CHAPTER 6

Decolonizing Western Medicine and Systems of Care: Implications for Education

Jacqueline Benn-John

Introduction

Canada's colonial history has generated many attempts at assimilating Indigenous people into Western institutions and systems. These efforts include rhetoric and practices that both subjugate Indigenous knowledge, cultural traditions, languages, and spiritual practices as well as those that attempt to re-appropriate these into Western institutions and systems (Dei, 2012; Hill, 2008; Wane, 2014). Recognizing traditional medicine and healing practices as legitimate and fruitful healing tools is limited as Canadian institutions of health—shaped by hegemonic notions of White superiority and capitalistic motivations within a globalized context—define the parameters of health, knowledge, and legitimate expertise. Drawing on anti-colonial and anti-racist theories, this chapter interrogates these hegemonic neo-colonial values and methods that privilege Western biomedical systems of care. This work then offers recommendations for decolonizing

J. Benn-John (✉)
Department of Social Justice Education, Ontario Institute for Studies in Education, University of Toronto, Toronto, ON, Canada
e-mail: jacqueline.benn.john@mail.utoronto.ca

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Western medicine and systems of care, thereby increasing options of care for all. In particular, this chapter advocates for widespread use and support for traditional medicine and healing methods.

The Canadian healthcare system clearly differentiates between Western medicine, often just referred to as *medicine*, and traditional or Indigenous medicine, which is referred to as *alternative medicine*. Singer and Fisher (2007) refer to the former as *orthodox* medicine, which is based on scientific knowledge and constructed as superior to other models of health care past and present. However, it is less clear what falls within the boundaries of "alternative" or "traditional" medicine.

A review of academic literature reveals many definitions for alternative medicine: However, notably, most often "alternative" and "traditional" refer to *who* administers the medicine or practice, and the *practices* it includes. For example, Amzat and Abdullahi (2008) define "traditional medicine" as "a term used to describe Chinese medicine and various forms of indigenous medicine like the African traditional medicine" (p. 154). Therapies may include "herbs, animal parts, minerals as well as non-medicine like acupuncture, manual therapies and spiritual therapies which may involve incantations to appease the spirits" (p. 155). More broadly, the World Health Organization has defined traditional medicine as

> the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness. [It incorporates] plants, animals, and or mineral based medicines, spiritual therapies, manual techniques and exercise applied singularly or in combination to maintain well-being as well as to treat, diagnose or prevent illness. (2002, p. 155; 2013, p. 16)

Key in both World Health's and Amzat and Abdullahi's definitions of traditional medicine is the identities (i.e., social locations, including racialization) of the practitioners—that is, Asian, African, and Indigenous. In addition, both identify practices that diverge from the hegemonic pharmaceutical, technological, and biomedicine traditions of Western medicine.

Aligning with these points, in "Indigenous Healing Practices among Rural Elderly African Americans," Harley (2006) refers to Indigenous healing or traditional medicine as

> the practices and knowledge that existed before the advent of modern conventional medicine that were used to promote, maintain, and restore health and well-being. Indigenous knowledge represents the accumulated experience, wisdom, and know-how unique to a given culture, society, and/or community. (p. 433)

Clearly, the alternatives to Western medicine are diverse and can include practices that are community-based and experiential. In this chapter, I use the term *traditional medicine/healing* to refer to pre-colonial and current health practices employed by some Indigenous groups to prevent disease and maintain or improve health (including practices that help people to cope with unexplainable conditions). In this paper, *Indigenous* refers to belonging to a place and the original inhabitants are from that place (Hill, 2008).

An Indigenous understanding of health and healing strives for harmony and balance among humans and the universe. In this model, one component of health and healing does not precede or supersede the others. Indigenous understandings of health and healing recognize and respect the interdependent relationship between humans and the universe in which they live (Dei, 2012; Wane, 2001). Similarly, Baskin (2011) argues that since all creation is interconnected, everyone is both dependent and connected with others in the environment. Drawing on the works of Wane (2001) and Dei (2012), this chapter reflects the above components in *traditional medicine/healing* models and practices. In addition, Indigenous knowledge in *traditional medicine/healing* includes the management of how the community deals with health and sickness.

In this chapter, I consider the Canadian healthcare system within the framework of anti-colonial and anti-racism discourses. In Dei and Kempf, George Dei identifies that contemporary race inequities are rooted in a global history of colonization (Dei, 2000). An anti-colonial perspective is useful in challenging racial inequities wrought by colonialism, emphasizing decolonization and "affirming Indigenous knowledge and culture" (Pon, Gosine, & Phillips, 2011). *Anti-colonialism* is defined as "the political struggle and active resistance of colonized peoples against the ideology and practice of colonialism. It emphasizes decolonization and affirms Indigenous knowledge and culture, while establishing Indigenous control over Indigenous national territories" (Pon et al., 2011, p. 400). *Anti-racism* is "an action-oriented, educational and political strategy for institutional and systemic change that addresses the issues of racism and the interlocking

systems of social oppression (sexism, classism, heterosexism and ableism)" (Dei & Calliste, 2000, p. 11).

Applying anti-colonialism and anti-racism frameworks to hegemonic beliefs about biomedicine and traditional medicine can help us to understand how colonialism and racism continue to structure Canadian medicine and systems of care today. These frameworks can also point to possibilities for active cultural and community-based resistance practices in response, such as increasing awareness and legitimacy of alternative health care and healing pathways (Gahayr, 2011). These frameworks also challenge the institutional powers and structures established by colonialism, instead offering a divergent privileging of the cultural knowledge and expertise of marginalized "Others." Anti-colonialism and anti-racism frameworks offer strategies for interrupting the production of social inequalities within Western medicine (such as the geographical inaccessibility and costliness of biomedicine, and a lack of traditional medicine healthcare options) and its systems. In these ways, this chapter aims to both disrupt colonial constructs of medicine and suggest decolonizing alternatives.

My Epistemological Standpoint

I am a Black African woman who was born in Trinidad. I immigrated to Canada from Trinidad as a one-year-old. My early understanding of a healthy body was informed by the cultural knowledge in my mother's teachings on the role of West Indian foods and herbal concoctions in maintaining health or in treating common conditions (colds and menstrual cramps, for example). My mother had learned about traditional healing and herbal medicine from her mother when she was a girl. Even today, the message from our culture and family members is consistent: A healthy body can only be achieved by eating healthy food. Immigrating to Canada, however, complicated my family's access to the herbs and plants that grew in abundance in backyards in Trinidad. This shift impacted my understanding of the usefulness of these resources. As I became acculturated to Canadian society, I embraced hegemonic Western ideals and began to view my cultural traditions as inferior. In particular, I rejected traditional healing methods. My reference points for defining valuable and non-valuable methods of healthcare were largely those of colonial health, medicine, and religion. Rather than consuming my mother's bitter concoctions, I opted for fast-acting extra-strength painkillers.

Until recently, my narrow definition of health and healing, whether of the mind, body, or spirit, reflected Western hegemonic notions of health and healing. As part of my decolonizing journey, I grew to challenge these notions. Instead, I have developed an understanding of Indigenous health and developed a deeper appreciation for my own cultural knowledge. This journey has been heavily influenced by the works of scholars such as Amzat and Abdullah (2008), Tsey (1997), Akomolafe (2010), Pederson and Baruffati (1985), Jagtenberg and Evans (2003), Harley (2006), Tupper (2009), and Tilburt and Kaptchuk (2008), and their insights are reflected in this chapter. In particular, they have helped me to recognize a pre-colonial perspective on health and healing, which I adopt in this chapter. Some of the implications of this perspective are that I've stopped denouncing my cultural knowledge, and I recognize and appreciate the work of traditional healers. I believe and have experienced the medicinal powers of food, and I now support the efforts of Indigenous societies around the world who resist the marginalization of their healing practices.

This chapter is itself an act of resistance to the colonization of Indigenous healing. My hope is that the decolonization of Western systems of care will allow Indigenous healing to become a viable option for anyone wishing to access it.

Alternative or Indigenous Medicine?

Language has a role in creating categories of social *inclusion* and *exclusion*. This is relevant to the construction of both healthcare systems, our understandings of well-being and our understandings of "legitimate" care options. For example, the term "alternative" health care implies a system of health care that is second or inferior to "mainstream" healthcare practices. When applied to healing and medicine, the adjectives "alternative" "traditional" or "Indigenous" perpetuate a dominant discourse—and, in this, an accompanying discourse of difference.

The language of our post-colonization society describes non-Western health care as health care created by and for racialized bodies: It is implicitly situated as by and for the Aboriginal, South Asian, Asian, and African. This "Othering" of the medical and health practices of Indigenous societies, which are also usually located in a fixed period of time (before modernity, for example), delegitimizes and disregards the efficacy of healing practices employed by colonized societies today. Differentiating traditional healing

with labels of exclusion (i.e., "alternative medicine") also helps to constitute Western medical systems: By default, Western models are legitimate, scientific, evidence-based, and universally relevant (Pederson & Baruffati, 1985, p. 5). Western medicine is grounded in biomedical understandings of the body, health, and wellness. In *Biomedicalization: Technoscience, health and illness in the US*, biomedicalization is broadly described as practices that "emphasize *transformations* of medical phenomena and of bodies, largely through…technoscientific interventions" (Adele, Mamo, Fosket, Fishman, & Shim, 2010). Biomedicalization, the authors note, is organized around a number of interactive processes, including "the technoscientization of biomedical practices where interventions for treatment and enhancement are progressively more reliant on sciences and technologies, [and] are conceived in those very terms" (ibid.). By and large, this model and interventions stand in contrast to other practices and treatments described as "alternative" or "traditional."

Language can also concretely impact *who* is included or excluded in a sector or profession: for example, which populations, which histories, and which knowledges retain value, social repute, or visibility. For example, populations that are included in the definition "Indigenous" are closely tied to Western-defined racial hierarchies and cultural hegemonies, in which persons and communities of white-skin privilege are situated highest on social hierarchies. With this in mind, Harley (2006) argues that African Americans meet the definition of Indigenous because they have "witnessed, been excluded from, and have survived modernity and imperialism" (p. 434); currently experience exclusion and discrimination from full citizenship and during colonialism; "remain culturally distinct with many of their native belief systems still alive" (ibid.); and "survive outside their traditional lands because they were forcibly removed from them and their connections" (ibid.). The exclusion of African Americans from the definition of *Indigenous* reproduces and reinscribes colonial notions of inferiority and exclusion on the bodies of Africans. While Indigenous knowledge is considered inferior to Western knowledges, African knowledge is not even included in the category *Indigenous*. Like many other Indigenous healing practices, the African and Caribbean tradition of obeah—a spiritual and healing practice—is not recognized in Western medicine. It has been dismissed as superstition and holds negative connotations aligning with myths of racial degeneracy and backwardness.

Yet despite its illegitimacy within Western frameworks, traditional medicine is shared around the world. For example, around the world, traditional medicine has been shared within communities through demonstration and practice as well as orally through speech, instruction, song, and story. This mode of knowledge transmission has transcended time and geographical boundaries, as Indigenous people migrated to Western nations. Dyck (2006) illustrates how cultural knowledge of health and illness is transmitted through immigrant women's storytelling. For example, South Asian migrant women living in British Columbia, Canada, transmitted knowledge about *desi* medicine (a concoction of *sarnaa, samf, kalkhand* and *malka* to ease *kavi*, or constipation) to their children and husbands. These women also transmitted knowledge of desi medicine to each other orally and acquired new Indigenous knowledge from immigrant co-workers with different healing traditions. Dyck's (2006) study underscores not only women's acceptance of Indigenous knowledge, but the critical role of oral transmission in India, as knowledge is passed on from mothers and grandmothers. Similarly, in her research on Embu rural women, Wane (2001) cites the work of Dei (2000) and Grenier (1998), highlighting the practice of imparting Indigenous cultural values, belief systems, and worldviews to younger generations through community elders.

Dei (2012) asserts that "knowledge is embedded within particular contexts and resists appeals to master narratives, transcendent experiences, or a universal 'human nature'" (p. 105). The above examples of South Asians in British Columbia and women in Embu reveal this resistance in practice: The practice and transmission of traditional medicine continue, despite the ongoing presence of a colonial and Western healthcare hegemony.

(De)Legitimizing Indigenous Knowledge and Healing

In spite of this—and in spite of the accessibility, convenience, and accuracy with which Indigenous knowledge is transmitted—dominant discourse continues to delegitimize Indigenous knowledge and oral transmission as primitive and backward. In fact, delegitimizing Indigenous knowledge is a strategy employed by the colonizer to control knowledge, including its transmission (Wane, 2014). Indigenous values of collectivity, oral tradition,

spirituality, cultural ties to the local, and ecology do not fit neatly into neocolonialism's globalizing homogenous tendencies (Tupper, 2009). Following this, much Indigenous medicine has also been systematically marginalized: Jagtenberg and Evans (2003), for example, note that "the historical lineage of herbal medicine is *outside the square* as far as Western mainstream has been concerned—since at least the scientific revolution and arguably the advent of a Christian Europe" (p. 321). In this context, Indigenous medicine and healing practices have been further delegitimized by their cultural roots in shamanism and nature worship.

One consequence of this is that the colonized person also becomes the recipient of the colonizer's brand of knowledge and medicine. This remains true even as there is a growing interest in and use of traditional herbal medicine among White Westerners. For example, in "The impact of co-option on herbalism: A bifurcation in epistemology and practice," Singer and Fisher (2007) identify a new trend in the West to modernize herbal knowledge and align this knowledge with principles of biomedicine and biomedical dominance. This not only reifies Western biomedical traditions and model, but also results in further marginalization of the "Other" and their healthcare practices (ibid.) by selectively "legitimizing" some Indigenous knowledge and healing. In this way, Canadian medical and healthcare industries can exploit Indigenous knowledge and healing practices for profit, without challenging the racial and cultural hierarchies that belie them.

Decolonizing Western Medicine and Systems of Care

The North American health industry is a billion dollar industry, and this sector is increasingly profiting from the commodification and appropriation of Indigenous medicine, research, treatment, and advice. Singer and Fisher's (2007) work on herbal medicines identifies this; Tilburt and Kaptchuk (2008) report that worldwide, nearly $60 billion (US) is spent on herbal medicine products each year. In 2005, $33 million (US) was spent on herbal medicines by the National Center for Complementary and Alternative Medicine at the National Institutes of Health (p. 595), and in 2004, the National Cancer Institute "committed nearly US 89 million" to researching traditional therapies (p. 595). This drive to mainstream and profit from Indigenous medicine has led to the category within the dominant heath care system of "complimentary alternative medicine." This term has been

"endorsed by the biomedical elite in order to assert control over non-orthodox practices through grouping together a vast range of practices under one umbrella" (Baer quoted in Singer & Fisher, 2007, p. 20).

The appropriation and co-option of Indigenous culture and healing take many forms. In some contexts, it mirrors early contact between Indigenous societies and colonizers. One such example is what Singer and Fisher (2007) refer to as "mainstreaming" of Indigenous practices. Rather than accepting, recognizing, and co-existing alongside different Indigenous knowledges, practitioners in the North American healthcare industry react to the clear success of Indigenous practices by co-opting the "Other's" knowledge resources for profit (Singer & Fisher, 2007). Just as Columbus and those who followed him extracted profit from colonized Indigenous societies, the healthcare industry responds to the resources of the Indigenous community not by building a beneficial and collaborative bridge between the two, but by selectively appropriating discrete components of Indigenous systems. For example, a medical doctor may take "a short course in the use of herbs for which there is 'evidence' of safety and efficacy" (p. 20). The doctor is then able to prescribe "herbal tablets to treat specific diseases, such as St. John's Wort for depression" (p. 20). Singer and Fisher describe a West-identified doctor, who, in wanting to be "seen as 'holistic' might engage an herbalist to consult for within their medical practice without necessarily engaging in a collaborative referral system" (p. 20). These are all examples of mainstreaming—and co-opting—Indigenous practices into the Western health system.

Mainstreaming and commodification may also occur in a more direct manner. For example, Australians spend twice as much on non-orthodox medicine than on orthodox medicine. In response to this rising market, healthcare providers and institutions have commodified Indigenous healing methods by packaging and marketing goods to sell in grocery stores not only to settlers, but also to Indigenous people living there. In Canada, major grocery stores typically have aisles offering "ethnic" foods and "organic" or "wellness" products. "Indigenous" roots, herbs, mixtures, and plants are marketed as authentic, despite the fact that mass production and profit motives not only affect the quality of the product, but remove the product from the context in which it has been used to heal.

All of these processes are occurring in the context of International capitalism, which creates national and trans-national inequalities that greatly impact Indigenous medicine and its practitioners. Peasant farmers cannot compete in the global marketplace, against corporations that rape the land

for its natural resources (herbs and plants, for example). Another effect of globalization, regulatory legislation under the banner of improved safety and efficacy for consumers (Jagtenberg & Evans, 2003), has had a profound effect on small, low-tech manufacturers of traditional herbal products who cannot easily meet regulatory conditions. According to Jagtenberg and Evans, over the last 15 years many small herbal manufacturers have been taken over or simply could not compete with "larger herbal companies and pharmaceutical companies" (p. 323). These realities illustrate the imposition of Western medicine's reliance on standardization, universalism, and globalization onto Indigenous systems of health and healing. In an increasingly standardized and globalized market, Indigenous societies' dependence on cultural knowledge, local communities, and local ecology is neither acknowledged nor accommodated.

Despite the continuing devaluation of Indigenous medicine, its use is increasing. Traditional healing methods have had notable clinical success in treating major illnesses such as HIV/AIDS, infertility, and mental illness (Flint, 2015). I believe that the way forward is for Western medicine to use its energies and power to *decolonize itself*, rather than continuing its efforts to consume the "Other." Imagine the possibility of multiple healing systems operating in tandem, with a plurality of healthcare systems in which people could choose the care and methods best suited to their circumstances. More importantly, people could choose *not* to access methods and practices that are incongruent with their beliefs, values, or presenting needs. Decolonizing Western medicine can offer practical and accessible strategies for improved health that, if practiced consistently, will yield improved health and well-being for all. Here, I detail a number of concrete strategies for decolonizing Western (and, by extension, Indigenous) medicine.

Western medicine can start a decolonization process by learning how traditional knowledge on medicinal and health practices is reproduced or transmitted from one generation to another—including the social contexts within which these practices occur. This is a foundational step to demystify the "Other," bring legitimacy to their knowledges, and help neo-colonialists to recognize that the constructed gap between Western medicine and Indigenous healing is not as wide as they have made it to be. I also recommend an intentional change in terminology that eliminates language of hierarchy and exclusion. Western professionals and institutions must acknowledge that there are many ways of knowing, including methods that are not amenable to scientific or other empiric tests. The "Other" must be accepted in all of their diversity—binary assumptions about the

relative qualifications and knowledge of "Indigenous" healers vs. Western-trained doctors should no longer be the dominant discourse in discussion of diverse healing and systems of care. While regulation ought to be imposed, regulations ought to be applied in a way that encourages equity and access for small farmers and local healers.

In the context of terminal illnesses, the Western heathcare and pharmaceutical industries should make life-saving medications available to those who need them, not those who can afford them, and should ensure a steady supply of effective medications (full strength, for example) to developing countries and to low-income and racialized communities.

Western medicine can also decolonize itself by reconsidering the ways in which it delivers mental health systems and services. For example, the delivery of culturally diverse healthcare practices would reduce the effect of "Othering" racialized individuals and increase access to and success of services. In addition, referrals to Indigenous healers and partnerships with Indigenous healing associations and shamans will help to ensure that those in need of mental health support can receive a full spectrum of care for their needs.

The strategies presented above are by no means exhaustive. However, I put them forward in an attempt to demonstrate how the decolonization of Western medicine can begin to challenge the institutional powers and structures established by and maintained through colonialism. The strategies discussed in this chapter that are involved in the continuation of traditional medicine are evolving. In fact, this is the reason traditional medicine and worldviews continue to transcend geographical borders, time, and space—therefore, traditional medicine is a key factor in decolonizing Western medicine.

Conclusion

This chapter has advocated for the widespread use and support for traditional medicine. It did not advocate for the integration of traditional medicine and healing practices into Western systems of care, due to the belief that this perpetuates hegemonic neo-colonial values and methods by subsuming traditional medicine and healing into a supporting branch of Western health care. We know that one size does not fit all, and history has demonstrated the danger of a "single story" (Adichie, quoted in

Akomolafe, 2010). Indeed, there is no "single story" about health, healthcare, or healing. I argue that we need a variety of healthcare options, including Indigenous systems, that can respond to the unique needs of individuals. This approach recognizes the diversity of the populace and leaves space for the emergence of new healing methods. It is therefore imperative that the dominance of the single model of Western medicine be interrupted. Through the decolonization of Western medicine, the transmission, practice, and promotion of diverse cultural knowledges and healing methods will thrive.

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