Addressing Hegemony within the System of Medicine for an Inclusive and Sustainable Health System: The Case of Traditional Medicine in India

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Abstract

There is growing interest and belief in the effectiveness and efficacy of the traditional system of medicine and its sustainability within the health system. The domination and superiority of biomedicine over traditional medicine have been visible from postcolonial time to till date. At the same time, there is also an increased attempt to streamline and harmonize the diversity of the traditional system of medicine with the modern system of medicine. However, it has often resulted in detrimental outcomes for many traditional health practitioners, including the system of medicine they practice. The dominance and interplay of the power relationships and social structural inequalities are not discussed and deliberated extensively in the published literature as one of the crucial reasons for medical hegemony. Therefore, the essay's objective is to address the hegemony in traditional medicine regulation, professionalization, commoditization and intellectual property rights. In doing so, an attempt has been made to argue for the traditional care providers such as bonesetters and *Dais* (Traditional Birth Attendants) whose services remain undermined due to their social identity, often overlooking the difficult conditions in which they provide care. This may give us a more inclusive and sustainable health system perspective. The traditional medicine system and the care providers, deserve the long denied respect from the medical care and health science community; and better recognition, preservation and protection of their skills.

Keywords

System of medicine, hegemony, traditional medicine, biomedicine, regulation, professionalization, commoditization, intellectual property, traditional knowledge, marginalisation

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Introduction

Globally the health system is dominated by the experimental concepts of the biomedical system of medicine, which is often called modern western scientific medicine, allopathic medicine, and conventional medicine. It explains health in terms of biology and attaches importance to learning about body structure (anatomy) and systems (physiology). It has brought innovations with consistent research and updating knowledge. The infectious diseases that were the primary cause of high mortality are now conquered. Management of high-risk cases, surgical interventions, etc., has brought in marvels in the health sector.

Nevertheless, the presence of a traditional system of medicine is equally undeniable, even though the domination of biomedicine can be seen in all spheres of the health sector, from primary to tertiary levels of care. The traditional system of medicine (TSM) explains health in terms of ecosystem and community-specific health practices, approaches, knowledge and beliefs, which are embedded in the community worldviews and value systems. The knowledge incorporates to plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises. The medical application may be singular or in combination to treat, diagnose and prevent illnesses or maintain well being.

Going by the World Health Organization (WHO) estimation, it is estimated that 80 per cent of the population depends on TSM in certain African and Asian countries. Further, WHO stated two critical goals in its newly published Traditional Medicine Strategy 2014–2023. The first goal is to support the Member States in harnessing the potential contribution of traditional medicine to health, wellness and people-centred health care. The second is to promote traditional medicine's safe and effective use by regulating products, practices, and practitioners (World Health Organization, 2013). The stated goals echoed the ethos of sustainable health in tune with the sustainable development goals of reaching the last mile, where no one is left behind in achieving health for all.

At the same time, sustainability of health is all about the availability, accessibility, and affordability of health services through different medical and health care systems. However, the differential in access to health care and systems of medicine produces health inequality and inequities when there is a barrier in access to resources and services. Studies and writings on the genesis of modern public health amidst the industrial revolution and colonial past informed us that TSM was prominent in knowledge domains and commercial purposes. Various disciplines such as Sociology, Medical Geography, Anthropology, Ethnobotany, Pharmacology and industry—the pharmaceutical industry have engaged with the question of traditional medicinal knowledge and traditional healing within medicine. While there is acceptance and acknowledgement of TSM globally, there has remained a sense of undermining their importance in more than one way. For instance, an increased attempt to streamline the diversity of TSM has often resulted in detrimental outcomes for many practitioners.

In the study by Guite and Reddy (2021),[1] it was found that there have not been any schemes for the upliftment of the skills of traditional healers and practitioners. When the interviews were done with the modern health care workers, they discourage mothers to utilize the traditional birth attendants (TBAs) for child delivery. According to one medical officer, "even though the TBAs might have abilities and experience in helping to give birth but they are not well equipped for emergencies", she mentioned, "if a mother suffers from postpartum haemorrhage then there is 90% chance the mother will die in the hands of TBAs, which can easily be treated in the hospital". According to some traditional healers, there have also been instances where they were given a warning not to continue their practice of healing by the health care workers. Such incidences and situations highlighted why WHO proposed training the TBAs in developing skills and understanding the mechanism to reach the hospital.

Further, the ever-decreasing power of the traditional healers and practitioners in their medical practices can be seen throughout the evolution of TSM from postcolonial to globalization in India. For instance, the traditional healers in the study (Guite and Reddy, 2021) also shared that they have expectations from the government. They believe that they have been neglected. They are not allowed to make use of their potential. They expect the government to provide life skill programs to the healers to enhance their capability, provide incentives to the certified healers to make them effectively work and help them effectively make full use of their potential. Therefore, as informed by the study, one can conclude that the dominance and interplay of the power relation and social structure within the system of medicine are there but not discussed and deliberated extensively in published literature. Therefore, the objective of the essay in addressing the hegemony in traditional medicine regulation, professionalization, and commoditization and intellectual property rights is to have a more inclusive and sustainable health system.

Hierarchies within the System of Medicine

The colonization period in India by the Britishers saw an increase in interactions of TSM and Biomedicine. It resulted in the propagation of scientific rationalization and obstruction of TSM by the British colonizers. It further weakens the power of the TSM medical practitioners in folk and spiritual medicine, whose practice is considered irrational and therefore disregarded. On the other, it textualized and standardized classical medicine, such as Ayurveda and Unani (Wujastyk, 2008), as they saw classical medicines as more reliable, with rational, central, discrete theories (Prakash, 1999).

Analysis of research writings on medical hegemony and hierarchies within the system of medicine, reveals that there is the dominance of biomedicine over classical medicine and the classical over folk and spiritual medicine. Majority of the folk and spiritual medicinal care providers are affected by their individual and

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[1]"Traditional Healing Practices and Health care Utilization Among Mother and Children: A study of four North-eastern States of India", Major Research Project funded by ICSSR (Ministry of Human Resource Development), New Delhi. 2021.

group's identity which is more often than not, at the lower social rank, in addition to the medical hegemony and hierarchy. While the Government of India has made efforts in the last three decades to bring TSM into the central fold of health care provisioning by creating separate departments and then ministries within the health and family welfare ministry, there is a clear hierarchical position of one over the other. For example, the state patronage of biomedicine followed by the recent AYUSH Ministry giving importance to the centuries-old codified and classical systems like Ayurveda, Yoga, Unani, Siddha and Homeopathy and down below is the lesser-known but widely prevalent non-codified folk traditions (National Policy on Indian Systems of Medicine and Homeopathy, 2002). The folk and local healing systems serve the most marginalized who cannot afford private care or reach inaccessible public health services and non-functional primary level care in a few places. They depend solely or partially on the folk healers, who do not charge the patients much. For generations, the folk healers have served the community at doorsteps with utmost humility and generosity. The state now recognizes their wisdom and abundant knowledge of flora/ fauna. AYUSH is documenting the folk practices, but anxiety and mistrust are building among the healers who are not benefiting from sharing their knowledge. The advent of allopathic medicine created distrust in TSM and accentuated the gap between western and traditional medicine. It also left many without care due to inaccessible regimes as far as the western systems of medicine were concerned. The notion that what was 'local' needed to be ratified by the 'global' pushed the TSM to the periphery thereby paving way for certification.

Certification has enhanced the utilization of the care services, as evident from government reports. However, the question is certifying whom? Do we need to certify a knowledge system, which has existed for generations, by much recent history, and much shorter training span system of medicine? Therefore, an enquiry into the fundamental causes of the inequities created in the system of medicine needs to be highlighted. When it comes to explaining social inequalities and health outcomes, various theoretical points of view ranging from structural to cultural and behaviour explanations have been approached to answer questions about why gender, class, race, and caste-based differences produce and treat health inequalities as an artefact. Similar arguments are put forward to question the existing power relations in the study of the system of medicine as an artefact. Why is one system of medicine considered superior, rational and scientific to the other? Is the inequality natural or manufactured? Alternatively, this has to do with the social and economic background of the medical practitioners in a given system of medicine. Are the disparities in the differential social identities the culprit? Is it because their position in the social ranking laying at the lower end, renders them devoid of the kind of power available to the other system of medicine? Is it the power dynamics between the traditional healers and the western allopathic care providers (and users)? Or, because 'knowledge' has remained the preserve of the few at the higher social rung, the advent of the western allopathic healing system provided space for usurping the 'knowledge' from those to it belonged? Perhaps these questions are struggling to seek answers from various

quarters, especially those who claim concerns about traditional medicinal knowledge and healing traditions. Let us explore pertinent issues of concern which lead to some challenging questions in harmonizing modern and traditional systems of medicine.

Regulation and Marginalization

The official and legal recognition of the traditional system of medicine in the Indian health care system is an attempt to create national ownership by including and excluding certain forms of traditional medicine. In this process, the healers or traditional medical practitioners who are not registered with the respective national medical councils are not legally allowed to practice. This means that only those practitioners with certification by the Central Council for Indian Medicine can practice. For example, under the officially legalized "Indian medicine," only *vaids* and *hakims* with government certificates are certified to practice (Berger, 2013). Marginalization of certain traditional medicines is also observed in the list of medicines approved as national medicine in India. The Government showed support only for scientific forms of traditional healing (Habib and Raina, 2005), following the legacy of the colonizers as power was in the hands of people who were educated under the colonial system. Marginalization of local health traditions such as folk and spiritual medicine is done in the name of being unscientific and irrational. The Indian Systems of Medicines (ISM) under the Ministry of AYUSH, recognizes seven traditional systems of medicine—Ayurveda, Yoga, Naturopathy, Unani, Siddha, Sowa rigpa, and Homeopathy. The diversity of traditional medicine is altered by officially adopting national medicines, thereby creating a barrier and thus marginalizing certain medicines. Even though Folk medicine was recognized and endorsed as mainstream traditional medicine for the first time in the National Policy on Indian Systems of Medicine and Homeopathy by the Indian Government in 2002 (Payyappallimana, 2010) there are specialist traditional medical practitioners such as bonesetters, massage therapist (for muscle and nerves problems) who were still marginalized as their knowledge was not textualized (Lambert, 2012). Similar is the case with *Visha* (poison) healers and folk psychiatric healers. They are excluded from the Indian Systems of Medicine because of their oral-only and regionally diverse traditions. The situation of the dais (midwives) is no better. They are neither traditional practitioners nor skilled birth attendants. They are still marginalised even if they are the ones who attend emergency child deliveries in remote rural regions where there is the absence of modern medically trained gynaecologists or midwives. A study by Guite and Reddy (2021)[2] highlighted the hardship and marginalisation faced by the dais and healers in north-eastern states of India. The Quality Control of India (QCI) with the help of AYUSH has been certifying the competent healers and North East Christian University (NECU), Dimapur, Nagaland acts as the third party facilitator by facilitating the certification process. There are two steps in certifying the healers,

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first, the healers are interviewed on their knowledge and abilities of healing and the next step is the healers are made to show the demonstration of their healing process and if AYUSH finds them competent enough, then they are certified. Many traditional healers are made aware of NECU and QCI certification but still many are unaware of it, therefore if awareness and widespread seminars can be made for the healers so that all the healers' capabilities can be enhanced and they can work more effectively. The study also found that after 2005 a Dai training programme was created in certain states to bring midwives into mainstream modern health services (Sadgopal, 2009).

Professionalization in Public Health

Professionalization in public health refers to establishing suitable educational and professional standards for medical practitioners of a different system of medicine. This is done basically to protect the public against unqualified practitioners by establishing qualifying boards. Professionalization in public health reflects broader institutional, social and political forces. The Government of India set up systems to professionalize them through universities, allowing direct control over medical practitioners and ownership of traditional medicinal knowledge. Universities and Institutions were created to train, educate, conduct research and provide a degree in the classical system of Indian Medicine. For instance, the National Institute of Ayurveda, Homoeopathy, Unani, Siddha, Yoga, Panchakarma, and Naturopathy were set up by the Indian Government. The council for scientific, industrial research (CSIR) and the Ministry of Health and Family Welfare collaborated to set up the Traditional Knowledge Digital Library (TKDL) in 2002 on codified traditional knowledge to preserve knowledge and counter biopiracy (http://www.tkdl.res.in/accessed on 14 May 2022). The professionalization process adopted pulled power away from the local indigenous practitioners and demonstrates the heavy influence of biomedicine in all spheres. The social and economic backgrounds of the traditional medicine health practitioners were not considered in the whole process of professionalization. The institutions and universities created were not inclusive in their approach and pedagogy. Besides the marginalization and exclusion of traditional health care providers, there was a realization that the dominance of biomedicine continues in the curriculum and in understanding the cause and nature of diseases. The unique holistic characteristics of understanding health and illness were diluted in the name of science. The dominance of biomedicine was acknowledged in the 2002 National Policy on Indian Systems of Medicine and Homeopathy. It stated that the "component of modern medicine should be reduced, and study of Sanskrit in Ayurveda discipline and Urdu and Persian in Unani discipline should be incorporated in the curricula" (National Policy on Indian systems of medicine and homeopathy-2002). Professionalization and regulation of the traditional system of medicine should therefore be inclusive and be modified to allow culturally sustainable and its niche in public health.

Globalization and Commoditization of Traditional Medicine

The nature of traditional medicine is characterized by the inclusion of the social and the natural sciences. Anthropological studies and field observations describing the local use of nature-derived medicines are the basis of multidisciplinary scientific enquiries. It helps sustain local health care practices and demonstrates relevance in modern societies with therapies related to ageing, and chronic and infectious diseases. However, the intensified globalization and economic liberalism, which allows the interchange of knowledge and easy access via international trade using different communication and technology platforms, further excluded and marginalized the traditional health care providers, who do not have access to modern technological communication. So globalization led to another trajectory of reducing power from the traditional practitioners.

The state regulatory mechanism for streamlining the trade of herbal, aromatic and medicinal plants is weak due to the trade secrets involving forest officials, dealers and pharmaceutical companies. The traditional health providers were restricted from accessing the community forests due to improper extractions and extinctions of certain plant species of high international trade value. They are blamed for all the ecological imbalance and destructions because they are easy targets to cover up the nexus between forest officials, private dealers, and pharma companies (both national and international) involved in mass extractions from the wild (Guite, 2014). The profit from the selling of traditional medicine and indigenous medicinal knowledge is not shared with the local traditional health providers, even though they are the health care custodians and primary care providers to the community people who have no access to modern health services. The commodification of traditional medicine, information sharing and straightforward marketing strategy of herbal, aromatic and medicinal plants brought about by globalization further excluded traditional health care providers socially, institutionally and politically. The era of globalization also witnesses the rise in consciousness among the local traditional health providers and the formation of professional bodies and associations to fight for their right to ownership of knowledge and benefit-sharing. The era also led to discussions of different aspects of traditional medical knowledge in several international forums, including WHO[3] and the WTO (World Trade Organization).[4]

Intellectual Property

The outcome of globalization is the commodification of traditional medical knowledge, and growing commercial and scientific interest. As discussed earlier, the

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[3]WHO (World Health Organisation) promotes the use of traditional medical knowledge for health care. See WHO Fact sheet No. 134 "Traditional Medicine", www.who.int/mediacentre/factsheets/fs134/en/.accessed on 14 May 2022

[4]The WTO's work on access to medicines and IP issues relating to public health is guided by the Doha Declaration on the TRIPS Agreement and Public Health; this clarifies the flexibilities in IP rules available to governments under the WTO's Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). See www.wto.org/english/tratop_e/trips_e/who_wipo_wto_e.htm. accessed on 14 May 2022

modern system of medicine derived drugs and vaccines based on natural resources and associated knowledge. On the other hand, traditional medicine and its related knowledge are authentic to the specific social and cultural context of the indigenous communities. However, the growing commercial and scientific interest in traditional medicine systems calls for respect from the medical science community, better recognition, preservation and protection.

In traditional medical knowledge, medicinal use of herbs is often associated with genetic resources. For instance, the Kani tribe of South India has shared their knowledge of the medicinal plant '*arogyapaacha*' for a sports drug (World Bank, 2004; WIPO, 2004; WIPO, n.d). The existence of genetic resources is in nature and not the creations of the human mind. Therefore they cannot be directly protected as intellectual property as the knowledge is in the public domain. They are, however, subject to the access and benefit-sharing regulations under international agreements (WIPO, 2004). In order to prevent erroneous patents on traditional medicine, various international and national initiatives were sought. The World Intellectual Property Organization (WIPO) is primarily concerned with the "protection" of the intellectual property of traditional medical knowledge. It means protection against unauthorized use by third parties. The WIPO Intergovernmental Committee on Intellectual Property and Genetic Resources, Traditional Knowledge and Folklore (IGC) seek to develop an international legal instrument that would provide adequate protection of traditional cultural expressions/folklore and traditional knowledge (including traditional medical knowledge) and address the IP aspects of access to and benefit-sharing of genetic resources.

One key example is the Traditional Knowledge Digital Library created by the Council of Scientific and Industrial Research (CSIR), the Ministry of Science and Technology, and the Ministry of Health and Family Welfare in India (Ministry of DST and Ministry of AYUSH 2022). The Library documents traditional medicinal practices in India. It presents the information to be checked by international patent offices, thereby preventing the granting of erroneous patents on traditional medicines. However, not all the traditional medical knowledge could make it to the digital library. The knowledge holders face social, educational, economic and infrastructure barriers. They are pushed to the periphery in commoditization in our global economy, which further reduces the power of traditional practitioners. Often, local practitioners using traditional medicine knowledge are not given their due credit (Reddy, 2006). While it is essential to place traditional medicine globally, local medicinal practitioners should be given deserved credit and financial benefit for their work.

Conclusion

As the world moves ahead in the twenty-first century, we must take a balanced and inclusive approach. Let us acknowledge that the traditional system of medicine and its medicinal knowledge provides a pathway to social and economic development. The marginalization of the traditional system of medicine and its practitioners, in the name of regulation, professionalization, commodification and intellectual property

has to be stopped. The manifestation of social structural inequalities in the system of medicine and its providers is visible. We need to work in line with positive discrimination to bring about equality in the system of medicines. The knowledge possessed by traditional health practitioners deserves to be protected, promoted, and strengthened like modern health practitioners. Inferiority and superiority status based on science and rationality of a system of medicines are manufactured and can be prevented and avoided. The ancestral knowledge of the indigenous communities and traditional healers or practitioners can be explored to inculcate the ethos in multiple disciplines. This would most certainly bring the much-needed balance in achieving the United Nations Sustainable Development Goals, which aim to *leave no one behind*. Where the world is fast losing its natural resources, promoting traditional knowledge (TK) could become an initiative for its reconstruction in post-COVID 19 scenarios.

The Traditional Knowledge (TK) is in the discourse not only in medicinal knowledge but also in international discussions on a host of issues—food and agriculture; biological diversity, desertification and the environment; human rights, especially the rights of indigenous peoples; cultural diversity; trade and economic development. The TK has also moved towards the centre of policy debate about intellectual property (IP). This also leads us to some challenging questions. Is the IP system compatible with the values and interests of traditional communities and their system of medicine, or does it privilege individual rights over the community's collective interests? Is there the uneven power dynamics playing up too? These are pertinent questions to be addressed for bringing the due acknowledgement to the traditional health systems and its practitioners.

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