of dais, so they can back up home births in a model of community-based cooperation and coordination? (Sadgopal 2009: 52)

These questions plead for better clarity in the rationales and mechanisms for the revitalisation of LHTs, explicating the practices of pluralist health systems.

As is evident in the aforesaid text, LHTs are brought back to the pluralism debate through two major policy strands, that is, by (i) addressing the increasing demand for a growing herbal/traditional medicine market and potential threat of commercial exploitation of traditional health knowledge, and (ii) as a mode of strengthening primary healthcare. These strands imply that LHTs are positioned as malleable enough to serve several needs/objectives, engage different actors and at different levels (as much the local community as an international audience; as much for the market as for primary healthcare). However, each of these strands raises different questions and imposes different demands on LHTs. For example, while the rationale for bringing in AYUSH, including LHTs, is largely the acknowledgement of the potential of these medicines and therapies to address emerging health needs, one of the central concerns in the policy documents is precisely to do the same—demonstrating the strengths and efficacy of AYUSH and LHTs. The WHO, while promoting effective national policies on traditional systems, consistently focuses on strategies for strengthening safety, quality and effectiveness through regulations of products, practices and practitioners (WHO 2002).

In the Indian context, while rehearsing the language of evidence and efficacy, the policy document states that the revitalisation of LHTs would figure in the agenda of the AYUSH sector to be "identified, reinforced, validated and propagated to the community" (Government of India 2002). If the community has been using community-based knowledge for long, why does the community need efficacy studies? Many countries in the South East Asian region affirm that when a medical substance has a long-standing practice in a community, toxicity and efficacy studies are not needed unless the substance is marketed outside its place of origin (Bode and Unnikrishnan 2013). Who are the end users of such knowledge? As per the policy discussions, LHTs could speak to local communities (through the primary healthcare rationale), the nation (being nested within the AYUSH and potentially contribute to national health goals) and the global public (through herbal medicine). One wonders what the spatial, social and epistemological relevance of LHTs really is. Does this indicate new variants of pluralism that subscribe to plural notions of science and sites of power? These questions are not adequately reflected in the discussions on the documentation and validation of LHTs.

Conclusions

While there has been a resurgence of policy interest in traditional health knowledge, particularly indigenous forms of knowledge as LHTs, there does not seem to be a coherent vision of such resurgence. Our analysis shows how policy documents demonstrate ambiguity and inconsistency around what the ultimate rationale for LHTs is—choosing to highlight multiple ones: linkage to community and primary healthcare (localness), linkage to codified systems (nesting within the codified systems of medicine within an overarching dominance of biomedical systems), linkage to market ("herbal medicine"), and linkage to science (struggles with efficacy). These multiple rationales are assumed to be unproblematic though each of these raises different demands on and directions for traditional medicine, including LHTs. Thus, while the multiple rationales project LHTs through different forms of linkages, these actually

serve to marginalise LHTs by creating categories and taxonomies that have little connection or reflection to the practices and practitioners, not to say the products themselves, and reflect a logic of highly vexed and fragmented pluralism. These bear additional significance in the current policy climate when the WHO's latest traditional medicine strategy (2014–23) sharply articulates the urgent need for harnessing the potential contribution of traditional medicine to health, wellness and people-centred healthcare through suitable national level strategies. We would argue that while the policy intent on revitalisation of traditional forms of medical knowledge, including LHTs serves as an opportune moment to revisit the pluralism debates, it is equally important to explicate several problematic questions and issues involved in such an endeavour.

NOTES

1 Hardiman and Mukharji (2010) refer to these traditions as "subaltern therapeutics" and argue why conventional formulations to refer to these traditions through oppositional categories as "folk," "traditional," "non-textual" and "little traditions" are unsatisfactory.

2 Though several other international policies and discourses like the UN Declaration on Rights of Indigenous People's Rights (2006) and the UNESCO Declaration on Science and the Use of Traditional Knowledge (2002) have an impact on shaping the discourse on traditional medicine, we consciously limited our analysis to the health sector alone for analytical precision.

3 Several civil society networks, including the Medico-Friend Circle, Voluntary Health Association of India, Lokswasthya Parampara Samvardhan Samiti (a network of organizations, individuals) actively advocated for the need for revitalisation of LHTs. See Unnikrishnan and Harirammurthi (2012); Bajpai and Sadgopal (1996) for more details.

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