Health and Wellbeing: Role of Traditional Medicine Practises in India and Southeast Asia

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Abstract

Traditional medicine constitutes a well-established science and practice within the domains of medicine and healthcare, enduring through generations and often perceived as an alternative to Western medicine, especially within Southeast Asian communities. Historically, both flora and fauna have been utilized as sources of medicinal compounds, and even in the present day, systems reliant on these natural resources continue to hold importance in healthcare. The understanding of health within traditional medicinal paradigms is shaped by a broad spectrum of spiritual and empirical influences. These influences include religious and philosophical systems followed by vast populations, as well as local folk beliefs, each uniquely distinct. Health crises have a profound impact on developmental activities worldwide, necessitating the mobilization of political, financial, and technical resources on a global scale. In Southeast Asia, for millions, traditional healing or medicine serves as the primary means of addressing physical, mental, and emotional distress. For those who consistently engage in traditional healing practices, illness is understood not just as a specific organic disorder but as a disruption of the physical, mental, and emotional balance within their community. This balance is shaped by the socio-cultural environment, spiritual beliefs, and

divine principles. This present paper will try to find out, how traditional medicine practices has been dealing with diseases, in India and Southeast Asia. Simultaneously, present study will also try to understand the interconnection between health care system and traditional systems of medicine practised in South-east Asia in context of health and wellness of people. Also, this study will try to comprehend the relevance of the traditional medicine system and health seeking behaviour during Public Health Emergencies in South East Asia. Proposed study will use secondary data from literatures.

Introduction

Traditional medicine (TM) includes a wide array of medical systems, such as traditional Chinese medicine, Arabic Unani medicine, Indian Ayurveda, along with numerous indigenous healing practices. In circumstances where allopathic medicine serves as the predominant healthcare system, or where TM has not been formally integrated into national health policies, it is typically classified as "complementary," "alternative," or "non-conventional" medicine (Alves and Rosa, 2007: 1).

Authors Ales and Rosa (2007) emphasize that traditional medicine (TM) remains a vital component of healthcare systems, particularly in developing nations where it is extensively utilized by substantial segments of the population. Historically, TM has served as the primary healthcare framework in numerous cultures, addressing both preventive and therapeutic needs. The interconnections between public health, TM, and biodiversity conservation are increasingly acknowledged as areas of significant importance, reflecting broader global health and environmental challenges. This perspective aligns with the World Health Organization's (WHO) the objective is to advance health outcomes and preserve lives by guaranteeing the quality, effectiveness, safety, and rational application of all medications, encompassing traditional therapies.. Moreover, the WHO champions equitable and sustainable access to essential medicines, with a particular emphasis on reaching underserved and marginalized populations (Alves and Rosa, 2007: 07).

In Asia, Traditional medicine has long been widely accepted at the community level and has received formal recognition for several aeras. In 1956, Vietnam became the first nation in Asia to

formally incorporate its traditional medicine system into the national healthcare framework. China followed suit in 1958, and India did so in 1970. Historically, this system has operated on two parallel tracks, with consumers independently choosing between them. It has not constituted an integrated clinical model of care that combines the advantages of both systems to meet consumer needs. However, this situation is now beginning to evolve. Initial collaborative investigations in China into traditional febrifuges led to the recognition of the herb *Artemisia annua*, historically utilized for the treatment of hot-cold fevers, which are now identified as malaria.. This line of research eventually culminated in the detection of the *sesquiterpene lactone artemisinin*. This facilitated the emergence of a novel class of antimalarial drugs and led to the awarding of the 2015 Nobel Prize in Physiology/Medicine to Professor Tu Youyou of China's Yunnan Institute of Pharmacy and Shandong Institutes of Parasitology (Bodeker. G, 2021 :28).

Alves and Rosa (2007), drawing on earlier works by Lee (1992) and Labadie (1986), highlight that traditional medicinal systems are increasingly being formally acknowledged and respected on a global scale. The increasing legitimacy of traditional medicine, combined with its prevalent use in the rising need for affordable and alternative therapeutic solutions in both developing and industrialized countries underscores the global significance of promoting research and development in the area of traditional pharmaceuticals. Furthermore, in their examination of traditional medicine, Alves and Rosa refer to Bodeker and Kronenberg (2002), who argue that the expanding recognition of traditional medicine is significant not only for its potential to contribute to new drug discoveries but also for its embedded socioeconomic, environmental, and cultural value. Bodeker and Kronenberg emphasize that public health researchers should take a leading role in establishing research agendas that are responsive to the broader political, social, cultural, and economic dimensions in which traditional medicine is practiced, thereby enhancing its integration and effectiveness within global health systems (Alves and Rosa 2007: 7).

The *WHO International Standard Terminologies on Siddha Medicine* underscores the significance of traditional, complementary, and integrative medicine (TCIM) plays an important role in promoting health and well-being. According to the WHO Global Report on Traditional and Complementary Medicine 2019, nearly eighty eight percentage of WHO associate States have officially recognized the incorporation of traditional and complementary medicine into their healthcare frameworks within their healthcare systems. As part of its 13th General programme of work, the WHO is actively supporting nations in their efforts to achieve universal health coverage

and meet health-related SDGs. Acknowledging the increasing relevance of traditional medicine in both national and international contexts, WHO and its Member States have committed to developing mechanisms for the appropriate and evidence-based integration of complementary and traditional medicine into formal healthcare systems (Jakab, 2022).

In the context of Southeast Asia, WHO notes that traditional medicine has been historically embedded in diverse health practices throughout the region. In many remote and underserved areas, traditional healers continue to serve as primary, and sometimes the sole, healthcare providers. Consequently, most Southeast Asian countries have integrated traditional medicine into their national healthcare frameworks to address diverse requirements.

In response to the Delhi Declaration on Traditional Medicine in 2013 and the succeeding endorsement of the WHO Traditional Medicine Strategy 2014-2023, a regional action plan was developed in October 2015. This plan outlines 5 strategic focus areas: monitoring of traditional medicine structures, promoting research on system organization and supervision, strengthening the capacity of traditional medicine practitioners, establishing mechanisms for reporting adverse events, and enhancing communication strategies to support the safe and effective practice of traditional medicine.

Author Payyappallimana (2009) studied and cited work of Nambiar et al. (2007) and Janska (2005) which argued that the persistent prevalence of communicable diseases, including malaria, HIV, other parasitic infections, diarrhea, pneumonia, and TB, alongside chronic conditions such as ischemic heart disease and diabetes, constitutes a significant public health challenge, often referred to as the "double burden" of disease. These health issues continue to adversely affect populations in these countries. Additionally, the high rates of maternal and child mortality, coupled with rapid demographic variations and urbanization, signify significant public health challenges in these economies. Furthermore, the underutilization of public health services, unsuccessful health support systems for impoverished populations, increasing privatization of healthcare facilities, environmental changes, migration of medical professionals, and associated epidemics further worsen these concerns. In countries such as India, high out-of-pocket healthcare expenditures, which account for approximately 78%, coupled with inadequate health insurance and social security systems, present significant concerns. Furthermore, in the context of globalization and the World Trade Organization (WTO) regime, there is a recognized challenge concerning the increasing inaccessibility of healthcare services for economically underprivileged

residents within these societies. As Nambiar et al. have observed, a fundamental challenge for healthcare planners is the integration of health promotion and disease prevention with the treatment of acute illnesses and chronic care. This integration must occur at all stages of the health service system, with the objective of delivering quality services efficiently and equitably to the entire population (Payyappallimana, 2009: 67).

Similarly, The United Nations' Millennium Development Goals (MDGs), alongside strategies from the WHO and initiatives by the United Nations Human Rights Office (UNHCHR), emphasize the urgent need to improve healthcare access. However, this remains a significant challenge both globally and nationally due to the complex nature of 'access,' which includes physical, social, political, and economic factors. In 2005, the World Health Assembly adopted key resolutions aimed at addressing the human resource crisis, enhancing the health of the most impoverished populations, improving the health outcomes for children and women, promoting healthy aging, and combating microbial resistance and cancer through preventive and control measures are critical areas of focus (Payyappallimana, 2009: 67).

Here, authors Singh and Madhavan (2015) found in their study which revealed several important results regarding the use of non-traditional versus traditional healing practices. Firstly, traditional healing is significantly less prevalent than non-traditional healing in both urban and rural settings. Secondly, this tendency persists across all socioeconomic and demographic groups, with traditional healing being significantly less utilized. Thirdly, there is a slight increase in the use of traditional healing in rural areas among Scheduled Tribes and Minorities (STMs) compared to urban areas. Fourthly, traditional healing is more normally employed for certain diseases, such as asthma, cataracts, leprosy, polio, epilepsy, paralysis, and mental illnesses. Notably, the highest usage of traditional healing is observed for epilepsy in rural areas and for mental illness in urban areas. Fifth, the overall care expenses and the average waiting time at healthcare facilities or in getting healthcare services are significantly higher for non-traditional healing compared to traditional healing in both rural and urban settings. Finally, among patients who use both traditional and non-traditional healing methods, there is a clear preference for non-traditional healing when treating serious, long-term illnesses. In contrast, they tend to use traditional healing supplemented with non-traditional methods for short-term sicknesses. (Singh and Madhavan, 2015: 1236).

Background of the Study

The authors refer to Huang's (1999) examination of Chinese traditional medicine, which outlines its long-standing historical roots. Chinese medical practices are documented as early as 1100 BCE through the Wu Shi Er Bing Fang, which catalogued 52 medicinal substances. This was followed by the Shennong Bencao Jing around 100 BCE, listing 365 herbal remedies, and later by the Tang Materia Medica in 659 CE, which expanded the compendium to 850 medicinal substances. Dev (2001) explores the ancient beginnings of Indian traditional medicine, tracing its origins back more than 5000 years. He cites the Charaka Samhita and Sushruta Samhita, which document 341 and 395 herbal remedies, respectively, dating to approximately 1000 BCE. Meanwhile, the ancient Western world also experienced notable advancements by Roman and Greek medical practitioners. For example, around 100 CE, Greek physician Dioscorides, meticulously recorded the classification, preservation, and use of traditional medicines throughout the known world of his time.

Kassaye K. D. et al., (2006) say in their study that, traditional treatment has maintained its acceptance in most of the world particularly in developing region and its use is quickly scattering in the industrialized regions. While giving an example, they gave an example of China, and it reveals that traditional herbal remedies represent 30-50 per cent of the total medicinal consumption. In nations such as Mali, Nigeria, Zambia and Ghana, herbal medicines serve as the initial treatment for 60% of children suffering from high-grade fever due to malaria, typically administered at home. According to the WHO, traditional birth attendants act significantly in the majority of childbirths across several African countries (Kassaye K. D. et al., 2006: 127).

Adhikari & Paul (2018) cited Ringler et al. (2016) study, which highlights in their research that natural products, often promoted as herbal or dietary supplements, make up about half of the top fifty pharmaceutical products available in European pharmacies. In addition, modern pharmacopoeia still heavily relies on nature, with over a quarter of today's medications being sourced from or inspired by natural plants (Adhikari & Paul, 2018). The authors also reference the WHO's (2000) definition of traditional medicine, which contains the practices, knowledge, and skills in the ideas which are rooted in beliefs and practices among indigenous to various cultures. These regular practices, whether or not they have been scientifically validated, are applied in the preservation of health and in the same prevention, treatment, enhancement, or diagnosis of both physical and mental health conditions. Adhikari and Paul (2018) cited work of Wah et al. (2014)

and finds observe that traditional medical systems are practiced across the globe, shaped by diverse belief systems and socio-cultural factors. Among these, Ayurveda, a branch of traditional Indian medicine, is recognized as one of the most ancient and philosophically rich healing practices (ibid, 2018: 421).

Here, the curative knowledge and healing idea embedded within Indian historical or traditional medicine knowledge has given rise to a range of regionally significant systems, each characterized by distinct or overlapping theoretical frameworks and practices. Following India's independence, the establishment of the Planning Commission in 1951 marked a step toward structured health planning. Subsequently, the *Department of Indian Systems of Medicine and Homoeopathy* was established in 1995 to focus specifically on these traditional medical practices. In 2003, it underwent a name change to AYUSH, which stands for "Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy", and it became an independent unit under the MH&FW, Government of India.

Even though modern pharmaceuticals dominate the market and allopathic medicine enjoys widespread public trust, traditional Indian medical systems still encounter institutional and systemic obstacles. It is crucial to integrate and organize these indigenous practices into a cohesive framework and progressive framework aimed at preserving and promoting India's rich medical heritage. To this end, Adhikari and Paul (2018) advocate for sustained phytochemical and biochemical research, alongside efforts to rejuvenate and disseminate traditional Indian medical knowledge for the broader benefit of society (Adhikari and Paul, 2018: 425).

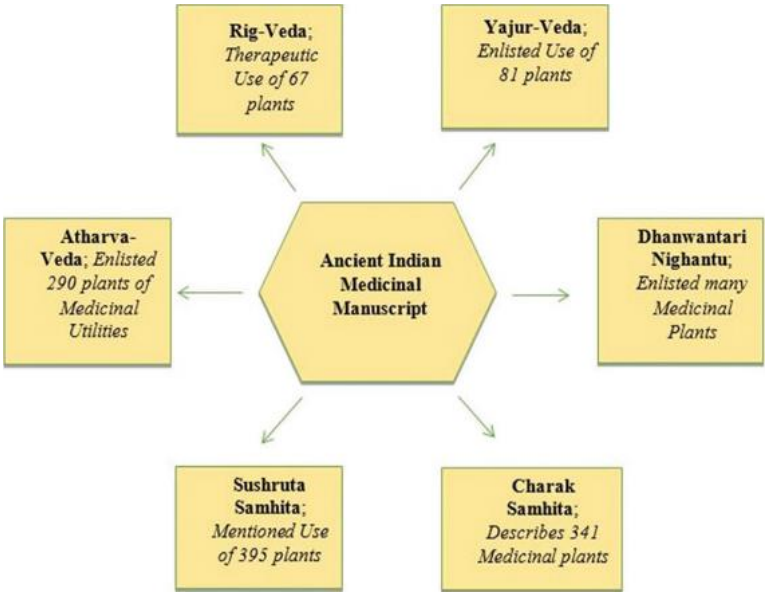


FIG 1: Enlisted plants of the ancient Indian medicinal manuscript

Source: Adhikari and Paul, 2018: 425

The referred article, including "Charaka Samhita" in the year 990 BCE, "Sushruta Samhita" in the year 660 BCE, and "Dhanwantari Nighantu" in the year 1800 CE, extensively detail the use of tree or plants and complex herbal combinations. Figure 1 offers additional insights into these ancient Indian medical texts.

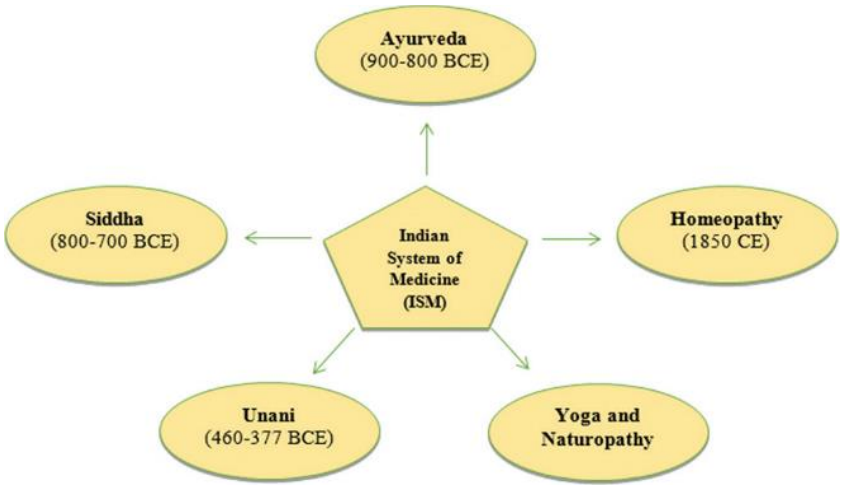


FIG 2: Systems of Indian Medicinal Practice

Source: Adhikari and Paul 2018: 425

Kumar et al., (2007) define traditional medicine of India as encompassing both indigenous medical practices and those introduced from other regions that have been culturally assimilated over time, as illustrated in Figure 2. India is distinguished by its officially recognized array of traditional medical systems, which include Naturopathy, Siddha, Yoga, Ayurveda, Homoeopathy and Unani. Although in 18th century Homoeopathy was introduced to India, it has been thoroughly integrated into Indian cultural and therapeutic frameworks. Over time, it has evolved and developed in parallel with other indigenous systems, ultimately becoming an enriched component of India's traditional medical heritage (Adhikari & Paul, 2018: 422).

In the year 2013 while discussing discussion on CAM, author Andrew emphasizes the potential benefits of these approaches in both treating and managing ill-health, as well as in promoting and maintaining overall health and healing. CAM practitioners clearly articulate the potential they perceive, as demonstrated by their promotion of specific modalities and related treatments. The author elaborates on their therapeutic approach, which involves viewing the individual as an

integrated entity within their life context. This method includes addressing and mitigating symptoms associated with specific conditions, uncovering the fundamental causes of health issues, and enhancing a strong sense of health and well-being. Furthermore, it aims to empower individuals to regain or improve their autonomy over their health and to identify effective coping strategies. A significant and expanding body of evidence supports these viewpoints. To try to of set increasing polypharmacy (individuals using excess drugs at same time) gradually found in the situation of older persons with multiple co-morbidities, estimated at 40% of USA seniors citizens, for instance, on the possible of mind-body interventions, to assist in stress decline with consequent cooperative effects on blood pressure levels and risk of heart attacks. In the same situation, it is also good evidence of the usefulness and effectiveness of acupuncture to treat low neck pain and low back pain, chronic knee, and a potential role in treating *gastro-oesophageal* disease (Andrew, 2013: 04).

A comparative analysis of "Traditional Indian Medicine (TIM) and Traditional Korean Medicine (TKM)" reveals that, despite their distinct origins, these two medical systems share numerous similarities. Both systems prioritize the individual over the disease and emphasize therapeutic practices aimed at disease prevention rather than treatment. Their primary objective is to maintain good health and boost the quality of life for individuals. TIM and TKM have successfully coexisted with conventional medical practices on both local and global scales, despite the persistent challenges presented by the latter. The notable parallels between TIM and TKM can likely be ascribed to the similar traditional and complementary medicine (T&CM) educational frameworks in both countries (Kang et al., 2017 :112).

Authors Upchurh and Rainisch (2015), while talking on CAM and use as health self-management of the socio-behavioral wellness model, also consider CAM as one aspect of healthy self-care. Self-management of health refers to activities individuals engage in to sustain their health and wellness, to prevent illness and disease, or to manage illness. Segregating CAM use for wellness and health versus treatment is essential because factors that contribute to each type of use are probably different (Upchurh and Rainisch, 2015: 02).

Kassaye K. D. et al., (2006) the research indicates the absence of training institutes dedicated to traditional medicine. It is widely recognized that trained healers are adept at rapidly acquiring and integrating new knowledge into their practices. Furthermore, the training of sufficient modern health specialists can improve the understanding of traditional medical systems. The knowledge

acquired by professionals in both medical systems may foster shared respect, empathetic, fruitful collaboration, and the delivery of effective health services (Kassaye K. D. et al., 2006: 132).

The existence of numerous potentially valued medicinal plants is gradually threatened by environmental degradation, deforestation, agricultural expansion, overgrazing, and rapid population growth. This tendency poses a significant risk to the ethnobotanical and other natural resources of the country, particularly in the highland areas. The primary factors causative to this issue include overpopulation, lacking environmental policies, and the lack of effective implementation of existing regulations. (Kassaye K. D. et al., 2006: 132).

Objective of the Study:

1. How traditional medicine practices has been dealing with diseases, in India and Southeast Asia.
2. The present study will also try to understand the interconnection between the health care system and traditional systems of medicine practised in Southeast Asia in the context of the health and wellness of people.

Methodology

The proposed study will use secondary data/ information from the literature. This study also used thematic analysis of qualitative information and developed the core argument thematically. Different sources like research journals and organizations' reports have been taken into consideration as secondary data.

Discussion and Findings

South Asian medical systems have historically developed within distinct political and institutional frameworks. In contrast to South Asia, Chinese medicine benefited from the centralized and stable bureaucratic structures of imperial China, where successive dynasties actively supported the codification and expansion of medical texts—positioning traditional Chinese medicine as a state-driven initiative. In the 20th century, this trajectory continued under the Communist regime, particularly during the *Great Leap Forward* and subsequent socialist healthcare reforms, reflecting a continued pattern of strong state involvement in medicine. Conversely, South Asian medical traditions such as Sowa Rigpa, Siddha, Ayurveda, Unani, and local-specific medicinal plant

systems evolved under the patronage of various monarchs and dynasties. Their encounters with colonial powers subjected them to varying degrees of marginalization, suppression, and neglect, with state policies after independence remaining inconsistent and often ambivalent. However, with the global rise in acceptance of yoga and Asian traditional medicines, countries like India undergoing neoliberal economic reforms and a resurgence of cultural nationalism in the 1990s began to renew institutional interest and policy support for traditional medicine systems (Sujatha, 2020: 9).

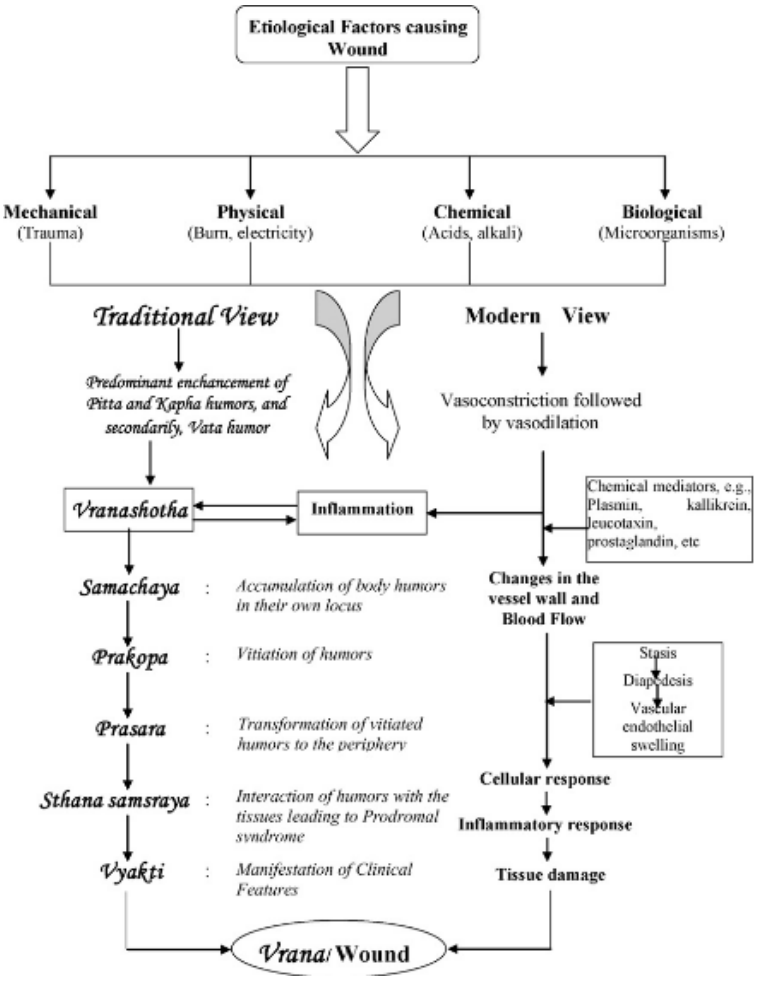
While talking on Need of Traditional Medicines here author Ghatak, S (2021) expressed that, the rise of non-communicable and lifestyle diseases has emerged as a significant threat to human survival globally, with India and the Association of Southeast Asian Nations (ASEAN) countries being no exceptions. In 2019, India reported that non-communicable diseases accounted for 64% of its total mortality, with cardiovascular disease contributing 27%, respiratory disease 12%, stroke 7%, and diabetes 5%. The ASEAN countries encountered comparable issues, as non-communicable diseases were more prevalent than communicable diseases during the same year. Additionally, the incidence of mortality attributable to noncommunicable diseases has markedly increased in nearly all ASEAN countries, with the exception of Singapore, as well as in India, during the period from 1990 to 2019 (Ghatak, S, 2021: 02).

Ayurveda:

According to Prasad (2001), the word *Ayurveda* comes from the Sanskrit terms *"ayur" (life)* and *"veda"* (science or knowledge), which translates literally to "The Science of Life." It embodies a structured philosophy focused on balanced and harmonious living, with its conceptual origins found in ancient Indian scriptures like the *Rigveda* and *Atharvaveda*. Mukherjee further notes that while the precise origins of Ayurveda are obscured in antiquity, its theoretical foundations and practices were significantly refined between 2500 and 500 BCE. The Ayurvedic tradition emphasizes the utilization of natural resources, shaped through continuous observation, empirical practice, and experiential learning over generations. Central to Ayurvedic treatment is a two-fold principle: the prevention of disease and the cultivation of patient awareness regarding the underlying causes of illness. At its core, Ayurveda aims to guide individuals in navigating both a joyful and distressing life experience, as reflected in its holistic vision of health and well-being (Adhikari & Paul, 2018: 422).

When we discuss about the Empirical Foundations and Medicinal resources in Ayurveda author Kumar et al. (2007), referencing the work of Biswas and Mukherjee (2003), highlight that the Indian traditional medical system is grounded in empirical knowledge accumulated through centuries of observation and experiential learning. Classical Ayurvedic texts document over 1,200 distinct diseases, with their management involving a diverse range of therapeutic agents. Specifically, more than 1,000 medicinal plants (comprising 89.93% of the total), 58 types of raw materials, metals, rocks or ores (5.24%), and 54 animal or materials from sea substances (4.86%) are utilized in various research and formulations (Kumar et al., 2007: 104). This comprehensive pharmacopeia reflects the extensive biodiversity and rich traditional knowledge systems embedded in Ayurveda.

The author Kumar et al. (2007) also said that Ayurvedic Understanding and Classification of Wounds healing, a critical domain in clinical Ayurveda, is extensively discussed under the term *Vranaropaka*. The earliest conceptualization of wounds, termed *Vrana*, is attributed to Maharshi Agnivesha in the *Agnivesha Samhita* (later incorporated into the *Charaka Samhita*), with further elaboration provided by Maharshi Sushruta in the *Sushruta Samhita*. These texts describe *Vrana* as a disruption in the integrity of a body surface that, upon healing, leaves a permanent scar a definition comparable to modern understandings of wounds. Inflammation, or *Vranashotha*, is recognized in Ayurvedic literature as a primary phase in wound pathology. The categorization of wounds includes both endogenous causes stemming from imbalances in the bodily functional entities *Pitta* (enzymatic and hormonal activity), *Picchita* (contusions), *Kapha* (body fluids) and *Vata* (nerve impulses) as well as exogenous causes, such as physical trauma. These trauma-induced wounds are further classified into types such as *Kshata* (lacerations), *Viddha* (puncture wounds), *Chinna* (incised wounds), *Bhinna* (perforated wounds), and *Ghrishta* (abrasions) (Kumar et al., 2007: 105).



Source: Kumar et al., 2007: 105

Fig 3: Representation of etiopathogenesis of the wound in modern medicine and Ayurvedic.

Here author Kumar et al., (2007) trying to find out the periods of wound curing outlined in conventional Ayurvedic manuscripts exhibit significant parallels with those recognized in modern medical science, as illustrated in Figure 3. According to the *Sushruta Samhita*, traditional wound management is structured into sixty therapeutic steps, beginning with the application of aseptic dressings and culminating in the complete restoration of normal anatomical structure and physiological function. These interventions were designed not only to promote effective and timely healing but also to preserve the functional integrity and aesthetic appearance of the affected area. Classical Ayurvedic references including the *Dhanwantari Nighantu* (circa 1800 CE), *Sushruta Samhita* (circa year1000 BCE), *Astanga Hridaya* (circa year 600 CE), *Bhavaprakash Nighantu* (circa year 1500 CE), *Charaka Samhita* (circa year 5000 BCE), and *Ayurveda Siksha* (20th century CE)-suggest that approximately 70 per cent of Ayurvedic formulations used in wound healing are

derived from plant-based substances, with 20 per cent of mineral origin and the remaining 10 per cent sourced from animal products (Kumar et al., 2007: 104).

Biswas and Mukherjee (2003), as referenced in Kumar et al. (2007), further underscore the traditional application of these Ayurvedic formulations in addressing a diverse array of wound-related conditions. These conditions incorporate *Vrana* (wounds or ulcers), *Vidradhi* (abscesses), *Bhagandara* (fistula-in-ano), *Pramehapidaka* (diabetic carbuncles), *Upadamsha* (syphilitic ulcers), *Vranajakrimi* (maggot-infested wounds), *Dustavrana* (infected wounds), *Nadivrana* (sinus tracts), *Vranashotha* (wound inflammation), *Vranavisha* (cellulitis), *Ugravrana* (purulent ulcers), *Netravrana* (styes or eyelid infections), and *Visarpa* (erysipelas). Furthermore, systematic research have been conducted to substantiate the injury-healing efficacy of several of these traditional remedies (Kumar et al., 2007: 104).

According to the Indonesian Country Study on Biodiversity in 1993, the estimated range of different flowering plant species in Indonesia is between 25,000 - 30,000. Historically, herbal medicines have been utilized by almost 40 million Indonesians for both disease prevention and treatment. The Indonesian populace employs about 6,000 plant species for medicinal purposes. It is noteworthy that the data regarding the quantity of medicinal plants establishes variability. PT Eisei in the year 1995 revealed in a publication, which was "Dictionary of Indonesian Medicinal Herbs", which encompasses and includes over 2,500 plant species with potential for medicinal development. Additionally, the author referenced the work of Zuhud et al. (2001), who discover 1,845 species with potential medicinal plant in the forests (Elfahmi, 2014: 03).

While discussing on Jamu as a way of traditional and conventional curative and Rational ‘phytotherapy’ with jamu and phytomedicine author Elfahmi et al. (2014) analyses and found that WHO also suggested Jamu, a traditional form of medicine deeply rooted in historical experiences and cultural traditions, is in a state of perpetual evolution and development. Like old practice medicine, it encounters challenges concerning its appropriate and rational application. These challenges include ensuring the eligibility and licensing of practitioners, the appropriate utilization of high-quality products, effective communication between traditional medicine practitioners and patients, and the distribution of scientific & logical information and guidance to the public (WHO, 2002). The WHO backing and supports the use and growth of traditional medicine as a means to

provide accessible and affordable healthcare for all individuals (WHO, 2005). Here author also indicate that, despite the certification of the pharmacological effects of certain jamu components, there remains a very significant glitch in the literature regarding the efficacy of jamu medicine, particularly jamu gen-dong. To promote the proper utilization of these products, the Indonesian government, through the National Agency of Drug and Food Control (NADFC), has classified medicinal plants into three distinct categories. This classification is based on their preparation methods and the evidence supporting their efficacy: jamu, standardized herbal medicines (Elfahmi, 2014: 06).

Siddha

WHO here mentioned that Traditional medicine has been historically utilized for the promotion of health, as well as for the prevention and treatment of various diseases. As reported in the second Global Survey conducted by the WHO, Siddha medicine is acknowledged as a widely use form of traditional and complementary medicine by many members from states. In this context, the development of WHO's global standard vocabularies on Siddha remedy represents a essential initiative and crucial step toward ensuring the safety, efficacy, and global recognition of Siddha-based healthcare services.

The WHO document further notes that the development of these standard terminologies occurred between 2019 and 2022, supported by extensive technical collaboration. Contributions were made by a diverse group of international experts and institutions across WHO regions, including professionals specializing in Siddha medicine, other traditional medical systems, medical linguistics, and the Tamil language. This collective effort aimed to enhance the consistency and clarity of Siddha medical terminology, thereby facilitating its integration into global health discourse and practice.

Here, author Sebastia (2019) outlines that the Siddha corpus, comprising elements such as magic, asceticism, alchemy, medicine and astrology, along with related fields like botany, toxicology and physiology, is traditionally attributed to the *cittarkaḷ*-spiritual adepts. While Tamil tradition identifies eighteen such figures, a survey of historical texts and authored manuscripts suggests that the number may exceed ninety (Sébastia, 2018; Venkatraman, 1990). Drawing upon Jolly (1994),

Sébastia highlights a key distinction between the Siddha and Ayurvedic traditions in terms of their origins and modes of knowledge transmission. Whereas Ayurveda traces its divine and genealogical foundation to the Vedic pantheon, beginning with Brahma and continuing through Prajāpati, the Aśvins, Indra, and various Ṛṣis, with figures like Ātreya, Suśruta, and Caraka serving as the primary textual authorities, Siddha medicine developed independently, rooted in a Tamil heterodox framework. This tradition is marked by tantric influences, emphasizing devotion to the Śiva-Śakti principle (the union of masculine and feminine forces), and is characterized by anti-Brahmanical and anti-ritualistic orientations. These ideological and devotional undercurrents continue to inform the Siddha milieu, as evidenced in its practice beyond India, including in Singapore, where Siddha medicine is embraced by practitioners across various groups of castes and religious backgrounds (Sebastia, 2019: 4).

Further, Sebastia observes that numerous clinics in India, especially those near the Kerala border, display dual signage for Siddha and Ayurveda, indicating a degree of terminological and institutional overlap. This may be attributed to the global prominence of Ayurveda, which often overshadows the lesser-known Siddha system. Nonetheless, historical and ethnographic accounts such as that of Frederick C. Colley (1978) suggest that a pluralistic approach to traditional medicine is common in the Indian diaspora, particularly in Malaysia. Colley notes that Indian practitioners in Malaysia often integrate multiple AYUSH systems-including Homeopathy, Ayurveda, Unani, and Siddha-into their medical practice. Each system is perceived to offer distinct benefits: Ayurveda is valued for its plant-based tonics and nutritional therapies, Unani for its unique remedies and appeal to Muslim patients, Siddha for its potent mineral-based formulations, and Homeopathy for its effectiveness in managing chronic illnesses over extended periods (Sebastia, 2019: 5).

Unani

Unani medicine is widely recognized as a significant traditional healthcare system practiced across various parts of the world. In this context, the establishment of standardized terminology specific to Unani medicine is considered essential for the development of associated standards, guidelines, classifications, and regulatory frameworks. A globally accepted vocabulary facilitates the integration of Unani medicine into formal health systems and enables international comparison,

evaluation, and exchange of information. The standardized terminologies are intended to support not only Unani practitioners but also policymakers, healthcare service providers, academician, researchers, and the common public in adopting unified concepts, definitions, and communication practices within healthcare delivery, documentation, and policy development (WHO, 2023).

Although Unani medicine has a longstanding history in promoting health and preventing and treating disease, efforts to standardize its educational, clinical, and research frameworks remain underdeveloped at the global level. According to the second global survey WHO, Unani treatment is acknowledged as a prominent traditional and complementary medicine system by several Member States. In response, the development of WHO's International Standard Terminologies on Unani Medicine has emerged as a critical initiative for ensuring the safe, effective, and coherent delivery of Unani-based healthcare services. Despite growing demands for standardization in training, education, research, and healthcare-related communication within the field of "traditional, complementary, and integrative medicine" (TCIM), there has been limited international progress in these areas. Recognizing this gap, the WHO has issued benchmarking resources for the training and clinical practice of Unani medicine, highlighting the urgent need for standardized terminologies to facilitate their implementation and to strengthen the development of other technical materials.

The creation and finalization of the WHO international standard terminologies for Unani medicine occurred between 2019 and 2022. This initiative involved significant technical collaboration with a network of global experts and institutions. Contributors were drawn from various WHO regions and included professionals with expertise in Unani medicine, other traditional medical systems, medical linguistics, and relevant linguistic traditions, including Arabic, Persian, and Urdu. The outcome is a structured set of definitions aimed at reducing inconsistencies and promoting the accurate use of core concepts fundamental to Unani medical theory and practice.

According to Sheehan and Hussain (2002), who cite Shah (1996), Unani medicine is a traditional healthcare system that is currently practiced in South Asian nations such as India, Pakistan, and Bangladesh. This system has its roots in the medical practices of ancient Greece, the Arab world, and Persia. Unani medicine or treatment is based on the humoral theory, which suggests that health and illness are determined by the balance or imbalance of four bodily : yellow bile (*safra*), blood

(*khun*), phlegm (*bulghum*), humors (*akhlaat*) and black bile (*sauda*). These humors are linked to four fundamental qualities (*quwaat*): heat (*garmi*), cold (*sardi*), moisture (*rutubaat*), and dryness (*yabis*), which together inform the system's diagnostic and treatment methods (Sheehan & Hussain, 2002: 123).

In contemporary South Asia, Unani medicine remains a significant healthcare practice, serving both cities and rural communities. It coexists alongside homeopathy, biomedicine and other traditional therapeutic systems, including Ayurveda and Siddha, as well as various folk and tribal healing practices. Sheehan and Hussain (2002) referenced the work of Manfred Ullmann (1978), which observed that Unani medicine, originally of Greek origin but subsequently transmitted and expanded through Arabic and Persian influences, has been continuously practiced in India and remains integrated within the broader healthcare system. The foundational text of Unani medicine remains the *Canon of Avicenna*, supported by various commentaries and elaborations, reflecting the enduring scholarly and clinical relevance of this classical medical tradition (Sheehan & Hussain, 2002: 123).

The cultural and social importance of Unani medicine in South Asia, along with significant political endorsement from Muslim leaders and other prominent figures in earlier historical eras, significantly contributed to its revival-particularly in regions of India with historical Muslim influence, as well as in countries such as Pakistan and Bangladesh, which have mostly Muslim populations (Metcalf, 1985; Jaggi, 1977). From the late of year 1960s onward, there has been a notable resurgence of indigenous or original medical systems in India, including Siddha, Unani and Ayurveda. In response, the Indian government established dedicated central and state-level bureaucratic institutions to support the regulation and research of these systems. For the first time, successive Five-Year Plans integrated traditional medicine into formal health policy planning, emphasizing their role in primary health care and increasing budgetary allocations (GOI 1992; 1995b; 1997). Earlier national plans had either ignored or minimized the significance of traditional medicine. More recent health policy decisions in India have promoted: (1) the inclusion of Indian medical systems in the MBBS (biomedical) curriculum (GOI 2002; Napier 2002); (2) the promotion of medical tourism incorporating both biomedical and traditional medicine institutions (GOI 2002); and (3) the development of traditional medical/ health education, research infrastructure, drug development, and continuing education for physicians (GOI 1997) (Sheehan & Hussain, 2002: 132).

The Department of AYUSH, MOH & FW, Government of India (2013), noted that the Unani system of medicine is distinguished by its highly effective and safe healthcare practices. A defining feature of Unani medicine is its holistic approach, which considers a broad and integrated spectrum of factors including biological, sociological, geographical, and psychological elements and classifies them systematically through the concept of Temperament. This framework enables practitioners to determine the appropriate type and quantity of each factor tailored to an individual's specific needs (ibid: 43). Furthermore, in its discussion of therapeutic strategies, the document explains that treatment is initiated when preventive measures are insufficient and disease manifests. The therapeutic approach primarily relies on Heterotherapy, wherein disease understood as the manifestation of an abnormal temperament is addressed through the administration of drug and non-drug interventions characterized by opposing temperaments. Given that environmental influences, dietary habits, and psychological states also possess or impact Temperament, Unani medicine extensively employs non-pharmacological factors alongside medicinal treatments, guided by their correlative relationships. Additionally, the Unani system has identified certain drug actions that derive from the essence of substances rather than their qualitative attributes (ibid: 39).

Yoga and Naturopathy

Although health systems like Ayurveda and Chinese medicine primitively emerged as substitutes to reductionist biomedical models, their evolution particularly through processes of globalization and survival has led to their increasing pharmaceuticalization. In contrast, European-origin medical treatments such as naturopathy and homeopathy, which historically critiqued the positivist origins of biomedicine, have encountered a distinct set of challenges during their adaptation to South Asian contexts. In her analysis, Sujatha (2020) explores the transnational trajectory of naturopathic thought, tracing its roots in the United States, where it developed from Christian ethical resistance to vivisection, and how these principles intersected with Gandhian bodily politics during India’s colonial period. The chapter concludes by examining the subsequent transformation of naturopathy in Kerala, South India, as an example of how medical systems are continuously reconfigured through assimilation into local socio-political frameworks (Sujatha, 2020: 25).

Naturopathy today is recognized as a form of primary healthcare that integrates traditional therapeutic approaches with contemporary scientific advancements. It adopts a holistic perspective

on health and wellness, placing particular emphasis on immunity enhancement, disease prevention, natural healing, and nutritional well-being. Therapeutic interventions in naturopathy may include dietary regulation, nutritional assessment, hydrotherapy, homeopathy, Ayurveda, the use of limited pharmaceuticals, and, in some cases, minor surgical procedures (Sujatha, 2020: 25).

Talreja and Tiwari (2021) cited that the fundamental objective of naturopathic medicine is not only to treat illness but also to promote full holistic health by focusing on addressing both psychological and physical well-being. A key strength of naturopathy lies in its individualized approach, wherein treatment is tailored to suit the specific symptoms, conditions, and constitution of each patient. This personalized methodology acknowledges that disease manifestations and therapeutic needs can vary significantly from one person to another. Naturopathic care emphasizes the integration of physical, emotional, and psychological dimensions, thereby supporting a comprehensive model of well-being. Rooted in the belief that the human body possesses an inherent capacity for self-healing, naturopathy employs a wide range of interventions-from herbal and natural remedies to medically guided treatments-to assist and accelerate this internal healing process. In contrast to conventional biomedical approaches, which primarily concentrate on symptom management and disease eradication, naturopathy adopts a systems-oriented perspective that seeks to restore balance and overall vitality (Talreja and Tiwari, 2021: 2821).

In line with its holistic philosophy, naturopathy places strong emphasis on immune system enhancement as a means of illness prevention. Strengthening the body's natural defense mechanisms is regarded as central to maintaining long-term health and resilience (Talreja & Tiwari, 2021: 2821). In their analysis of naturopathy’s role in public health, Talreja and Tiwari (2021) draw on findings from Kohli et al. (2020) and Pradeep et al. (2014), who propose five foundational principles of naturopathic medicine and its mechanisms of healing, offering further insight into its relevance and application within contemporary healthcare systems. According to Talreja and Tiwari (2021), naturopathy is grounded in five core principles that guide its philosophy and practice:

a. The Healing Power of Nature

This foundational principle asserts that all living organisms possess an inherent ability to heal themselves. In the context of human health, this refers to the regenerative capacity of cells and tissues, which initiate repair and recovery following injury and disease. The responsibility of the

physician or healthcare provider, therefore, is to support and facilitate the body's natural healing mechanisms, rather than override them.

b. The Health Practitioner as Educator

This principle underscores the critical role of health literacy in maintaining well-being. Healthcare providers are seen not merely as clinicians, but also as educators who empower individuals by enhancing their awareness of personal health conditions. It is through informed decision-making and lifestyle choices that individuals ultimately take responsibility for their long-term health.

c. Emphasis on Prevention and Wellness

Naturopathy prioritizes disease prevention and health promotion over reactive treatment. It advocates for early intervention and lifestyle modifications aimed at preventing illness before it manifests or progresses. By fostering a state of holistic wellness, this approach reduces dependence on curative measures and promotes sustainable health outcomes.

d. Addressing the Root Cause of Illness

Effective healing, according to this principle, requires identifying and eliminating the underlying causes of disease rather than merely managing symptoms. Treating symptoms in isolation may provide temporary relief but fails to offer lasting solutions. Thus, etiological investigation is central to naturopathic diagnosis and therapy.

e. Treating the Whole Person

Naturopathic medicine views the human body as an integrated system, where imbalances in one area may affect overall health. This principle promotes a complete and customized approach to treatment, considering the mental, physical, emotional and even social aspects of the patient. It acknowledges that holistic well-being is essential to effective healing (Talreja & Tiwari, 2021: 2823).

Yoga

Yoga has increasingly been acknowledged as a significant practice for promoting health at individual, community, and national levels, contributing to the enhancement of both physical

health and mental well-being. Yoga plays a crucial role in the anticipation and management of NCDs and constitutes one of the eight Flagship Priorities outlined by the WHO for the Southeast Asia Region. Chronic lung diseases, cancer, diabetes and cardiovascular diseases, the four major NCDs, are responsible for over eighty per cent of premature mortality associated with NCDs globally. Notably, approximately eighty-five per cent of these deaths occur in LMIC countries, which consist of low- and middle-income countries, merging those within the Southeast Asia Region. To address this burden, it is recommended that schools, workplaces, community organizations, and civil society institutions integrate yoga into routine activities. This approach aligns with the global commitment to reduce physical inactivity by 15 per cent by the year 2030, as outlined in the Sustainable Development Goals (SDGs).

Importantly, research indicates that yoga confers immediate psychological benefits, including reductions in stress and anxiety, as well as enhancements in emotional and social well-being. Unlike traditional forms of physical exercise that may lead to fatigue, yoga has been demonstrated to reduce heart rate and activate the parasympathetic nervous system, thereby making it accessible to individuals with health conditions. During the COVID-19 pandemic, yoga played a crucial role in enhancing global public health by promoting the well-being of millions across various populations and cultures (Poonam Khetrapal Singh, 2022: WHO).

Traditional medicinal practices can significantly contribute to addressing this issue. The Indian traditional medicinal systems boast a rich history of efficacy, having delineated methods for the protection and management of lifestyle disorders. Here, the author tried to focus more on these traditional therapies not only encourage individuals to take responsibility for their health but also aid in regulating the incidence of lifestyle diseases by maintaining blood glucose levels and promoting cardiovascular health, among other benefits. The exercise of yoga has been identified as having substantial psychological benefits. It not only fosters increased kindness and optimistic emotions but also mitigates negative emotions such as aggression, depression, and anxiety. This approach offers an effective strategy for wellness, utilizing natural, low-tech, safe, and relatively cost-effective alternatives. Traditional medicinal systems, particularly yoga and Ayurveda, have gained widespread popularity globally (Ghatak, S, 2021: 02).

Homeopathy

Homeopathy, a medical practice with a history exceeding two hundred years, is distinguished by the oral delivery of substances that have been significantly diluted. The foundational principles are predicated on the concepts of "like cures like" the notion that elements capable of eliciting symptoms in a sound health or healthy individual can, in a diluted form, be employed to treat analogous symptoms in an sick or ill person and "ultra-dilution," which asserts that the therapeutic efficiency of a substance is enhanced with dilution, provided it is accompanied by a specific shaking process known as succussion. Advocates of homeopathy suggest that it operates by activating the body's innate self-healing mechanisms (McKee et al., 2010: 5).

The WHO, in its progress report (2014-2019), acknowledges homeopathy as a structure of alternative medicine formally developed in the year 1796 by Samuel Hahnemann. Treatment of homeopathy medicine is predicated on the principle of "like cures like," positing that medicines which induce symptoms in healthy individuals can be employed to alleviate those same indication and symptoms in individuals who are ill. In the Indian context, Kaur et al. (2019) reference Manchanda et al. (2013) to demonstrate the integration of homeopathy within the broader AYUSH framework, which encompasses which includes different modern and traditional medication methods which includes homeopathy, yoga and naturopathy, unani etc.. Despite homeopathy's formal inclusion within the AYUSH systems, its integration into non-AYUSH or mainstream healthcare infrastructure, such as the Central Government Health Scheme (CGHS), remains limited. Currently, only approximately 13% of CGHS wellness centers offer homeopathy services. In contrast, conventional allopathic medicine continues to predominate in terms of institutional presence and patient volume.

Nevertheless, within the AYUSH framework, homeopathy remains one of the most widely accepted and utilized systems. Despite its origins as a Western medical practice introduced to India in the early nineteenth century, it has been successfully localized and widely adopted. According to usage trends, homeopathy has even outpaced other long-established systems such as Unani, Siddha, and Naturopathy in terms of popularity and patient preference in India (Kaur et al., 2019: 81).

The continued relevance of homeopathy in India is unsurprising, given its alignment with the cultural and philosophical understanding of health prevalent among the Indian population, who

often view illness as encompassing more than just physical symptoms. Although there is currently only one homeopathic wellness centre for every 19 allopathic centres, the annual patient volume in homeopathy units is approximately one-fifth of that seen in allopathic facilities. Nevertheless, Thompson et al., (2016) indicate a strong public demand for homeopathic services within the CGHS settings.

This disparity in utilization may not solely reflect patient preference, but rather limited access to homeopathic services, which could be resulting in patients being diverted to allopathic care by necessity rather than choice. Kaur et al. (2019) suggest that if a greater number of co-located homeopathic wellness centres were established, the utilization patterns could shift significantly in favour of homeopathy, particularly in the management of conditions where it has shown therapeutic promise. These include allergic conditions, dermatological and paediatric disorders, as well as musculoskeletal, respiratory, gynaecological, and genitourinary ailments (Kaur et al., 2019: 81).

The preceding discussion reveals that a substantial number of qualified homeopathic practitioners are actively engaged in public health and wellness centres, as well as in various national health programmes across India. Their involvement plays an important role in supporting the country's pursuit of universal health coverage, while simultaneously offering employment opportunities for trained graduates aspiring to enter the public healthcare sector. Furthermore, the institutional promotion of homeopathy should be strategically expanded, particularly in the context of disease conditions frequently encountered in homeopathic clinics that also align with national health priorities. Such promotion could be effectively advanced through targeted health programmes and public health advisories. However, it is important to acknowledge that in certain scholarly and clinical circles, homeopathy is often excluded from the domain of Indian traditional medicine, and its therapeutic efficacy remains contentious, with critics citing a persistent lack of conclusive scientific validation.

Conclusion

Scholarly engagement with South Asian medical systems, particularly their global circulation and reception, has been well represented within the fields of medical anthropology, history of

medicine, and more recently, the sociology of health. However, these contributions remain largely absent from mainstream globalization theory, which tends to frame global processes predominantly through the lens of capital accumulation and technological flows originating from the West. Within this paradigm-often influenced by world-systems theory-regions such as South Asia are typically positioned as laboure exporting peripheries, while the capital-intensive economies of the Global North are viewed as the centre. This analytical framework tends to overlook the cultural and epistemological contributions of non-Western societies, particularly in the domain of healthcare, and fails to account for the disjunction between economic and cultural global flows that characterize much of the contemporary health and wellness landscape.

The preceding analysis indicates that as South Asian medical systems enter global circulation, they are often grouped with other non-biomedical therapeutic modalities, such as homeopathy, chiropractic, and osteopathy under the broad classification of CAM. However, the recognition of CAM at both national and international levels continues to face substantial resistance from scientific and biomedical communities, leading to ongoing tensions and debates regarding its legitimacy and institutional integration. These transnational flows of medical knowledge and practice, therefore, are not seamless but are instead marked by contestation and friction.

Moreover, while the concepts of health and wellness have gained widespread popularity in both academic and public discourse, their theoretical development remains limited. Nonetheless, as existing literature demonstrates, the multidimensional nature of wellness has been articulated and operationalized in sociological and psychological research, even though it has yet to be widely established as a robust conceptual framework for assessing the broader benefits of CAM systems. Scholars in the social sciences have long argued that individual experiences of health and illness are shaped by cultural and societal interpretations, wherein individuals may be labeled as “ill” according to biomedical standards, yet continue to perceive themselves as “well” within their own social context.

In this sense, wellness extends beyond the mere absence or prevention of disease, encompassing a broader understanding of holistic well-being. It includes the capacity to function physically in response to illness, maintain psychological and spiritual balance, adapt to social roles and relationships, and experience security, economic stability, personal freedom, opportunity, and emotional fulfilment. Such an expansive view of wellness underscores the relevance of CAM approaches, which often integrate these multiple dimensions into their therapeutic philosophies.

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