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ORIGINAL ARTICLE

Instituting Traditional Medicine: changes to identity and legitimacy in global health

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Abstract
Based on reports from the World Health Organization, this ethnography concerns the concept of tradition/traditional as a quality of contemporary medicine. The discussion focuses on the way in which this term has been mobilized within the context of global health and, not least, on its effects while being instituted as a therapeutic category. From a medical anthropology approach, I track the mobilization of this concept from the 1960s to current reports, through the Organization's headquarters to its regional branches. I intend to highlight the shifts in its conceptualization, specifically, how the term has reshaped the identity and legitimacy of medicine and medication.

Keywords Global health · International agencies · Technical reports · Traditional Medicine · World Health Organization

An ethnography through WHO Traditional Medicine reports

In this article I trace the growth of the term tradition/traditional as an emergent term of identity and legitimacy in global health, looking at how it was mobilized and subsequently officialized by secular health organizations. In particular the World Health Organization (WHO) has been promoting the term "traditional" to classify medicine since the mid-1960s. The joint term, Traditional Medicine, which was initially highly restricted and confined, described in WHO reports as belonging to the culture of "others", gradually transitioned to something that was more transculturally operative "for everyone". In this article, I underline this shift to examine the intersections between its local and the global boundaries, the informal and the institutional

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standing, indicating how and what medicine emerges when the term "tradition" starts to be a medicine qualifier.

To do so, during 2019 and 2021 I followed the Traditional Medicine reports, guidelines, and meeting minutes about this theme published between 1961 and 2020 by the WHO headquarters and the African and Asian offices. I analysed 41 documents. Of these, I made a more in-depth analysis of 29 and I expressly refer to 11 in this ethnography, where the term's trajectory can be more suitably retraced.

I examine the pivotal role of WHO documents as essential tools to produce realities that govern practices, policies, and bodies beyond the bureaucratic field. The key interest of this ethnography is the institution of the term tradition/traditional, understood here as the way in which a concept circulates from one document to another, thus producing the context of officiality intended by the Organization.

My contact with these documents was mainly through the WHO virtual library.[1] This database was quite important for this research, not because it became one of the few places possible for fieldwork researchers to move forward during the Covid-19 pandemic, but also because it supports an extremely large and multilingual archive, highly sought-after by bureaucrats from Member States whenever they need quick access to WHO documents. When producing public policies, for example, this archive dispenses with controversies and provides greater contextualization among State agents. Among health professionals, when carrying out routine activities, it is used both to fill gaps of national legislation and to create broader references than those agreed by national health surveillance bodies. In this way, the WHO virtual library would have become central for this ethnography even if the research had not been affected by the reinvention of participatory observation imposed by the pandemic.

Therefore, my dealing with these documents is far from a systematic analysis of techno-scientific literature, or any historiographical intent, although I have chosen to organize some events, concepts, and documents on a timeline frame. I made this choice to produce an ethnography more accessible for those unfamiliar with the terminology used by the WHO. I dealt with these documents fundamentally as "ethnographic artifacts" (Riles 2006), aiming to contextualize how the tradition/traditional term came to qualify and expand medicine without, thereby, subjugating it to the placebo, psychological, symbolic, or contextual effects.

This approach argues against the idea of "traditional" medicine as a counterpart to the "conventional", using WHO's own categories. In accordance with previous ethnographies that examine this framework locally (Kloss 2017; Blaikie 2016; Gaudillière 2014; Saxer 2013; Simon and Egrot 2012; Bode 2006), and drawing on insights from previous studies about the regulation and standardization of WHO Traditional Medicine (Ashworth and Cloatre 2022; Cloatre 2019; Forsyth 2017), through a global health perspective I indicate that both traditional and conventional medicine mirror each other to fit into organizational disputes and respond to public demands.

[1] Available online at: https://www.who.int/publications/i and https://apps.who.int/iris. Accessed on 13/05/2024.

A pre-modern reminder

What made the WHO rise internationally was partly its ability to deal with distinct worlds. Founded in 1948 amidst the Cold War era, WHO's agenda focused on two contrasting and interconnected objectives during its first two decades. First, was to embrace the new conceptions of health that emerged from liberal urban societies. Second, was to consolidate primary health care to promote social equality (Cueto et al. 2019).

Both goals were supported by the effervescence of the preceding decades, especially in the wake of transformations promoted by the New Age movements of the middle classes in North America and Europe (Koch and Binder 2013; Baer 2003). The criticism of biomedicine in public debate was amplified through its intersection with other causes and struggles, such as therapeutic pluralism, environmentalism, and the participation of minority groups in the construction and strengthening of democratic nation states. In this context, the valorisation of practices and knowledge systems that were once marginalized emerged to rectify the Western development, an effort WHO was keen to recognize and embrace.

As healthcare and illness domains began to be regulated worldwide by state medicine, WHO envisioned a favourable scenario for the recognition of non-biomedical knowledge, practices, and therapeutic resources, while making them available alongside the medicine already practiced. During the First International Conference on Primary Health Care held by WHO in 1978 as a way to fulfil the ambitious goal of "Health for All by the Year 2000," the Organization advocated health care as a field of action of:

> "physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the Community" (WHO 1978a, p. 2).

Through the Alma-Ata Declaration, resulting from the First International Conference on Primary Health Care, WHO demonstrated its attentiveness to emerging conceptions of health, cures, and illness that emerged in public discourse. Furthermore, it also addressed the criticism from earlier decades about the lack of human attention given to patients by proposing an alliance between techno-scientific work and other care regimes. In this respect, it declared that regardless of whether their health regimes were traditional or not, all of its member states had formally agreed to take action to accomplish this specific goal. In 1978, the WHO established the Traditional Medicine Programme, where the term Traditional Medicine was understood as:

> "the sum total of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing" (WHO 1978b, p. 8).

> [It] “might also be considered as a solid amalgamation of dynamic medical know-how and ancestral experience” (id. ibid.).
>
> [It] “might also be considered to be the sum total of practices, measures, ingredients, and procedures of all kinds, whether material or not, which from time immemorial...” (id. ibid.).

According to this interpretation, the adjective "traditional" refers to both medicine and medication, that is, the medical professional and the therapeutic object recognized and validated through the knowledge and techniques of medical science, respectively. This double meaning encompassed by the same word reiterates the tautological sense of the medicine/medication binomial addressed by WHO.

In the following years, the proposal spread worldwide as a way to revisit health practices, the concept of tradition turned into a trigger to reconstruct medicine/medication itself. In this regard, Fassin (1988) recalls that the term "medicine" has a long history, intertwined with the establishment of the category as a professional and commercial field of activity. Unlike other emerging sectors of class struggle, the practice of medicine originated from bourgeois societies, supported by a particular system of values that legitimized it over other ways of understanding the phenomenon of treatment, healing, and illness. In addition to this argument, Emilie Cloatre and collaborators have been describing the regulation of Traditional Medicine globally, which, in order to become official, imposed homogeneity on the set of practitioners who previously operated through diversity (Cloatre et al. 2023; Urquiza-Haas and Cloatre 2023). It is not coincidental that in order to legitimize the variability of its recommended practices, WHO subordinates the idea of "tradition" to "medicine," always written in the singular form and capital letters.

The idea that, in different contexts, healing practices are carried out through some form of "medicine" suggests the functionality of the merged term, which is autonomous and distinct from other modes of producing social life. However, this is a fundamentally specific conception, as there is no a priori attribute capable of configuring its logic as cross-cultural. We can then say that "medicine" refers to a particular set of practices that cannot be treated as synonymous or symmetrical with other ways of assigning meaning to health or disorder. Consequently, Traditional Medicine is also part of a certain "tradition": the modern one. Yet, this latter term has been systematically used to maintain the division of us/them since it was constantly being surrounded by a lower semantic significance that is subject to validation and context in order to be accepted in the framework of medical practices. By subjugating "tradition" to "medicine", WHO has helped to foster a stable and romanticized understanding of culture, more easily mobilized by the framework of health consumerism.

I make this observation as a prelude to the discussion that will follow in this article, not as a form of premature pessimism, but rather as an antidote to premature optimism. Paraphrasing Annemarie Mol (2008) when raising objections to care as a necessary other to technology, I prefer to consider WHO’s proposal as a kind of premodern reminder in a modern world. In the subsequent sections, I will follow the author’s invitation and examine how the modern world has dealt with this reminder.

Enlarging the "traditional"

In recent reports, WHO has highlighted the international feature of what it refers to as Traditional Medicine. Today, the category is institutionalized by more than two-thirds of the Organization's member nations, benefit from a regulatory system addressing professional practice, education, and research, along with government recognition (WHO 2019).

The advent of WHO Traditional Medicine proposal provides an opportunity to examine how the propositions and terms established within the scope of international health agencies have effects that go beyond the bureaucratic arena. They have a considerable impact on the setting up of national healthcare systems, as well as on the treatment that is given in and out of institutions. As João Biehl (2016) has indicated, the notion of culture—which can also be matched to culturally situated ways of care provision—changes after appropriation by others, making this movement a very distinct form of politics.

Reading digitized documents available in the online library of the WHO, reveals that the term Traditional Medicine is not static. Among numerous reports, agendas, and meeting minutes, the term Traditional Medicine takes on semantic contours and political perspectives that are consistently variable and contextual, constantly intertwining with official medicine. To contextualize this argument, I review the Alma-Ata Declaration, which represents a turning point in attempts to stabilize the term tradition/traditional within the scope of international health recommendations. Before and after this declaration, the term's interpretations varied, ranging from recognizing therapeutic cultures of "others" to a possible healthcare proposed for "for everyone".

During the first two decades of WHO, from 1948 until the end of the 1960s, the term "tradition" referred to a set of characteristics that needed to be taken into account to ensure the practical success of medical assistance. The term "medicine" referred directly to clinical and epidemiological practices chosen to address public health demands that guided WHO's attention, such as access to clean water and containment of communicable diseases. However, the term itself was the subject of controversies among experts within the Organization, shown by the report of the 11th session of the Eastern Mediterranean Regional Committee.

> "It is not often fully realized that in order to raise the standard of services, the standard of the community itself should be raised, that in order to create and utilize better standards of medicine, the promotion of society becomes conditional. The mistake is often made of introducing prematurely highly specialized services to provincial areas where the general duty doctor would still be the most useful health agency. The provision of medical care cannot be determined by application and demand in economics" (WHO 1961, p. 2).

The incommensurability of these two terms can be observed in several documents prior to 1978. For instance, the 20th Annual Report of the Southeast Asia Regional Office stated how WHO failed to establish a national healthcare system in certain East Asian regions because the local populations prefer to use their

own conventional treatments. Thus, the few healthcare facilities that existed in these territories were rendered idle or ineffective (WHO 1967; 1973). An excerpt from the 11th session of the Eastern Mediterranean Regional Committee reveals that WHO acknowledges the most controversial feature of its interventions in relation to the mental health of the population, even indicating them as disruptive to practices and knowledge considered "traditional". However, the excerpt states that the establishment of medicine in rural areas is both a stage of rupture and future evolution,[2] a bitter pill applied to non-globalized ways of life, which paradoxically was increasingly valued in the urban context of advanced industrial societies. Beyond polarization, attempts to formalize national healthcare systems undeniably reveal the more anthropocentric mark of health interventions, where culturally operative care systems are seen as obstacles to the establishment of an allopathic medical system.

Until this point, the term Traditional Medicine played only a small role in the international arena. Its usage was circumstantial and lacked any systematization, as shown by the Organization's documents. References to Traditional Medicine were limited to citations made by regional offices aiming to document the various and distinct ways of contextualizing and attributing meaning to the phenomena of illness, treatment, and healing. "Medicine" and "tradition" began to operate together in a systematic manner only in the wake of the transformations generated by the advent of the "primary care" concept.

A significant portion of these early references began in 1972 during the 25th session of the Southeast Asia Regional Committee held in Colombo, Sri Lanka. In the report, WHO celebrates the progress of its interventions in the region, citing examples of success such as increased life expectancy and decreased infant mortality in countries like Bangladesh, India, Indonesia, Thailand, and Nepal. In the introduction of the report, WHO attributes these results to the establishment of a comprehensive network of professional healthcare education and practice in Asia, which began operating in harmony and collaboration with local populations, national universities, and foreign health agencies.

Referring to these results, in the following year, 1973, WHO commissioned a study on "Alternative approaches to meet basic health needs of populations in developing countries" (Djukanovic et al. 1975), whose findings would be presented to the WHO/UNICEF Joint Committee on Public Policy. As a step towards promoting national healthcare systems related to primary health care, a mixed team of senior officials from these two institutions ventured out of their offices to various regions of India and Bangladesh. This event helped shape the writers' viewpoint on defining the term and its first attributes. From the reported observations, in 1975, the global office of WHO established an international committee to be based in the Southeast Asia office which aimed to "develop guidelines for the provision of health coverage to the maximum number of people by using the services of traditional practitioners" (WHO 1978c, pp. 105–106).

[2] "Nevertheless, we should not confuse the passing with the permanent. After all, any process of evolution carries in itself the seeds of devolution of an older regime" (WHO 1961, p. 3).

This is the moment when the distances between regionality and universality are reduced, and both the notions of medicine and tradition intertwine and reconfigure themselves.

"The Promotion and Development of Traditional Medicine" (WHO 1978b), the inaugural report on this topic, is written in technical language and organized as a manual. In its early pages, it provides a list of academics and health professionals responsible for promoting Traditional Medicine worldwide. By showing how culturally based practices succeed in managing and addressing specific health demands in Africa, Asia, and Central America, the document reiterates how these practices deserve acknowledgement from official health systems around the world and are feasible to "develop for the wider use and benefit of mankind" (WHO 1978b, p. 13).

To that end, it endorses the selection and scaling up of successful experiences through scientific validation, to be carried out by Member State agencies. In order to contextualize WHO's actions and understandings at this time, it is worth highlighting the concept of scientific validation. The first report uses Mexico as an example, indicating that the local operational health work "is oriented towards the validation or invalidation of popular knowledge". This assumes that the experimental research and its findings serve as a powerful referee to mediate cultural differences, because "it permits feedback to the traditional healers themselves and to community in general" (WHO 1978b, p. 29).

In light of this power, it is crucial to remember that in the 1970s, the major international mechanisms that would eventually advance intellectual parity had not yet been formed. The International Labour Organization published the Indigenous and Tribal Peoples Convention in 1986 and the United Nations Convention on Biodiversity took place in 1992. Both furthered the conceptual entwinement of Traditional Medicine with discussions about benefit-sharing, informed consent, and intellectual property rights, placing the law at the service of culture to safeguard its differences. Although these themes weakened over time, becoming minimal or even absent in the following WHO Traditional Medicine reports, they slowed down the dominance of scientific validation in a " last but not least" way. Using this example, I intend to demonstrate how some experimental procedures changed to geopolitical tools when the scientific validation matched the WHO's agenda.

The term "traditional medicine" itself speaks to the changes I point out. While the trajectory of sciences and techniques in modernity has proclaimed medicine as the primacy of reason, separating it from discourse and politics, the term Traditional Medicine evokes the opposite and gains strength through the convergence of the biological and contextual effects of what it refers to. Beyond the always very partial boundaries of a certain symbolic efficacy, "traditionality" becomes an important active ingredient of medicine.

> "An integral part of the people's culture, it is particularly effective in solving certain cultural health problems", and "It can and does freely contribute to scientific and universal medicine" (WHO 1978b, p. 13).

In this document, WHO recognizes the differences between traditional knowledge and techno-scientific knowledge, without, however, reassessing the commitments of their terms and practices. Furthermore, the proposal suggests a controversial

protectionist conversion: the "traditional" healing knowledge and materialities are transformed into "medicine," being validated and regulated by the state. However, autochthonous populations, indigenous people, and traditional communities continue to lack the same rights and privileges of the medical class. In this regard, Dominique Perrot reminds us that in order to understand how indigenous people and self-referred traditional knowledge relate to the distinct development characteristic of the West, we must first acknowledge that this relationship occurs through institutions—Institutions that control the language, definitions, and adaptations of development (Perrot 2002).

In the second thematic publication (WHO 2002), both the content and presentation of what WHO recognizes as "traditional" undergo significant changes. From normative language and aesthetics, as preferred in the inaugural document, the subsequent version gives way to a document whose aesthetics and content lean more towards openness rather than contingency. This is achieved by incorporating elements that allude to holism and globalization.

In the new version, drawings of yin yang, branches, and flowers intertwine with maps and terrestrial globes, elements that bring forth new ways of socializing modern medicine. The endorsement of this gamble, which fuses medicine into a non-biomedical iconography, broad and globally well-valued, consolidates the WHO head office position: the "traditional medicine", previously scrutinized, and written in lowercase letters, has proliferated to the point of being recognized. Promoted by WHO offices to “Traditional Medicine”, it gained not just capital letters, but an official recognition allowing it to spread globally as a universally viable option. In the next section, I will delve into the course of this conversion.

Reducing differences

In 1986, during the First International Conference on Health Promotion, WHO began advocating for health services to adopt "a comprehensive stance that recognizes and respects cultural peculiarities". The Ottawa Charter, written as a summary of the event, ratified the efforts made in the previous decades and suggested a possible commensurability of allopathic medicine with other care regimes. Thus, as indicated in the document, "health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems" (WHO 1986).

Through this commitment, WHO not only encouraged the coexistence of different care techniques and knowledge regimes but also created space for local health authorities and agencies to embrace a certain medical pluralism based on complementarity.

In the context of global health, the consolidation of this proposal primarily occurred through the familiarity of member states with what was established as "traditional." I say this because in a context of dilution or even narrowing of boundaries between particular and universal, whether due to affinity or exoticism, what began as "traditional" quickly turned into "alternative" and "complementary", resulting in a polysemy of terms used to produce differences and similarities with allopathic

medicine. Complementary and alternative medicine (CAM), traditional and complementary medicine (TCM), traditional medicine/complementary and alternative medicine (TM/CAM), and traditional & complementary medicine (T&CM) are some of them.

At the turn of the millennium, the WHO headquarters, in collaboration with the drug policies sector of regional branches, developed a strategic plan intended to improve the accuracy of the categories proposed by the Organization while preserving certain characteristics of each. For example, the term Traditional Medicine (TM) was associated with countries in Africa, Asia, and Latin America, whereas "complementary and alternative medicine" (CAM) was related to countries in North America and Europe. The differentiation primarily operated on a socioeconomic and geographical scale but also had implications for identity, legislation, and health regulations.

Particularly prompted by the Convention on Biological Diversity, from 1992, the concept of "traditionality of use" sparked important debates and controversies in many countries regarding equal rights between traditional communities and the pharmaceutical industries.[3] In various instances, however, WHO equates the terms "traditional" and "complementary/alternative," thus indicating a shared genealogy between the terms it sought to define. It also presents the possibilities and scopes of each of them.

> "Traditional medicine" [TM] is a comprehensive term used to refer both to TM systems such as traditional Chinese medicine, Indian ayurveda and Arabic unani medicine, and to various forms of indigenous medicine. TM therapies include medication therapies — if they involve use of herbal medicines, animal parts and/or minerals — and nonmedication therapies — if they are carried out primarily without the use of medication, as in the case of acupuncture, manual therapies and spiritual therapies. In countries where the dominant health care system is based on allopathic medicine, or where TM has not been incorporated into the national health care system, TM is often termed "complementary", "alternative" or "non-conventional" medicine" (WHO 2002, p. 1).

As soon as it became part of global health, the category began to reconfigure care practices beyond the institutional and bureaucratic fields. Simon and Egrot (2012), for example, in an ethnography conducted in sub-Saharan Africa, comment that categorical pairing both strengthened the pharmaceutical industry by gaining new fields of expansion and weakened local healers, as their therapies were produced and marketed as "enhanced" traditional products, quickly reconverted through a particular interplay among identity, material, and symbolic interpenetrations.

[3] The Convention on Biological Diversity is a multilateral international agreement that was negotiated in 1992 in Rio de Janeiro, Brazil, under the auspices of the United Nations. Among the objectives of this agreement, which broadly addresses strategies for the conservation, access, and use of biodiversity, I highlight the establishment of principles for the equitable sharing of benefits derived from the exploitation of fauna and flora, as well as the development of new guidelines for the patent system of technologies and products derived from biodiversity, including those accessed through traditional knowledge.

Because of the conceptual merging, the term "alternative" quickly lost its strength in the international arena. In previous decades, as the health sciences experienced a true explosion of intellectual, technological, and practical developments regarding non-biomedical care,[4] rejection of the term "alternative" grew due to its more discordant connotation with "conventional" medicine. This shift relies upon a non-oppositional dichotomy compatible with both hegemonic knowledge and other forms of caring.

Cant and Sharma (2004) demonstrate this shift by addressing the institutionalization of homoeopathy in the United Kingdom's National Health Service. As the authors point out, beginning in 1993, the British Medical Association, which was supportive of what was then known as "alternative medicine," began to shift its public standpoint, which was initially opposed to the funding of non-allopathic services and drugs. To manage this controversy, the British association replaced the term "alternative" with "complementary". The same movement was followed in Australia, Brazil, the United States, Israel, and the European Union (Baer 2001; Fadlon 2005; Carlessi and Ayres 2021; Phan 2017; Van der Valk 2017).

In response to this criticism, WHO did not hesitate to opt for the term T&CM (traditional & complementary medicine), abandoning the "alternative" identity (WHO 2019). It is interesting to note that this shift invests in a kind of non-oppositional dichotomy, aligning with both hegemonic knowledge and other forms of care. Thus, they are presented as "medicine," but now as "complementary," separated from the "traditional." The proposal no longer lies in the polarization of classical dualities (regionality/universality, disease/health, remedy/medication), but rather in a supposed totalizing power. According to the report "Strategy for Traditional Medicine 2002–2005," the users of CAM also positively valued the term "complementary":

> "A national survey in the USA showed that the majority of CAM users do not in fact perceive CAM as "alternative to" but rather as "complementary to" allopathic medicine" (WHO 2002, p. 14).

However, the term reveals the asymmetry of the relationships between biomedical and non-biomedical practices. While a wide range of experiences are presented as "complementary" (in the sense of expanding therapeutic possibilities by adding

[4] To organize this extensive production which moves among traditional, alternative, complementary, and integrative approaches, in 2017, the Pan American Health Organization (PAHO) in partnership with the Latin American and Caribbean Center on Health Sciences Information (BIREME) created a dedicated domain within the virtual health library (https://mtci.bvsalud.org) called the Virtual Health Library on Traditional, Complementary, and Integrative Medicine. In June 2017, which marks the platform's inception, the library featured over 2.5 million bibliographic references indexed on this theme. This does not only signal the expressiveness of the topic within the health sciences since the turn of the millennium (given the volume and prominence of the referenced articles) but also indicates an active and dynamic production of identities in the ways of recognizing and categorizing this extensive array of pluralistic practices (reflected by the omission of the term "alternative" in the platform's name). Furthermore, the creation of the library also underscores the maintenance of power relations as a separate domain was established to organize these references, thereby preserving their distinctiveness from the more orthodox intellectual production contained within the Virtual Health Library (https://bvsalud.org).

symbolic, moral, and practical attributes), the reference also signals how they should relate to the hegemonic domains of health care, merely complementing them.

Traditional, alternative, and complementary medicine, in the sense of a heterogeneous set of non-biomedical practices, emerged from the recommendations of WHO as an invitation to possible alliances. However, it appears that the WHO proposed a conceptual framework as a way to highlight similarities and obscure differences that exclusively took into account the perspective of synthetic-allopathic medicine.

Integrating similarities

In this last section, I will address the relationship between "traditional" and "conventional" medicines—according to the WHO—and focus, in particular, on how this dichotomy is elaborated. I argue that the opposition between these categories points to a more complex interplay of interactions. In other words, the emergence of medicine that is referred to as "traditional", "alternative", and "complementary", along with their therapeutic resources, does not arise from a mixture of "original" or "pure" identities, nor does it reveal endangered authenticities. This conceptual path discloses the recognition and formalization of a movement where what is distant appears to be increasingly closer and more valued, while the familiar becomes present and imminent even in the farthest corners of the globe. This condition, in turn, signals not only the inaccuracy of thinking in terms of linear and hermetic cultures or traditions but also indicates that hybridity, which was once fought by medical sciences, becomes a new way to gain legitimacy in the international health agenda.

By addressing how certain terms have an impact on this new way of gaining legitimacy, I noticed that WHO reports on traditional, alternative, and complementary medicine are consistently supported by terms such as "integrative care", "comprehensive care", "comprehensive health services", and also "comprehensive health system". Unlike the terms traditional, alternative, and complementary, which have taken on a prominent role to the point of being promoted as therapeutic qualities, even serving as titles for the Organization's own reports, the adjectives comprehensive and integrative play a supporting role.

In the 25th annual report of the Southeast Asia Regional Committee, the term "integrated health services" is used to indicate a collaborative approach between medical specialties and described local care practices:

> "In Bangladesh, the first National Training Seminar for Health and Family Planning Personnel to strengthen rural health services was held at the Institute of Post-graduate Medicine, Dacca, in December 1972-January 1973, with 500 participants. A one-month "re-training" workshop for lady health visitors and lady family planning visitors was organized for the same purpose. Training was given to 300 new doctors to be assigned to the thana health centre complex for the implementation of integrated health services" (WHO 1973, p. 4).

The report uses the concept of "integration" when referring to different skills mobilized to compose a unified therapeutic regime, delineated by terms and conceptions specific to specialized medicine, as suggested in the following paragraph:

> "A National Seminar for the Training of Medical Officers in Rural Areas was held at Najafgarh (near Delhi) in October, with 18 participants from the different States of India. The objectives were to enable these medical officers to exchange ideas and experience on problems in the rural health establishment with community health personnel, to develop an orientation programme for medical officers in the rural health services [...]" (WHO 1973, p. 4).

As WHO began to acknowledge plural therapeutic grammars in its thematic reports and encouraged member states to incorporate/integrate them within their healthcare systems, these latter underwent a transformation. Precisely, the porosities and openings between what is referred to as conventional, traditional, alternative, and complementary, promoted by the heuristic power of this interaction, started to produce diverse, adaptive, and mutable regimes of care, both in their practical and epistemological sense. I am referring to a gap between what is recommended and what is actually carried out based on the recommendation. This displacement, while being induced in a homogeneous manner, is implemented as something new that is no longer "that" tradition nor "this" medicine. In the words of Marilyn Strathern (2005), it is something that is "more than one and less than two," an ontologically novel proposition. I illustrate this issue with another meaning attributed by WHO to the concept of "integrative", which refers not only to the organization of health services, but to the assistance given to patients.

The WHO's thematic documents progressively incorporate references to the "social," "psychological," and, more recently, the "spiritual" in understanding and addressing proposals for health promotion (WHO 1978a, 1984). Terms such as integrative care and comprehensive care were introduced as a way to harmonize the material and immaterial dimensions that are involved in health care. I argue that this represents an attempt to restore a certain "lost unit" in the history of medicine. In this sense, it would be incorrect to say that the attempts of institutionalized health care to overcome the fragmentation of the sick individual are new. What becomes new from the turn of the millennium (and for which WHO is its main proponent) is the will to merge opposing paths under a single clinical endeavour. The most controversial aspect arising from this movement is incorporating the pluralistic notion of "traditional" into "medicine" while also defining the more dispensable boundaries of the "complementary." These elements gain form and momentum within the unified framework of "integrative" medicine.

> "In mid-2017, WHO's Traditional and Complementary Medicine unit was renamed to include the term "Integrative Medicine", to cover the integrative approaches of both T&CM and conventional medicine regarding policy, knowledge and practice. The unit is now officially referred to as Traditional, Complementary and Integrative Medicine (TCI)" (WHO 2019, p. 14).

As of today, WHO has not produced any thematic report specifically dedicated to integrative medicine, as it has done with traditional, alternative, and complementary medicine since the 1970s. However, the concept of integrative medicine has shown to be deeply influential and informs the clinical approach to knowledge suggested by the Organization since the early editions of the thematic reports it has produced.

In the effort to bridge the gap between the opposition of part-whole, the most recent thematic reports have favoured an approach to "integration" that fundamentally highlights the similarities and commensurabilities between allopathic and non-allopathic care, rather than conflicts and dissent that arise from this encounter. Especially from the 2000s onwards, when terms like comprehensive and integrative were employed in proposals directed to the entire globe, the controversies previously associated with terms like traditional, alternative, and complementary were settled. In the early thematic reports on the subject, indeed, these terms were evoked in critical propositions that questioned the dominance of specialty medicine (WHO 1967, 1973, 1978c). In contrast, in more recent reports the terms "comprehensive" and "integrative" dissolve this opposition: associated with the regulation of products, services, and health systems, they become a form of specialization within the medical-pharmaceutical field.

Over the years, and especially as WHO's suggestion became effective globally as a kind of vector for the production of national public policies, the terms comprehensive and integrated were elevated to the status of a "system":

> "In an *integrative system*, TM/CAM is officially recognized and incorporated into all areas of health care provision. This means that: TM/CAM is included in the relevant country's national drug policy; providers and products are registered and regulated; TM/CAM therapies are available at hospitals and clinics (both public and private); treatment with TM/CAM is reimbursed under health insurance; relevant research is undertaken; and education in TM/CAM is available" (WHO 2002, pp. 08–09).

Once converted into a "system", the sense of integration presented here becomes a broader reference that encompasses alternative approaches, traditional practices, complementary therapies, and other propositions presented in previous reports. By framing it as a system, the proposal also becomes more capable of encompassing different forms of clinical intervention, therapy, and diagnosis. According to WHO, the commensurability of this fusion becomes possible by bringing together all these elements—complementary, alternative, traditional, and integrative—under the same care project: to treat the patient not in a "fragmented" sense, but in a "unified" manner.

Alongside the pursuit of "comprehensiveness" in healthcare, many other theoretical and practical approaches seem to propose paths to overcome the sense of fragmentation. Examples include the emphasis on "interdisciplinary" science, "sustainable" development, and a truly "democratic" republic. All these terms, by the way, are involved in WHO reports on traditional, alternative, complementary, and integrative medicine, without discussing the scope and limitations of these propositions.

The idea of considering the integration of different "medicines" or different "parts" of the same human being as a solution to fragmentation, and investing in the opposing facet of the same binomial in part and whole, reveal the imprecision of this proposal as it originates from a world that has not yet found a solution to a problem it created. I say this by drawing on WHO's reports, which were recently unequivocal in recognizing that only countries that have developed technologies rooted in their own cosmologies have been successful in implementing an "integrative system":

> "Worldwide, only China, the Democratic People's Republic of Korea, the Republic of Korea and Vietnam can be considered to have attained an integrative system" (WHO 2002, p. 09).

To the other member states of WHO, the proposal may appear utopian, as suggested by the Uruguayan writer Eduardo Galeano: something that keeps you moving forward.[5] To broaden the scope of life sciences, it is crucial to address the divide between care and technological advancements. This requires considering that the alternative to relativism and fragmentation—whether healthcare systems, humans, or modes of care production—does not lie in integration, but rather in partial, localized, and critical knowledge. Otherwise, the vision of the whole may also lead nowhere.

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Data availability The World Health Organization documents used in this study are available to the public under a Creative Commons license at the WHO institutional database (https://www.who.int/publications/i) and at the Pan American Health Organization repository (https://apps.who.int/iris).

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[5] Original, in Spanish: *La utopía está en el horizonte. Camino dos pasos, ella se aleja dos pasos y el horizonte se corre diez pasos más allá. ¿Entonces para qué sirve la utopía? Para eso, sirve para caminar* (Galeano 1991). "Utopia is on the horizon. I walk two steps, it moves two steps away, and the horizon moves ten steps further. So, what's the point of utopia? It's for walking" (Galeano 1991).

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