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‘A light inside a pot’: Sites and sources of power emerging from an ethnography of traditional healing in South India

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Abstract

Medicine and healing have been critical elements of nation-building and governance in India. There is a clear hierarchy: biomedicine, followed by systems like Ayurveda which are to be ‘mainstreamed,’ and local health traditions, which are to be ‘revitalised’. Mindful that power nonetheless resides in positions of marginality, this analysis drew from a health system ethnography on revitalisation of local health traditions in three southern Indian states. Data from multiple interviews with 51 healers, observations of meetings, healing sessions and events convened by healers, as well as a multi-stakeholder dialogue on local health traditions convened by authors were analysed using a grounded analytical process. The state was a source of power, but in an enmeshed, individualised form. Other sources of power included accomplished others who viewed healers and their practices with respect, healers’ collectives that produced and reinforced power through the exercise of certain rituals, and the sacred calling to heal, which assumed stringent criteria for practice and training, while also creating a moral imperative for service orientation. Our study shows how power rests in or is derived from multiple sites and sources that inhere and interact in critical ways with the state and other systems of medicine.

Keywords

Power; local health traditions; India; ethnography; medical pluralism

Introduction

Medicine has featured centrally in the project of nation-building in India (Amrith, 2006, 2007, 2009; Pati & Harrison, 2008). The treatment of various systems of medicine has been a critical element in this project, notably with Western imperial gestures to ‘civilise’ its colonies (Drayton, 1999; MacLeod, 2000). Colonial administrators demonstrated ‘tolerance’ to indigenous systems and practices in India, largely because the footprint of biomedicine was limited: ‘mostly employed in the growing State bureaucracy – in the army, the jails, the

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railways and so on' (Jeffery, 1982, pp. 1835–1836). Further, 'western medicine after 1835 was taken as the hallmark of a superior civilisation, a sign of the progressive intentions and moral legitimacy of colonial rule in India and the corresponding backwardness and barbarity of indigenous practice' (Arnold, 2000, p. 63).

India's independence saw the colonial legacy – of biomedicine being intimately linked to the exercise of state bureaucracy – endure, establishing a clear hierarchy. As a result, in India, as in many other countries, 'popular choice notwithstanding, a hierarchy of systems of medicine, whether or not acknowledged, is exercised in most societies, with biomedicine at the top, certain Traditional, Complementary and Alternative Medicine (TCAM) systems next and local health traditions last' (Lakshmi et al., 2015, p. 9). Perhaps the clearest instantiation of this is in India's first health system blueprint, drawn up in 1942 by the Sir Joseph Bhore Committee, convened by the British colonial government (Amrith, 2006; High Level Expert Group on Universal Health Coverage, 2011; Murthy, Sarin, & Jain, 2013; Priya, 2012, 2013). Premised on the Bhore Committee Report, newly independent India's health system was to be

> based on a single. historically recent system: a bureaucratically ordered set of schools, hospitals, clinics, professional associations. companies and regulatory agencies that train practitioners and maintain facilities to conduct biomedical research, to prevent or cure illness and to care for or rehabilitate the chronically ill. From this perspective other forms of health care are outside the medical system and they are usually ignored. When they are not ignored they are derogated as curiosities, or as fringe medicine, quackery and superstition. (Leslie, 1969, p. 191)

The Bhore Committee Report was followed by the Chopra Committee, tasked with recommending a role for indigenous systems of medicine in 1948 (Committee on Indigenous Systems of Medicine, 1948). The Chopra Committee recommended 'moving towards a "synthesis" of all the systems to formulate one Indian system. There has been a reiteration of "integration" by several subsequent documents over the six decades since then … ' (Priya, 2013, p. 25). *De facto* integration of other systems into a dominant biomedical paradigm has been vexed throughout India's history, vulnerable to multiple power imbalances (Sheikh & Nambiar, 2011).

This hierarchy was formalised through the First Five Year Plan, which called for recognition of only those systems and practices that could conform to the standards of biomedicine (Banerjee, 2009). Thus non-biomedical systems and practices have had to move from intangible oral practices to systems of documentation and becoming legible through what Moir (1993) calls *kaghazi raj* (or the rule of paper), the origins of which, in turn, issue from colonial systems of writing and reporting. This *raj* has been rehearsed and mimicked in nationalist and post-colonial practices of administration and bureaucracy, including in the realm of health: governance qua paper is what has given legitimacy to processes, people, and participating institutions (Mathur, 2015). Many have observed that divers non-biomedical codified systems – grouped in the phrase AYUSH in India, which stands for Ayurveda, Yoga & naturopathy, Unani, Siddha & Sowa-rigpa and Homeopathy (AYUSH) – have been amenable (and expected) to being moulded into biomedical parameters, through processes of training, certification, standardisation of practice and drug manufacturing practices

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(Banerjee, 2009; Chandra, 2012; Sheikh & Nambiar, 2011; Sujatha & Abraham, 2009). As Lambert (2012, p. 1030) explains

> What the 'AYUSH' traditions actually have in common is simply that they are not biomedical and are regulated through state accreditation of training institutions and official recognition of degrees. Insofar as sociological theory has shown the development of the professions to be strongly associated with state formation, the processes by which selected medical traditions become health professions can be seen as part of modern governance.

Even as health professions, AYUSH disciplines remain nested in a hierarchy wherein disproportionately higher allocations are usually made to biomedicine relative to other systems (Jeffery, 1982; Lakshmi et al., 2015; Priya, 2013). As Khan (2006) has pointed out, this dominance reflects a colonial legacy of subordinating and rendering subservient Indian knowledge systems and practices.

AYUSH systems of medicine have official recognition in subservience to biomedicine, as distinct from what policy documents refer to as Local Health Traditions (LHT): practices that do not clearly assimilate into the clear 'systemic' frameworks of biomedicine and AYUSH, like bone setting, home remedies, traditional birth attendance, snake-bite treatment and spiritual healing. Officially, LHT are defined in the first National Policy on Indian Systems of Medicine and Homeopathy as 'folk health traditions related to birth attendants, herbal healers, bone setters, Visha (poison) healers' (Government of India, 2002, p. 14). In the gaze of the state, LHT are cast as 'the residua that, in modernist narratives of progress, are always-already disappearing' (Lambert, 2012, p. 1030).

But they are not disappearing as much as may be thought. A 2010 study in 18 Indian states found that in all but four of these states, 80–100% of households surveyed reported the use of local health traditions; southern Indian states reported use of LHT among 50% to 75% of households (Priya & Shweta, 2010). Further, about 80% of allopathic doctors surveyed across these Indian states found value in home remedies, 55% of allopathic doctors were suggesting local remedies, while a third of the sample found value in the work of traditional providers. Given the pervasiveness of use, there is warranted policy emphasis, particularly since the 2002 National Policy on Indian Systems of Medicine and Homeopathy, but especially the 2005 National Rural Health Mission, on 'revitalising local health traditions'. The policy prescriptions for revitalisation have been documentation of their practices, accreditation of practitioners, and support for research and pilot projects led by Non-Governmental Organisations (NGOs). Though there may be myriad – sometimes even conflicting – objectives of these efforts,[1] they represent an intention on the part of the state – enjoined by civil society organisations – to revitalise LHT.

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[1] **Notes**

Elsewhere we have written about the emphasis on documentation in the revitalisation agenda (Mishra, Nambiar, & Madhavan, 2018). The irony of course is that if we are to look at the definition of LHT as 'undocumented knowledge', documentation would turn LHT into something that is not. It is unclear how this would serve the agenda of revitalisation. This is not merely a rhetorical question, as our work has revealed. *Ad hoc* forms of accreditation or registration for practitioners have emerged, which, problematically, embed these practices at the lowest rung of the health professions hierarchy. Further, once introduced, schemes for accreditation and registration have been withdrawn altogether, serving to discredit and further marginalise LHT practitioners who have actively sought to engage with the state (Lambert, 2012; Sujatha & Abraham, 2012). Finally pilot projects led by NGOs have cast LHT practitioners

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Mindful of the history of the politics of medical pluralism in relation to the state, we undertook a health system ethnography seeking to understand the policy lessons of and for revitalisation of local health traditions (2014–2016). The discourse on revitalisation cannot be oblivious of power relations among different systems and non-systems of medicine and the state. Given the lack of state recognition of and support for projects and practices of LHT, they could be said to occupy the 'fringe'. Yet as our research revealed, LHT practitioners are themselves redefining and recasting their positions not only relative to the state (Baviskar, 2007; Cunningham & Andrews, 1997; Li, 2005; Mathur, 2015), but also in relation to other entities and considerations. This paper specifically discusses how healers alluded to sites and sources of power, which had a vexed relationship with the state and other systems of medicine.

Methods

This analysis is part of a larger health systems ethnography in the states of Karnataka, Kerala and Tamil Nadu in South India that sought to interrogate the policy lessons of and for 'revitalisation' of local health traditions (2014–2016). It was reviewed and approved by the research centre at Azim Premji University in June 2014.

We identified healers using purposive criterion sampling to cover a range of specialties, in both rural and urban areas, engaged in practice or in other interactions relevant to their healing (like preparing medicine, gathering raw materials, attending and presenting at meetings, etc.). With their expressed consent, healers from across three states were interviewed repeatedly and, in some cases, their practice was observed. Separate permission was taken to record interviews. On multiple occasions, we were observers at meetings and conference convened by healers.

In January 2016, seeking to bring these perspectives and views together, we hosted a dialogue of healers, NGO representatives, academics and government officials in Bangalore. This meeting was a turning point in our research, allowing both presentation and re-examination of our data, gesturing towards sources and sites of power that we subsequently sought to understand more deeply with interviews, meetings and observation. Following this, we gathered further data to expand upon themes and narratives that emerged as salient from our dialogue through additional interviews, observation and interaction with healers, NGO representatives and representatives of government departments and research institutes. Overall, 51 healers were interviewed in depth.

Transcription and transliteration of interviews (which were carried out in multiple regional Indian languages) were conducted by project research assistants based on recorded interviews as soon as possible after interviews were undertaken. Additional notes and field observations were also compiled regularly and reviewed by the research team during monthly meetings. The analytical process was grounded (Glaser & Strauss, 2009) and iterative, involving coding and review by multiple individuals jointly and individually during

themselves in minority or totemic roles, which has on the one hand given them some visibility, but not on terms that they may themselves have set.

the course of data collection. Coding categories were created for each state by a lead researcher and then brought in for discussion across them at monthly team meetings. Shared themes were triangulated across sites, while distinct ones were also noted. There were additional group meetings of lead researchers to consolidate themes.

It must be noted that, as expected, whether in the vernacular or in English, the word power never featured *per se* in these transcripts. It is our interpretation of these as power – which resonated with healers in our January meeting – that we now present. Many (but not all) healers we interviewed mentioned the desire for state recognition in the form of certification of their existing knowledge or some other formal mechanism.[2] Interestingly, the most common reason why this recognition was sought was to avoid harassment from the police or other state department authorities (e.g. the forest department not permitting healers to use forest produce). As such, a prominent form of state power experienced by many healers was obstruction of their practice. In the course of interviews, various other sources and sites of power emerged.

Results: Sources and sites of power

Accomplished others

For healers, interaction with and recognition from accomplished others – doctors, artists, lawyers, judges, ministers and government functionaries – was a source of power and of pride:

> Actually what happened in the past is that we treated cancer of a lawyer. After that we got publicity about being able to treat cancer. This was word-of-mouth publicity: if we cure one patient, then he will come back with 10 more patients. But the advocate mentioned this to Dr. A…Dean of [a famous hospital in another state]. She called my father asking him to give her medicine for cancer and HIV. You know, na, that hospital? It is famous! They studied how our medicine helped the patient. He was all over the newspapers, and the radio. (Male traditional healer, Gavnal, Karnataka)

> For earlier generations my forefathers were not that famous but when my father treated a reputed judge from Bangalore, he became famous. Everyone got to know as words of successful healing spread around. The judge recommends and sends his relatives to us. Before this, we were treating only local patient but soon patients started to come from other parts of Karnataka, Maharashtra, and Goa. (Male traditional healer, Davengere, Karnataka)

[2]As Li (2005, p. 384) points out, '"the state" has seldom had a monopoly on improvement. It shares this function with social reformers, scientists, missionaries, the so-called non-governmental agencies, and, in the global south, donor agencies with their teams of expert consultants'. In this case, too, there are various non-governmental stakeholders vested in the recognition of healers. Many of them, however, have insisted that having this legibility necessarily requires dealing with governmentality, for the state is the epicentre of healers struggles for power. Take for example the efforts of the Foundation for Revitalisation of Health Traditions, which had advocated vigorously for the accreditation of practice of local healers – even piloting a programme for this in collaboration with a large institution of higher learning. These efforts appear to have become victims of their success, offering a *modus vivendi* for healers in the eyes of the state, and thereafter (or thereby) not receiving continued support or endorsement from it. So these paths to power – paved with the good intentions of NGOs – are appreciated but not unanimously endorsed by healers, quite simply because they are not seen to be enough.

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It was significant in this case as in others that the healers themselves did not go out to seek fame or recognition; it came to them, through the word-of-mouth from those already famous by virtue of their contribution to the legal and medical professions, amplified then through mass media (see Figure 1a). In some ways, to be recognised by the most accomplished in these particular professions – legal, and medical – brought about a kind of legitimacy with deeper significance than having government accreditation pro *forma*.

Moreover, this amplification extended to having foreigners relying on their care, seen as a marker of healer's prowess, inspiring greater dedication to their practice:

> Previously there were days of consultation, but now patients are coming from Miraj, Mumbai, Pune, Singapore, Dubai, Kuwait. They spend large amounts of money. How can I say 'Come 3–4 days later?' These patients are coming with a lot of suffering and pain. How can I send them away empty-handed? This is not service. So I do give medicine on all days. (Male traditional healer, Gund, Karnataka)

Here again, the need of patients from afar was as meaningful an enabler of their practice as certification (sometimes more). Moreover, just as media helped 'spread the word', having the ear of foreigners was also proclaimed in talking about power. The reliance of these patients was seen as a marker of their fame and inspired greater dedication to their practice. In some cases, however, this amplification and its interface with commerce invited the unwanted scrutiny of the state:

> When I was a healer treating only local people, nobody cared for me, but when I started having foreign patients and have collaboration with Ayurvedic tourism centres, the government wants to know the details…(Male traditional healer, Palode, Kerala)

These were all, as recognised by healers, sites and sources of their power – in effect this power was attractive and drew people into their practice – and as in the last case, attracted state scrutiny.

The state enmeshed

Healers' testimonies laid bare for us the lack of strict separation between state and society, in keeping with Mitchell's (1991, p. 90) observation:

> the boundary of the state (or political system) *never marks a real exterior.* The line between state and society is not the perimeter of an intrinsic entity, which be thought of as a freestanding object or actor. It is a line drawn internally, *within* the network of institutional mechanisms through which social and political order is maintained.

Our methodological approach – ethnography – emphasised the perspective of healers such that we did not view the state and society as decidedly distinct, but rather nested and intercalated (Chatterji, Palriwala, & Thapan, 2005). In this sense, healers and the state were enmeshed in various ways.

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At times, through accomplished others, the state appeared to provide endorsement and spaces for legitimation of healers as well. Formally, the Indian government has allowed LHT to operate between the stools of legality and criminality. Yet, in more politically nebulous ways – which we read as its informal or internal institutional mechanisms – the state demonstrates recognition, approbation, even, of traditional healers. For instance, an official of the AYUSH department in Karnataka noted that 'If you take the legal route, all the healers will need to stop practicing. But we allow them on humanitarian grounds'. Ironically, lawmakers (judicial and legislative) often endorsed healers, as was explained to us with a show of photographs by a male healer in Kinaye, Karnataka: 'I am consulting in Goa for more than 25 years. Last week Mr. X, minister in Goa, was with me. I have treated every minister in Goa except the Chief Minister'.

Individual healers negotiated multiple relationships and interactions with state functionaries. A senior official in the Department of AYUSH in one of our study states in response to our invitation to the dialogue:

> I do not know much about LHT. I can recommend people who you should invite. Are you inviting *nattur vaidyas* (local healers)? Like Vaidya X from X1 block and Vaidya Y and also researcher Z who has spent extended time with the healers in Z1 district in documenting their knowledge. They will be able to reflect in your dialogue better.

Officials from outside the health sector – typically the forestry department and tribal welfare – often had personal experiences of care from traditional healers and had gone on to seek their greater engagement in primary health care through state channels – we saw examples of this in all three states.

For LHT as a category of practitioners on the other hand, this endorsement is contested: within the same office, a research officer emphatically dismissed LHT practitioners as being absent from *kaghazi raj:* 'They are all quacks. You can check with all alternative medicines boards, none of their names are registered. If their names are not there in these boards' registers means they are not legitimate practitioners'. The simultaneity of these views is striking: acknowledgement and specific recognition of individual healers on the one hand, and on the other, dismissal of healers in general through reference to the state registration procedure norm. It seems, therefore, that just as healers can name accomplished individuals who stand by them, reciprocally, state representatives respect accomplished LHT practitioners as well. This was thus a vexed and varying form of power: not legal recognition as practitioners, but as individuals of singular accomplishment, who transcended censure or criminalisation.

Other times, healers laid claim to 'invited spaces' (Gaventa, 2006) of recognition by the state as representatives of 'the people' or certain communities (like indigenous groups). For instance the Biodiversity Board of Kerala, which in 2012 was the first state in the Indian union to complete a People's Biodiversity Register, an extensive catalogue of local biological resources and traditional knowledge from 500 Biodiversity Management Committees across the state, which included many practitioners of LHT (Suchitra, 2012). The Karnataka Biodiversity Board has sent out repeated notices in local newspapers about

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press conferences requesting traditional knowledge holders to share their knowledge. As a senior official of the Karnataka board observed:

> Many traditional knowledge holders including healers come to such conferences as this is a sort of acknowledgement of their knowledge and [of] them. Since this is a government body, they treat this an important opportunity to make them visible.

Linked to this have been invitations to various events sponsored by government ministries (tribal affairs, forestry, rural development) – again sometimes outside the remit of the health sector – in which healers were asked to showcase their knowledge and reflect on the state of traditional healing. Healers shared photographs of these sources and sites of power with us enthusiastically (see Figure 1a). Another example is the Kerala Institute for Research, Training, and Development of Scheduled Castes and Scheduled Tribes[3] (KIRTADS), established in the early 1970s. In 2012, KIRTADS disbursed funds to healers identified by a non-governmental organisation as support for cultivation of medicinal plants and improvement in facilities for treatment in healers' homes.

Ethno-medical knowledge of plants, herbs and forest received unique emphasis from the state apparatus, even as it only indirectly conferred legitimacy onto healers. Several regional units of the Indian Council of Medical Research as well as other government agencies have undertaken processes of 'screening' practitioners:

> We documented the knowledge of 140 LHT practitioners. After a thorough screening, we shortlisted some practitioners. These practitioners were visited by our team repeatedly to interact with healers and patients. (Government official involved in processes of documentation, Karnataka)

More established traditional practitioners were also given some recognition, as this was seen to be politically expedient. In Kerala, in the early 2000s, for instance, both dominant political parties allowed traditional healers' certification under the Medical Practitioners Act for those who could establish 20 or more years of practice. In Tamil Nadu as well, multiple political administrations maintained a campaign of enlistment of traditional practitioners in the 1980s until the legality of the practice was questioned by the Central Council of Indian Medicine and the process discontinued (Sébastia, 2013).

The collective

Healers also drew power from the collective – we were told of various formations – *sangams* (collectives), *sangathanas* (unions) and *parishads* (boards) that met and interacted regularly, often issuing certificates of participation. More broadly, these formations served as platforms for exchange of knowledge, expansion of networks and refinement of practice. This was seen as a source of power and increasing prowess as a community of healers. There is a long and established history of associations of traditional practitioners dating back to the early twentieth century in the state of Tamil Nadu, for instance, whose processes are extensively

[3]Articles 341 and 342 of the Indian Constitution recognise castes and tribal/indigenous groups facing historical disadvantage as added to a Schedule by the President and state governors, which entitles them to special provisions of protection, development and empowerment. Once added, they are referred to as Scheduled Castes or Scheduled Tribes, as appropriate.

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documented and described as 'very parallel to that of the government' (Sébastia, 2013, p. 16).

In the course of our fieldwork, at a conclave of *sangams,* or *mahasangam* meeting of 300 *nattu vaidyars* (local healers) in Palakkad, Kerala (Figure 1b), an organiser mentioned:

> The purpose of our coming together is to share and impart knowledge to one another. Our aim is to create a system of *gurukula* (the ancient mode of learning through apprentice). So we are not merely interested in registration of healers like some individual associations are.

Two years prior to this, the 2014 Siddha Varma National Conference organised in the southern city of Kanyakumari in Tamil Nadu similarly placed emphasis on demonstrations of state-of-the-art techniques in *marma* (massage) therapy. Close to 300 traditional healers hailing from Tamil Nadu, Puducherry, Kerala and Andhra Pradesh were in attendance, with logistical support from a local religious charity.

These meetings appear to have some similarities in duration and size: over 2–3 days with 200–300 healers from multiple *sangams* or *sangathanas* assembling placing emphasis on sharing knowledge using demonstration and experiential learning – an affirmation of traditional pedagogical styles. There is relatively less discussion and emphasis on state recognition at these meetings, although they typically include plenaries where famous personalities with existing or former government affiliation highlight the contributions of LHT. At the aforementioned Palakkad meeting, a retired High Court judge felicitated a number of healers, while the chief guest of the Kanyakumari congregation was a senior functionary in the defence ministry. This individual spoke about his traditional healer father and the many celebrities who had gained from LHT, including a former Indian President.

In between meetings, the group remained in contact through social media (WhatsApp and Facebook groups, typically). There was a certain cadence in their functioning, and predictable and iterative rituals that secure and reassert power. Notwithstanding this, there was also an appreciation of the insular nature of such meetings. As was put by convenor of the *marma* conference in the opening plenary, siddha varma is *'Kudathirkul irukkum oli,'* meaning like a light inside a pot that has to be taken out to the world. The power as they experienced it was burning bright – just contained and hidden from broader view.

Decades ago, associations had political motivations vis-a-vis the state, for instance *sangams* in Kerala that successfully petitioned the government for legal recognition. In recent years, however, such broader campaigns were not prioritised by healer associations, possibly because of recurrent failures in the past to engage formally with the state (Sébastia, 2013). At the time of our fieldwork, the mode was of individual, *ad hoc* engagement by certain LHT practitioners with the state. In Tamil Nadu, the more recent trend had been the assertion of practitioners of codified systems: a codified Siddha professional association was brought onto the board of Tamil Nadu state and district antiquackery committees to limit the practice of illegitimate traditional healers.

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The divine

A key source of power for healers was the divine. The mere ability to practice for many we spoke to was attributed to divine providence. They were chosen ones and this is why not just anyone could get trained to be a traditional healer just by taking a course and receiving a degree. This kind of power was different.

> Our community people will respect the healers who practice Siragadithal as it is considered as a gift from God. (Female tribal healer, Tamil Nadu)

> Many people come here…[One] person had fallen from a height and broken his leg. …He was taken to Kozhikode, but they couldn't correct. I corrected it. It is not my power. It is god's power. I will do it, I will touch, but the wisdom to do and orders are given by God. ((Another) Female tribal healer, Tamil Nadu)

The implications of this were various, with implications for the acquisition and transfer of health-related knowledge, the moral and economic dimensions of practice, and the relationship of the healer to his/her ecology (Nambiar & Mishra, 2017). In the case of Siddha vaidyas, moreover, the possession of miraculous ability was inherent to practice and linked the practitioner to a sacred lineage, as observed and documented at length by Weiss (2009).

Since healing was a sacred calling, training was necessary, but insufficient to earn one the title of *vaidya* (healer). Additional qualities, particularly piety, were essential, not just of the chosen healer but also his/her teacher, who would also serve as his/her guarantor and selector (this is why many healers were strongly hesitant to share their knowledge for documentation purposes with researchers or lay persons):

> This shouldn't be given to anyone; people are taking advantage of this treatment. See I don't take any money for the treatment of poison, but the one I teach would be making money and there is no sanctity in that. (Male traditional healer, Trivandrum, Kerala)

In Tamil Nadu, medical knowledge was recounted as having been transferred from sages without financial gain, which further motivated the service orientation of the current generation of healers:

> The sages would say, "people are dying, you keep these medicines with you and treat them." Whatever they gave is with us. They also didn't give it us for a price. We also didn't buy it from them. I am continuing the same service.…Even in our sasthras, it is told that you shouldn't ask for money in vaidyam. (Male traditional healer, Coimbatore, Tamil Nadu)

Traditional healers repeatedly described examples of 'quacks' who operated with a profit orientation, seeing it as being at odds with the requirement of piety demanded of such knowledge and the context of its practice. Further,

> the requirements and demands of a traditional healer – aside from piety and a lack of desire to profit from his/her practice – included careful observation of not just symptoms but conditions and contexts of the environment and nature, knowledge of and command over the selection and preparation of medication and the exercise of

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> interventions in harmony with a range of factors beyond the individual, even as the nature of medicaments may be highly customised to an individual particular comportment and context. (Nambiar & Mishra, 2017, pp. 2–3)

This entailed an intricate ecological relationship on the part of most healers with sacred spaces, like groves, entities like trees and herbs (see Figure 1c), times of day and the seasons. These cosmological, moral, economic and ecological considerations sharply contrasted with the ontology of power inhering in biomedicine and even the state for that matter, and was significant for many healers.

Discussion

Like a light shining in a pot, we found that traditional practitioners made claims to power that are not typical or widely visible: from the recognition of accomplished others, *ad hoc* linkages to the state, rituals and interactions in peer groups and collectives and finally, critically, the sacred linkages they and their practice had. These negotiations occurred in a broader context where formal and established legitimacy in the eyes of the state did not exist. In contesting the assumed centrality of the state as arbiter of the location of power in healer communities, our work is similar to that of researchers working in health (Fassin & Fassin, 1988; Lambert, 2012; Naraindas, Quack, & Sax, 2014; Priya, 2012; Weiss, 2009), and those not (Baviskar, 2007; Mathur, 2015; Mosse, 2005).

That said, as healers made clear in interviews and at our January dialogue, the role of the state was prominent in delegitimising the extant power they had, which they at times sought to mediate, negate or negotiate through the means described here. This reinforces the fact that the state remains a critical frame of reference in the negotiation of power, a legacy of India's first Prime Minister Nehru, that has endured since India's independence (Khan, 2006). As Khan observed of this earlier time, even the 'nature cure' alternative proposed by Gandhi received little more than a mention in a sub-committee report: biomedicine, linked then and now to the exercise of state governance, is all-powerful.

This phenomenon is not unique to India; it is a global trend. Lakshmi et al. (2015) point out that in most low- and middle-income countries, there had been *de facto* pluralism, followed by the establishment of western medicine or biomedicine as the official system by state governments, followed by de-legitimation of other systems and the pursuit of *de jure* pluralism, which in turn excludes certain systems. In Thailand, Tantipidoke (2013, p. 3) noted that the evaluation of traditional healing methods through the logic of biomedicine is a central way in which the state asserts the 'official imposition of Western biomedicine'. In Senegal, traditional healing practices and systems are arranged in a hierarchy of professionalism, with biomedicine at its apex (Fassin & Fassin, 1988). In high-income countries as well, it is observed that the '(bio) medical profession was able to keep practitioners of 'marginal medicine' at bay by actively pursuing strategies of subordination, limitation or exclusion, while also ostracising the medical heretics amongst their own ranks who dared to stray from orthodoxy' (Wahlberg, 2007, p. 2309). Thus biomedicine, by being the official state system for health, has exercised power to amplify its dominance.

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Most sociological, anthropological and even health systems research have questioned and problematised the hierarchization of systems of medicine and healing in the statist frame (Hardiman & Mukharji, 2013; Josyula et al., 2016; Lakshmi et al., 2015; Lambert, 2012; Mishra & Chopra Chatterjee, 2013; Naraindas et al., 2014; Sheikh & Nambiar, 2011; Sujatha, 2011). Elsewhere in the world, studies have found alternate sources or authorities for legitimation beyond the state and indeed outside of mainstream biomedical institutions through peer or professional associations as well as collaboration with NGOs on specific health issues or campaigns (Fassin & Fassin, 1988; Tantipidoke, 2013). These sources are apparent from the vantage point of healers and may be invisible when viewing the situation of healers from the lens of the state or of policy *de jure*.

This analysis, in particular through its emphasis on the perspective of healers, joins the ranks of others (Baviskar, 2007; Chatterji et al., 2005; Gupta & Ferguson, 1997; Li, 2005; Mathur, 2015; Mitchell, 1991) that have demonstrated that far from being a monolith, the state does not entirely ‘govern’ the fates of systems and practices of healing in India, such as through the passing of policy or the documentation of products or practices. Rather, the state in various forms – informal, individualised, superannuated (in the case of retired officials) and institutional – is enmeshed in and part of the exercises of power of healers. This is also historically the case: quite often, traditional or folk practitioners were under the vigilance not of the state, but of the village community where they practised and thus subject to regulation by the people they served (Leslie, 1980; Sujatha & Abraham, 2009; Tantipidoke, 2013).

Along similar lines, Naraindas et al. (2014) talk about asymmetries of power that are continually negotiated by healers, where the state is not necessarily the arbiter. They gesture towards the possibility that rather than viewing the non-status of local health traditions as disempowering, we acknowledge the agency that nonetheless does exist. This agency could actually be impinged upon through well-intentioned exercises of seeking greater power through recognition of the state. How? In India, as seen in other low- and middle-income countries, state planning and programming proposes solutions and, in so doing, circumscribes the very nature of the problem into technically soluble components (Ferguson, 1994; Li, 2005; Rose, 1999). In the context of LHT, the abiding preoccupation of the state has been with documentation and validation, while attention to recognition or accreditation or increasing voice of healers has been perfunctory. In finding these connections, our work contributes to the growing contemporary literature on medicine, state and society, with an emphasis on the diversities and complexities of such relationships in India (Banerjee, 2009; Mishra & Chopra Chatterjee, 2013; Sheikh & George, 2012; Sujatha & Abraham, 2012) and globally (Bodeker, 2001; Fassin & Fassin, 1988; Tantipidoke, 2013; Wahlberg, 2007).

There certainly are other practitioners who self-identify as traditional healers but neither conform nor ascribe to the characteristics, motivations or even sources of power described here. Healers cited here also lamented the mounting evidence on gross misrepresentation in marketing and profiteering by individuals claiming to be traditional healers, drawing on the media as a source of power and legitimacy. The sources and sites of power described may be considered in defining ‘quackery’ over which there is such policy concern, particularly inasmuch as having predominantly commercial motivations is questioned by traditional

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healers, officials and NGO practitioners alike (Nambiar & Mishra, 2017). Further, a key area of further inquiry should be into the role that the media (mass, social and others) play in empowering traditional healers or those proclaiming to be traditional healers.

Finally, the process of gleaning the various sources and sites of power for traditional healers in the three states was also one of coming to terms with the inherently political nature of our own inquiry. Whether through our conversations with healers, or in the larger staging of the dialogue held in January 2016, we are now – as we were throughout – made deeply and repeatedly aware of the responsibility (and power) reposed in our actions. NGOs, healers and even state officials expressed their expectations of us and suggested possible outcomes issuing from our research. These included: annual dialogues with healers that would allow exchange and dialogue across constituencies, enabling the recirculation of power; the revival of now abandoned or as yet incomplete processes of documentation or accreditation of healers; participation or support of validation of documented evidence; advocacy and awareness raising in the wider public health community or the public at large. These expectations revealed the multiplicity of actors in the narratives unfolding before us, who were also putative audiences and agents in any further activities we would pursue in this area. As such, we found ourselves 'sited' – often in intricate, sometimes in contradictory ways – in the relations of power of traditional healers.

In conclusion, this ethnographic study of power from the locus and perspective of traditional healers in India has gone beyond the statist lens to identify other sources and sites and what these meant for the practice of (undemocratic) medical pluralism (Priya, 2012). Therein, we extend the argument of Erasmus and Gilson (2008, p. 367), who call for 'clearer and more comprehensive understandings of power…to build-up rich and nuanced descriptions of the forms, practices and effects of power in health policy implementation'. Our study shows how power rests in or is derived from multiple sites and sources that inhere and interact in critical ways with the state and other systems of medicine, demonstrating not the lack, but rather the complexity of power held by LHT practitioners.

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b)

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Figure 1.

Sources and sites of power. (a) Source of power – photographs of famous patients, felicitation and commendations received. Photo credit: BR Rajeev, 2016. (b) Site of power- a meeting of healers. Photo credit: Maya Elias, 2016. (c) Site of power – a sacred grove in Tamil Nadu. Photo credit: BR Rajeev, 2016.