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# Power and Politics of Knowledge: Investigating Traditional Medicine *Episteme*

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**ABSTRACT**

*Taken a clash of cultures at the face value, Modernity in all its manifestations has attempted to displace the so-called 'traditional' episteme. Presumably beyond-political, there is a multi-layer contestation among knowledge systems—indigenous, 'traditional', modern et all, for the 'modern' episteme adopted by the modern nation-states questions the epistemological foundations of the 'traditional' knowledge. Medicine offers exemplary insights into the politics of knowledge and rewards us with a different perspective of power. The contestation between 'traditional' and 'modern' is a tussle between two epistemes rather cultures. 'Traditional' is not a homogenous entity and is tremendously plural where each component is distinctively different fighting for a space of its own. The struggle for recognition and quest to capture the space among the different (and distinct) knowledge systems expands the study of the "political" to peripheries otherwise deemed apolitical.*

*The present paper examines the two policy documents viz. WHO Traditional Medicine Strategy (2002) and India's National Policy on Indian Systems of Medicine (2002). The selection of the documents is deliberate to have an insight how a 'modern' international institution like WHO look at and strategize 'traditional' healthcare and similarly to examine India's stand who has a distinction of having immense diversity in healthcare practices though its healthcare policy exhibits a clear disregard to her own cosmologies for it also officiates the 'modern'. The whole cry of WHO for 'internationally accepted norms and standards', 'rational use', and adoption of 'modern' techniques are deeply political. If there is a contestation between 'traditional' and 'modern' medicine at one level, there is a deep friction between traditional medicine and folk practices of health care at another.*

## Introduction

The 'modern' knowledge systems including medicine enjoy a special, privileged and dominant place in the policies of the state for the hegemony of modernity penetrates into the knowledge systems which are presumably not only *apolitical* but immune to power exercises. Modern Nation-states have generally adopted 'modern' knowledge systems as '*Official*' (with Capital 'O' implying of its certainty and truthfulness) knowledge for being 'scientific' and, thus, trustworthy. The triumph of 'modern' knowledge systems in capturing larger space in States' policies has pushed the indigenous and so-called 'traditional' knowledge system into some sort of oblivion. Though feeble at sometimes, but the continued practice and following of traditional knowledge systems by the people at their own *understanding* and resultant faith in it sustained traditional knowledge systems at people's level. Modern States patronize the 'modern' and, thus, attempt to discipline the public life through and around it. They *believe* in 'rational' and *have* faith in science, as Nietzsche would call it, which rationality stands against. It has had success but does not go unchallenged. Medicine offers exemplary insights into the politics of knowledge and rewards us with a different perspective of power.

Reverting back to and growing popularity of Traditional Medicine is one of the profound challenges to the whole project of modernity. The consequent contestation is more a tussle between two *epistemes*—'traditional' and 'modern' than cultures. The existence of many indigenous practices within the grand umbrella of traditional medicine has its own spheres of contestation. This multi-layered tussle for democracy of knowledge brings forth a complex functioning and exercise of *power.* One of the very interesting dimensions of this contestation is the plural character of the contestation itself. All traditional practices of medicine are grounded on a certain understanding of the human being and environment. Each has a particular 'world view' and it is this cosmology which influences the *episteme* of practices. It is for this reason cultures can be *similarly* dissimilar and *dissimilarly* similar. It is, thus, the *particularity* of the episteme which makes cultures unique and not the vice versa. It is this thinking line that shall be a guiding line in analyzing the two policy documents on 'Traditional Medicine' by two agencies; one international and second a national. This interrogation shall underline the *antagonistic,* or distinct to say the least, epistemologies and how this epistemological foundation is *political.* In addition to this, how is Traditional Medicine *conceptualized* in different perspectives for member States that are in a particular hierarchy of the 'development' and *prescribed* for whom and by whom? The WHO policy document is reflective of practices of politics of knowledge in the formation of its strategy for the traditional medicine.

While making a comparison[i], we shall focus on how the two policy documents supposedly for the traditional medicine *have* different perspectives about the same and how the two documents reflect different *political* notions of

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knowledge. The language of the documents would be analyzed in light of politics of knowledge and the 'usage' of words and terms, in this case, represent *different* positions on traditional medicine: thus, political. The definitions of traditional medicines, in both the documents, reflect a power structure and its daily exercise in the everyday life. The struggle for recognition and quest to capture the space among the different (and distinct) knowledge systems expands the study of the *political* to the previously deemed extreme corners beyond-political or non-political or commonly (mis)used *apolitical*. The whole diktat scheme of World Health Organization for the member states to go for 'internationally accepted norms and standards', 'rational use', 'standardization', 'accepted research', 'modern' techniques and 'policy formation' and its target population (the poor) are deeply political. Rather making a holistic study of the nature of policies prescribed by the two documents and analyzing the possible outcomes, we shall limit the study to the interface of power, knowledge and medicine[ii]. It is to be noted that it does not mean that 'Traditional Medicine' is uniform in *itself* and there is no politics of knowledge within. There is a huge diversity within and, more so, since it is in the *codified* form, therefore, the process of codification of the health practices *might* have included the privileged and dominant practices. The indigenous practices are, therefore, not only marginalized of the 'modern' but by 'traditional' as well. If there is a *contestation* between 'traditional' and 'conventional' which has 'metamorphosed'[iii] into 'modern' medicines at one level, there is a deep friction between traditional medicine and indigenous practices of health care at another. It is certainly beyond the scope of this paper and, hence, sets a second limitation to the paper.

**Epistemological Foundations and Practices of Power**

Quite interestingly, and expectedly, the two documents perceive the Traditional Medicine (TM, now onwards) in different ways which is suggestive of the 'prejudices' for and against a particular knowledge system. While the WHO Traditional Medicine Strategy (2002) makes an extensive use of adjectives, the National Policy on Indian Systems of Medicine (2002) highlights its practices in non-adjective language. This is not accidental rather intentional. For WHO, the continued use of TM in Asia and Latin America is due to the 'historical circumstances and cultural beliefs'[iv]**.** It further says:

> Traditional medicine may be codified, regulated, taught orally and practised widely and systematically, and benefit from thousands of years of experience. Conversely, it may be highly secretive, mystical and extremely localized, with knowledge of its practices passed on orally. It may be based on salient physical symptoms or perceived supernatural forces.[v]

On the contrary, the National Policy (of India) acknowledges Indian Systems of Medicine as 'rich, centuries-old heritage of medical and health *sciences*' which has been 'addressing the health care' of the majority of the people and 'for some, it is also a *way of life*'[vi] (emphasis mine). Could one ask what makes the TM 'highly secretive', 'mystical' 'super-natural' and 'belief-embedded' for the WHO and, contrarily, 'a way of life' for the people who practice and benefit from it? This speaks of the *political* positions on defining, *hierarchizing* the knowledge systems and, finally, adopting a particular knowledge as the *official* knowledge which in both the cases has been allopathic medicine irrespective of the different epistemological positions taken by the WHO and Indian government[vii]. The WHO, in the entire document except at two places where it refers of UNCTAD, does not refer to TM as *knowledge* rather as 'historical' and 'cultural belief,' the National Policy documents acknowledges it as rich heritage of health sciences. The discursive formation of the documents underlines the contestation between the two knowledge systems rather cultures. The allopathic medicine, as the WHO document itself holds, is taken as 'value-free' and '"unmarked" by the cultural beliefs' and contrarily the 'common basis' of TM 'is a holistic approach to life, equilibrium between mind, body and environment, and an emphasis on health rather than on disease.'

**Incorporation of TM in national health care: the politics of categorization**

There are three 'health systems', according to the WHO, which describe the interaction between the TM and her member states namely:

a. **Integrative System**; in which TM 'is officially recognized and incorporated into all areas of health care provision' practised only in China, Republic of Korea and Vietnam;
b. **Inclusive System**; in which TM has not yet been fully integrated but 'work on policy, regulation, practice, health insurance coverage, research and education' is 'underway';
c. **Tolerant System**; in which 'health care system is based entirely on allopathic medicine, but some TM/CAM practices are tolerated by law.'[viii]

This categorization and placement of countries is quite interesting. The *only* three countries in the category of *Integrative System* are China, Republic of Korea and Viet Nam[ix]. India, Sri-Lanka, Indonesia, Japan, Australia, UAE, Germany, Norway, UK, Canada, USA, Ghana and Nigeria figure in 'Inclusive System' of health care[x]. [One can underline a serious *ideological* bend within the WHO document which may be considered later in the paper]. While it places of India in the Inclusive Category, the Indian National Policy aims at 'meaningful phased *integration* of Indian Systems of Medicine with the modern medicines' owing to the growing popularity of ISM for its 'simpler, gentler therapies for improving the *quality of life'*[xi] (emphasis mine). The National Policy calling its 'integration' is substantiated by the fact that there is a 'huge infrastructure' available 'comprising [of] thousands of hospitals and dispensaries, registered practitioners' which is more than *double* of available infrastructure of allopathy[xii]. As of 2002, the ISM document mentions, there are 404 ISM colleges in India and more than 70 per cent of people access TM in India, according to WHO. Despite such popularity and mass following, the ISM 'gets *only* 2 % of the total health budget of the nation, while 98 % is incurred on western modern medicine'[xiii]. The policy, therefore, strongly recommends for the corrective measures and revisiting the entire health policy of the nation.

**Standardization and Quality Control: the politics of knowledge**

A cursory examination of the WHO policy document shall *even* bear out the fact that this is more about the standardization of TM on the lines of 'modern' medicine and whole application of 'modern' epistemology over the traditional medicine than to develop a strategy to develop the TM on its *own* knowledge base. While the document generously refers to the 'positive' features of the TM like 'diversity and flexibility; accessibility and affordability…; broad acceptance …; increasing popularity…low cost; low level of technological input; and growing economic importance,' it cautions on the challenges like 'varying degree with which it is recognized by governments; the lack of *sound scientific evidence*…and the problems in ensuring its proper use' [xiv] (emphasis mine). It speaks of the 'some challenges' which 'are *common* to regions' (emphasis added):

> [T]he Chinese and Indian Governments are concerned with how best to use TM to strengthen primary health care in remote areas. In Africa, many countries are seeking means of making best use of local TM resources and how to make TM an integrated component of minimal health care packages. For European WHO Member States, safety and quality, licensing of providers and standards of training, methodologies, and priorities of research, have rapidly become issues of great importance[xv].

What is *common* in these supposedly 'common challenges'? In case of China and India, it is a simple policy matter (though political) of *expanding* the reach of Traditional Medicine to their remote areas for the TM stands already integrated within the national health policies. Africa is following them, but, in case of Europe these are the questions regarding recognizing a knowledge system on the conditions of 'safety', 'quality, 'licensing', 'training', 'methodologies and priorities of research.' This involves whole politics of knowledge.

One of the chief 'worries' for the WHO is that 'since TM/CAM practices have developed within different cultures in different regions, there has been no parallel development of standards and methods…for undertaking evaluation' and 'sound methodology is lacking' [xvi]. Traditional Medicine, like Ayurveda, has its set standard procedure of preparation which is laid down in the scriptures. In fact, the technological input in manufacture of the traditional medicine has to be *appropriate* and in accordance with the preparation procedure of the medicine. Each plant or herb has a unique medicinal value which can be obtained only through the standard procedure and the technological input cannot be blindly followed. Even if the case was not so, the indigenous practices of health care are rooted in the local knowledge which fairly understands the intricacies of the plant growth, medicinal value, ways of extraction and, above all, the maintenance of biodiversity. The India's National Policy categorically mentions that 'it is not desirable to subject all these (treatment, therapies and drugs of TM) to validation on modern scientific lines' precisely for the foundational knowledge base of these two does not match. This arbitrary imposition of a particular methodology born in 'value-free' environment on a so-called 'culturally born and belief embedded' medicine system highlights the mission project—Modernity.

The National Policy of ISM & H refers to earlier policies like National Health Policy [1983] which was the first institutional initiative to integrate ISM & H and subsequently the Central Council for Health and Family Welfare in 1999 recommended for the availability of 'at least one physician from ISM & H in every primary health care centre'. It also recommended for a creation of a separate wing within the 'existing state and district level government hospitals to extend the benefits of these systems to the public'[xvii]. Very importantly, it also resolved that the expenses on treatment taken in ISM hospitals 'should be recognized for reimbursement for the central government employees' which is unlike in the developed states where the expenses incurred on TM/CAM are not covered under social insurance. Despite this, as mentioned earlier, the ISM & H gets only 2 % of the total health budget in India. There is another dimension which needs attention to uncover another layer of *politics*: folk medicine. Whereas the National Policy admits that the folk medicine 'has not yet been fully taped' and makes a (slight but significant) mention of folk medicine, it completely ignores the folk veterinary medicine. The Policy aims to emphasize on research and *standardization* 'keeping in view the strengths of the systems (of medicine) and contemporary relevance,' it pushes folk medicine to further extreme margins and, thus, follows the footsteps of *giant* (the WHO). *This unique spherical marginalization has a unique concurrent way of functioning: marginalized marginalizes the marginalized.* As upon throwing a stone or pebble in a pond that every new wave pushes the earlier formed wave to extremes, so happens here.

**Traditional Medicine and Poor People: the trajectories of development and politics**

Traditional Medicine, as strategized by the WHO, is for whom, by whom and why—for both the people as well as states? The policy formulation has *three* major orientations of Integration, Inclusion and Toleration towards the TM determined by the placement of states in the 'Development Index' developed by the organizations like World Bank. The very presence of the World Bank in the WHO committee formed to chalk out the strategy for the TM is sufficiently indicative of obvious political game. The states that have somehow stable Human Development Index *tolerate* TM, the countries like UK and USA are constrained to *include* TM for the poor populations who cannot access 'modern' medicine for the lack of social insurance (and those who have social insurance cannot avail the benefits of TM under social insurance) and 'non-capitalist' states like China fully *integrate* TM. The developed countries do not perceive TM as an *alternative* rather as *complementary* to allopathic medicine. The role perceived for the TM in the developed countries is confined to the diseases like AIDS with an entire focus on 'curative' dimensions of TM. Interestingly AIDS, till now, to 'modern medicine is *incurable* and WHO, therefore 'prescribes' TM for it *may* mitigate the agony rather *cure* it. Contrarily to ISM, TM is a vast body of knowledge for the promotion of *good health* covering 'preventive, promotive [sic] (of good health),

mitigating and curative'[xviii] features of it. This underlines the two notions of human health in the two different knowledge systems.

While setting a role for herself, the WHO maintains that her 'principal, current objectives in TM/CAM are to provide *normative* and country programme support' [xix] to all the members states so that they frame a policy for its integration (in some countries), inclusion (in some), *rational use* (in all the countries) and emphasize 'on [its] access to poor populations'[xx]. The WHO 'is particularly active in supporting development of TM in Africa, South-East Asia and the Western Pacific'[xxi]. The WHO also provides 'guidelines' for, what it calls, the 'appropriate', 'effective' and 'rational' use of TM and it facilitates 'information exchange' through Collaborating Centres for Traditional Medicine. The *only* Collaborating Centre of the WHO for TM is at College of Pharmacy at the University of Illinois, Chicago USA, which develops *Monographs* of medicinal plants and provides 'information *free* of charge to developing countries'[xxii] (emphasis mine). This systematic and structural effort of 'providing information' results, firstly, in a huge supply (and smuggling) of medicinal plants from developing countries to the 'developed world' and, secondly, in a dominance of a particular knowledge system with a total disregard to 'traditional' or indigenous knowledge. It is also a concerted effort to *level* and *homogenize* the tremendously *diverse* and *heterogeneous* knowledge on the basis of so-called modern knowledge system which is foundationally blind to non-binaries.

**Conclusion**

The reach and desired dominance of 'modern' knowledge systems is quite vast. While these serve 'people', they disproportionately benefit their producers and entrepreneurs. One of the effective ways of legitimizing of creating huge revenue is to *destabilize* the very nature and foundation of the indigenous, folk and traditional, knowledge systems. The textual analysis of the two documents bears different trajectories of exercises of power out. If there are serious differences in the two documents, there are parallels as well. While the WHO tries to homogenize, standardize and rationalize the TM/CAM on the lines of 'modern' medicine, the National Policy attempts to integrate ISM & H at every level of health care *at the cost of vast untapped folk knowledge.* Both policies reflect multilevel contestation and politics of knowledge. The 'standardization' and 'rationalization' project of both the policies uncovers all together a different *political;* functional in knowledge of healthcare. The Intellectual Property Rights of both the systems of knowledge, which WHO document forcefully takes up for obvious reasons, *may* be recognized after analyzing implications of such acknowledgement[xxiii], we strongly believe that introduction of GIS into TM/CAM practices is indispensable to maintain the biodiversity and, more so, the medicinal value of the plants and knowledge of the 'local'. Unlike the (pre-programmed) role suggested for the social scientists by the National Policy on ISM & H to 'popularize' the TM, they must (and should) problematize it to uncover the politics of knowledge with an aim of realizing the dream of *democracy of knowledge.*

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**Notes and References**

[i] For a simple descriptive intertextual reading, see Javid Ahmad Dar (2019), 'Aftermath of Treaty of Amritsar (1846): Revisiting Accounts of Robert Thorp and Arthur Brinckman on Kashmir', *Research Review -International Journal of Multidisciplinary,* Vol. 4, No. 1 (January, 2019), pp. 2821-2825.

[ii] I have borrowed the phrase and the conceptual framework from Dr. Madhulika Banerjee (2009), *Power, Knowledge, Medicine—Ayurvedic Pharmaceuticals at Home and in the World,* Hyderabad: Orient BlackSwan.

[iii] Vaidya, A. D. B., (2005), "Effective Integration of Indian Systems of Medicine in Health Care Delivery: People's Participation, Access and Choice in a Pluralistic Democracy" in *Financing and Delivery of Health Care Services in India,* National Commission on Macroeconomics and Health, Ministry of Health & Family Welfare, Government of India, New Delhi, p-82.

[iv] *WHO Traditional Medicine Strategy 2002-2005,* World Health Organization, Geneva, 2002, p-1.

[v] Ibid, p-7.

[vi] *National Policy on Indian Systems of Medicine & Homoeopathy-2002*, Government of India, p-1.

[vii] Needful is to distinguish Indian State and Indian Society in this regard for the State has in its all practical functioning embraced 'modern' medicine and the latter continued with the traditional knowledge system and, despite the State

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apathy, the TM sustains its value and the consequent failure of the '*official*' to address the public healthcare made way for the 'integration' of ISM necessary.

[viii] WHO, pp. 8-9.

[ix] WHO, see Table 2, p. 10.

[x] Ibid, see Table 3.

[xi] *National Policy*, pp. 1 & 2.

[xii] Ibid, p-2.

[xiii] Ibid, p-3.

[xiv] WHO, p. 19.

[xv] ibid.

[xvi] Ibid, pp. 22 & 24.

[xvii] *National Policy*, p. 3.

[xviii] ibid, p. 8.

[xix] WHO, p. 29.

[xx] Ibid, p. 5.

[xxi] Ibid, p. 29.

[xxii] WHO, p. 34.

[xxiii] Kaushik Basu cautions against, what he calls, the 'colonization of future'. There are about 6 million ideas which are *owned* and are, hence, property of their producers and their legal heirs. There will be generations who will have 'claim' over the 'future output' facilitated by Intellectual Property Right. This shall create huge inequality in the world and be worse for the working class as 'wages will see a relative decline and rates of employment will fall'. See Kaushik Basu (2010), *Beyond the Invisible Hand—Groundwork for New Economics,* New Delhi: Penguin Books (also published by Princeton University Press, Princeton, USA) particularly Chapter 10.