

The recognition of Sowa Rigpa in India

How Tibetan medicine became an Indian medical system

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Abstract

In 2010, the Government of India officially recognized Tibetan medicine as an ‘Indian system of medicine’ called ‘Sowa Rigpa’. This article documents the processes that led to Sowa Rigpa’s recognition, and situates them at the confluence of economic interests and political strategies within a larger historical and cultural context. Recognition emerges here as a twofold process that makes Sowa Rigpa legible to the state while simultaneously facilitating its incorporation into the market as capital. Previously an inalienable part of Tibetan and Buddhist Himalayan cultural heritage, Sowa Rigpa could now be legitimately claimed or appropriated as cultural, political, or economic capital, giving rise to tensions over ownership and control. Tracing how Sowa Rigpa’s recognition transformed from an initial struggle for protection to one over control, this article offers a critical new perspective on the recognition of cultural heritage, India’s pluralistic health care system, and the Asian traditional pharmaceutical industry.

Keywords

Sowa Rigpa, Tibetan medicine, India, recognition, cultural heritage, minority politics

In September 2010, the Government of India officially recognized Tibetan medicine as an ‘Indian system of medicine’, making India the fourth country after China, Bhutan, and Mongolia to recognize Sowa Rigpa (Tibetan: *gso ba rig pa*, ‘the science of healing’) as an integral part of its national health care system. Sowa Rigpa in India thus constitutes the latest case where a major Asian medical tradition gained state recognition, as did Ayurveda, Unani, Siddha, Traditional Chinese Medicine (TCM), Kampo medicine, Korean medicine, and others before it. It is precisely because it was granted so recently that India’s recognition of Sowa Rigpa stands out as a worthwhile subject of scholarly attention. Perhaps for the first time, we are able to study the legal and administrative integration of a ‘traditional medicine’ into the state’s governmental apparatus, not as an historical event *ex post facto* but as an ongoing process in real time, from multiple ethnographic perspectives (see also articles by Blaikie, Gerke, and Craig in this issue). The relative lateness of Sowa Rigpa’s recognition in India, furthermore, also enables historical comparisons to other Asian medicines recognized before it – most notably Ayurveda – and its contextualization within larger, global trends. Thus, it may serve as an illustrative case study highlighting the increasing inclusion of traditional and complementary medicines into national health policies (especially in Asia) and, by extension, the domain of global health (see, for example, WHO 2002, 2008, 2013). This, in turn, is closely connected to the growth of a strong traditional pharmaceutical industry in Asia with an increasingly global presence and impact (Craig and Adams 2008; Zhan 2009; Gaudillière 2014; Pordié and Gaudillière 2014) in general, and the recent emergence of a transnational Sowa Rigpa industry in particular (Craig 2012; Saxer 2013; Kloos, forthcoming).

While few ethnographic studies have so far focused directly on the recognition of Asian medicines, anthropological work on indigeneity has productively engaged with recognition in the context of ethnic or tribal minority groups fighting for land ownership, affirmative action, or political representation (for example, Niezen 2003; Ghosh 2006; Cadena and Starn 2007; Clifford 2013). This literature is partially relevant to the case of Sowa Rigpa, in so far as it analytically reinvests cultural difference with political agency and economic value, and enables the identification of Sowa Rigpa’s recognition as a process of making it legible to the (post/colonial) state (Povinelli 2002; Shah 2010; Middleton 2015). Yet, considering its ongoing industrialization and global vision, Sowa Rigpa’s recognition far exceeds the struggles for indigenous rights and representation described by these authors, and is more productively contextualized in the political economy of late capitalism (for example, Jameson

2000).¹ Indeed, the main argument proposed in this article is that Sowa Rigpa's legal recognition is directly connected to its commercialization and industrialization: in other words, it is inseparable from the economic recognition of its market potential. This enables us to situate Sowa Rigpa's recognition within a larger context where cultural identities and traditional medical knowledge are increasingly perceived as valuable but threatened resources, in need of protection but also, simultaneously, promising profits. I argue that official recognition fulfills both functions – protection and profit – by inserting Sowa Rigpa at once into the political framework of state governance and the capitalist framework of the global market. It is this reconfiguration of medicine first into cultural heritage, and then into cultural/political/economic capital, that provides the context for understanding Sowa Rigpa's recognition in India.

In the Indian context, a number of studies document the gradual integration of Ayurveda and Unani into the colonial and postcolonial state's health policies during the twentieth century as a consequence of their increasing industrialization, pharmaceuticalization, professionalization, and commercialization (Leslie 1968, 1976; Attewell 2005; Sivaramakrishnan 2006; Bode 2008; Wujastyk 2008; Banerjee 2009). Thus, it was only when Ayurveda was transformed into a mass-produced 'product' for the market in the late nineteenth century that it became noticeable to the Indian state, and eventually able to gain legal recognition during the latter half of the twentieth century (Banerjee 2009). In contrast to this, Sowa Rigpa's recognition in India has a much shorter, but no less interesting history: while almost a century passed between the beginnings of Ayurveda's industrialization and its official recognition, Tibetan medicine undertook the same journey in only a little over a decade. Tracing this brief but eventful journey, this article describes the various and at times conflicting Tibetan, Himalayan, and Indian interests and strategies that turned Tibetan medicine into an 'Indian medical system' called 'Sowa Rigpa' in the late 2000s. I show that the tenuous and often unequal encounters involved in this process produce much more than the protection and preservation of cultural heritage that recognition usually stands for. Understood as a complex process rather than a singular legal act, recognition creates a space for the simultaneous conflation and reallocation of cultural, political, and economic capital in the context of Sowa Rigpa's industrialization (see for example Comaroff and Comaroff 2009).

1 Late capitalism is commonly defined as marked by its unparalleled reach, involving multinational corporations, globalized markets, mass consumption, and multinational flows of capital. My point here is to push Elisabeth Povinelli's (2002) insightful argument that difference and its recognition constitute the crucial markers of 'late liberalism' into the more explicitly economic direction of 'late capitalism'.

Based on ethnographic and archival data collected between 2005 and 2012, this article focuses on the three main groups of stakeholders involved in this process: the Tibetan medical community in exile, a small medical elite from Ladakh representing Himalayan *amchi* (practitioners of Sowa Rigpa), and members of the Indian Ayurvedic and political establishment, most notably the Department (now, Ministry) of AYUSH.² Each group played a crucial role in Sowa Rigpa's recognition. While Tibetan medicine had been known and practiced for centuries in the Tibetan-influenced Indian Himalayan regions, it was only with the arrival of Tibetan refugees in India in 1959 and their subsequent institutionalization of Tibetan medicine there that this health tradition developed into a 'medical system' (Kloos 2013) with sufficient standards, popularity, and political clout to be recognized by the Indian state. The Himalayan *amchi*, for their part, not only participated in the struggle for recognition but also leveraged their strategic position as Indian citizens located at the sensitive borders of Pakistan and China (Aggarwal 2004). Ayurvedic representatives, finally, acted as important gatekeepers of legitimacy vis-à-vis the Indian state. Sowa Rigpa's recognition in India thus can be said to have occurred at the confluence of Tibetan and Himalayan efforts to gain legal security and government support for their cultural heritage and livelihoods, against a backdrop of Indian desires to incorporate Sowa Rigpa into Ayurveda, or at least the family of Indian medicines.

What looks at first glance like an unproblematic meeting of common interests, however, is revealed upon closer ethnographic inspection as a range of difficult interactions and conflicting interests. Providing an historical overview of Tibetan medicine's legal status within the context of Indian health bureaucracy, this article contextualizes these different interests, and traces the resulting interactions among the different groups through the crucial period between 2004 and 2010, when the main struggle for recognition took place. The developments after Sowa Rigpa's recognition and its larger consequences constitute a rich – and still evolving – field of enquiry that will be addressed in future publications.

A lost form of Ayurveda

If there was one theme that informed discourses on, and shaped the development of, Tibetan medicine in exile during the first decade of the 2000s more than any other, then it was that of legal recognition. In conversations and interviews with Sowa Rigpa practitioners

2 AYUSH stands for Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy, all of which are officially recognized health care traditions under Indian law. '*Ayush*' is also a Sanskrit and Hindi term meaning 'long life'. The Ministry of AYUSH is charged with the standardization and regulation of these so-called Indian systems of medicine and homeopathy, especially by upholding educational standards, and supporting research and the cultivation of medicinal plants.

throughout India between 2005 and 2008 – be they Tibetan or Himalayan, institutionally affiliated or lineage holders, based in large cities or remote mountain areas – the topic of recognition emerged as the biggest and most pressing challenge for Tibetan medicine at the time. For example, Bangalore-based Dorjee Rabten, then chairman of the Central Council of Tibetan Medicine (CCTM), told me: ‘Saving, preserving, and promoting Tibetan medicine is not only about clinical practice or pulse and urine analysis. It’s also about getting legal recognition. Our doctors get visas to travel to Europe, but Tibetan medicine has no such visa’. Tsering Thakchoe Drungtso at the Dharamsala Men-Tsee-Khang, the premier institute of Tibetan medicine in exile, stressed in regard to his institution’s priorities: ‘the most important thing is to meet the legal needs at this time’. Some even framed recognition as a question of survival. As chief *amchi* Tsering Phuntsog from Ladakh told me, ‘Recognition is our main concern. Without it, *amchi* medicine will disappear’. In the completely different context of the Central University for Tibetan Studies (CUTS) in Sarnath, too, Tashi Dawa warned that ‘if we don’t get recognition, Tibetan medicine won’t survive in exile’.

Indeed, during the 2000s, there was no aspect of Tibetan medicine in India that was not connected to the common effort of gaining recognition. As Tsering Phuntsog alluded in the quote above, the difficult socioeconomic transitions of ‘*amchi* medicine’ in Ladakh (Pordié 2002, 2008; Kloos 2006; Blaikie 2009, 2013) caused Ladakhi *amchi* to look for state support to ensure their survival as a profession. Among the exile Tibetan community in Dharamsala and elsewhere, Tibetan medicine’s role in Tibetan nationalism (Kloos 2012) gave its legal recognition considerable political significance and urgency, while its growing economic success demanded not only legal security but also the official registration and accreditation of Tibetan drugs, factories, and medical colleges outside of Tibet. The Men-Tsee-Khang’s engagement with modern science (Prost 2006; Kloos 2011, 2015) was informed by the desire to prove Tibetan medicine’s safety, efficacy, and validity vis-à-vis state, market, and world, and the CCTM’s efforts to regulate and standardize Tibetan medicine (Kloos 2013) directly aimed at making Sowa Rigpa recognizable to the Indian health bureaucracy. Even Tibetan medicine’s role in rearticulating relations of Tibetans in exile with other Himalayan and Central Asian states and communities (Kloos 2016) was hinged on its legal status in India. In short, all significant developments and concerns within the field of Tibetan medicine in India either directly addressed, or were centrally informed by, the common problem of recognition. But as strong and universal the exile Tibetan doctors’ emphasis on the importance of Tibetan medicine’s legality may have been in the 2000s, it was a very recent phenomenon.

In 1961, Yeshe Donden opened a small medical center in Dharamsala – later to become the Men-Tsee-Khang – with the mission to provide health care to sick refugees while also preserving Tibetan medicine and culture in exile. Only three years later, in 1964, reports

about clandestinely practicing Tibetan doctors reached the Indian Ministry of Health in New Delhi. Bhagwan Dash, an Ayurvedic scholar-physician sent to Dharamsala to investigate these reports, began his visit by informing Yeshe Donden that ‘medical practice without the permission of the Indian Medical Council is not allowed on Indian soil’. After a week of investigations, however, Bhagwan Dash was sufficiently impressed to report to the government that Tibetan medicine was not only a serious medical science but actually a form of Ayurveda that India had lost, and that it was therefore in India’s own interest of cultural preservation to support it. While Bhagwan Dash went on to publish several books on Tibetan medicine over the ensuing decades (for example Dash 1976, 1988, 1997), his report served as the foundation for the semi-official rationale in Indian government circles that Tibetan medicine, as just another form of Ayurveda, did not need any separate recognition.

The resultant freedom to practice and expand Tibetan medicine without any official interference on part of the Indian government suited the Tibetans³ well. Unconcerned about matters of official status or recognition, Tibetan medicine managed, between 1964 and 2010, to develop from a poor medical center with only a handful of doctors and students to a significant health resource with more than eighty clinics all over India,⁴ catering to over 600,000 patients per year. A large majority of these patients were Indians: from poor farmers in Bihar and Orissa to business leaders like the Tatas or Ambanis, from individual members of Parliament to elite institutions like the All India Institute of Medical Sciences (AIIMS)⁵ or the Indian Ministry of Defense,⁶ India embraced Tibetan medicine. To be sure, repeated claims by Indian officials that Tibetan medicine was actually ‘Indian’ made this embrace tighter than the Tibetans – struggling for their own cultural survival – would have wished. But for the most part, the Indian government was too occupied with the recognition, regulation, and standardization of its other medical traditions to concern itself with Tibetan

3 I use the term ‘the Tibetans’ as a shorthand to refer to Tibetan practitioners of Tibetan medicine, Tibetan medical administrators, and a small group of Tibetan politicians, all in exile, involved in the recognition process.

4 This number does not include several hundred non-Tibetan Himalayan practitioners in India, many of whom still practice from their homes. It does include the fifty-four Men-Tsee-Khang branch clinics that existed in 2010, five clinics run by the Chagpori Institute in and around Darjeeling, a clinic each at CUTS in Sarnath and the Central Institute of Buddhist Studies in Choglamsar, and an estimated minimum of twenty private Tibetan clinics in Dharamsala, Delhi, Kolkata, South India, and elsewhere. Meanwhile, the total number has grown to over a hundred.

5 Between 1997 and 2001, the Men-Tsee-Khang conducted a clinical trial and a survey on diabetes mellitus in cooperation with AIIMS, building on its good relations with the institute after having successfully cured the wife of high-ranking AIIMS physician Dr. Nandi.

6 In early 2007, the Indian Ministry of Defense contacted the Men-Tsee-Khang about possibilities to treat altitude sickness with Tibetan medicine.

medicine. Thus, for several decades both the Tibetans in exile and official India were happy with this practical arrangement, each side convinced that its own unique culture was being preserved.

This peculiar situation, however, had changed dramatically by the time I arrived in Dharamsala in 2007 to study Tibetan medicine's cultural and political role in exile. Tibetan practitioners across all institutional affiliations and internal divisions were up in arms against Indian attempts to appropriate Tibetan medicine as a lost form of Ayurveda or an 'Indian medicine'. As Tashi Dawa put it at the time: 'We need to be very cautious, because if we acknowledge that it [Tibetan medicine] is just Ayurveda, then we have a total cultural genocide'. Although drastic, this statement summed up the Tibetans' concerns well. Between the 1960s and the 2000s, the Indian embrace of Tibetan medicine had somehow turned from a cozy arrangement of mutual happiness into a threat against Tibetan culture. What had happened? And what had turned Tibetan medicine's legal recognition into its practitioners' top priority, after such a long and comfortable existence in the legal gray zone?

The Indian context

Any account of Tibetan medicine's relationship to the Indian state needs to begin with the wider context of medical pluralism in India. It was only in the 1960s, around the time Bhagwan Dash first visited Dharamsala, that the so-called 'Indian systems of medicine and homeopathy' (ISM-H) gradually gained national recognition after decades of political struggle (see Leslie 1968, 1976; Wujastyk 2008; Banerjee 2009). The Central Council for Ayurvedic Research (CCRAS) was established in 1962 and upgraded to the Central Council of Research in Indian Medicines and Homeopathy (CCRH) in 1969. In 1970, the Indian Medicine Central Council Act was passed, enabling the foundation of the Central Council of Indian Medicine (CCIM) in 1971 and of the Central Council of Homeopathy in 1973, as the first national bodies charged with standardizing medical education and registering ISM-H practitioners. The achievement of legal recognition and government support, however, was only the beginning of the integration of ISM-H into the Indian state apparatus and its political and bureaucratic regimes of governance. Thus, in 1978, the Central Council of Research in Indian Medicines and Homeopathy was split into different research councils for Ayurveda and Siddha,⁷ Unani medicine, and homeopathy in order to better promote and coordinate scientific research into these medicines. In the same year, the first volume of the

7 On 4 March 2010, the Indian Union Cabinet decided to bifurcate the Central Council of Research in Ayurveda and Siddha and establish a separate Research Council for Siddha, after over a decade of efforts by representatives of Siddha medicine (see Weiss 2008 for a general background).

Ayurvedic Pharmacopoeia of India came out after sixteen years of work, which would be followed by nine more official volumes to date, not to mention several others published by private Ayurvedic and Unani companies (Bode 2008, 53). In 1979, the Indian Drugs and Cosmetics Act was amended to include detailed regulations for the commercial production of Ayurvedic, Unani, and Siddha medicines. By 1995, the commodity value of these medicines had grown sufficiently (Banerjee 2009, 91) to prompt the Indian Ministry of Health and Family Welfare to establish a Department of ISM-H, which was upgraded and renamed the Department of AYUSH in 2003. In 2002, furthermore, the Government of India passed its first comprehensive policy on ISM-H in over fifty years (Government of India 2002; Banerjee 2002). Most recently, in 2014 the Department of AYUSH was elevated to ministry status with a yearly budget of about four billion rupees (2015–2016), and forms a powerful politico-medical establishment with Ayurvedic institutions at the helm.

The shifts in the Indian state's position vis-à-vis traditional medicine had little to do with any shifts in political power or ideological contestation, but much with the changing domestic and global economic scenario (Banerjee 2009, 107). As Banerjee argues, it was only by entering the market through the development and mass production of Ayurvedic pharmaceuticals, the proliferation of modern Ayurvedic textbooks, and the creation of Ayurvedic clinics that Ayurveda could compete with biomedicine and begin to be taken seriously by the colonial state. As we have seen, this initially slow and gradual process of industrialization finally bore fruit after independence in the 1960s and 1970s, when ISM-H gained official recognition and began to be integrated into the Indian health care system. Since the mid-1990s, a spate of new policies, regulations, and budget allocations have considerably upgraded ISM-H just at the time their market value skyrocketed. The spate of Indian patent applications for herbal medicines based on traditional knowledge between 2001 and 2010 (Sahoo, Manchikanti, and Dey 2011) are a good indicator of the market potential attributed to the sector by private and public entrepreneurs. This close correlation between economic interest, regulation, and recognition is also evident in India's Five Year Plans. With notions like industrial research, good manufacturing practices (GMP), and intellectual property rights (IPR) already introduced to the field of traditional medicine in the tenth Five Year Plan (2001), the eleventh Five Year Plan (2007) adopted an even clearer language of business (see Blaikie 2014). Defining economic and industrial (instead of public health) goals, Indian traditional medicines were to be upgraded through mass production, standardization, the upscaling of industrial facilities, increased marketing efforts, and close cooperation with the private sector in order 'to capture a fair share of the global herbal market' (Government of India 2007, 114; see also Harilal 2006; Sujatha 2011). It is against this backdrop of India's economic vision that Sowa Rigpa's recognition needs to be understood, both in terms of why it remained a nonissue for so long, and in terms of why – when it finally became one – it could be achieved with relative speed and ease.

Considering the political and bureaucratic work surrounding the official recognition and integration of ISM-H into the state apparatus between the 1960s and the 1990s, it is not surprising that Tibetan medicine's arrival on the scene was mostly disregarded, all the more so since its medical, political, and economic presence in the vast health care context of India was negligible. There were sporadic offers on the part of Indian bureaucrats since the 1960s to recognize Tibetan medicine as Ayurveda, an uncomplicated and quick process that carried the promise of considerable financial support, but the Tibetans consistently turned them down. Besides the Tibetan practitioners' core concern with preserving their cultural identity, the work of reestablishing Tibetan medicine in exile was challenging enough even without having to navigate Indian bureaucracy or battling Ayurvedic chauvinism. Thus, apart from some discussions at the Men-Tsee-Khang in 1967 and the early 1980s, and some half-hearted individual attempts by private practitioners to get official recognition for Tibetan medicine during the 1980s,⁸ nobody gave its legal status much thought until the 1990s.

All the while, the Men-Tsee-Khang and the Central Tibetan Administration pursued a strategy of ensuring a certain amount of legal security by cultivating good relations with high Indian officials, whether by posting some of the best physicians to the Men-Tsee-Khang's flagship branch clinic in Nizamuddin, New Delhi, or in arranging private meetings with the Dalai Lama. Tsering Tashi Phuri, who had served as the Men-Tsee-Khang director from 1994 to 1997 (and again since 2012), illustrated the Men-Tsee-Khang's interactions with Indian officials in a conversation with me in 2009:

The Ayurvedic officials were, in a way, quite jealous of Tibetan medicine. So they wanted Tibetan medicine under them, and offered a lot of financial help. Our policy was to stay away from them, for many reasons. [One was that] they wanted to recognize Tibetan medicine as Ayurvedic medicine. Many things are similar to Ayurveda, but it's not the same. We want to call it 'Tibetan medicine'. And once it comes under Ayurveda, financially we may benefit, but the Men-Tsee-Khang would surrender our medicine to them. If we are under their authority, but they let us do our own thing and make our own medicine, that's ok. But that would not be the case. . . . One time some officials told us in quite a high-level meeting that we can't have our clinics, that we are illegal, and so on. I explained how our medicine helps, and then I said, 'Ok, first of all, we'll close our Nizamuddin clinic, where so many Indian ministers, MPs, etc. go'. [laughs] They got the message.

8 Both Tashi Yangphel Tashigang and Tsewang Dolkar in Delhi applied for an official recognition of Tibetan medicine during the 1980, but quickly realized that this was beyond their personal capacities.

While this strategy was certainly effective, it did not offer any legal security, since it relied on goodwill and gratitude rather than official support from its high-profile patients. Nor was it sustainable in the long run, because it was based to a considerable extent on the aging Dalai Lama's great popularity in India.

Aware of all this, Samdhong Rinpoche, the vice chancellor of CUTS⁹ in Sarnath and later prime minister of the Central Tibetan Administration in Dharamsala, founded a new department for Tibetan medicine in 1994. As he told me in an interview in 2008, the idea was to lobby for Tibetan medicine's recognition from within the Indian bureaucratic system. Since CUTS was officially an Indian rather than a Tibetan institution, a Tibetan medicine department with direct Indian government funding and official Indian graduate degrees would constitute an important step towards Tibetan medicine's overall recognition. Firmly embedded in the Indian university system, Tibetan medicine's future would be secured regardless of what happened to the Central Tibetan Administration, the Men-Tsee-Khang, or the Dalai Lama. Thus, as soon as the medical department was established, Samdhong Rinpoche sent an official application for Tibetan medicine's recognition to the Central Council of Indian Medicine in Delhi. The council never replied, so he tried again in 2000. This time, the Department of ISM-H sent a committee of Ayurvedic scholars to inspect the Sowa Rigpa department. According to CUTS staff, however, their classified report portrayed Tibetan medicine as a less developed version of Ayurveda, criticized the lack of hygiene in their facilities, and ultimately led to nothing.

If efforts to claim official recognition for Tibetan medicine in India had remained largely limited to smaller-scale initiatives such as Samdhong Rinpoche's until the turn of the millennium, by the late 1990s this began to change. Both the stakes and the risks involved in practicing Tibetan medicine had grown exponentially, as Tibetan medicine was now a small but noticeable presence in the Indian and international markets for traditional medicine, and had become an important source of revenue and political support for the Tibetan exile community. Its drugs were increasingly mass-produced in factory or cottage-industry settings, and distributed through both formal and informal networks throughout India, Asia, and the world. As a consequence, it was more exposed than ever before to legal challenges in India and abroad, threatening its growth and potentially even its existence. Already in the early 1990s, the Dalai Lama's personal physician Tenzin Choedrak and the Men-Tsee-

9 The Central Institute for Higher Tibetan Studies was established in 1967. Following its upgrade to 'Deemed University' status and receiving a five-star rating by the National Assessment and Accreditation Council of the Indian University Grants Commission in 2009, it was renamed as the Central University for Tibetan Studies. For sake of clarity, in this article I solely refer to it as CUTS, even for the time before 2009.

Khang's director Namgyal Lhamo had to cut short a US medical tour to avoid a lawsuit after purportedly claiming that Tibetan medicine could potentially cure AIDS. At the time, the Men-Tsee-Khang was still able to dismiss this as an unfortunate cultural misunderstanding. Around the turn of the millennium, however, two widely publicized incidents of heavy metal contamination in Tibetan pills in Finland (1998) and Switzerland (2001) not only had direct legal consequences for Sowa Rigpa practitioners in Europe, but also drove home the dangers of globalizing Tibetan medicine without quality regulations and legal recognition (see Kloos 2008, 35f).

In Dharamsala, where Tibetan medicine's growing heterogeneity and commercialization already informed a latent power struggle over its regulation and control, the shock of these events triggered a political process that resulted in the passing of the Central Council of Tibetan Medicine Act in late 2003 (Kloos 2013). For the first time, the Central Tibetan Administration thus legally recognized Tibetan medicine – until then simply taken for granted – by passing legislation concerning its practice and administration. Based on this act, the Central Council of Tibetan Medicine (CCTM) was established in January 2004 as the official governing body of Tibetan medicine, charged with the mission to not only regulate and control Tibetan medical and pharmaceutical practice in exile (*ibid.*), but also and especially to lobby for its official recognition by the Government of India. Most obviously, the CCTM did so by representing Tibetan medicine's interests vis-à-vis the Government of India. Moreover, its mandate to standardize, regulate and control Tibetan medicine in India was directly connected to the goal of recognition, which required that Tibetan medicine be established as a medical system with a distinct body and clear boundaries. Modeled after the Indian Central Council of Indian Medicine in name, structure and function, the CCTM was to be that body, making Tibetan medicine more legible and thus more recognizable to the Indian government.

Himalayan perspectives

Meanwhile, for Himalayan and particularly Ladakhi *amchi*, too, legal recognition had become an increasingly important concern during the 1990s. Just when Tibetan medicine had finally stabilized after decades of struggling for survival in exile, and even began to transform into a profitable industry, its counterpart in Ladakh increasingly suffered from the consequences of the socioeconomic transformations of Ladakhi society, brought on by modern lifestyles and the capitalist market system (see Pordié 2002, 2008; Kloos 2004, 2006; Blaikie 2009, 2013). With traditional practices of reciprocity vanishing, even well-established *amchi* found it difficult to financially sustain their medical practice, while the younger generation looked to other professions for economic security and advancement. As the number of practicing *amchi* dwindled and whole lineages died out, the survival of Sowa Rigpa in Ladakh was

increasingly seen to depend on its inclusion into India's ISM-H scheme, which offered financial support in the form of government jobs, clinical facilities, and educational programs. Chief *amchi* Tsering Phuntsog, one of Ladakh's most respected practitioners, told me in 2008:

Our tradition of *amchi* medicine in Ladakh will not be sustainable [without official recognition]. If we don't get proper government jobs, the younger generation will not come towards Sowa Rigpa. So government jobs are very crucial. And if we get recognition, we will get government jobs. . . . Otherwise, *amchi* medicine will disappear. We have only one training center here, but with no good facilities and only five or six students. If you look at government schools, on the other hand, and how much funding and facilities they get – So there needs to be some security, and then the future generation will also be interested in Sowa Rigpa.

Technically, *amchi* medicine had already been recognized on the Jammu and Kashmir state level since the 1970s through the foundation of the Sowa Rigpa Research Center in Leh and the appointment of about forty 'government *amchi*' to serve rural areas.¹⁰ Despite this early inclusion at the margins of state-sanctioned health care, however, *amchi* medicine remained largely ignored by central and state authorities as a 'tribal medicine'. During the 1980s and 1990s, it was thus mostly Tibetans exiles rather than the Indian state who supported Ladakhi *amchi* through local teachings and empowerments, providing medical instructors, syllabi, and exam questions to the Central Institute for Buddhist Studies, and establishing special quotas for Himalayans at the Men-Tsee-Khang college. As Maling Gombu, a Himalayan official at the National Minorities Commission in New Delhi, pointed out in 2008:

Amchi medicine didn't get any help from the Indian government, only from the Tibetan exile government. They [the Ladakhi *amchi*] didn't know they could also apply for support from the Indian government. . . . India is a big country, and the government is not aware of many things that are going on. It's thanks to the Tibetans that Sowa Rigpa came to the awareness of the government, because they developed it. In the Himalayas, although we also have Sowa Rigpa, there is not much development.

Against this dual backdrop of Tibetan medicine's success in metropolitan India and its socioeconomic crisis in Ladakh, a small Ladakhi medical and political elite began to actively lobby for an upgrading of Sowa Rigpa's official status in the late 1990s. These efforts were

10 These government *amchi* received a nominal salary and some material support from the state government in return for making regular health rounds to a number of designated villages in their region. See Tondup (1997) or Kloos (2005, 2006) for more information.

embedded in a wider, older political movement for the preservation of Ladakhi culture, spearheaded by the Himalayan Buddhist Cultural Association.¹¹ Its main proponents were the association's president, Lama Chosphel Zotpa, formerly the vice-chairman of the National Commission for Scheduled Castes and Scheduled Tribes and then member of the National Commission for Minorities, his assistant Maling Gombu, and Padma Gyurmet, the head of the Sowa Rigpa Research Center in Leh. By the time the Central Council of Tibetan Medicine was founded in Dharamsala, then, there existed two separate movements for the recognition of Sowa Rigpa, one initiated by Tibetans in exile (mostly doctors and administrators) and the other by a small Ladakhi elite group representing several hundred Himalayan *amchi*.

As momentum built on both sides, the struggle for recognition entered a new level, and it soon became clear that some form of coordination and collaboration was desirable. In February 2004, just a month after the CCTM's establishment, the Himalayan Buddhist Cultural Association convened a National Seminar on Sowa Rigpa in Delhi, to which Tibetan exile representatives were also invited. The most important outcome of this seminar was an agreement on the common denominator 'Sowa Rigpa' as the basis of the joint strategy to gain recognition. Since the Ladakhi term 'Amchi medicine' was unacceptable to the Tibetans, but their own preference for 'Tibetan medicine' was out of the question due in large part to India's delicate relations with China, this compromise seemed sensible. After all, both the classical Tibetan texts as well as Ladakhi *amchi* (when speaking Ladakhi) routinely used the generic Tibetan term for medicine, 'gso ba rig pa', that is, 'the science of healing'. Nevertheless, neither side was satisfied with the compromise, and kept reverting to its own terminology in the following years. Especially the Tibetans were – and still are – upset about deleting the word 'Tibetan' from what they strongly consider *their* medicine (see Gerke and Craig, this issue).

In order to understand the shaky nature of this compromise, and the Tibetans' persistent unhappiness with this terminology (notwithstanding the fact that it was even used in their own scriptures), we need to consider the interests and stakes involved in Sowa Rigpa's legal recognition. While both the Tibetans and the Ladakhis regarded recognition as a matter of Sowa Rigpa's long-term survival, upon closer inspection the debate over its denomination reveals two very different positions and agendas. As we have seen, for the Ladakhis the preservation of *amchi* medicine was mostly an immediate economic problem, easily solved by

11 Despite Ladakh's carefully cultivated image as a 'Little Tibet', about half of Ladakh's population is Muslim. See Martijn van Beek's (for example, 2000, 2004) insightful discussions of the politicization of Buddhism, cultural politics, and the increasing tensions between Buddhists and Muslims in Ladakh during the 1990s.

securing government jobs, new facilities, and generous yearly subsidies. To a considerable extent, their rhetoric and approach followed the lines of well-established tribal and minority politics in India (see for example Middleton 2015), and could be summed up in the message ‘we need (and are entitled to) help from the state’. The Ladakhi priorities concerning Sowa Rigpa’s recognition were thus clear: what mattered was how fast it could be achieved and how much the Himalayan *amchi* would gain from it. Questions about Sowa Rigpa’s Tibetan identity and legal security, or its independence from Indian influence, on the other hand, were of little concern to the Ladakhis, who in this case enjoyed the triple privilege of holding Indian citizenship, being classified as a ‘scheduled tribe’ eligible for affirmative action quotas, and receiving preferential treatment on account of living in a strategic border zone near Pakistan and China. Hence, they strove to simply amend the existing Central Council of Indian Medicine Act, and add Sowa Rigpa to it as one more ‘Indian system of medicine’.

Tibetan perspectives

In contrast to the situation in Ladakh, Tibetan medicine had become the single largest and most important economic resource for the Tibetan exile community in India, and was in no immediate danger of disappearance. Quite to the contrary, it was just emerging as a highly promising industry of potentially international scope, held back only by its lack of official legitimacy both in India and abroad. Therefore, although the Tibetans welcomed Indian government funding and remained concerned about their cultural survival in exile in the 2000s (Kloos 2016), financial support or the preservation of Tibetan medicine per se were only secondary motivations. For them, the recognition of Tibetan medicine was first and foremost an issue of legal security. As Dorjee Rabten, the CCTM chairman at the time, told me in 2008:

For the Himalayans, it’s about the money. If the government doesn’t recognize Tibetan medicine, they won’t get any grants or aid. But for us, it’s not about money, it’s mainly a legal issue. Most importantly, if the Government of India accepts Tibetan medicine legally, this will also be an incentive for other countries, like Europe, the USA and so on, to adopt a similar approach towards Tibetan medicine. So we look at this as a first step forward, to bring Tibetan medicine also to the Western world, legally.

The desire for legal security to bring Tibetan medicine to the West was informed by an economic as well as a political agenda. The Tibetans were well aware that the ability to legally practice their medicine internationally was a crucial step to expanding the Sowa Rigpa industry, and thus constituted an economic opportunity dwarfing any amount of Indian government funding. Equally importantly, the Tibetans’ humanitarian agenda to ‘help the

world' with Tibetan medicine coincided with their ability to draw attention and support to their political cause. Its wider recognition and international availability would thus serve as a powerful legitimization of, and forum for, Tibetan national identity claims. For all of this, it was considered essential to keep the word 'Tibetan' in Sowa Rigpa's name, and to retain control over it as one of the most important assets of Tibetan culture, nation, and exile economy today.

Instead of the Ladakhis' 'shortcut option' of having Tibetan medicine declared as 'Indian', which threatened to transfer cultural, political, and economic control to India and the Himalayans, the Tibetans therefore pursued their own goal of a separate recognition under a new legal act, similar to that granted to homeopathy. Instead of positioning themselves as a disadvantaged minority group asking for state support, they argued from a position of relative strength: they had something to offer, not only to India but to the whole world, and they were not going to compromise their long-term vision for some immediate financial benefits. Although this involved a much more complicated legal and bureaucratic process, and necessitated the scientific validation of Tibetan medicine through clinical studies, the Tibetans hoped that it would leave their medicine largely independent, give the Central Council of Tibetan Medicine official power and control over all practical matters concerning Sowa Rigpa under Indian law, and above all acknowledge Sowa Rigpa as Tibet's (and not India's) unique heritage. Amidst ongoing debates about whether or not the 2004 agreement to collaborate with the Ladakhis was a mistake, the CCTM's executive board convened in March 2006 to decide on its future course of action. The upshot was the first official decision by a Central Tibetan Administration-affiliated body to pursue Sowa Rigpa's recognition, in the form of an unanimous resolution that reconfirmed the Tibetans' readiness to collaborate with the Himalayans, provided certain conditions were met. The resolution had four points: 1) the Tibetans should apply for Sowa Rigpa's official recognition by the Government of India; 2) the terminology to be used was 'Sowa Rigpa (Tibetan system of medicine)' in English, 'bod kyi gso ba rig pa' in Tibetan ('Tibetan Sowa Rigpa'), and its equivalent 'bhot chikitsa vidya' in Sanskrit; 3) the ongoing effort of Himalayan regional associations to gain Sowa Rigpa's recognition should be supported, but only as long as they do not go against the interests of the Tibetans (in other words, as long as they acknowledge Sowa Rigpa's Tibetan identity); and 4) a common committee for Sowa Rigpa's recognition should be established with representatives from all four Tibetan medical institutions in India (Men-Tsee-Khang, Chagpori Tibetan Medical Institute, and the medical faculties at CUTS and the Central Institute for Buddhist Studies).

Such compromises and agreements notwithstanding, the two groups pursued profoundly different agendas, which can be summed up as revolving around the question of Sowa Rigpa's identity. While the Tibetans insisted, with good historical reason, on Sowa Rigpa's

Tibetan identity, the Himalayans stressed its *Indian* identity and origins out of strategic considerations. In fact, no Ladakhi *amchi* I talked to denied Sowa Rigpa's Tibetan identity, and most felt uncomfortable with their representatives' official position. However, they were all interested in gaining recognition as fast as possible, and this seemed the most pragmatic way to achieve it. Indeed, this was also Padma Gyurmet's rationale, as he told me in the summer of 2008:

We should tell AYUSH that we are quite close to Ayurveda. If we told them that we are completely different, it will be difficult. But if we present Sowa Rigpa as having Indian origins, it will be easier to push the Government of India to recognize it. We can tell them that it is a Buddhist system of medicine, which has been lost in India. So it's the Government of India's duty to revive this tradition. They also gracefully accept this, that they have lost a lot of traditions, knowledge, even texts. . . . So our number one argument is that it is an Indian medical system. Number two: it is the main medical system in the Himalayan regions of India. A large number of people are following and accepting this system. So whatever is practiced, there should be some legislation for it. This is how we argue with the Government of India.

Padma Gyurmet certainly had a point, as subsequent conversations with Indian officials confirmed: while being sympathetic to the Tibetans' concerns, they all argued, to quote one of them, that "Tibetan medicine has the best chance of recognition if they stress their similarity to Ayurveda. If they stress the opposite, that it's not Indian, they will have a lot of difficulties. They would need a lot of research to prove its efficacy. Ayurveda already has all of that, so they could just use that" (Darshan Shankar, pers. comm. 2008). The Tibetans knew this well, but most high-level practitioners I talked to still preferred the slower route to recognition in order to keep Sowa Rigpa 'Tibetan'.

It is hardly surprising that these different agendas caused a considerable amount of confusion as well as tension between the Tibetans and the Ladakhi representatives. The controversy around Sowa Rigpa's identity was really a question of who would govern an increasingly valuable cultural, political, and economic resource that both the Tibetans and the Himalayans – and now even the Indians – claimed as their own unique tradition. Ultimately, what was at stake was Sowa Rigpa's future ownership and control. Bhagwan Dash was clear about this when I discussed Sowa Rigpa's identity with him in 2008: 'For recognition, it doesn't make a difference whether it's the same or different from Ayurveda. It's to have control over the practice of Tibetan medicine'. Thus, by the late 2000s, Sowa Rigpa's recognition had turned from a quest for legitimacy, legal security, state protection, and economic support into a reallocation of political governance, cultural ownership, and economic control. If Sowa Rigpa had been partially redefined from medicine to cultural heritage between 1960 and 2000, the protection and preservation of the latter through

recognition now required yet another transformation. That is, in order to become recognizable to both state and market, Sowa Rigpa needed to become an attractive (in other words, profitable) cultural, political, and economic resource. As such, cultural identity or heritage was no longer intangible or inalienable, but could be reified and appropriated as capital (see Bhabha 1994; Comaroff and Comaroff 2009; Saxer 2013), giving rise to conflicts such as the one between the Tibetans and the Ladakhis.

The road to recognition

As we have seen, the common interest in gaining recognition for Sowa Rigpa to protect a shared cultural heritage increasingly morphed into an antagonistic struggle over cultural ownership and political and economic control. However justified each side's concerns and interests were within their own context, and however much each side relied on the other for the resources it lacked, productive collaboration had become impossible in a climate of mutual distrust. Recognizing the impasse, in April 2007 the Dalai Lama and the Tibetan prime minister in exile, Samdhong Rinpoche, asked CUTS vice-chancellor Prof. Geshe Ngawang Samten in private meetings to take the matter into his hands. This was not made public at the time, and Ngawang Samten kept a low profile throughout the ensuing developments in order to proceed with minimal interference. Yet the importance given to the matter by the highest authorities among the Tibetans was clear, and Ngawang Samten was an obvious choice for them. Not only did he possess the necessary political skills and connections but he was also personally keen to resolve the issue of Sowa Rigpa's recognition. When receiving orders to take over the project of Sowa Rigpa's recognition, therefore, Ngawang Samten wasted no time in taking the matter to the national level. Much of the following account stems from a long interview with him at CUTS in April 2012, which has been cross-checked and supplemented, wherever possible, with data from written reports and interviews with other key actors. Although this account unavoidably remains filtered by Ngawang Samten's subjective viewpoint and partial recollections, it nevertheless constitutes the most accurate – and above all the most complete – rendering available of the events and strategies leading to Sowa Rigpa's recognition.

One month after returning to Sarnath, during a CUTS society meeting in May 2007, Ngawang Samten had a private discussion with the society's chairman Badal Kumar Das, the secretary of the Indian Ministry of Culture. In this conversation, he mentioned that he needed to discuss a special project with AYUSH and the health minister. To his surprise, Das readily agreed to arrange a meeting with the AYUSH secretary Anita Das, who, as it turned out, was his wife. Anita Das for her part was pleasantly surprised to learn that Sowa Rigpa was not an unsophisticated folk medicine, as had been the prevailing opinion at AYUSH, but rather a complex medical science with a long history and a rich body of

scholarly literature. Impressed, she arranged a second meeting for more questions, after which she told Ngawang Samten:

Prof. Samten, you have dispelled my ignorance on this. Now I am fully confident that this medical system is a very rich tradition and it deserves recognition. I was not told about this earlier, and whatever information I had was wrong. Now, you need my help, and I need your help. I need this project of recognition to go ahead under your leadership. We have to select people who would be helpful, but who are also knowledgeable and respected. Do you have such people? We need a good team, and you will be the chairperson. (Ngawang Samten, pers. comm. 2012)

Indeed, Ngawang Samten knew such people, and quickly assembled a list of names. This list included Prof. Ram Harsh Singh, an eminent Ayurvedic scholar and former vice-chancellor of the Rajasthan Ayurveda University who was also a highly respected teacher at Benares Hindu University (to which CUTS had strong links); G.S. Lavekar, then director of the Central Council for Research in Ayurveda and Siddha; Bhagwan Dash, who had an avid interest in Tibetan medicine ever since his first investigative visit to Dharamsala in 1964; and Dilip Inamdar from Pune, a biomedical practitioner and Ayurvedic scholar as an outside member. Lavekar suggested including Padma Gyurmet, in charge of the Sowa Rigpa Research Center in Leh under the Central Council for Research in Ayurveda and Siddha. The expert committee thus consisted of six people, including a high-level Tibetan scholar as its chairman, an elite Ladakhi Sowa Rigpa practitioner, three renowned Ayurvedic scholars, and a high-profile biomedical practitioner, who all had in common a sincere appreciation of Sowa Rigpa and an interest in its recognition. At the same time, however, there were also several fault lines running through this group. For example, the three Ayurvedic representatives considered Sowa Rigpa as a Tibetan version of Ayurveda, an opinion that neither Ngawang Samten nor Padma Gyurmet agreed with. The latter two, on the other hand, disagreed with each other on whether the origins of Sowa Rigpa lay in Tibet or India. Finally, in the context of his own community, Ngawang Samten had little understanding for the continued terminological discomfort about ‘Sowa Rigpa’ among the CCTM and the Men-Tsee-Khang.¹²

12 As Ngawang Samten told me, and them, ‘We don’t need to tell people that it’s “Tibetan Sowa Rigpa”. Do the Indians say “Indian Ayurveda” or just “Ayurveda”? They call it “Ayurveda” because that in itself is Indian. In the same way, Sowa Rigpa is Tibetan: the language is Tibetan, it originated in Tibet. If you say “Tibetan Sowa Rigpa”, then you imply that Sowa Rigpa in general is larger than Tibet, and only one part of it is Tibetan. But if you accept that Sowa Rigpa is synonymous with Tibetan medicine, then it also applies to Mongolia, China, India, the Himalayas, Russia, and now also other countries. This is much better; there is no need to worry’.

Aware of these differences in opinion within and beyond the expert committee, Ngawang Samten strategically planned a number of events, conferences, and seminars at different Sowa Rigpa institutions (Samten et al. 2008, 4). The first was a two-day committee meeting at CUTS from 10–11 August 2007, for strategic discussions as well as to introduce the committee members to Sowa Rigpa, its history, and its theoretical foundations. Initially, the Ayurvedic committee members felt their opinion about Sowa Rigpa was confirmed: ‘It’s the same as Ayurveda’, they remarked, ‘why do you need a separate recognition?’ Ngawang Samten, however, who had carefully choreographed the meeting for maximum dramatic effect and kept the presentations highlighting the uniqueness of Sowa Rigpa for the afternoon session, told them to wait. The plan worked. At 3:30 PM, even before the afternoon session had closed, Ram Harsh Singh reportedly told him, ‘Oh, this is very special, it’s not the same as Ayurveda. I’m very excited to know more about this’ (Ngawang Samten, pers. comm. 2012). By the end of the meeting, the committee agreed that despite a significant overlap between Ayurveda and Sowa Rigpa, the differences were important enough to merit a separate recognition.

The next step was to demonstrate that far from leading a marginal existence among some Himalayan tribes, Sowa Rigpa had a well-developed infrastructure in India and served a sizeable Indian patient population. For this purpose, Ngawang Samten organized a second meeting from 22–24 September at the Dharamsala Men-Tsee-Khang. While Men-Tsee-Khang experts gave presentations on specifically chosen topics to further showcase Sowa Rigpa’s uniqueness, the main emphasis of this visit lay on a tour through the institute. Again, the strategy worked: the Indian committee members were highly impressed by the Men-Tsee-Khang’s pharmaceutical facilities, quality control standards, cleanliness, and its sheer magnitude and sophistication, which – as they personally told me a few months later – were far better than those of comparable Ayurvedic factories and institutes. Having thus established both awareness of and respect for Sowa Rigpa, Ngawang Samten then organized a National Seminar on Sowa Rigpa and Ayurveda at CUTS from 8–11 October. There, Ayurvedic and Tibetan scholars from both CUTS and Men-Tsee-Khang compared, on an equal footing, the two medical systems by addressing seven predefined topics, with the proceedings published as a book (Roy 2008).

Meanwhile, the CCTM and the Himalayans – although at least partially involved in the above events – continued their own efforts to gain recognition, which manifested in two large, consecutive events in March 2008 described by Calum Blaikie (this issue). The first of these was a National Conference-cum-Workshop on Tibetan Medicine organized by the CCTM and Men-Tsee-Khang in Dharamsala from 24–28 March, which was mostly an event attended by Tibetans but that also included some Indian and international speakers and guests. The Himalayan Buddhist Cultural Association, for its part, organized a National

Seminar and Workshop on Sowa-Rigpa (Amchi System of Medicine) in New Delhi only a few days later, from 30–31 March, which was well attended by Ladakhi *amchi* and high Indian officials, but had very little Tibetan and foreign participation. As Blaikie illustrates in detail, the respective conference titles (one using ‘Tibetan medicine’, the other ‘Sowa Rigpa’ with ‘Amchi System’ in parentheses), the almost-conflicting dates, and the striking attendance patterns clearly indicate the extent to which the Tibetans and the Ladakhis remained embroiled in their conflict over Sowa Rigpa’s name, identity, ownership, and control. Still, both events were successful, especially insofar as they made visible the considerable progress achieved by Ngawang Samten and his committee up to that point, most noticeable in the consistent expressions of interest and support by the highest levels of the Indian government. For the first time, both the Tibetans and the Himalayans got a clear sense that recognition was not only eminently possible but also possibly imminent.

Reaching the goal

After a two-week tour visiting Sowa Rigpa clinics and practitioners in India’s Himalayan areas (Sikkim, Arunachal Pradesh, and Ladakh) in April 2008, the expert committee drafted and completed a detailed account, entitled ‘Report on the Status, Strength, and Association of Sowa-Rigpa with Ayurveda’ (Samten et al. 2008) during two final meetings in Delhi and Sarnath in May. The report’s two most important features were a section identifying the commonalities between the two systems as well as the unique features of Sowa Rigpa, taken directly from the proceedings of the Sarnath seminar (Roy 2008), and a list of over 2,200 classical Tibetan medical texts that underscored Sowa Rigpa’s long history, scholarly weight, and Tibetan identity. While Ngawang Samten personally wrote most of this report, in another strategic move he delegated the section on Sowa Rigpa’s history to Padma Gyurmet. Even as a member of the expert committee, the latter had initially continued to portray Sowa Rigpa as an Indian and Himalayan (rather than a Tibetan) medicine (see for example Gurmet 2008).¹³ Seeing that the Indian committee members were inclined to believe Padma Gyurmet, Ngawang Samten called a meeting to which he also invited a few of Ladakh’s most respected *amchi*. As he recounted to me in 2012, he had asked them in front of the committee, ‘What do you practice?’ to which they responded, ‘Tibetan medicine’. Then he asked, ‘Could you please name two medical texts written by Ladakhis?’ to which they replied, ‘No, all texts are written by Tibetans’ (Ngawang Samten, pers. comm. 2012). This convinced the Indians, and Padma Gyurmet was forced to change his official stance. Being asked to assemble the history section of the committee report, finally, made Padma Gyurmet confirm

13 For example, in the *Souvenir* of the 2008 Delhi seminar, Padma Gurmet (2008, 39) explicitly claimed that Sowa Rigpa ‘originated from India’.

the Tibetan identity of Sowa Rigpa in writing (Samten et al. 2008, 12–14). Even if Tibet could not be mentioned in Sowa Rigpa's name, the report left no doubt about its Tibetan origins.

Still in May 2008, G. S. Lavekar and Ngawang Samten personally handed the report over to Anita Das, who promptly sent it to the minister for health and family welfare, Ghulam Nabi Azad. The ministry as well as the Union Cabinet agreed to amend the 1970 Indian Medicine Central Council Act in September 2009, and completed the relevant Amendment Bill on 23 April 2010. Since this amendment bill still needed to be passed by both houses of Parliament, however, a Parliamentary Standing Committee consisting of thirty-two members of Parliament and chaired by Amar Singh was created. After consulting the AYUSH secretary S. Jalaja (who had meanwhile succeeded Anita Das) on 9 June, the Committee invited four Sowa Rigpa representatives for an extensive hearing on 21 July. In contrast to Ngawang Samten's earlier expert committee that was predominantly Indian, this time three of the four invited representatives of Sowa Rigpa were Tibetan (Geshe Ngawang Samten, Men-Tsee-Khang director Tsewang Tamdin, and CCTM chairman Tsering Thakchoe Drungtso), with Himalayan Buddhist Cultural Association president Lama Chosphele Zotpa the only Indian citizen and Himalayan representative. Acting as their spokesperson, Ngawang Samten spoke uninterrupted for over half an hour to an exceptionally receptive and friendly committee. In the tea break after the hearing, Amar Singh told Ngawang Samten: 'This was very good, we will do our best to help you, don't worry. I'm sorry my colleagues asked you questions afterwards' (Ngawang Samten, pers. comm. 2012). Considering the usual procedure of Indian parliamentary committee hearings, where speakers are often interrupted after only a few minutes, this successful hearing was another clear indication of the Indian government's interest in recognizing Sowa Rigpa.

Based on these two hearings and on written communication with the AYUSH Department, the parliamentary committee drafted a report (Rajya Sabha 2010), which it finalized and adopted in a last meeting on 9 August and handed over to the Rajya Sabha and Lok Sabha on 11 August. The report voiced 'no objection' against the recognition of Sowa Rigpa through an amendment of the Indian Medicine Central Council Act of 1970, which had originally recognized Ayurveda, Unani, and Siddha:

The 'Sowa-Rigpa' system of medicine practiced in the Sub-Himalayan region needs to be included as a system within the definition of 'Indian Medicine' . . . so as to develop the system and its practices within a legal framework. The amendments to various provisions of above said Act are required in order to legalise Sowa-Rigpa as a system of Indian Medicine. This will also enable the protection and preservation of this ancient system of medicine and will help its propagation and development. The

recognition of the 'Sowa-Rigpa' system of Indian Medicine will also lead to the setting up of a regulatory mechanism in the field of its education and practice. (Rajya Sabha 2010, 6–7)

Although emphasizing Sowa Rigpa's (new) identity as an 'Indian medicine', the report was relatively even-handed throughout. Thus, Tibet as well as Tibetan institutions and practitioners in exile were mentioned prominently, Sowa Rigpa was also referred to as 'Tibetan medicine', its unique features were listed alongside its similarities to Ayurveda, and both its Buddhist identity and its scientific nature were highlighted. It also specified a number of issues that the bill failed to address, such as that of Sowa Rigpa's representation in the Central Council of Indian Medicine, the necessity for a standardized national Sowa Rigpa syllabus, as well as the introduction of specific regulations concerning quality control, drug labeling, and the registration of practitioners and clinics.

As the synopses of debates show, support for the amendment bill was unanimous in both houses of Parliament. While many members of Parliament had sympathies for traditional medicine and the Tibetans in general, Sowa Rigpa's recognition also struck several other chords in the Indian political context. Here, after all, was a bill that supported rural development in the Himalayas and promoted affordable primary health care for the poor, which was not only popular with voters but also carried special political significance in India's efforts to establish and maintain strong administrative, economic and moral ties with its populations along the sensitive northern borders (Aggarwal 2004). Costing little and threatening no one, furthermore, the bill opened an emerging and so-far informal industry sector to public and private investment and business, in line with India's economic vision for traditional medicine as outlined in its eleventh Five Year Plan (Government of India 2007) described above. Finally, the bill also promised to expand the government's reach of regulatory power as well as AYUSH's size and budget, and asserted India's postcolonial nationalist claims to cultural greatness vis-à-vis a perceived Western biomedical hegemony. Ironically, what made Sowa Rigpa's recognition particularly attractive in all these regards was its widespread perception among Indians as a 'purer' alternative to Ayurveda, as yet unspoiled by commercialization, industrialization, and government corruption. The Rajya Sabha thus formally passed the amendment bill on 25 August, with the Lok Sabha following suit on 31 August. On 26 September, the Parliament received the assent of the president of India, and on 27 September 2010, the *Gazette of India, Ministry of Law and Justice* officially published the Central Council for Indian Medicine (Amendment) Act, 2010, giving it legal status. Only three and a half years after the Dalai Lama had put Ngawang Samten in charge of the process, Sowa Rigpa was thus finally recognized by the Indian government as an independent – albeit 'Indian' – medical system.

Conclusion

Where does all this leave us? Some would see the outcome of the recognition process as a victory for the Himalayans, who got exactly what they wanted, and a loss for the Tibetans, whose medicine was now declared 'Indian'. Indeed, the Ladakhis were satisfied: recognition had been achieved fast, government funding was finally secured, the research center in Leh was upgraded to India's only National Research Institute for Sowa Rigpa, and more new jobs would soon be created for Himalayan *amchi* in rural government clinics.¹⁴ The Tibetans, on the other hand, had mixed feelings. While official Tibetan statements and media reports hailed Sowa Rigpa's recognition as a success – after all, the main objective of legal security was achieved – in private conversations Tibetan medical representatives adopted a wait-and-see attitude, reflecting ambivalence about the recognition and uncertainty about its effects. On the one hand, Sowa Rigpa's recognition did ensure independence from Ayurveda, but on the other, no mention of its Tibetan origins in the reports could make up for its official classification as an 'Indian medical system' and the ensuing Indian media coverage portraying it as an Indian Himalayan heritage. Moreover, it was unclear whether Tibetan doctors without Indian citizenship would be eligible for government funding, jobs, and – most importantly – representative positions within AYUSH and the Central Council of Indian Medicine; whether there would be a future for the Central Council of Tibetan Medicine with Sowa Rigpa falling under the administration of AYUSH and CCIM; and how much control the Tibetans could therefore retain over their medicine and its institutions.

What is certain is that Sowa Rigpa's recognition was in India's national interest. By officially including a highly sophisticated and increasingly popular medical tradition with significant business potential into the family of Indian medical systems, it not only ostensibly enlarged India's own medical-cultural heritage and extended its sphere of governmental power but also laid claim to an emerging industry and potential global health resource. Even so, it had been necessary to gain the government's attention and make Sowa Rigpa legible to the Indian state (see Scott 1998), which was indeed the primary function of the recognition process described in this article, with all its reports, seminars, conferences, and committee meetings. This final push for recognition, in turn, would have been unthinkable without the cumulative effect of earlier efforts and developments. Thus, Tibetan doctors and institutions in exile were involved in translations of Tibetan medical texts into English since the 1970s, new book publications for lay audiences since the 1980s, and clinical and pharmacological studies since the 1990s, and they established the CCTM (modeled in name and function after the CCIM) as a regulatory body for Tibetan medicine in the early 2000s. On the Himalayan

14 Already in 2009, thirteen clinic positions had been created for Himalayan *amchi* as part of the National Rural Health Mission.

side, the appointment of government *amchi* and the foundation of a Sowa Rigpa Research Center under the Central Council of Research in Ayurveda and Siddha in Ladakh in the 1970s also played an important role, as did the latter's good connections to AYUSH and the health ministry in New Delhi. All of this contributed, wittingly or unwittingly, to the establishment of Sowa Rigpa as a discernible medical system in the Indian state's eyes.

However, as shown throughout the above account, there is more to Sowa Rigpa's recognition than simply state legibility and governance. Ever present in the background as a motivating force, but rarely directly expressed in practitioners' discourses or expert committee reports, Sowa Rigpa's larger economic potential centrally informed the recognition process. To be sure, India's main criterion for recognition is that a medicine serves a significant section of the Indian population. Yet Sowa Rigpa had medically served Indians for decades, and in the Himalayan regions even for centuries without gaining recognition. It is also true, as we have seen, that in the Indian political context, high-level personal connections and the strategic maneuvering of a range of interests and desires are crucial factors for success. Yet, connections at the highest levels have long existed between New Delhi and Sowa Rigpa stakeholders (be they Tibetan exiles or Himalayans), and there was certainly no lack of strategic maneuvering. It was only when Sowa Rigpa's cultural, political, and especially economic value as an emergent industry became visible and could be perceived as capital, that the state began to show a more serious interest.

In a world where the different forms of 'capital' (Bourdieu 1977) – social, cultural, ethical, political, economic – become increasingly interchangeable as means for financial profit, the recognition of cultural heritage, particularly in the shape of 'traditional medicine', unmistakably follows the logic of capitalism (Comaroff and Comaroff 2009). This is clearly visible in India's growing interest in bio-resources and the development of an internationally competitive herbal pharmaceutical industry based on 'traditional' knowledge (see Harilal 2006; Sujatha 2011; Sahoo, Manchikanti, and Dey 2011; Blaikie 2014), as reflected in India's recent Five Year Plans (Government of India 2007, 2013) and its strategic targets for AYUSH. Legibility for the state has thus become directly connected to profitability in the market: each facilitates – but also requires – the other. In order to become attractive and recognizable for the Indian state, Sowa Rigpa had to become profitable in a capitalist framework; but to work as a profitable industry, Sowa Rigpa needs state recognition and support. The recognition of traditional medicine thus involves its integration into two increasingly interrelated frameworks at once: the governmental structures of the state and the capitalist logic of the market. In short, Sowa Rigpa's state recognition was linked to a simultaneous, but mostly unspoken recognition of its economic potential, embedded in a larger context where traditional medicines are increasingly industrialized and incorporated into domestic and global health policies and pharmaceutical markets (Kloos, forthcoming).

None of this means, however, that global capital and profit making have become the overriding concern and motivation for Sowa Rigpa's stakeholders, most of whom remain committed to preserving their medical-cultural heritage while providing the best possible health care to their patients. What I describe in this article is not so much a shift of interest, from public health or cultural survival to capitalist profit, but the reconfiguration of Tibetan medicine first into cultural heritage and then into global capital. Cultural preservation was a core concern for Tibetans right from the beginning of their exile and remains so today, but up to the turn of the millennium, these efforts did not envision Tibetan medicine in terms of property. To the contrary, Tibetan medicine and culture were long seen as intrinsically and unquestioningly connected to Tibet as a nation, threatened with extinction under Chinese oppression or gradual disappearance through assimilation in the Indian exile. Today, this is no longer the case, as the process of Sowa Rigpa's recognition illustrates: having become 'capital', Sowa Rigpa now needs protection not from disappearance, but from appropriation by others. The struggle for cultural survival has not lost any of its importance or urgency for the Tibetans, but it has changed its form and meaning.

This, finally, is both the promise and the paradox of state recognition: promising the protection of intellectual and cultural property through legislation, it simultaneously creates the conditions for appropriation by others, as it inserts culture – as exchangeable property – into the market. Just as the Tibetans hoped, this undoubtedly facilitates Sowa Rigpa's growth as an industry and catalyzes its global spread in the long run, thereby ensuring its continued existence. But just as they feared, it also undermines their claims as Sowa Rigpa's sole legitimate stakeholders. While constituting the successful culmination of the Tibetans' efforts to preserve and promote their medicine, its recognition as an 'Indian system of medicine' thus also raises uncomfortable questions about cultural and economic ownership rights. As these questions will centrally shape Sowa Rigpa's development in the years to come, recognition is not so much the conclusion, but the real starting point of the struggle over Sowa Rigpa's future.

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