Perspective

Unintended consequences of regulating traditional medicine

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ABSTRACT

The World Health Organization (WHO) has the noble goals of advancing traditional medicine and simultaneously promoting the regulation and professionalization of traditional healers. However, such regulation has the unintended consequence of withholding power from traditional practitioners. This review explores this concept through a historical analysis of traditional medicine in both India and Zimbabwe. During the post-colonial period in both countries, traditional medicine contributed to the creation of national identity. In the process of nationalizing traditional medicine, regulations were set in place that led to a rise in the university-style teaching of traditional healing. This period of professionalization of traditional healers resulted in certain types of traditional medicine being marginalized, as they were neither included in regulation nor taught at university. Since then, the current era of globalization has commoditized traditional healing. Private industries like ZEPL and Dabur have rapidly and vastly altered the role of traditional healers. Consumers can now buy traditional medication directly from companies without visiting a healer. Additionally, disputes over patents and other intellectual property rights have led to important questions regarding ownership of certain plants traditionally known for healing properties. Through regulation and commercialization of traditional medicine, healers have lost some of their independence to practise.

Key words: traditional medicine, healer, nationalism, globalization, regulation, professionalization, India, Zimbabwe.

INTRODUCTION

The World Health Organization (WHO) estimates that in certain African and Asian countries, 80% of the population depend on traditional medicine. The newly published WHO Traditional Medicine Strategy 2014–2023 has two key goals: to support Member States in harnessing the potential contribution of traditional medicine to health, wellness and people-centered health care; and to promote the safe and effective use of traditional medicine through the regulation of products, practices and practitioners.1

Prior to colonial rule

Prior to colonization, the ruling classes supported traditional medicine in both India and Zimbabwe. Local kings were responsible for the financial development of medicine.2 While this paper will not delve into the specifics of medical practices at that time, the diversity of legitimized medicine will be noted. Classical, folk, and religious medicines were all public forms of legitimate medical practices. Educational training occurred through individualized apprenticeship models or even at times through spiritual calling. However, the start of colonization saw an increase in interactions with biomedicine, which resulted in the propagation of scientific rationalization.

Irrational forms of folk and spiritual medicine were disregarded, while classical medicine such as Ayurveda and Unani, became textualized and standardized.3 In India, for example, Orientalists believed that the golden age of rationalized medicine had been diluted over hundreds of years by the plethora of folk and spiritual medicines prevailing throughout the country in the 18th and 19th centuries. They
saw classical medicines as more reliable, with rational, central, discrete theories. One could argue that traditional forms of medicine were obstructed due solely to pressure from British colonizers. However, it is essential to understand a nuanced argument in which both the nationalized state and private industry are largely responsible for the changes that weakened power from medical practitioners of indigenous medicines.

TRADITIONAL MEDICINE AND NATIONALISM

National identity through traditional medicine

There was strong congruence between indigenous medicine and nation-building in the post-colonial era. In India and Zimbabwe – both of which lacked a strong notion of “nation” due to the existence of different local ethnicities and languages – nationalists used indigenous medicine as a way to create a shared, unified national identity and disown colonial rule. In India, nationalists heavily contextualized Ayurveda within a Hindu and regional identity in order to reinforce nationalism. Ayurveda’s ancient and encompassing past was emphasized as a method of unifying local regions as well as glorifying Indian history. Thus, Indian medicine started to reinvent Ayurveda during the nationalist era. “Rational” Sanskrit texts were consolidated into volumes, while texts written in regional languages were marginalized.

Similarly in Zimbabwe, a sense of national identity was created through indigenous medicine during post-colonialism in the 1980s. Interestingly, nationalists used the name of a spirit healer – Nehandra Charwe, who led the first Chimurenga or revolutionary struggle in 1896 – as one of the key symbols of resistance to colonial rule. Almost 80 years after the first Chimuregna, nationalists again used spirit healers and indigenous practitioners to create bonds among ethnic groups, while disowning colonial beliefs.

Governmental regulation and marginalization

However, the creation of national medicine did not occur through a simple glorification of ancient traditional medicine. Rather, the governments of India and Zimbabwe attempted to generate national ownership by officially and legally including certain forms of traditional medicine in the healthcare system. This meant that if healers were not registered with the respective national medical councils, they were not legally able to practise. In Zimbabwe, ZINATHA (Zimbabwe National Traditional Healers’ Association), formed in 1980, provided certificates to healers that approved their practice. Similarly in India, the Central Council for Indian Medicine officially legalized “Indian medicine,” making only vaids and hakims with government certificates legal practitioners.

An examination of medicines approved as national medicine in both Zimbabwe and India highlights the marginalization of certain types of traditional medicines. Power in the newly independent nations was in the hands of people who had been educated through the colonial system. Thus, similar to colonials, the national governments showed support only for scientific forms of traditional healing.

In Zimbabwe, for example, even though nationalists initially idealized spirit healers like Charwe, ZINATHA did not recognize spirit healing as regulated national medicine. Indeed, government officials educated in elite schools portrayed spirit mediums as witchcraft. Thus, the nationalists themselves created a system of regulation that marginalized unscientific aspects of healing.

The process of officially adopting national medicines inherently creates a barrier, thus marginalizing certain medicines and significantly altering the diversity of indigenous medicine. Folk medicine was recognized for the first time by the Indian Government in 2002 in the National Policy on Indian Systems of Medicine and Homeopathy, and was thus finally endorsed as mainstream traditional medicine. However, Lambert highlights that haad vaids (bone doctors) were marginalized as their knowledge was not textualized. Similarly, dais (midwives) are considered neither as traditional practitioners nor as skilled birth attendants. Only since 2005 have certain states in India created Dai Training Programmes, attempting to bring midwives into mainstream traditional practices. Visha (poison) healers and folk psychiatric healers, again because of their oral-only and regionally diverse traditions, have also been excluded from the Indian Systems of Medicine.

Professionalization through universities

To validate national medicines, the governments of Zimbabwe and India set up systems to professionalize them through universities. This allowed direct national control over medical practitioners and ownership of the traditional medicine itself. In India, both public and private organizations created Ayurvedic universities. Similarly, ZINATHA created medical courses. India allowed experience-based registration prior to 1970; vaids and hakims who had completed an apprenticeship (traditional guru-shishya method) could demonstrate their ability to practise and earn national qualifications. However, post-1970, formal qualifications were only provided to vaids and hakims who trained at medical colleges for professional degrees. Thus, the national state controlled both how traditional medicine was practised and the medical educational model. By completely restructuring education into a university format, both the Government and the private sector pulled power away from local indigenous practitioners.

While universities have helped regulate traditional medicine with the intention of creating adequate medical practitioners, there are various negative consequences of university-
setting Ayurveda and Unani education. Langford, through an ethnographic analysis of various Ayurvedic colleges, demonstrates the heavy influence of biomedicine at these colleges. Instead of first understanding a patient’s doshas (Ayurvedic method of understanding body composition), students identify the biomedical disease and subsequently apply a dosha to the ailment. Most students interviewed stated that they planned to use their Bachelor of Ayurveda, Medicine and Surgery (BAMS) degree in a career in Ayurveda and biomedicine.19 This is mirrored by Nisula’s study of Ayurvedic practitioners in Mysore, India who believed it was necessary to integrate modern medicine into Ayurveda for it to be popular.20

The 2002 National Policy on Indian Systems of Medicine and Homeopathy 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.”21 Thus, there was an understanding that current traditional medicine universities had become too heavily focused on biomedicine. With regard to the wave of professionalization, the Policy stated that “the deep interest in the biomedical model of health has often been prompted by considerations which are not always rooted in concern for the health of citizens.”22 Professionalization and regulation of traditional medicine should therefore be modified to allow its niche in public health.

Globalization and commoditization of traditional medicine

Globalization led to another trajectory of nations or states reducing power from traditional practitioners. In parallel, private industries started to profit from indigenous knowledge, selling traditional medicine pharmaceuticals nationally and internationally. Two examples of this follow.

In Zimbabwe, ZINATHA Enterprises Private Limited (ZEPL) formed a public–private partnership to manufacture traditional drugs. ZEPL propagates that industry standardization provides more accurate and hygienic doses than can healers. In this way, ZEPL uses standardization to delegitimize medicines created directly through practitioners. Further, decoctions and balms were transformed into pills to make a more easily usable product; and unscientific native medicines like love potions were never manufactured.23 Thus, drug companies significantly diminished the vast diversity of indigenous pharmaceuticals in order to match a rational and somewhat biomedical trajectory.

In India, international pharmaceutical companies started selling Ayurvedic pharmaceuticals directly to patients. Banerjee demonstrates a change in Dabur’s customer base through the company’s advertising strategies over time.24 Originally, Dabur’s advertisements featured traditional vaids asserting that the company’s prepackaging improved the ability of vaids to provide medicines to their patients. Interestingly, initial adverts portrayed Dabur products as sustaining the traditional aspects of Ayurveda. However, recent adverts focus on the ability of Dabur to modernize Ayurveda, showing, for example, women using Dabur traditional Ayurvedic products to attain a modern image of beauty and health. By changing marketing strategies, companies like Dabur and Himalaya now provide off-the-shelf Ayurvedic products directly to patients.

In both Zimbabwe and India, the direct interaction between pharmaceutical companies and patients has slowly decreased the need of the traditional medical practitioner. Moreover, forms of medicine that cannot be directly pharmaceuticalized like bone-fixing are deeply marginalized.25

Intellectual property

The global era has also led to a new interplay between pharmaceutical companies and national governments. Indigenous medicines have become international commodities driven by both market and cultural nationalism. Building on the concept of national medicines developed in the post-colonial era, medicines are redefined along nationalist lines and non-textual knowledge is moulded into a property that must be protected by the government.

Various international and national initiatives have sought to prevent erroneous patents on traditional medicines. 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.22 The Library documents traditional medicinal practices in India, and presents the information in such a way that it can be checked by international patent offices, thereby preventing the granting of erroneous patents on traditional medicines.

However, as discussed above, the process of commoditization in our global economy reduces the power of traditional practitioners. Often, local practitioners using traditional medicine knowledge are not given their due credit,26 a situation recognized by the 2002 National Policy on Indian Systems of Medicine and Homeopathy. While it is essential to place traditional medicine in a global context, local medicinal practitioners should be given rightful credit and financial benefit for their work.

CONCLUSION

In both India and Zimbabwe, the government and private pharmaceutical companies function as hegemonies that sap the ownership of indigenous medicine from native practitioners. During the post-colonial era, nations started to regulate and professionalize indigenous medicine to create a sense of national identity and unity. The globalized era accelerated this sense of ownership, as both pharmaceutical companies and national patent systems commoditized fluid knowledge into property. While organizations like WHO laudably support traditional medicine through regulation, such agendas may tie the hands of native practitioners to the point that true indigenous medicine can no longer exist. It is therefore important to strike a balance so that regulation and globalization of traditional medicine do not eliminate native traditional healers – the very source of traditional medicine.
REFERENCES


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