HHR
Health and Human Rights

DREXEL UNIVERSITY Dornsife School of Public Health

FXB Center for Health & Human Rights at Harvard University

Governing Difference: Traditional Peoples' Rights and the Institutionalization of Traditional Medicine in South America

PEDRO CREPALDI CARLESSI, VITOR HENRIQUE PINTO IDO, AND ISLÂNDIA MARIA CARVALHO DE SOUSA

Abstract

Since the 1970s, the World Health Organization (WHO) has advanced "traditional medicine" as a global policy category for culturally grounded health care. In South America, this framework has encountered a distinct political landscape in which traditional peoples have emerged as collective subjects mobilizing around rights, territorial claims, and expanding conceptions of citizenship. This paper examines how the codification of "tradition" from an identity category into a health regulatory term reconfigures the conditions under which difference can be expressed, claimed, and sustained. Drawing on archival research across 10 South American countries, as well as WHO and United Nations documentation, the study traces how the global framework has been incorporated, requalified, or displaced across distinct national contexts. The analysis reveals a spectrum of regulatory arrangements in which institutional incorporation and the political force of collective difference are not commensurate, ranging from frameworks that engage with the political projects through which traditional peoples have sought to reshape citizenship to those in which "tradition" operates as a market authorization criterion detached from the subjects who sustain it. The codification of tradition into governable categories does not simply extend recognition to those who bear it; it reconfigures the terms under which they can act as political subjects.

Pedro Crepaldi Carlessi is a researcher at the Democracy and Collective Action Research Group, Brazilian Center of Analysis and Planning, and a research member of the National Institute of Science and Technology – Transformations of Participation, Associativism, and Political Confrontation (INCT Participa, Process: 406630/2022–4), São Paulo, Brazil.

Vitor Henrique Pinto Ido is a professor at the Law School of the University of São Paulo, Brazil.

Islândia Maria Carvalho de Sousa is general coordinator at the National Observatory of Traditional, Integrative and Complementary Health Knowledge and Practices, Oswaldo Cruz Foundation, Recife, Brazil.

Please address correspondence to Pedro Crepaldi Carlessi. Email: pccarlessi@gmail.com.

Competing interests: None declared.

Introduction

In a 2009 interview reflecting on Indigenous participation in Brazil's 1988 National Constituent Assembly, Ailton Krenak compared the state to a beast: "one of those beasts that can be restrained but, from time to time, still devours someone."[1] The comparison was made without metaphor. The Krenak people were, at the time of that interview, facing the imminent risk of being devoured themselves. In that same year, 2009, while two decades of constitutionally recognized Indigenous rights in Brazil were being celebrated, the Brazilian Supreme Court was considering the possibility of summarily retracting them.[2] Far from hyperbolic, Ailton Krenak's image served as a reminder that, for certain identities, the distance between being devoured and almost being devoured remains perilously narrow. Recognizing that a restrained beast never ceases to be a beast is, therefore, a prudent way to avert danger.

Although constantly aware of such threats, the Krenak people in Brazil, like the Aymara in Peru, the Kichwa in Colombia, the Montubio in Ecuador, and other groups engaged in struggles for life and territory against latifundia and biopiracy, witnessed a regional shift as many South American states began to incorporate cultural difference into their legal and institutional frameworks. While not without ambiguity, this shift signaled a new political moment in the region in which the long-standing pressure to dissolve difference into a homogenized nation-state gave way to its formal recognition as a constitutional principle and the basis for collective rights.[3]

In much of South America, this reconfiguration was articulated through the idea of "tradition" (or "traditionality"). Despite its diffuse conceptualization, the term proved politically productive precisely because of its openness, allowing heterogeneous groups to organize their distinct projects of autonomy under a shared political front. Encompassing Indigenous, Afro-diasporic, mestizo, peasant, and other local communities, the category of "traditional people" became a key marker of identity from the 1980s onward, enabling historically marginalized groups to assert themselves as political subjects within the national political arena.

During this same period, the World Health Organization (WHO) intensified its framing of "traditional medicine" as a strategic concept for achieving culturally grounded health care. The encounter between WHO's conceptualization and South American traditional peoples' agenda became a key vector in public debates, linking processes of citizenship pluralization to the incorporation of medical pluralism into public policies.

Previous studies have shown that the reframing of "tradition" within global health governance tends to displace its political and relational dimensions.[4] The South American context calls for closer attention to this dynamic. In the region, the notion of "tradition" is deeply embedded in long-standing struggles over the very terms of citizenship—struggles that have produced constitutional transformations, collective rights instruments, and expanding arenas of political participation.

This paper examines how the institutionalization of WHO's concept of traditional medicine across 10 South American countries intersects with broader processes of citizenship pluralization in the region, and what that intersection does to the political projects through which traditional peoples have sought to reshape the terms of belonging.

Tracing the institutional life of "traditional medicine": Sources, scope, and analytical approach

This study focuses on South American countries that explicitly reference "traditional medicine" in their public health policies, encompassing both highly institutionalized frameworks (Bolivia, Brazil, Chile, Colombia, Ecuador, Peru, and Venezuela) and more circumscribed regulatory approaches (Argentina, Paraguay, and Uruguay).

Through archival research, we selected public policies, health programs and regulations, and development plans and government reports. The selection prioritized documents that reflect the institutional consolidation of traditional medicine within public policy, including legislation and other instruments that make this consolidation observable. Particular attention was given to documents that reveal how regulatory forms intersect with the operationalization of rights and the participation of traditional peoples.

We identified documents using the term "traditional medicine" as endorsed by WHO, alongside regionally specific terminologies such as "ancestral medicine," "Andean medicine," "Indigenous medicine," "traditional knowledge," and "traditional practices." To address terminological variation, the study assumes equivalence not at the level of meaning but at the level of policy function: Since all countries in the corpus engage with the WHO category—whether by adopting, requalifying, or displacing it—the term functions less as a fixed referent than as a site where the relationship between global regulatory frameworks and nationally situated political projects becomes legible. The variation in how countries mobilize, reframe, or depart from WHO's formulation is part of what the analysis seeks to trace.

We conducted online searches in Portuguese, Spanish, and English, using official government portals and other relevant digital platforms. Among the 249 documents identified, we paid particular attention to a subset of 87 documents published between the 1990s and 2010s. This period captures the moment when the international consolidation of traditional medicine as a policy category became most pronounced, coinciding with the democratic reopening and the simultaneous intensification of neoliberal reforms across South America—what Evelina Dagnino has described as a "perverse confluence." In this context, the adoption of the WHO framework produced its most consequential and ambivalent effects on the processes through which traditional peoples were asserting themselves as political subjects.[5] Documents published after 2010 were incorporated where relevant to trace subsequent regulatory developments and their implications for the relationship between therapeutic institutionalization and citizenship pluralization.

The analysis follows a twofold orientation. It examines how the WHO framework travels downward into national policies and whether the regional innovations in traditional peoples' rights find upward resonance within global health governance or remain marginal to it.

Analytically, the study addresses "traditional medicine" as a political category whose effects are not fixed but emerge from the contexts in which it is mobilized. The analysis therefore examines how traditional medicine operates within institutional frameworks to frame the recognition of culturally differentiated subjects and their citizenship claims. The central move is to track how groups for whom "traditional" is a self-ascribed marker of identity are positioned within these frameworks—as beneficiaries, providers, rights holders, or sources of evidence—and what that stance does to the conditions under which they can act as political subjects.

Contributing to studies on citizenship and pluralism, this paper argues that the codification of "tradition" into a governable policy category does not simply extend recognition to those who bear it; it reconfigures the conditions under which difference can be expressed, claimed, and sustained.[6] Although these effects vary according to the social configurations and national frameworks of each country, they consistently operate across a spectrum of possibilities in which greater institutional incorporation does not necessarily preserve, and may actively reconfigure, the political force of those who sustain these practices.[7] What is at stake, ultimately, is not whether recognition occurs but under what conditions, and whether those conditions allow difference to remain a living political force or instead render it governable at the cost of its own dynamism.

Forging a global path

In its earliest formulations, developed between the 1960s and the late 1970s, WHO's category of "traditional medicine" referred to a heterogeneous set of locally embedded health practices and knowledge systems.[8] Particularly attentive to the multiethnic configurations that had emerged from colonial rule in Southeast Asia and Sub-Saharan Africa, WHO approached cultural difference as both an obstacle and a strategic resource.[9] Within this framework, the term "traditional" pointed to difference from Western medicine, while "medicine" functioned as an aggregating category, gathering diverse care regimes defined less by their distinctions than by their pragmatic convergence.[10]

The conceptualization remained openly unsettled—traditional medicine was variously described as "the sum total of all the knowledge and practices, whether explicable or not, used in diagnosis and prevention," as "a solid amalgamation of dynamic medical know-how and ancestral experience," or as "the sum total of practices, measures, ingredients, and procedures of all kinds"—yet WHO advanced a resolute assertion that "the essential differences among the various systems of medicine arise not from differences in their goals or effects, but from the cultures of the people who practice them."[11] Aligned with the internationalist ethos of the United Nations, this formulation located medical difference in the populations who sustain it, while framing such diversity as compatible with integrated health governance. Within the horizon of the Global Strategy for Health for All by the Year 2000, traditional medicine was conceived as a pathway to universalize health coverage.[12]

From the 1990s onward, WHO increasingly rearticulated traditional medicine as a domain capable of policy integration and transnational circulation. This process reached its clearest expression in the Traditional Medicine Strategy 2002–2005, in which WHO reformulated the category as "a comprehensive term used to refer both to traditional medicine systems such as traditional Chinese medicine, Indian Ayurveda and Arabic Unani medicine, and to various forms of Indigenous medicine."[13] Here, the place of difference was simultaneously redefined. No longer anchored in the subjects who sustained these practices, "tradition" was recast as a resource to be integrated into national health systems and emerging therapeutic markets. This redefinition was not only about who sustains the tradition being referred to but also about where the term is applied: "'traditional medicine' is used when referring to Africa, Latin America, South-East Asia, and/or the Western Pacific, whereas 'complementary and alternative medicine' is used when referring to Europe and/or North America (and Australia)."[14] That geography is not incidental; it maps a distinction about how recognition claims could be made, where, and by whom, quietly displacing the broader disputes over political belonging that had driven the mobilization of "tradition" in its earliest global formulations.

From the mid-2010s onward, this trajectory culminated in a further inflection of the category itself. Rather than stabilizing the distinction between "traditional" and "complementary and alternative" medicine established in the 2002 strategy, subsequent WHO publications progressively blurred it, producing a proliferating polysemy: "complementary and alternative medicine," "traditional and complementary medicine," "traditional medicine/ complementary and alternative medicine," and "traditional and complementary medicine" coexist across WHO documentation without stable definitional boundaries.[15] Far from a merely terminological question, this drift reflects a gradual repositioning of the term "traditional" within a broader regulatory horizon.

The consolidation of this trajectory became particularly visible in the First Traditional Medicine Global Summit, convened by WHO in 2023 in Gandhinagar, India. The summit revealed how major powers are now projecting the category onto a shifting geopolitical landscape in which the global governance of health is itself being reconfigured by emerging stakeholders. India and China showcased distinct yet convergent models: China promotes a state-sanctioned "tradition" centered on Han medicine within a framework of health commodification, while India reframes Ayurveda within a Hindu-nationalist agenda. Despite their differences, both models expand the global circulation of their medical systems through the export of educational frameworks, regulatory models, and pharmaceutical products.[16]

Thus, the mediating role of regional institutions acquires particular significance at this juncture, where global health governance progressively redefines tradition as a strategic category detached from the subjects who sustain it.

PAHO and WHO: A distant embrace

In South America, the Pan American Health Organization (PAHO) functions as the primary institutional bridge between WHO's global agenda and the region's own political configurations.[17] Repeatedly caught between the political demands of traditional peoples whose claims have become increasingly present in the region's institutional arena and the global regulatory frameworks within which it operates, the organization has rarely fully aligned with either. The Health of the Indigenous Peoples Initiative offers a particularly illustrative case of this pattern.

From 1993 to 1997, two PAHO resolutions—CD37.R5 and CD40.R6—formally recognized the structural inequities shaping Indigenous peoples' access to health care and committed member states to addressing them. More than instruments for expanding service coverage, they stood out for their political framing, affirming Indigenous peoples' right to self-determination, calling for the recognition of their distinct therapeutics, and requiring governments to establish mechanisms for Indigenous representation in the design of health care systems.[18] In the years that followed, this political momentum found initial institutional expression in a work plan developed for 2000–2001, which still maintained the specificity of its agenda, positioning so-called Indigenous medicine as a distinct area of engagement alongside (but not subsumed within) the broader category of "traditional, complementary and alternative medicine," each carrying its own questions and constituencies.[19]

That specificity, however, proved difficult to sustain. As the hybridized concept of traditional, complementary, and alternative medicine gained increasing institutional density, expanding into national departments, international frameworks, and dedicated policy instruments, Indigenous medicine has remained largely confined to its own domain. This compartmentalization has had a specific consequence. The political claims that had originally shaped the Indigenous agenda—benefit-sharing, prior informed consent, and collective rights over knowledge—have never been systematically extended to the very regulatory domains where they are most at stake. Traditional, complementary, and alternative medicine frameworks—herbal medicine above all—have advanced without engaging these claims, even as they draw extensively on the knowledge systems of the peoples whose rights they leave unaddressed.

In a context where the particular dimensions of Indigenous claims had lost institutional traction, interculturality emerged from the turn of the millennium as a bridging concept that carried the promise of a mutually valorizing encounter between distinct therapeutic traditions.[20] In practice, however, it has operated in a way that deepens rather than resolves the existing compartmentalization. By framing traditional medicine primarily as a space of convergence between therapeutic systems, interculturality has progressively disconnected it from the collective subjects and the rights most directly associated with traditional peoples—claims that have been increasingly confined to the domain of Indigenous medicine, while non-Indigenous traditional peoples have been largely left outside both formulations. What had been a terrain where recognition, belonging, and rights could be contested has been recast as an approach to the administration of cultural difference, with traditional medicine repositioned as a therapeutic category rendered compatible with the expanding frameworks of complementary and alternative medicine.[21] Institutional recognition of difference thus proceeds on terms that constrain its political scope, gradually requiring a certain dispossession of alterity as the price of legibility within the health system.

This dynamic has produced what may be described as a double distancing. PAHO's progressive alignment with global regulatory logics has moved the organization away from the demands of traditional peoples, who had mobilized traditional medicine as a site of political struggle. At the same time, the region's distinctive political innovations have found little resonance within WHO's global architecture, where PAHO's limited influence has constrained their upward circulation.[22] South American demands have remained distant from PAHO, just as PAHO has remained distant from WHO, reproducing at each level the conceptual divergences that have hindered effective strategic alignment between the two agendas.[23]

At this intersection, one can observe how global regulatory logics do not simply absorb locally grounded demands; they reconfigure the terms under which those demands can be expressed. How national governments across South America have navigated this double distancing, and with what consequences for the relationship between medical pluralism and the broader political projects of citizenship pluralization unfolding in the region, is the question to which the analysis now turns.

Traditional peoples' rights and the institutionalization of traditional medicine in South America

From the 1980s onward, South American countries progressively responded to WHO's call to develop national policies addressing traditional medicine. Although this agenda was widely adopted across the region, its implementation followed divergent timings and trajectories that cannot be understood apart from the broader institutional transformations unfolding during the same period, particularly those associated with democratic reopening and the progressive consolidation of difference as an organizing principle of citizenship pluralization across the region.

Ecuador, Bolivia, and Colombia represent the cases where constitutional transformation went furthest, and it is precisely in these cases that traditional medicine has been most deeply articulated with broader political projects of citizenship pluralization, yet through distinct institutional pathways.[24]

In Ecuador, whose 2008 Constitution established plurinationality as a foundational principle of the state, institutionalization proceeded through hybridization. The National Directorate of Intercultural Health and Equity incorporated *hombres y mujeres de sabiduría* into the Ministry of Public Health under a dedicated ethical code that reframed biomedical categories, such as "medicine," "ethics," "diagnosis," and "specialization," recasting them through concepts and distinctions drawn from Indigenous cosmologies.[25] This process conferred significant institutional legitimacy upon these subjects through a logic that was, at its core, one of translation—and translation, as Viveiros de Castro argues in discussing the asymmetries of intercultural encounters, is always a form of betrayal.[26] The ethical code itself acknowledges that in adopting this denomination—*código de ética*—its authors are translating their practice into terms legible to the surrounding Ecuadorian society, while insisting that the document expresses something that cannot adequately be rendered in Castilian. In this case, the categories through which difference is recognized belong to one of the two worlds being bridged, and the bridge runs in one direction. Difference is acknowledged, but on terms that make it fully administrable, a recognition secured through the internal reconfiguration of the very practices it claims to recognize.

Bolivia's trajectory suggests a different institutional logic. Its 2009 Constitution, the first in the region to establish the state as explicitly plurinational and to constitutionalize Indigenous self-government as a foundational right rather than a policy concession, created the normative conditions under which traditional medicine could be institutionalized on different terms.

The Law on Bolivian Ancestral Traditional Medicine (Law 459 of 2013) did not simply incorporate traditional practitioners into the national health system; it created devices that attempted to preserve the relational conditions under which these practices make sense. Remuneration, for instance, was regulated in accordance with "the mode that makes sense for each nation," explicitly accommodating non-monetary forms of exchange rather than converting reciprocity into a wage relation. Similarly, accreditation was structured as a community process. It is the community, not the state, that validates the practitioner.

Yet the critical notes within Bolivia's own institutional documents regarding the incorporation of traditional practitioners into national health settings highlight the political limitations of this framework. The 2016–2020 Strategic Plan, aimed at operationalizing the Plurinational Constitution and consolidating health concerns raised since the pre-constituent assemblies, acknowledged plainly that the health sector had consistently failed to assume traditional medicine as an operative part of its structure—and that, in practice, traditional medicine remained separate from official services, with the attendant risk of becoming little more than the defense of corporate interests.[27] Even where normative devices attempt to preserve relational logics, their encounter with biomedical infrastructure produces reconfigurations that the framework itself acknowledges as problematic.[28]

Notably, Bolivia and Ecuador are also among the countries whose policy arguments make least reference to the WHO framework, constructing instead a normative repertoire more directly tied to the constitutional transformations that redefined citizenship in both countries.

Colombia occupies an analytically distinct position. Its 1991 Constitution recognized the multiethnic nature of the state and established collective rights, producing a constitutionalism in which alterity is recognized within the state rather than becoming partially constitutive of it. This distinction is legible from the outset in the institutional architecture of health policy.

With Resolution 5078 of 1992, Colombia's Ministry of Health separated "traditional medical cultures" from "alternative therapeutics," inscribing cultural difference as a criterion of recognition irreducible to the logic of professional certification.[29] This opening created a space of expanding citizenship, in which new collective actors were incorporated into state provision. The case of Afro-Pacific midwifery regulation illustrates both the reach and the limits of this incorporation.[30] Its recognition as cultural heritage induced a displacement from the field of health, where specific categories for traditional practices had advanced without inscribing their practitioners within a system of autonomous collective rights, toward a framework in which the link between knowledge and the rights of those who hold it as a community could be formally established. As this case suggests, alterity is recognized on its own terms only insofar as the available instruments permit, and not as far as the recognized subjects might claim.

In Brazil and Argentina, traditional medicine has been inscribed within institutional arrangements structured primarily by a universalizing logic of rights that creates openings for the inclusion of difference without producing the conditions for alterity to operate as a self-sustaining political force.

In Brazil, the 1988 Constitution established health as a universal right, producing the institutional architecture of the Unified Health System and, within it, a logic of inclusion that tends to absorb difference as a variant of the universal rather than recognize it on its own terms. This is most visible in the institutional separation between two distinct policy trajectories. Complementary and alternative medicine—nationally designated as *práticas integrativas e complementares em saúde*—was institutionalized through a 2006 national policy and has since expanded to make Brazil the country with the largest number of institutionalized complementary and alternative medicines among WHO member states, incorporating globally circulating practices such as Ayurveda and acupuncture and 26 others through the universalist logic of access.

Indigenous health, by contrast, was constituted as a separate subsystem—SasiSUS, established in 1999—structurally centered on biomedical care adapted to Indigenous contexts, within which Indigenous therapeutic and diagnostic systems remain without formal recognition as constituent parts of the subsystem and without dedicated state support. This separation is not merely organizational. It reflects a configuration in which the most globally mobile therapeutic practices are absorbed into the universal right to health, while practices most directly tied to collective identity and territorial belonging are lateralized within it.[31]

Argentina's 1994 Constitution recognized the ethnic and cultural preexistence of Indigenous peoples and established collective rights as a foundational principle. The country has no specific framework concerning traditional medicine; instead, its regulatory architecture is limited to herbal medicine. The National Administration of Drugs, Food and Medical Devices' 2015 phytotherapeutic regulation, strongly influenced by the European Medicines Agency framework, introduced the criterion of "long tradition of use" as the basis for herbal drug registration without clinical evidence, a formulation that reveals how the universalizing logic through which traditional knowledge enters the national regulatory field is shaped by evidentiary standards produced entirely outside the communities whose practices they purport to govern.[32]

Taken together, these cases suggest that the relationship between institutionalization and political agency is neither linear nor uniform. Where institutionalization was grounded in constitutional transformations that repositioned traditional peoples as collective subjects of rights, and where those peoples sustained organized forms of agency capable of shaping the terms of recognition, the encounter between traditional medicine and state frameworks produced configurations in which difference retained, at least partially, its capacity to operate as a living political force. Where institutionalization proceeded through the adoption of globally circulating regulatory frameworks, disconnected from collective rights instruments and from the political struggles that had produced them, recognition tended to operate as accommodation, extending institutional space to difference while constraining the conditions under which it could be claimed and sustained. What varies across these cases is not whether recognition occurs but the degree to which its terms remain open to contestation by those who bear it.

The political imagination of legal subjects

The redemocratization processes that reshaped South American political life coincided with a significant expansion of international binding agreements that progressively extended the political horizon of citizenship. The near-simultaneous adherence of all countries examined here to the Convention on Biological Diversity throughout the 1990s, and to the Nagoya Protocol in the following decades, consolidated within the regional juridical architecture concepts such as traditional knowledge, prior informed consent, community sovereignty over biological resources, and benefit-sharing arrangements. These concepts were not merely extensions of existing human rights frameworks but carried within them a different understanding of the subjects of rights, one more compatible with the non-Western cosmologies that modern legal tradition had historically rendered invisible.[33]

Several countries went further than environmental protection, constitutionalizing collective subjects as inseparable from the territorial and ecological relations in which they are embedded.[34] The political imagination behind this original formulation was one in which citizenship is grounded in ecological relations.[35] From this, the subject of rights is not abstracted from the territory that sustains it, and health cannot be governed as though detached from the conditions of collective life. Yet even where this imagination was constitutionalized with greatest depth, it remained bounded. The broader regulatory frameworks governing traditional medicine did not incorporate this body-territory nexus, and the constitutional vision did not migrate into the general regulatory architecture. What was recognized in one register was contained in another, granted a bounded institutional space that left the dominant ordering of the health system undisturbed.

Nothing in the available juridical architecture made this outcome necessary. The international instruments ratified during the same period—International Labour Organization (ILO) Convention 169 (1989), the Convention on Biological Diversity (1992), the Declaration on the Rights of Indigenous Peoples (2008), and the Nagoya Protocol (2010)—offered a juridical language through which the regulation of traditional medicine could have been coordinated with the territorial and ecological frameworks that the region's constitutions were simultaneously constructing. During the same decades in which South American countries were ratifying instruments that recognized collective subjects as sovereign over their biological resources and traditional knowledge, WHO's traditional medicine agenda was consolidating in a direction that systematically bypassed these frameworks. Tellingly, ILO Convention 169 is absent from WHO programmatic documents on traditional medicine, and the Declaration on the Rights of Indigenous Peoples appears only marginally in the most recent WHO report.[36] Global health governance and the international legal instruments governing collective rights for traditional peoples developed in parallel, without sustained articulation, and this disjunction has reproduced itself regionally.

The Peruvian case documents this reproduction with particular precision, since it allows the disjunction to be traced as a historical process with a visible turning point. In 2008, the National Health Institute convened the First Forum on Research and Biotrade in Traditionally Used Medicinal and Food Plants, gathering the Ministry of Health, the Ministry of Commerce, the National Biocommerce Program, and the National Commission Against Biopiracy. The commission's representative grounded his intervention explicitly in the Convention on Biological Diversity, describing it as the instrument that had "changed the global paradigm" by recognizing state sovereignty over genetic resources and affirming that "traditional knowledge belongs to the peoples who developed it."[37]

What the consolidated regulatory framework retained from that encounter was the product, not the subject. The registration system distinguished between unprocessed plant materials, which could circulate without sanitary authorization provided they carried no therapeutic indication, and processed natural health products, which required registration and proof of pharmacological activity. For the latter, a 2000 decree introduced a further provision. Products lacking clinical studies could be commercialized bearing the label "traditionally used for," a formulation that translates traditional knowledge into a regulatory threshold, detached from any reference to the communities that hold it.[38]

In the following decades, the binding international instruments continued to deepen traditional peoples' rights in other domains of Peruvian state action: the creation of the Intercultural Affairs Ministry in 2010, charged with promoting compliance with ILO Convention 169 and implementing the right to prior consultation, and the approval in 2026 of the National Policy for Indigenous and Native Peoples to 2040, structured around the Convention on Biological Diversity statements, tracing a trajectory of progressive recognition that has never reached the regulated pharmaceutical sector. The registration system has developed according to its own logic, insulated from the democratic innovations reshaping other areas of state recognition.

This pattern has not been confined to Peru. Across the region, the binding instruments that reshaped the juridical horizon of citizenship in other domains have left the regulated pharmaceutical sector structurally untouched—one grounding tradition in collective rights, the other converting it into a privately certifiable good. The result is not contradiction but compartmentalization, and it is in that compartmentalization that the political force of difference is most consistently contained.

Recognition and its limits

South American citizenship pluralization also unfolds through disputes over the status, ownership, and circulation of knowledge. In this context, the regulation of traditional medicine becomes a key site where competing frameworks define what counts as "tradition" and which institutional actors are entitled to authorize its use.

The regulatory model governing traditional herbal products, first established by the European Medicines Agency and subsequently reinforced by WHO for its member states, introduced an alternative route for pharmaceutical registration in which "documented traditional use" substitutes for clinical evidence.[39] In this framework, "tradition" is no longer anchored in the communities that sustain it but in the temporal continuity of a practice as established through documentary records. The terminological displacement is telling: from "medicine" to "product," from collective knowledge to certifiable property, and from lived practice to documentary record, raising the prior question of who holds access to such archives and who is recognized as their legitimate author.[40] What disappears in this process is precisely what the binding international instruments sought to protect: the collective subject as sovereign over its own knowledge and the territorial relations that give that knowledge meaning.

In Brazil and Uruguay, this regulatory recodification operated more immediately, aligning national regulatory frameworks with the European model and dissociating the therapeutic product from the rights and recognition of the communities that generated it. Yet this alignment was not achieved without contestation. In Brazil, traditional peoples and their organizations sought throughout the first decade of the 21st century to articulate health regulation with the expanding citizenship that had been under construction since redemocratization, bringing that demand into institutional spaces of representation and political participation.[41] That coordination was never achieved. While traditional peoples and their organizations pressed for the inclusion of their demands within the regulatory framework, the national health surveillance authority moved in a parallel and contrary direction, deepening its alignment with international regulatory harmonization spaces, progressively constraining the regional particularities that those disputes sought to introduce.[42]

In countries where constitutional recognition of collective subjects went further, the operation is more complex. The Ecuadorian case illustrates this with particular clarity. Its plurinational constitutional framework, established in 2008, did not merely recognize cultural diversity within a pre-given state order; it subjected the foundations of that order to renegotiation. Yet even within such a framework, the regulatory architecture governing pharmaceuticals followed a more limited trajectory. The framework concerning herbal medicine aligned with the logic of industrially simplified registration based on documented traditional use, extending sanitary authorization to products whose therapeutic legitimacy rested on bibliographic records of local practices, requiring these medicines to be registered and commercialized under health authority surveillance.[43] Even in earlier versions of this regulatory framework—more closely aligned with the international harmonization that consolidated around the standard established by the European Medicines Agency in 2004—rather than constructing a direct link between this registration system and the collective subjects who generated the knowledge it drew upon, the Ecuadorian state established itself as co-owner of any herbal medicine patent, entitled to receive the corresponding royalties.[44]

This provision was explicitly framed as a response to the threat of international biopiracy, consistent with Andean Community Decision 391, a regional instrument concerning access to genetic resources registered within the framework of the World Intellectual Property Organization. Yet in both cases, by positioning the state and market rather than the traditional peoples themselves as the effective holders of co-ownership rights, it constructs a chain of institutional mediations between the knowledge and its generators, enacting at the regulatory level the dynamic that marks citizenship pluralization across the region, where the admission of difference and the containment of its political force are one and the same operation.

What these cases reveal, taken together, is a specific mode of incorporating difference that liberal frameworks of recognition tend to obscure. Ghassan Hage has argued that multicultural recognition does not redistribute power but confirms it.[45] The subject who recognizes remains at the center, while the recognized is positioned at the periphery of a structure the recognizer controls. What is at stake is not whether recognition occurs but what kind of political subject it produces. Across the region, traditional medicine has been admitted into the institutional architecture of health governance, but on terms that fix the "traditional" in a given position rather than allowing its presence to reconfigure the conditions of its own recognition.[46] Citizenship has pluralized; the regulatory frameworks through which that pluralization has been institutionalized have not followed. What has expanded is not the capacity of traditional peoples to define the terms of their own participation but the capacity of existing structures to accommodate their presence without being transformed by it.

Conclusion

The institutionalization of traditional medicine in South America has unfolded at the intersection of two processes that do not move together: the expansion of citizenship to encompass collective difference, and the progressive codification of "tradition" into regulatory categories shaped by global health governance.

This paper has traced, across national frameworks and international institutions, not simply a gap between rights and regulation but the specific ways in which that codification reconfigures the terms under which difference can be expressed, claimed, and sustained.

The spectrum of configurations documented here—from normative architectures that attempt to preserve the relational conditions of traditional practices to frameworks in which "tradition" operates exclusively as a market authorization criterion—reveals that what is at stake is not the recognition of difference but the conditions under which difference can remain a living force within the broader political projects through which traditional peoples have sought to reshape the terms of citizenship in the region.

References

1. M. A. T. Coelho and A. Krenak, "Genocídio e resgate dos 'Botocudo', São Paulo," *Estudos Avançados* 23/65 (2009).
2. A. Sheps, "The Dispute over the Raposa Serra do Sol Reserve Demarcation: A Matter of Indigenous Constitutional Rights or National Sovereignty?," *Anuario Mexicano de Derecho Internacional* 10 (2010).
3. R. Merino, "Reimagining the Nation-State: Indigenous Peoples and the Making of Plurinationalism in Latin America," *Leiden Journal of International Law* 31/4 (2018).
4. M. Ashworth and E. Cloatre, "Enacting a Depoliticised Alterity: Law and Traditional Medicine at the World Health Organization," *International Journal of Law in Context* 18/4 (2022).
5. E. Dagnino, "Sociedade civil, participação e cidadania: De que estamos falando?," in D. Mato (ed), *Políticas de ciudadanía y sociedad civil en tiempos de globalización* (Universidad Central de Venezuela, 2004).
6. P. Wade, *Race and Ethnicity in Latin America*, 2nd edition (Pluto Press, 2010).
7. N. G. Postero, *Now We Are Citizens: Indigenous Politics in Postmulticultural Bolivia* (Stanford University Press, 2007).
8. World Health Organization, Eleventh Session EM/RC11/16, Regional Committee for the Eastern Mediterranean (1961).
9. World Health Organization, "Health Development in South-East Asia," WHO Regional Publications, South-East Asia Series No. 7 (1978).
10. P. C. Carlessi, "Instituting Traditional Medicine: Changes to Identity and Legitimacy in Global Health," *Social Theory and Health* 22/4 (2024).
11. Ibid., p. 9.
12. H. Mahler, "Health for All by the Year 2000," *World Health* (February–March 1981), https://iris.who.int/server/api/core/bitstreams/b977d535-7a53-4d16-8f13-a86addc50f41/content.
13. World Health Organization, *Traditional Medicine Strategy 2002–2005* (2002), p. 1.
14. Ibid., p. 8.
15. World Health Organization, *WHO Global Report on Traditional and Complementary Medicine 2019* (2019); World Health Organization, *WHO Traditional Medicine Strategy 2014–2023* (2013).
16. M. Rong, "A Han vs. Minorities Dual Structure of Chinese Society," *China: An International Journal* 11/2 (2013); A. Mazumdar, "India's Soft Power Diplomacy Under the Modi Administration: Buddhism, Diaspora and Yoga," *Asian Affairs* 49/3 (2018).
17. M. Cueto and S. Palmer, *Medicine and Public Health in Latin America: A History* (Cambridge University Press, 2014).
18. J. K. Cowan, "Culture and Rights After Culture and Rights," *American Anthropologist* 108 (2006).
19. Pan American Health Organization, *Traditional, Complementary and Alternative Medicines and Therapies: Evaluation Plan of Work 2000–2001 and Plan of Work 2002–2003* (2002), https://iris.paho.org/server/api/core/bitstreams/bdd305aa-ee8e-4b3f-906e-b88dfff0bd87/content.
20. Pan American Health Organization, Development and Strengthening the Implementation of Local Health Systems: Resolution V; Health of Indigenous People (1993), https://iris.paho.org/items/ca00be12-69f7-44d9-a221-0df468abcad.
21. Pan American Health Organization and World Health Organization, *Traditional, Complementary and Alternative Medicine and Therapies in the Americas: Policies, Plans and Programs* (2002).
22. B. M. Meier and A. S. Ayala, "The Pan American Health Organization and the Mainstreaming of Human Rights in Regional Health Governance," *Journal of Law, Medicine and Ethics* 42/3 (2014); A. Perez-Brumer, D. Hill,

and R. Parker, "Latin America at the Margins? Implications of the Geographic and Epistemic Narrowing of 'Global' Health," *Global Public Health* 19/1 (2024).

23. O. Feo Istúriz, C. Feo Acevedo, and P. Jiménez, "Pensamiento contrahegemónico en salud," *Revista Cubana de Salud Pública* 38/4 (2012).

24. D. J. Yashar, *Contesting Citizenship in Latin America: The Rise of Indigenous Movements and the Postliberal Challenge* (Cambridge University Press, 2005).

25. Ministry of Health (Ecuador), *Código de ética de los hombres y mujeres de sabiduría de la medicina ancestral-tradicional de las nacionalidades y pueblos del Ecuador: Nuestra manera de pensar, sentir, conocer y hacer medicina* (2021).

26. E. V. de Castro, "Exchanging Perspectives: The Transformation of Objects into Subjects in Amerindian Ontologies," *Common Knowledge* 10/3 (2004).

27. Ministry of Health (Bolivia), *Plan estratégico institucional 2016–2020* (2017).

28. G. E. Morales, *Decolonizing Medicine: Indigenous Politics and the Practice of Care in Bolivia* (Stanford University Press, 2025).

29. Ministry of Health (Colombia), Resolución 5078: Por la cual se adoptan normas técnico-administrativas en materia de medicinas tradicionales y terapéuticas alternativas y se crea el Consejo Asesor para la conservación y el desarrollo de las mismas (1992), pp. 1–3.

30. Ministry of Culture (Colombia), Resolución 1077: Por la cual se incluye la manifestación "saberes asociados a la partería afro del Pacífico" en la Lista Representativa de Patrimonio Cultural Inmaterial del ámbito nacional (2017), https://normograma.mincultura.gov.co/compilacion/docs/resolucion_mincultura_1077_2017.htm.

31. E. J. Langdon and L. Garnelo, "Articulation Between Health Services and 'Indigenous Medicine': Anthropological Reflections on Policies and Reality in Brazil," *Salud Colectiva* 13 (2017).

32. National Administration of Drugs, Food and Medical Devices (Argentina), Disposición 5418/2015: Drogas vegetales (2015), https://www.argentina.gob.ar/normativa/nacional/disposici%C3%B3n-5418-2015-249127/texto.

33. A. Escobar, "Whose Knowledge, Whose Nature? Biodiversity, Conservation, and the Political Ecology of Social Movements," *Journal of Political Ecology* 5/1 (1998).

34. C. G. Barié, *Pueblos Indígenas y derechos constitucionales en América Latina: Un panorama*, 2nd edition (Instituto Indigenista Interamericano, Comisión Nacional para el Desarrollo de los Pueblos Indígenas y Editorial Abya-Yala, 2003).

35. M. C. Garrido and A. M. Alarcón, "The Commoditization of Ecosystems Within Chile's Mapuche Territory: A Violation of the Human Right to Health," *Health and Human Rights* 25/1 (2023).

36. World Health Organization, *Global Traditional Medicine Strategy 2025–2034* (2025).

37. National Institute of Health (Peru), *I Foro: Investigación y biocomercio en plantas medicinales y alimenticias de uso tradicional en el Perú* (2010), https://repositorio.ins.gob.pe/bitstream/handle/20.500.14196/172/CENSI-0001.pdf, p. 46.

38. Ministry of Health (Peru), Decreto supremo 004-2000-SA: Modifican el reglamento para el registro, control y vigilancia sanitaria de productos farmacéuticos y afines (2000).

39. European Parliament, Directive 2004/24/EC Amending, as Regards Traditional Herbal Medicinal Products, Directive 2001/83/EC on the Community Code Relating to Medicinal Products for Human Use (2004).

40. M. Strathern, M. Carneiro da Cunha, P. Descola, et al., "Exploitable Knowledge Belongs to the Creators of It: A Debate," *Social Anthropology* 6 (1998).

41. P. Carlessi and J. R. Ayres, "Neo-Traditional Medicines: Ethnographic Contributions to Conceptual Definition," *Canadian Bulletin of Medical History* 38/S1 (2021).

42. A. C. B. Carvalho, J. P. S. Perfeito, W. B. Vidal Filho, and D. Silveira, "A Decade Retrospective and Future Prospects: How European Regulatory Alignment Shapes Brazil's Herbal Medicine Market," *Journal of Ethnopharmacology* 353 (2025).

43. National Agency for Sanitary Regulation, Control and Surveillance (Ecuador), Resolución ARCSA-DE-023-2016-YMIH: Normativa técnica sanitaria sustitutiva para la obtención del registro sanitario y control de productos naturales procesados de uso medicinal (2016), https://www.gob.ec/sites/default/files/regulations/2018-11/Documento_ARCSA-DE-023-2016-YMIH_normativa-tecnica-sanitaria-sustitutiva-obtencion-registro-sanitario-control-productos-naturales-procesados-de-uso-medicinal.pdf.

44. Ministry of Public Health (Ecuador), Acuerdo Ministerial 244: Reglamento y control de productos naturales de uso medicinal (2006), https://www.controlsanitario.gob.ec/wp-content/uploads/downloads/2014/07/Reglamento-y-Control-de-Porductos-Naturales-de-Uso-Medicinal-Decreto-Ejecutivo-1395.pdf.

45. G. Hage, *Alter-Politics: Critical Anthropology and the Radical Imagination* (Melbourne University Publishing, 2015).

46. G. Boccara and P. Ayala, "Patrimonializar al indígena: Imaginación del multiculturalismo neoliberal en Chile," *Cahiers des Amériques Latines* 67/1 (2011).