The Development of Malay-Javanese Traditional Medicine in Communities: Cultural Heritage Preservation and Policy Needs

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ABSTRACT

Traditional medicine is not only a health-related practice but also a repository of inherited knowledge, values, skills, language and social memory. This article examines Malay-Javanese traditional medicine as living cultural heritage rather than as a clinical treatment system. It asks how such knowledge can remain socially meaningful while responding to changing generational expectations, documentation technologies and institutional policy. The study employs a qualitative documentary analysis supported by a comparative review of heritage and cultural-policy materials. Sources were selected purposively from peer-reviewed scholarship, academic books, official heritage instruments, legal and policy documents, and institutional materials concerning Malay-Javanese identity, Malay traditional medicine, intangible cultural heritage, cultural sustainability and traditional-knowledge governance. The material was interpreted using reflexive thematic analysis. Four interconnected themes were identified: transmission as the social infrastructure of living heritage; community agency as the basis of heritage legitimacy; cultural resilience through adaptation rather than fixity; and ethical governance of documentation, ownership and commercialisation. Comparative analysis of Malaysia, Indonesia and Singapore further shows three complementary policy approaches: statutory recognition and documentation, community-centred cultural advancement and inventorying, and co-created heritage planning with youth and community capacity-building. Drawing these themes together, the article proposes a Community-Centred Living Heritage Sustainability Framework comprising five dimensions: transmission, community agency, cultural resilience, ethical governance and institutional support. The framework is intended as an analytical and policy tool rather than a clinically oriented model. The study concludes that safeguarding Malay-Javanese traditional medicine requires more than recording practices; it requires maintaining the social conditions through which communities can interpret, transmit, adapt and govern their knowledge. Because the study is document-based, its conclusions represent a thematic synthesis of available evidence and do not claim to reproduce the direct views of all Malay-Javanese communities.

Keywords: Malay-Javanese community, traditional medicine, intangible cultural heritage, cultural sustainability, cultural policy

INTRODUCTION

Traditional medicine occupies an ambiguous but important position at the intersection of health, culture and social memory. It may be approached as a set of therapeutic practices, but it may also be understood as a cultural repertoire through which communities organise knowledge about the body, nature, spirituality, family responsibility and everyday well-being. The World Health Organization (WHO) notes that traditional, complementary and integrative medicine is practised in 170 countries and that the current global policy agenda emphasises evidence, safety, regulation, appropriate integration and respect for cultural diversity and traditional knowledge (WHO, 2025). For the present study, however, the primary concern is not clinical effectiveness. The concern is how traditional knowledge acquires meaning, continuity and legitimacy as part of cultural heritage.

This distinction is important in Malaysia because traditional medicine is already situated within the country's heritage-administration framework. The Department of National Heritage places traditional medicine within the domain of intangible heritage under customs and culture, alongside other inherited practices, and identifies

research, documentation, public awareness and preservation as part of its safeguarding responsibilities (Department of National Heritage Malaysia, n.d.). The National Heritage Act 2005 provides the wider statutory framework for the conservation and management of national heritage. These institutional arrangements show that traditional medicine can be discussed simultaneously as health-related knowledge and as cultural heritage, although cultural recognition should never be treated as proof of clinical efficacy.

The Malay-Javanese context adds a further layer because cultural identity itself has developed through migration, assimilation and adaptation. Jandra et al. (2016) describe the integration of Javanese identity into Johor's Malay cultural environment and emphasise adaptability as an important feature of that process. Sunarti and Fadeli (2021) similarly argue that Javanese-Malay communities have actively preserved elements of Javanese cultural heritage in Malaysia while negotiating identity through adaptation and assimilation. Their discussion includes medicinal herbs among the cultural forms carried and maintained by Javanese communities. These studies are important because they suggest that cultural continuity is not necessarily achieved through the unchanged reproduction of an original form. Continuity may instead depend on a community's capacity to reinterpret inherited knowledge within a new social environment.

Within Malay scholarship, traditional medicine has also been documented as an organised body of knowledge rather than a collection of isolated remedies. Haliza Mohd Riji (2000) discusses Malay medical knowledge as a system shaped by observation, experience, natural resources and inherited understandings of health, while Harun Mat Piah (2015) demonstrates the depth of medical knowledge preserved in Malay manuscripts, including classifications of illness, medicinal substances and treatment practices. Such works establish the historical and intellectual significance of traditional medicine, but a heritage perspective requires an additional question: what social conditions allow such knowledge to remain meaningful and transmissible after the contexts in which it originated have changed?

The 2003 Convention for the Safeguarding of the Intangible Cultural Heritage provides a useful starting point. UNESCO defines intangible cultural heritage in terms of practices, representations, expressions, knowledge and skills that communities recognise as part of their heritage, and it emphasises transmission across generations, continuous recreation, identity and continuity (UNESCO, 2003). This understanding moves heritage away from a model of simple preservation. A living tradition is not safeguarded by freezing it. It survives because people continue to recognise, practise, reinterpret and transmit it. UNESCO's guidance on safeguarding similarly warns that intervention should not detach heritage from the communities that give it meaning or disregard customary restrictions on access.

Indonesia's Jamu wellness culture, inscribed on UNESCO's Representative List in 2023, provides a particularly relevant regional example. UNESCO documents Jamu as knowledge and practice transmitted informally within families and among neighbours, while also noting transmission through universities. The nomination and safeguarding process involved practitioners, associations, community contributions, training, digital documentation and inventorying. The significance of the example is not that Malay-Javanese traditional medicine in Malaysia should be equated with Jamu. Rather, Jamu demonstrates that health-related traditional knowledge can be treated as living heritage when safeguarding attends to transmission, community participation, education, documentation and adaptation rather than merely to the preservation of a product or recipe (UNESCO, 2023).

At the same time, heritage recognition creates ethical and political questions. Laurajane Smith (2006) argues that heritage is not simply a thing with an inherent value; it is a cultural process through which meanings, memories and identities are produced and authorised. Her critique of the Authorized Heritage Discourse is especially relevant when institutions classify, document or promote community knowledge. If heritage policy is designed primarily by external authorities, community members can be reduced to sources of information rather than recognised as agents who define what their heritage means, how it should be represented and which aspects should remain restricted. UNESCO's Ethical Principles reinforce this point by placing communities, groups and individuals in the primary role in safeguarding and by requiring transparent collaboration, informed consent, respect for customary access and protection against decontextualisation, commodification and misrepresentation (UNESCO, 2015).

A second challenge concerns cultural sustainability. Soini and Birkeland (2014) show that cultural sustainability is interpreted through several overlapping storylines, including heritage, vitality, diversity, locality and eco-cultural resilience. Beel et al. (2017) further demonstrate how community heritage activities and digital archives can contribute to cultural resilience when they strengthen local participation, identity and the capacity to reproduce cultural knowledge. These perspectives suggest that the sustainability of traditional medicine should not be measured only by whether a named practice still exists. It should also be assessed through the continued presence of transmission networks, meaningful community control, adaptive capacity and institutional conditions that allow knowledge to remain socially relevant.

The research problem addressed in this article therefore lies at the intersection of heritage, community and policy. Existing literature provides important historical and cultural accounts of Malay medicine and Javanese identity, while international and national institutions provide increasingly sophisticated safeguarding frameworks. What remains less clearly integrated is a policy-oriented explanation of how transmission, community agency, cultural resilience, ethical documentation and institutional support can be brought together to sustain Malay-Javanese traditional medicine as living heritage. The article addresses this gap through qualitative documentary analysis. It asks how documentary evidence frames the continuity of traditional knowledge, what risks arise when preservation is reduced to documentation alone, how Southeast Asian policy models distribute responsibility between communities and institutions, and what integrated framework can be proposed for culturally responsible safeguarding.

METHODOLOGY

Study design and analytical boundaries

This study employed a qualitative documentary-analysis design with a comparative policy component. The design was selected because the research question concerns cultural meanings, patterns of representation, mechanisms of transmission and policy approaches rather than the measurement of treatment outcomes or the collection of first-hand clinical data. No interviews, observations, surveys or other forms of fieldwork were conducted for this article. Documents were treated as socially situated sources that both record information and reveal how scholars, governments and heritage institutions define cultural value, risk, responsibility and legitimacy. Bowen (2009) notes that document analysis is appropriate for systematically reviewing and interpreting documentary material in order to elicit meaning, develop understanding and generate empirical knowledge within qualitative research.

The substantive focus was Malay-Javanese traditional medicine understood as a form of community-based cultural knowledge in Malaysia. The analysis was geographically centred on Malaysia because the article is concerned with Malay-Javanese heritage in the Malaysian social context, while Indonesia and Singapore were included only as comparative Southeast Asian policy cases. The temporal scope combined foundational scholarship on Malay medical knowledge and Javanese cultural identity with contemporary heritage and policy documents available up to August 2026. Conceptually, the study was bounded to five issues: transmission, community agency, cultural resilience, ethical governance and institutional support. Materials whose main purpose was to establish pharmacological efficacy, clinical effectiveness or detailed treatment protocols were excluded unless they contributed directly to a policy or heritage argument. These boundaries shaped interpretation by preventing claims about medical outcomes and by requiring each analytical theme to be supported by evidence relevant to heritage continuity.

Document identification and selection

Documents were identified purposively from peer-reviewed scholarship, academic books, official legal and policy materials, UNESCO heritage instruments, government heritage portals and authoritative international organisations. Academic sources were prioritised when they addressed Malay traditional medicine, Javanese-Malay identity, cultural sustainability, community heritage or qualitative methodology. Policy and institutional materials were included when they provided formal information on safeguarding, inventorying, community participation, intellectual-property concerns, cultural planning or traditional-medicine governance. Searches used combinations of terms such as “Malay traditional medicine,” “Javanese cultural heritage Malaysia,”

"Malay-Javanese community," "intangible cultural heritage," "knowledge transmission," "community participation," "cultural sustainability," "traditional knowledge," "cultural policy," "Jamu heritage," and "heritage plan Southeast Asia." Sources without identifiable authorship or institutional provenance, purely promotional material, and duplicated content were excluded.

The documentary corpus was not treated as a systematic review designed to calculate prevalence or effect size. It was constructed as an information-rich qualitative corpus in which different source types served different analytical functions. Scholarly works provided historical and conceptual interpretation; legal and policy documents established formal responsibilities and institutional mechanisms; UNESCO and WIPO materials provided normative principles concerning living heritage, consent and knowledge rights; and regional policy examples allowed comparison of how safeguarding is operationalised. This source diversity was necessary because no single document category could adequately explain the relationship between community knowledge and public policy.

Table 1. Documentary source categories and analytical function

Source category	**Examples**	**Primary analytical function**
Malay and Javanese scholarship	Malay medical studies; Javanese-Malay identity and diaspora studies	Historical context, cultural continuity, adaptation and inherited knowledge
Heritage and sustainability scholarship	Smith; Soini and Birkeland; Beel et al.	Community agency, meaning-making, cultural sustainability and resilience
International heritage instruments	UNESCO 2003 Convention; UNESCO Ethical Principles; Jamu nomination	Transmission, participation, consent, safeguarding and living-heritage principles
National and regional policy documents	Malaysia National Heritage framework; Indonesia Cultural Advancement Law; Singapore Heritage Plan 2.0	Institutional mechanisms, inventorying, co-creation, education and policy design
Traditional-knowledge and health governance	WHO strategy; WIPO traditional-knowledge instruments	Clinical boundary, safety, ownership, attribution and commercialisation risks

Analytical procedure and trustworthiness

Data extraction was organised through a document-analysis matrix recording author or institution, year, source type, geographical context, central argument, evidence relevant to transmission, references to community authority, descriptions of adaptation, ethical or ownership concerns, institutional mechanisms and stated limitations. The matrix was used to distinguish descriptive information from the researcher's interpretation and to avoid building themes from isolated quotations. Where sources disagreed, the disagreement was retained for analysis rather than resolved by selecting only material that supported the preferred argument.

The analysis followed Braun and Clarke's reflexive thematic approach (Braun & Clarke, 2006, 2021). First, the researcher became familiar with the corpus through repeated reading and analytic note-taking. Second, relevant passages were coded according to their meaning within the research problem rather than according to a predetermined list of desired findings. Third, related codes were grouped into candidate themes. Fourth, candidate themes were reviewed against the documentary corpus to determine whether they were internally coherent and sufficiently distinct. Fifth, each theme was defined in terms of a central organising concept. Finally, the themes were written as an integrated analytical account that connected documentary evidence to heritage theory and policy implications. Braun and Clarke (2021) emphasise that reflexive thematic analysis is interpretive; themes are actively developed through engagement with data rather than mechanically discovered or validated through coder agreement.

This approach produced four interconnected analytical themes: transmission as the social infrastructure of living heritage; community agency as the basis of heritage legitimacy; cultural resilience through adaptation; and ethical governance of documentation, ownership and commercialisation. Institutional support was then analysed comparatively through selected policy models from Malaysia, Indonesia and Singapore. These themes were not imposed as conclusions before analysis. They were retained because they provided the most coherent explanation of recurring relationships across the documentary material and because they addressed the article's central question of how traditional medicine can be sustained as living heritage without collapsing cultural recognition into clinical endorsement.

Trustworthiness was strengthened through source triangulation, transparent selection criteria, reflexive memo-writing and an audit trail of coding and theme development. Source triangulation involved comparing academic interpretations with legal, institutional and international normative documents. Convergence was treated as stronger support for an interpretation, while divergence was examined for differences in disciplinary purpose, jurisdiction or policy objective. Reflexive notes were used to identify assumptions such as the expectation that younger generations are necessarily disengaged, that digitisation is always beneficial, or that formal recognition automatically strengthens a tradition. Such assumptions were not accepted as findings unless the documentary evidence supported them. The absence of fieldwork also required a deliberate limitation: the article does not present documentary statements as direct evidence of what all contemporary Malay-Javanese communities currently believe or practise.

Ethical Considerations

Although this study did not involve human participants, ethical considerations remain central because traditional knowledge may be publicly documented while still carrying customary, collective or intergenerational claims. Public availability was therefore not treated as equivalent to unrestricted cultural permission. The analysis followed the principle that the communities and knowledge holders associated with intangible cultural heritage should remain central to decisions about documentation, representation and transmission. UNESCO's Ethical Principles state that safeguarding should involve transparent collaboration and free, prior, sustained and informed consent, respect customary restrictions on access, protect the moral and material interests arising from heritage, and allow communities to identify threats such as decontextualisation, commodification and misrepresentation (UNESCO, 2015).

These principles have direct relevance to traditional medicine because documentation can simultaneously protect and expose knowledge. Written descriptions, photographs, audiovisual recordings and digital archives may prevent loss and support education, but they may also detach knowledge from its cultural setting, reveal restricted formulations, facilitate imitation by unqualified actors or enable commercial use without acknowledgement or benefit-sharing. For this reason, the policy discussion in this article adopts differentiated access as an ethical principle: some heritage information may be suitable for public education, some may require community-controlled or research access, and some may appropriately remain confidential. The objective is not secrecy for its own sake but proportional governance based on cultural ownership, safety and the wishes of knowledge holders.

Intellectual-property developments reinforce the need for caution. The WIPO Treaty on Intellectual Property, Genetic Resources and Associated Traditional Knowledge was adopted in 2024 and introduces a disclosure requirement for certain patent applications involving genetic resources or associated traditional knowledge. As of August 2026, the treaty had not yet entered into force because the required number of ratifications or accessions had not been reached (WIPO, 2024, 2026). Its scope is also narrower than the broader cultural problem considered here. Nevertheless, it signals increasing international attention to the relationship between innovation systems, local communities and traditional knowledge. Heritage policy should therefore address attribution, documentation rights, benefit-sharing and misuse even where conventional intellectual-property law does not provide a complete solution.

A further ethical boundary concerns health claims. Cultural preservation does not validate the safety or effectiveness of a treatment. WHO's Global Traditional Medicine Strategy 2025-2034 places evidence, safety, appropriate regulation and community empowerment among its central objectives (WHO, 2025). Accordingly,

this article treats traditional medicine as cultural knowledge while maintaining a clear distinction between heritage recognition and clinical endorsement. No recommendation in the proposed framework should be interpreted as authorising unverified therapeutic claims or replacing professional medical assessment.

RESULTS AND DISCUSSION

The documentary analysis identified four mutually reinforcing themes that explain the sustainability of traditional medicine as living heritage. The first concerns transmission: knowledge persists only when social relationships enable it to be learned and reinterpreted. The second concerns community agency: heritage legitimacy depends on the authority of communities to define meaning and participate in safeguarding. The third concerns cultural resilience: continuity is sustained through selective adaptation rather than by eliminating change. The fourth concerns ethical governance: documentation and institutional recognition can protect heritage only when ownership, access, commercialisation and health-related risks are addressed. These themes are discussed below and then compared with existing policy models in Southeast Asia.

Transmission as the social infrastructure of living heritage

UNESCO's definition of intangible cultural heritage makes transmission a central condition of continuity. Heritage is not sustained merely because information has been recorded; it remains living when communities continue to recognise and recreate knowledge across generations (UNESCO, 2003). This distinction is especially important for traditional medicine because its cultural content may include terminology, practical judgement, narratives of inheritance, relationships with natural resources and moral expectations about who may learn, teach or use particular knowledge. A written record can preserve descriptions, but it cannot by itself reproduce the social relationship through which authority and competence are recognised.

Malay medical scholarship illustrates the coexistence of written and experiential transmission. Harun Mat Piah (2015) shows that Malay medical manuscripts preserve substantial bodies of medical knowledge, demonstrating the historical importance of textual documentation. Haliza Mohd Riji (2000), however, also emphasises observation, experience and inherited understanding as important foundations of Malay medical practice. Read together, these works suggest that documentation and lived learning perform different functions. Texts can stabilise terminology and historical memory, while experiential transmission carries contextual judgement, interpretation and social responsibility. A preservation strategy that privileges only manuscripts or only practice would therefore provide an incomplete account of heritage continuity.

The regional Jamu example strengthens this interpretation. UNESCO's 2023 inscription notes that Jamu knowledge is transmitted informally within families and among neighbours, while some teaching also occurs in universities. This combination is analytically significant because it demonstrates that intergenerational transmission does not have to remain confined to one channel. Family learning, community networks and formal education can coexist when the community continues to recognise the knowledge as meaningful. The safeguarding measures associated with Jamu also include associations, training, publications, research, digital information and proposed educational materials, showing that transmission can be supported by institutions without being completely transferred away from communities (UNESCO, 2023).

The implication for Malay-Javanese traditional medicine is that policy should focus on transmission capacity rather than simply on the survival of named practices. A tradition may appear visible in exhibitions, publications or social media while having weak pathways for learning. Conversely, a practice may have limited public visibility but remain viable because knowledge is actively transferred within families or trusted networks. This means that heritage assessment should ask whether there are active bearers, learners, opportunities for guided learning, recognised forms of authority and mechanisms through which meanings are explained. Such indicators provide a more substantive measure of living heritage than the number of photographs, publications or promotional events alone.

This theme also connects with cultural identity research. Sunarti and Fadeli (2021) argue that Javanese-Malay communities are active agents in preserving Javanese cultural heritage while adapting to Malaysian society. Their findings support a view of transmission as selective and negotiated rather than purely reproductive. Jandra

et al. (2016) likewise associate the continuity of Javanese identity in Johor with adaptability and integration. Although these studies are not specifically studies of traditional medicine, they provide relevant evidence about the social environment in which Malay-Javanese cultural knowledge is maintained. Transmission therefore needs to be understood as a cultural process of learning, selection and reinterpretation, not simply as the copying of an inherited form.

Community agency and the authority to define heritage

The second theme concerns community agency. UNESCO's Convention requires States Parties to seek the widest possible participation of communities, groups and individuals who create, maintain and transmit intangible cultural heritage and to involve them actively in its management (UNESCO, 2003). Smith's (2006) heritage theory deepens this principle by showing that heritage is a process of meaning-making rather than a neutral collection of valuable objects. Her critique of authorised heritage discourse draws attention to the power of institutions to define what counts as heritage, which versions are publicly represented and which forms of expertise are treated as legitimate.

For traditional medicine, this issue is particularly sensitive because the same body of knowledge may be interpreted differently by practitioners, descendants, researchers, health regulators, heritage officers and commercial actors. An institutional inventory may classify a practice as heritage, a health authority may evaluate it through safety and evidence standards, and a community may understand it through family history, spirituality, trust or local identity. These perspectives do not necessarily cancel one another, but they do not carry the same purpose. Community agency requires that institutional safeguarding does not erase the meanings held by those who identify with the knowledge.

The Jamu nomination offers a concrete example of participatory heritage governance. UNESCO's evaluation records strong community engagement in the nomination process and notes community involvement in inventorying, associations and digital contribution through Jamupedia. The significance is not simply that the State recognised Jamu; rather, recognition was supported by processes that included bearers and practitioners. This reflects UNESCO's broader position that communities should have a primary role in safeguarding and should participate in decisions concerning documentation, representation and access (UNESCO, 2015).

Singapore's Our SG Heritage Plan 2.0 provides a different but complementary example of institutionalised participation. The National Heritage Board reports that the plan for 2023-2027 was developed through consultation with more than 650 stakeholders and received more than 72,000 ideas and suggestions from the public. Its "Heritage X Community" pillar emphasises co-creation, community capabilities, youth involvement and support for ground-up heritage projects (National Heritage Board Singapore, 2023). The model is important for this study because it demonstrates that community participation can be designed as an ongoing governance mechanism rather than limited to consultation after policy priorities have already been determined.

Applied to Malay-Javanese traditional medicine, community agency would require more than asking communities to provide information for an external archive. Knowledge holders and relevant community representatives should participate in deciding what is documented, how categories are named, which historical narratives are presented, what access restrictions apply and what forms of benefit or recognition follow from public use. This approach also allows disagreement within communities to remain visible. Communities are not homogeneous, and younger members, elders, researchers and practitioners may have different expectations regarding disclosure, adaptation or commercialisation. A credible policy model should provide procedures for negotiation rather than assuming a single community voice.

Cultural resilience through adaptation rather than fixity

The third theme is cultural resilience. UNESCO explicitly rejects the idea that safeguarding should freeze intangible heritage in an idealised historical form. Living heritage is continuously recreated in response to social and historical change (UNESCO, 2003). This provides a theoretical basis for distinguishing continuity from fixity. A traditional practice can change in its language, medium, teaching format or institutional setting while still maintaining meanings that communities recognise as important.

Soini and Birkeland's (2014) analysis of cultural sustainability is useful here because it identifies heritage, vitality, diversity, locality and eco-cultural resilience as interconnected ways of thinking about the relationship between culture and sustainability. Their work suggests that preservation cannot be reduced to conservation of an unchanged object. Cultural vitality matters because communities need the capacity to continue producing meaning under changing conditions. Beel et al. (2017) reach a related conclusion in their study of rural community heritage and digital archives, showing how community heritage activity and volunteer participation can contribute to resilience by strengthening place identity and locally grounded cultural production.

The literature on Javanese identity in Malaysia illustrates adaptive continuity in practice. Jandra et al. (2016) describe Javanese cultural identity in Johor as shaped by integration with Malay culture and identify adaptability as a factor in social acceptance. Sunarti and Fadeli (2021) similarly describe the preservation of Javanese heritage through processes of adaptation and assimilation. These findings matter for a Malay-Javanese traditional-medicine perspective because they caution against treating cultural hybridity as evidence of loss. A knowledge tradition may remain culturally meaningful even when vocabulary, material forms, modes of communication or institutional settings change.

Digital documentation demonstrates both the potential and limits of resilience-oriented safeguarding. Digital archives can expand access, connect dispersed descendants, support education and preserve materials vulnerable to physical loss. Yet digitalisation may also separate fragments of knowledge from the relationships and contexts that make them intelligible. A video can record a procedure but may not explain why access was historically restricted, how authority was established, or what ethical responsibility accompanied the practice. Cultural resilience therefore requires context-rich documentation that records provenance, terminology, transmission history, community interpretation and access conditions rather than simply producing a large quantity of digital content.

The distinction between adaptation and erosion should ultimately be assessed through community meaning and transmission. Change can be considered resilient when it strengthens the ability to practise, teach, interpret or responsibly represent the heritage. Change becomes more problematic when it removes community authority, strips cultural terminology from its context, reduces knowledge to a generic commodity or eliminates the conditions through which future generations can learn. This criterion avoids romanticising the past while still recognising that not all transformation is culturally neutral.

Ethical documentation, ownership and commercialisation

The fourth theme concerns ethical governance. Documentation is often presented as an uncomplicated solution to heritage loss, but the documentary corpus shows that safeguarding creates its own risks. UNESCO's Ethical Principles require respect for customary access, informed consent, community moral and material interests, and community participation in identifying threats such as decontextualisation, commodification and misrepresentation (UNESCO, 2015). These principles shift the question from "How much can be documented?" to "What should be documented, under whose authority, for what purpose and with what access conditions?"

For traditional medicine, unrestricted documentation can be especially sensitive. Knowledge may concern recipes, plant combinations, prayers, terminology, preparation methods or practical procedures that families or knowledge holders consider restricted. Publication can also create safety problems if cultural documentation is interpreted as an instructional treatment manual. A responsible archive therefore needs metadata explaining that the material documents heritage and does not constitute clinical guidance. Where a source involves potentially hazardous practice or unverified therapeutic claims, the archive should preserve cultural context without converting the record into an endorsement.

Commercialisation adds another layer. Traditional knowledge can acquire economic value through wellness products, tourism, branding, digital content and intellectual-property claims. UNESCO's ethical framework requires communities to benefit from moral and material interests arising from the use, research, documentation, promotion or adaptation of their heritage. WIPO's 2024 treaty on intellectual property, genetic resources and associated traditional knowledge does not resolve all traditional-knowledge issues and had not entered into force by August 2026, but it reflects a wider policy shift toward transparency about the origin of genetic resources and

associated traditional knowledge in patent systems (WIPO, 2024, 2026). The lesson for heritage policy is that documentation, economic use and intellectual-property questions cannot be treated as separate domains.

A practical response is a tiered documentation system. Public-level material could include history, general terminology, biographies, non-sensitive photographs and descriptions of cultural significance. Restricted research material could contain more detailed technical or historical information accessible under agreed conditions. Confidential material could remain under community or family control and be excluded from public dissemination. Such a model is not presented here as a universal solution, but it translates UNESCO's principles of customary access and informed consent into a workable archival structure.

Ethical governance also requires a firm boundary between heritage value and medical validity. WHO's current strategy calls for a stronger evidence base, appropriate regulation, safe and effective provision, and community empowerment (WHO, 2025). Heritage institutions can document a practice because it has cultural significance without claiming that its therapeutic mechanisms have been scientifically demonstrated. This separation protects both cultural integrity and public safety and is especially important where heritage promotion may otherwise be interpreted as official medical endorsement.

Institutional support and Southeast Asian policy models

The comparative policy review shows that Southeast Asia already contains useful, though different, models for translating living-heritage principles into institutional practice. Malaysia provides a statutory and administrative model. The National Heritage Act 2005 establishes a national framework for heritage protection and registration, while the Department of National Heritage explicitly includes traditional medicine within intangible heritage. Its stated functions include research, documentation, awareness and preservation. This model is valuable because it gives traditional medicine a legitimate place within heritage administration rather than treating it solely as a private cultural activity. Its main policy challenge is to ensure that formal recognition is accompanied by sustained community participation and transmission rather than remaining primarily classificatory.

Indonesia provides a broader cultural-advancement model. Law No. 5 of 2017 on the Advancement of Culture organises cultural policy around protection, development, utilisation and guidance, with protection measures including inventorying, safeguarding, maintenance, rescue and publication. The Jamu safeguarding process demonstrates how these mechanisms can interact with community practice through associations, inventories, digital resources, training, educational materials and local-government support. The Indonesian example is especially relevant to traditional medicine because it combines recognition of a health-related cultural practice with measures directed at transmission and public knowledge rather than limiting safeguarding to legal designation.

Singapore provides a co-creation and capability-building model. Our SG Heritage Plan 2.0 is organised around Identity, Community, Industry and Innovation and was developed through large-scale stakeholder and public engagement. Its community pillar supports co-created heritage projects, youth participation, local heritage nodes and the strengthening of community capabilities. Singapore's intangible cultural heritage inventory is also explicitly described as a growing inventory that documents living traditions without ranking them or prescribing a single "correct" form (National Heritage Board Singapore, n.d.). This approach is useful for Malay-Javanese traditional medicine because it illustrates how public institutions can support evolving heritage while avoiding an overly rigid definition of authenticity.

The three models should not be copied mechanically because they operate within different legal and institutional systems. Their value lies in the design principles they reveal. Malaysia demonstrates the importance of statutory recognition and dedicated heritage institutions; Indonesia demonstrates the value of integrated cultural-advancement measures and community-oriented inventorying; Singapore demonstrates the potential of co-creation, youth engagement and heritage-sector capacity-building. Taken together, they suggest that a stronger policy for Malay-Javanese traditional medicine would combine legal recognition, participatory inventorying, intergenerational transmission, ethical documentation, digital stewardship and sustained institutional support.

Such a policy should also be cross-sectoral. Heritage agencies are best placed to address cultural significance, documentation and community participation, while health authorities are responsible for safety, regulation and evidence relating to therapeutic claims. Universities and archives can support historical research, digitisation and training, and intellectual-property or legal institutions can advise on ownership, attribution and benefit-sharing. A cross-sector design avoids two opposite errors: medicalising heritage so completely that its cultural meanings disappear, or romanticising heritage in ways that overlook safety and public accountability.

Table 2. Comparative Southeast Asian policy models and their relevance

Jurisdiction / model	**Key mechanism**	**Relevance to Malay-Javanese traditional medicine**
Malaysia: National Heritage Act 2005 and Department of National Heritage	Statutory recognition, National Heritage Register, research, documentation, awareness and dedicated intangible-heritage administration	Provides a formal heritage route in which traditional medicine can be recognised and documented while remaining distinct from clinical validation
Indonesia: Law No. 5/2017 and Jamu safeguarding	Protection, development, utilisation and guidance; inventorying; community involvement; associations; digital resources; training and education	Shows how health-related knowledge can be safeguarded through transmission, inventorying and community participation
Singapore: Our SG Heritage Plan 2.0 and ICH inventory	Co-creation, youth participation, community capability-building, digital innovation and a non-ranking, evolving inventory	Demonstrates a flexible model that supports living heritage without prescribing a single fixed or 'correct' form

Proposed Community-Centred Living Heritage Sustainability Framework

Drawing together the four themes and the regional policy comparison, this article proposes a Community-Centred Living Heritage Sustainability Framework (CC-LHSF) for Malay-Javanese traditional medicine. The framework is not presented as a statistically validated model; it is an analytical and policy synthesis derived from the documentary evidence. Its purpose is to organise safeguarding around five mutually dependent dimensions: transmission, community agency, cultural resilience, ethical governance and institutional support.

The framework is cyclical rather than linear. Transmission sustains knowledge, but transmission is meaningful only when communities retain authority over what is taught and how it is represented. Community agency supports cultural resilience because communities can decide which adaptations strengthen continuity and which changes undermine meaning. Ethical governance protects this process by regulating documentation, access and commercial use. Institutional support provides resources, legal recognition, education and long-term infrastructure. In turn, effective institutional support should strengthen rather than replace community transmission. The model therefore treats sustainability as the capacity of a cultural system to reproduce meaning, participation and responsibility across time.

The framework also provides a practical way to evaluate safeguarding programmes. A programme should not be judged only by outputs such as the number of items digitised or events organised. It should also be assessed by whether active transmission pathways exist, whether community representatives participate in decisions, whether adaptations retain recognised cultural meaning, whether access and commercial-use rules are clear, and whether institutional support is sustained beyond a short project cycle. These indicators would allow heritage agencies and researchers to distinguish between visibility and viability: a tradition can be highly visible yet weakly transmitted, while a less visible tradition may remain viable through strong community networks.

Table 3. Community-Centred Living Heritage Sustainability Framework (CC-LHSF)

Dimension	Core policy question	Safeguarding mechanisms	Indicative evidence / indicators
Transmission	Can the knowledge still be learned and meaningfully passed on?	Mentorship, intergenerational learning, oral history, educational partnerships, contextual documentation	Active bearers and learners; continuity of learning pathways; documented transmission histories
Community agency	Who has authority to define, represent and govern the heritage?	Community advisory structures, co-curation, informed consent, participatory inventorying	Community participation in decisions; documented consent; community-defined terminology and priorities
Cultural resilience	Can the tradition adapt without losing community-recognised meaning?	Support for adaptive practice, digital stewardship, youth engagement, retention of local language and context	Evidence of meaningful adaptation; continued recognition; participation across generations
Ethical governance	How are ownership, access, safety and commercial use controlled?	Tiered access, attribution protocols, benefit-sharing, restrictions on sensitive material, separation of heritage from clinical claims	Access classifications; permissions; attribution and benefit arrangements; clear health-claim boundaries
Institutional support	Are legal, financial and organisational conditions sustained?	Heritage registration, grants, archives, cross-agency collaboration, research support and periodic review	Long-term funding; active partnerships; updated inventories; continuity beyond one-off projects

Limitations of the documentary design

The documentary design has several limitations. First, the study analyses published and institutionally accessible material and therefore may underrepresent knowledge that remains oral, private, family-controlled or absent from formal archives. Second, policy documents describe official intentions and mechanisms but do not by themselves prove successful implementation. Third, comparative examples from Indonesia and Singapore are used analytically rather than as evidence that the same policy instruments will produce identical outcomes in Malaysia. Finally, because no fieldwork was conducted, the article cannot claim that its themes represent the present views of all Malay-Javanese knowledge holders or communities. Future research may test, refine or challenge the proposed framework through participatory research with communities and relevant institutions.

CONCLUSION

Malay-Javanese traditional medicine is most productively understood, for the purposes of cultural policy, as a living system of knowledge whose continuity depends on social relationships rather than on the survival of isolated techniques. The documentary analysis shows that transmission, community agency, cultural resilience and ethical governance are inseparable dimensions of safeguarding. UNESCO's living-heritage framework explains why transmission and continuous recreation matter; Smith's heritage theory clarifies why communities must retain authority in meaning-making; cultural-sustainability scholarship demonstrates that adaptation can be a source of resilience; and contemporary ethical and intellectual-property debates show why documentation must be governed rather than treated as automatically beneficial. The Southeast Asian policy comparison further demonstrates that safeguarding can be operationalised through different institutional routes. Malaysia provides a statutory heritage structure in which traditional medicine is already recognised as a domain of intangible heritage. Indonesia shows how cultural advancement, community inventorying and education can support health-related traditional knowledge, particularly through the Jamu example. Singapore shows the value of co-creation, youth participation, evolving inventories and community capability-building. The strongest lesson is

not the superiority of one national model but the value of combining recognition, participation, transmission, ethical documentation and institutional continuity.

The proposed Community-Centred Living Heritage Sustainability Framework translates these lessons into five linked dimensions: transmission, community agency, cultural resilience, ethical governance and institutional support. Its applied value lies in shifting policy attention from preservation as storage toward preservation as social continuity. A successful safeguarding programme should therefore ask not only what has been recorded, but who can still transmit the knowledge, who controls its representation, how the tradition adapts, what ethical protections govern access and use, and whether institutions provide durable support. At the same time, cultural recognition must remain analytically separate from clinical endorsement. Heritage value can be established through history, identity, transmission and community meaning, while claims concerning safety or therapeutic effectiveness require appropriate scientific and regulatory assessment. Maintaining this distinction allows traditional medicine to be respected as cultural heritage without weakening public-health standards. Within these boundaries, a community-centred approach offers a more credible basis for sustaining Malay-Javanese traditional medicine as living heritage in a changing social environment.

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