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A Survey of Kenya's Policies, Institutional Arrangements and Legislation on Traditional Medicine

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Abstract

Traditional medicine (also called ethno-medicine) is indigenous medicine based on traditional medicinal knowledge systems and passed down by word of mouth from generation to generation within the particular indigenous community, especially along familial lines as well as through informal apprenticeships; and which is largely undocumented. For a long time Kenya lacked policies, institutional arrangements and legislation on traditional medicine. Years later that scenario has changed, as the country now has an extensive policy framework and institutional arrangements on traditional medicine, comprising an avalanche of policies and institutional arrangements on the subject. It also has an extensive corresponding legislative framework comprising several pieces of legislation that are scattered over several sectors and line ministries and touching on one or other aspect of traditional medicine. New policies have been made, new legislation promulgated, and some of the then existing legislation amended. The earlier situation, and which has as already stated changed, was perhaps attributable to the nascent stage of traditional medicine policy and legislation at the time. With the effluxion of time, there have been marked developments in Kenya's policies, institutional arrangements, and legislation on the subject. Notably however, although the effective operation of these institutional arrangements together with that of these scattered pieces of legislation can to some extent promote or impact positively on traditional medicine, they are bedeviled by lack of coordination and harmonization. This paper makes recommendations that if implemented can provide the much-needed coordination and harmonization in Kenya's policies, institutional arrangements and legislation to ensure effective management and development of traditional medicine.

Keywords: A Survey, Kenya, Policies, Institutional Arrangements, Legislative Framework, Traditional Medicine

1. General Introduction, Definition of Key Words, and the Factual Background

1.1. General Introduction

The republic of Kenya is located in the Eastern region of Africa; where it borders South Sudan to the northwest, Ethiopia to the north, Somalia to the east, Uganda to the west, Tanzania to the south, and with the Indian Ocean on its south eastern coastal line. This paper discusses Kenya's policies, institutional arrangements and legislation on traditional medicine. Traditional medicine (also called ethno-medicine, as opposed to bio-medicine also called conventional medicine or western medicine) is a critical and integral part of the country's health care system. The research for this paper was prompted by previous reports and commentaries by commentators who over the years either reported that over the years either reported that Kenya lacked policies, institutional arrangements, and legislation on traditional medicine. Or who reported that there was a glaring disconnect among these three aspects of Kenya's traditional medicine regulatory regime. This paper has extensively discussed the author's findings on the present situation. It is divided into five main parts. Part One is this introductory part that makes a general introduction and lays out a factual background for the entire paper. It explains the main theme and main objective of the paper, then defines the key words, and subsequently lays out the subject's factual background, starting with

the basic facts on traditional medicine generally, then moving to the global context and finally laying bare the African context. Part Two delineates the conceptual framework for the entire paper; discussing the interplay between policy and legislation and then justifying the need for having in place policies, institutional arrangements and legislation on traditional medicine. Part Three discusses the state of allopathic and traditional medicine health care systems in Kenya, starting with the allopathic one, and then the traditional medicine one. Part Four discusses country's policies, institutional arrangements as well as legislation on traditional medicine. Part Five is the conclusion part that summarizes the paper and ties up its key findings in a solid conclusion, and then recommends certain interventional actions to address the current situation.

1.2 Definition of Key Terms

(a) The Term "Traditional Medicine"

The term "traditional medicine" as used in this paper refers to indigenous medicine based on traditional medicinal knowledge systems and passed down by word of mouth from generation to generation within the particular indigenous community especially along familial lines as well as through informal apprenticeships, and which is largely undocumented. The World Health Organization (WHO) defines traditional medicine (TM) 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' (WHO, 2002; Badal & Delgoda, 2017). It comprises health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercise, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being (Fokunang et al., 2011). It in essence is a system of health practices based on indigenous knowledge (also called folk knowledge, indigenous knowledge or ancestral knowledge) that has over a long span of time been passed on from generation to generation. Gakuya et al. (2020) have reported that this term is a broad one, incorporating various systems and forms of indigenous medicine.

(b) The Term "Policy"

Policy and legislation are at the core of this paper. The term "policy" as used in this paper refers to governmental policy, also known as public policy. It comprises statements on what the government intends to do or not to do, on a particular problem, cause or issue (Dye, 1972).

(c) The Term "Legislation"

The term "legislation" for its part, as used in this paper, refers to the law made by Parliament, comprising primary legislation (Acts of Parliament) as well as subsidiary legislation (comprising regulations and rules made pursuant to the provisions in the primary legislation). While the former is promulgated by Parliament itself, the latter is made by the executive to facilitate the former's application, implementation and enforcement.

1.3. A Factual Background on Traditional Medicine

Traditional Medicine Generally

Traditional medicine is indeed as old as humanity, and has been used in health care since time immemorial. FAO (1985) has opined that prior to western science and conventional medicine (orthodox medicine), medicinal practices were somewhat similar in many parts of the world. Indeed traditional medicine has been and remains important in the treatment and cure of diseases and illnesses, especially in the rural areas which are characterized by shortage of health care facilities, health care workers and allopathic medicaments. Akerele (1987) has further added that the WHO has for decades encouraged its use, especially in the developing counties by incorporating its useful elements into national health care systems (See WHO, 2002). While noting that traditional medicine as an alternative and complementary therapy is gaining prominence in primary health care worldwide, Adeniyi et al. (2015) attribute this increasing prominence largely to its phenomenal efficacy in the management of mild as well as chronic and seemingly incurable diseases and ailments.

Upretty & Asselin (2012) for their part have reported that medicinal plants have been used in traditional health care systems since prehistoric times and are still the most important health care source for the vast majority of the population around the world. They further estimate that 70 to 80 percent of people worldwide rely on traditional herbal medicine to meet their primary health care needs. This traditional herbal medicine can be an important driver in the primary health and even in the curative health of the predominantly poor, less literate and unsophisticated setting of the rural populations. This is not only for reason of being cheaper and more accessible than biomedicine, but also for reason of being based on traditional knowledge systems that have endemically existed in the local communities for generations. Given that it does not require the technological sophistry of modern medicine, it is more convenient and adapted to the circumstances of the largely traditional setting of environments. Writing on traditional medicine among the Maasai, Sankan (2006) identifies two parallel systems of traditional medicine, namely, the “genuine medical practice” and the “deceptive medical practice”; and observes that while the former is based on actual traditional knowledge, the latter is based on deceit and trickery, and is meant to exploit and fleece the public. In other words, the latter is a conduit for unjust enrichment.

Notably, traditional medicine is more of curative medicine than preventive medicine, in that it is more cure-oriented than prevention-oriented, as it is focused on cure rather than preventive health care; the cure of diseases rather than their prevention. Mothibe & Sibanda (2019) for their part have reported that ‘African traditional medicine has been used by African populations for the treatment of diseases long before the advent of orthodox medicine and continues to carry a part of the burden of health for the majority of the population; and further that it plays a role in health, in terms of preventive, curative and even palliative health care.’ Further, unlike allopathic medicine that focuses on diseases and health, traditional medicine not only focuses on diseases, but on social problems as well. It therefore comports well, with the World Health Organization’s definition of the concept of “health”. With regard to diseases, traditional medicine goes beyond the conventional diseases and encompasses other health maladies such as mental illnesses, sexual libido problems, bareness, as well as social problems and social maladjustments e.g financial problems, matrimonial problems, witchcraft, demonic attacks, evil spirits, bad luck, and love-related problems such as marital infidelity. The methods used in traditional medicine include: use of herbs, prayers, cursing, oathing, witchcraft, and even magic.

The International Recognition of Traditional Medicine

Traditional medicine has been the subject of interest and has received formal recognition at the local, national level and even the international level. International efforts for the formal international recognition of traditional medicine as a source of health care date back to the 1970s and were spear-headed by the WHO (Rukangira, 2001). These efforts begun when the 30th World Health Assembly (WHA) of the state parties of the WHO held at Geneva from 2nd to 19th May 1977 unanimously recognized the importance and role played by traditional medicine in the health systems especially of developing countries, and the need to mainstream it. The Assembly urged member states to promote this genre of medicine. This was in 1978 followed by a call to governments in their national drug policies and regulations to give priority to utilizing traditional medicines (Akerle, 1987). This call was made in the 1978 Alma Mata conference. This was the International Conference on Primary Health Care held the Alma Mata Kazakhstan from 6th to 12th September 1978. The conference even adopted a Declaration of Principles named The Alma Mata Declaration. Those resolutions and recommendations regarding traditional medicine were re-affirmed at the WHO’s 40th World Health Assembly at Geneva held from 4th to 15th May 1987. Akerle (1987) has further added that that the WHO has for decades now encouraged its use, especially in the developing countries by incorporating its useful elements into national health care systems (See WHO, 2002). While noting that traditional medicine as an alternative and complementary therapy is gaining prominence in primary health care worldwide, Adeniyi et al. (2015) attribute this increasing prominence largely to its phenomenal efficacy in the management of mild as well as chronic and seemingly incurable diseases and illnesses. In the year 2002, the World Health Organization designated the 31st of August of every year as the African Traditional Medicine Day (African Health Monitor, 2003).

The African Context of Traditional Medicine

In Africa, traditional medicine is indeed as old as humanity, and has been used in health care since time immemorial. FAO (1985) has opined that prior to western science and conventional medicine (orthodox medicine), medicinal practices were somewhat similar in many parts of the world. This genre of medicine has been and remains important in treatment and cure of diseases and illnesses, especially in the rural areas which are characterized by a shortage of health care facilities, health care workers and allopathic medicaments. Admittedly, traditional medicine, and especially African traditional medicine (ATM), remains the most affordable and easily accessible medical care in many poor countries, especially sub-Saharan ones such as Kenya. African traditional medicine is in fact the oldest of all the world's traditional medicine systems (Ebu et al., 2021). Yet, it is the least established traditional medicine system in the world and has remained rudimentary, informal and with little, and sometimes no governmental recognition, endorsement and/or support; as well as lack of overall public acceptance. This situation is in diametrical contrast with Asian traditional and alternative medicine for instance. It is largely due to those factors that Africa's traditional medicine has remained a cropper, yet it is an important source of health care for millions of the continent's inhabitants, and especially the pre-dominantly poor populations in sub-Saharan Africa, found mainly in rural and peri-urban areas of the continent.

Rasamiravaka et al. (2015) have observed that 'African traditional medicine is characterized by a belief in the supernatural as a cause of illness, divination as a diagnostic tool, and the ritualized use of a wide variety of plants and animal-derived agents in its treatment'. It is worth noting however, that WHO's support is only for scientifically-proven traditional medicine and not for superstitious claims. This is a tricky balancing affair because one of the major challenges that traditional medicine suffers is lack of scientific credibility for most of its claims. This can be majorly attributed to the fact of it being primarily founded on mysticism, superstition, deity, magic, supernatural powers, and even witchcraft, sorcery, as well as wizardry. Banquar (1995) has for his part reported that traditional herbal medicines, for instance, play a vital role towards the well-being and development of rural populations, and that herbal therapy although still an unwritten science, is well established in the indigenous people's cultures and traditions and has become a way of life for almost 80 percent of the people in Africa. Further that many diseases which could not be cured by the allopathic or other systems of treatment have been cured by traditional medicine. This view is corroborated by Kipkore et al. (2014), who have reported that traditional medicine remains an important component of the health care in sub-Saharan Africa largely due to the prevailing poverty, inadequate health services and shortage of health workers.

Despite its usefulness, traditional medicine in many parts of Africa is beset by multiple limitations and challenges, including the following: (a) Its tendency to imprecise diagnosis that is based on guess work, devoid of scientific diagnostic investigation such as X-Ray, CT Scan, MRI or even laboratory tests; hence its diagnosis and prognosis are usually presumptive and inaccurate (b) It offers symptomatic instead of etiological therapy (c) Its lack of precision in dosage forms (d) Its susceptibility to possibilities of poisoning as its concoctions and dosages are not preceded with scientific tests as to safety, quality standards fitness for human consumption (e) Its potential for witchcraft, sorcery and wizardry, especially due to its mystic nature and the fact of its being based largely on superstition, and with the thin line between it and the practice of black magic as well as witchcraft, sorcery and wizardry (f) Its proneness to quackery as a result of its having no requirements for academic or professional qualifications (g) Its being largely informal and unregulated (h) Its lack of firm formal legal recognition through law (i) There being no specific or identifiable official institution superintending it (j) Its lack of a specific governing legislation (k) The pharmacokinetics, pharmacodynamics, contraindications and even side-effects of many traditional medicaments are largely unknown, unascertained and/or undocumented.

2. The Conceptual Framework

2.1. The Policy-Legislation Interplay

There is a horse-rider relationship between policy and legislation; because the formulation of policy on any subject is usually followed by or accompanied with the promulgation of corresponding legislation on the same. Legislation therefore is an important tool for enforcing government policy; hence a policy always needs to be backed by the

enactment of corresponding legislation not only to enforce, but also to validate that policy to enable its implementation. There is thus, as already stated in this paper, a horse-rider relationship between policy and legislation, as the three primary functions of legislation in relation to policy are: (1) To validate policies by giving them legal legitimacy, (2) To enforce policies by converting them into legally enforceable edicts, and (3) To establish or designate the agencies responsible for implementing such policies as well as those for enforcing the legislation. (Sifuna & Mogere, 2002). Legislation thus validates policies, and also issues edicts and prescribes as well as proscribes certain conducts and actions; and often also creates or designates particular agencies and vests them with the responsibility of implementation- which are in this paper called implementing agencies. Whereas such agencies can be created or designated by those policies themselves, it is better if they are created or designated by law (the Constitution or legislation), rather than administratively or by policy alone, or by executive whim. However, unlike a policy, legislation creates legal sanctions for breach of its edicts and non-compliance with it. Ogolla (1992) has argued that law: "...translates policy into specific enforceable norms, standards of social behaviour and compels, by threat of sanctions, their observance by laying down to public officials, basic guidelines for implementation of demands of the normative regime." A law that criminalizes or characterizes particular actions and conduct as offences, will also usually prescribe sanctions and penalties for non-compliance. By so doing, law unlike policy, insulates itself from indifference and disregard, and also enhances compliance with its edicts. This is because it spells out punitive sanctions and penalties for those as willfully or negligently break or disobey it, or simply fail to comply with it. These sanctions/penalties include: imprisonment, fines, surcharge, restitution, restoration, as well as payment of compensatory damages; and are intended as punishment for infraction and non-compliance rather than a reward for obedience and compliance. Admittedly, the legal duty to obey the law has the effect of not only discouraging non-compliance, but also ensuring and even increasing compliance with laws.

Without the subsequent enactment of corresponding legislation, a policy is a toothless dog that barks but cannot bite; as it is legislation that gives policies the required "teeth" to bite; by converting its statements into enforceable prescriptions and proscriptions (backed by sanctions and penalties), as well as enforceable legal obligations and rights. Without corresponding legislation, policies remain mere "paper tigers" or innocuous empty rhetoric inked on paper, and remain mere rhetoric. On a lighter note, this could be the reason why some countries call their governmental policy documents, "Papers". In some countries they are called "White Papers", in others they are called "Blue Papers", while in others they are called "Green Papers". Admittedly, without the further act of legislation, these "Papers" remain merely "Papers" and just "Papers". It follows therefore that having policies and political will alone without subsequently enacting specific corresponding legislation is not enough. Any governmental policy should be followed by the enactment of corresponding legislation to implement it, as law is an important tool for enforcing policy (Sifuna & Mogere, 2002). Otherwise having policies alone without the supporting corresponding laws is not enough, hence it is illogical to have beautiful policies, without the subsequent enactment of the supporting corresponding legislation. This is because unlike a policy, law creates legal sanctions and penalties for breach of its edicts or non-compliance with it.

2.2. The Need for Policies, Institutional Arrangements and Legislation on Traditional Medicine

The protection and promotion as well as the growth and development of traditional medicine requires policies, institutions and a corresponding legislation. There is as already stated, a horse-rider relationship between law and policy, with policy being the horse and law being the rider; as one of the fundamental functions of laws is to implement policies. This is in the sense that the formulation of a policy always needs to be followed by the enactment of corresponding legislation, not only to validate it (policy), but also to enforce and enable its implementation. Law is thus a tool for enforcing governmental policy. As policies require the enactment of attendant legislation to implement them, they also require the creation and/or designation of the agencies vested with the duty of implementing them (implementing agencies). As already stated in this paper, while such agencies can be created or designated by such policies, it is better when they are created or designated by law rather than administratively or by executive whim. Just the way a policy will designate a particular agency and charge it with its (the policy's) implementation, a law will likewise create or designate a specific institution or entity to enforce

it (the law). Without enforcement, policies and even the law will be mere words and empty rhetoric. Even as policies create and designate implementing agencies, and as laws create and designate enforcement agencies, the law is further required to not only spell out the functions and responsibilities of such agencies, but to also prescribe penalties and sanctions for abdication of these functions and responsibilities by functionaries in those agencies, and also for law breakers. It cannot be gainsaid that legal creation or designation of agencies makes them legal entities hence giving them juristic legitimacy, as well as clothing them with legal authority in the sense that they have legal backing for their roles and are legally liable for their actions. That is why these agencies function well when they have been created (or designated) by the law, rather than administratively or by policy only, or by executive whim. While such policies, institutional arrangements and corresponding legislation are necessary, their effectiveness is even more crucial.

3. The State of Allopathic and Traditional Medicine Systems in Kenya

3.1. The State of Allopathic Medicine in Kenya

Kenya is a low-middle-income country (LMIC) with a land surface area of 580,367 square kilometers, and a population of 47.5 million people comprising 12.2 million households (GOK, 2019 National Population Census-KNBS); and a GDP of Ksh 9.6 trillion (GOK, 2020) and high poverty index, with almost half of its population living below the poverty line- earning less than 1 USD per day. Its governmental expenditure on health being approximately 8% of the general governmental expenditure (GGE), and 2% of the country's GDP instead of the 15% and 5% respectively, internationally recommended threshold. This is far below the stated threshold recommended by the Abuja Declaration (GOK, 2020). This paltry expenditure on health has still not taken health services close to the people, thus making the Kenya Government's policy clarion "Health for All", mere policy rhetoric with nothing to show for it. The actual state of affairs is that the bulk of the Kenyan populace still lacks access or any meaningful access to health care. This is especially in the predominantly rural setting, which comprises over 80 percent of Kenya, and which is characterized by illiteracy, low per capital income and a traditional health care system (traditional medicine) that has no governmental support. Besides, Kenya's health care facilities and workforce (health care workers- doctors, clinical officers, nurses and midwives) are far below the World Health Organization's internationally recommended ratio of the population; with most of these facilities and workforce being not only poorly distributed, but also largely concentrated mainly in urban areas (GOK 2020; The World Bank Group, 2018a, 2018b, 2020; Mulaki & Muchiri, 2019). Kenya's current ratio of doctors, clinical officers, nurses and midwives to 1000 people of the population which ranges between 0.2 and 1.2 is a far cry from the WHO's internationally recommended ratios; and so is the current ratio of approximately nine health care workers per health care facility (GOK, 2020). With this sad state of affairs, the country has challenges in meeting the Sustainable Development Goal of Universal Health Coverage (UHC).

Sadly, despite significant reductions in the recent years, Kenya still has high prevalence of diseases such as HIV/AIDS, malaria, tuberculosis, and other disease associated with water, sanitation, hygiene, environmental factors, nutrition. Its health workforce has a small and poorly distributed health workplace, of nine health workers per facility, with most of it concentrated in urban areas (GOK, 2020). In essence, Kenya's rural areas are heavily understaffed, yet it is these areas that bear brunt of diseases, illnesses, poor sanitation, poor hygiene, inadequate water supply, lack of access to safe water, high poverty levels and low literacy levels. Notably, this situation has from March 2020 been compounded by the COVID 19 pandemic which has overstretched not only the health budget but also the health care workers, health care infrastructure, health care supplies, health care equipment, health care transport such as ambulances, as well as health education and training. With such a limping and overwhelmed allopathic health care system, traditional medicine not only flourishes, but needs to be promoted and developed. While Okumu et al. (2017) have attributed its slow development in Kenya to inadequacies in regulation and promotion; and its thriving in rural areas to the poor state of allopathic health care system in such areas. Especially the shortage of health care workers and facilities. This means therefore that even in this 21st Century, Kenya is yet to meaningfully take health care services to the people; which makes the government's goal of attaining Universal Health Coverage (UHC) a pipe dream. Although allopathic medicine is Kenya's mainstream health care system, traditional medicine remains the complementary and alternative health care system, hence worthy of attention. The part below discusses the state of traditional medicine in Kenya.

3.2. *The State of Traditional Medicine in Kenya*

Although traditional medicine received international (and even national recognition) many decades ago, in many parts of the world including Kenya, its growth and development has been stifled by the skepticism and reluctance by governmental authorities and even the general public in accepting it. The general public, especially the elitist intelligentsia and the lot influenced by American and European cultures as well as western religions such as Christianity, have often doubted and challenged the knowledge and claims made by its practitioners and some segments of the community who support it or benefit from it. This state of affairs has been acknowledged by the Kenya Government; which in the 1989-1993 National Development acknowledged the important role played by traditional medicine in the country's health care but blamed its lack of growth on skepticism and lack of information about its contribution and potential (GOK, 1989). Gakuya et al. (2020) have observed that owing to its social, economic and cultural significance, traditional medicine is a concept that resonates well with many inhabitants of developing countries such as Kenya. Sindiga (1995) observed that despite the formal over-popularization of conventional medicine (biomedicine), the bulk of the population in Kenya especially in the traditional rural areas relies on traditional medicine for their primary health care as well as the treatment of diseases and illnesses. As illustrated in this paper, traditional medicine is undeniably an invaluable and complementary branch of medicine that should not be considered as inferior to conventional medicine. Following the official recognition of traditional medicine by Kenya in the 1990s, the Government later established a task force to craft policies and draft laws on it. While commentators and researchers such as Kigen et al (2013) have lamented Kenya's policy and legislative framework, the findings by this author in the study for this paper, is in contrast to those earlier findings and opinions, partly due to effluxion of time, and also due to sustained stakeholders' lobby efforts that nudged Kenya into adopting new policies and legislation on the subject. With the result that many of the then draft policies and draft bills were finally adopted; and are at present the prevailing regulatory framework in the country. This is because without their subsequent adoption and enactment, they would have remained mere recommendations for future action, as they could neither be implementable nor enforceable.

Traditional medicine is therefore important in the treatment and cure of diseases and illnesses in the country, especially in the rural and peri-urban areas which are characterized by widespread poverty as well as a shortage of health care facilities, health care workers and allopathic medicines. Almost two-thirds of the Kenya's population (especially in the rural and peri-urban areas) rely on traditional medicine for their health care needs; which makes it an integral and invaluable component of Kenya's health care system, such that the Kenya Government needs to accord ample attention to it. This requires that it be mainstreamed into the country's health sector, especially given its relative affordability and accessibility compared with allopathic health care (Banquar, 1995; Githae, 1995). It is an important and often underestimated part of health care services (WHO, 2014). In Kenya as many other jurisdictions especially in Asia and Africa, traditional medicine is a subject of policy and legislation—such that there exists a cocktail of policies and legislation on it.

Apart from its beneficial use for maintenance of health as well as in the prevention, diagnosis, improvement, or treatment of diseases and illnesses, traditional medicine in the African context is also used for malevolent purposes such as witchcraft, sorcery, wizardry and black magic. Its other malevolent uses include use in traditional oathing, curse ordeals, and many other harmful and malicious uses. Overall, however, this system of medicine is important in the treatment and cure of diseases and illnesses, especially in the rural and peri-urban areas which are as already stated in this paper characterized by widespread poverty as well as a shortage of health care facilities, health care workers and allopathic medicines. Indeed, traditional medicine's malevolent employment should be a cause for concern, as to warrant some regulation to ensure it is employed only for the common good of society. Such regulation being through policy-making and legislation.

In sum, it need not be gainsaid that traditional medicine is important in the treatment and cure of diseases and illnesses in Kenya, especially in the rural and peri-urban areas which are characterized by widespread poverty as well as a shortage of health care facilities, health care workers and allopathic medicines. Whereas allopathic medicine is Kenya's mainstream, most formal and dominant health care system, the weaknesses, challenges that

beset it has invariably resulted in more and more people resorting to traditional medicine for their health care needs as an alternative and complementary health care system. This is the opportunistic and resilience character of traditional medicine in the modern African society. Despite its resurgence, traditional medicine still lacks the blanket formalness and governmental embodiment that its counterpart (allopathic medicine) enjoys. There is in the typical African sub-conscious mind a general and perhaps mistaken belief, that “what allopathic medicine cannot do, traditional medicine can do”. This persuasive portfolio, makes traditional medicine a legitimate province of governmental policy-making and legislation. The next part examines the Kenya Government’s policies, institutional arrangements and legislation on traditional medicine.

4. Kenya’s Policies, Institutional Arrangements and Legislation on Traditional Medicine

As already noted in this paper, commentators have in previous reports and studies over the years either reported that Kenya lacked or lacks policies, institutional arrangements and legislation on traditional medicine, or that there was a glaring disconnect among these three aspects of Kenya’s traditional medicine regulatory regime. It is these harsh judgments, that years later prompted the author to conduct research that has led to this paper. In the part below, the author discusses Kenya’s policies, institutional arrangements and legislative framework on traditional medicine; and presents the findings of his research on the same. Interestingly, his findings are markedly different from the said previous claims, conclusions and assertions by commentators. This is the author’s contribution and point of departure from previous literature, commentaries and reports on the subject matter (e.g . Chebii et al., 2020).

4.1. Kenya’s Policies on Traditional Medicine

Although traditional medicine received international and even national recognition many decades ago, its growth and development in many parts of the world including Kenya has been stifled by the skepticism and reluctance by governmental authorities and even the general public to accept it. There has been marked doubt and skepticism on the knowledge and claims made by its practitioners and some segments of the community. This state of affairs has been acknowledged by the Kenya Government, which in the 1989-1993 National Development Plan acknowledged the important role played by traditional medicine in the country’s health care, but blamed its lack of growth on skepticism and lack of information about its contribution and potential (GOK, 1989). Gakuya et al. (2020) have observed that owing to its social, economic and cultural significance, traditional medicine is a concept that resonates well with many inhabitants in developing counties such as Kenya. Sindiga (1995) observed that despite the formal over-popularization of conventional medicine (biomedicine, also called allopathic medicine) the bulk of Kenya’s population especially in the traditional rural set up relies on traditional medicine for primary health care in the treatment of diseases and illnesses. It is, as illustrated in this paper, an invaluable and complementary branch of medicine that should not be considered as inferior to conventional medicine.

Following the official recognition of traditional medicine by Kenya in the 1990s, the Government later established a task force on it, to craft policies and draft laws on the same. While commentators and researchers such as Kigen et al. (2013) lamented Kenya’s dearth of a policy and legal framework on traditional medicine, the findings by this author in the study for this paper are different from those earlier findings, partly due to effluxion of time, and also due to sustained lobby effort, that nudged Kenya into adopting new policies and legislation. With the result that many of the then draft policies and draft bills were finally adopted; and are as at now the prevailing regulatory regime in the country. This is because without their subsequent adoption and enactment, they would have remained mere recommendations for future action, as they could neither be implementable nor enforceable.

Notably, the Kenya Government has in several policy documents over the years expressly formally recognized traditional medicine and acknowledged its importance in the country’s health care system. These policy documents include: The National Development Plan 1989-1993 (GOK, 1989), the National Drug Policy of 1994 (GOK, 1994), the National Policy on Traditional Medicine and Medicinal Plants of 2005 (GOK, 2005), as well as the National Policy on Traditional Knowledge, Genetic Resources and Traditional Cultural Expressions (GOK, 2009). The major problem with this policy framework has over the years been partly its inadequacy, and partly implementational challenges especially the lack of a supporting corresponding specific legislation and the lack of

total public acceptance by the Kenyan populace for traditional medicine. Admittedly, traditional medicine has until very recently been a kind of clandestine enterprise or underworld, operating in secrecy away from the public eye and meaningful governmental regulation. The part below examines that policy outlay to establish the extent of their support for traditional medicine.

4.1.1 The National Development Plan 1989-1993

It is in this Development plan (also called the 6th National Development Plan), that the Kenya Government was, for the first time, explicit on the role of traditional medicine, when it stated in part as follows:

“Although for a long time the role of traditional medicine and its potential contribution to health has been viewed with skepticism, a large proportion of people in Kenya still depend on it for their cure. One reason for the continued skepticism lies in the lack of information on its effectiveness, drug quality and safety. During the plan period [1989-1993], Government will encourage the formation of professional associations for traditional medicine practitioners. Such associations will facilitate the gathering of necessary information for use, development and appropriate adaptation of traditional diagnostic, therapeutic and rehabilitative control technologies that will become part and parcel of formal medical research and the Primary Health Care Programme.” (p.244)

4.1.2 The Kenya National Drug Policy of 1994

This policy was crafted with the object of ensuring that pharmaceutical services in the country meet the requirements of all Kenyans, for the prevention, diagnosis and treatment of diseases using efficacious, high quality, safe and cost-effective pharmaceutical products. Its part 5.6 was on Traditional Medicine. In it the Kenya Government acknowledged the place of traditional medicine and traditional medicines, and the need of mainstreaming them into the country’s primary health care system. It provided for registration and recognition of traditional medicine practitioners.

4.1.3. The National Policy on Traditional Medicine and Medicinal Plants of 2005

This Policy was formulated in the year 2005 by the Kenya Government as its policy on traditional medicine and medicinal plants. It proposes the establishment of an institution known as “Traditional Healers’ Council” and vests it with the task of registering, licensing and regulating traditional medicine practice and traditional medicine practitioners. It emphasizes the need to document current availability of plants and to promote nurseries and herb gardens (Okumu et al., 2017). It also proposes to establish an inventory of all medicinal plants in the country; and also provides for establishment of tree nurseries and herb gardens for bio-conservation and research.

4.1.4. The National Policy on Traditional Knowledge, Genetic Resources and Traditional Cultural Expressions, 2009

The policy defines these three terms. It defines “traditional knowledge” as a body of knowledge vital to the day to day life of indigenous and local communities derived through generations of living in close contact with nature. It defines “traditional cultural expressions” as any forms whether tangible and intangible, in which folklore and traditional culture and knowledge are expressed, appear or are manifested; and “genetic resources” as genetic material of actual or potential value. It states that traditional cultural expressions are expressed in tangible forms such as folk art, paintings, carvings, sculptures, pottery, crafts, costumes, musical instruments, as well as architectural forms. Further that it may also be expressed in intangible forms such as verbal expressions (e.g. stories, epics, legends, poetry, riddles and narratives) and musical expressions (e.g. folk songs). Luckily, Kenya is a state party to the 2003 UNESCO Convention on the Safeguarding of the Intangible Cultural Heritage (ICH), having ratified it in October 2007. The treaty recognizes Intangible Cultural Heritage as a mainspring of the cultural diversity and a guarantee to Sustainable Development. The policy is intended to protect, develop and promote all the foregoing aspects of Traditional Knowledge, Genetic Resources and Traditional Cultural Expressions.

It in its preamble states that it was developed in response to the growing need to address the challenges facing the

country today with regard to the three subjects, in terms of accelerating technological development, integration of world economic, ecological, cultural, trading and information systems. It notes that traditional knowledge, genetic resources (biological resources) and traditional cultural expressions (TCEs—especially folklore) are closely intertwined and raise similar concerns with regard to intellectual property rights (IPRs- the term generally refers to the property rights creations of the mind). In this regard, it notes that under the Industrial Property Act of 2001, some aspects of traditional knowledge and genetic resources can be protected as utility. It further acknowledges Kenya's cultural and biological diversity in terms of culture and biodiversity; as well as its richness in traditional knowledge and traditional cultural expressions (especially folklore). It further acknowledges the diversity of Kenya's people in terms of, *inter alia*, traditional literature; traditional arts and crafts; traditional music; traditional visual arts; traditional ceremonies; traditional beliefs; traditional architecture associated with particular sites; as well as traditional knowledge forms related to traditional medicines, traditional medical practices, agriculture, forest management, and sustainable use of biological resources. Further that traditional knowledge is transmitted vertically through generations and laterally through repeated practice as well as apprenticeship with elders and specialists. It further notes that traditional cultural expressions especially oral traditions including folklore is transmitted through oral means such as sayings, proverbs, and metaphors.

The policy however, also identified the following six major challenges that traditional knowledge, genetic resources and traditional cultural expressions continue to face in Kenya, namely: 1) Lack of recognition and mainstreaming into national policies and decision-making processes, 2) Lack of a comprehensive database, 3) High cost of their collation and documentation. 4) Weak community institutional linkages, and 5) Inadequate capacities 6) Inadequate framework for intellectual property protection. To attenuate these challenges, the policy outlined the actions that the Kenya Government would in collaboration with stakeholders undertake to support, protect, regulate, develop and promote traditional knowledge, genetic resources and traditional cultural expressions in the county. Having set out the Kenya's policy outlay on traditional medicine, it is now necessary to examine her legislation on the subject to see whether it is in tandem with and adequately supports the said policy outlay as there is supposed to be a horse-rider relationship between policy and legislation.

4.2. Kenya's Institutional Arrangements on Traditional Medicine

Policy and law are not self-executing; hence rely on external actors, personnel, agencies and institutions for enforcement (Sifuna, 2021b). For the most part, its usefulness will depend on the conduct of these enforcers together with other external factors. Indeed, the functionality of policies and laws are often influenced by extraneous drivers manifested in the actions of the actors and institutions entrusted with their implementation. Notably therefore, understanding these institutional dynamics that inform and influence the formulation and implementation of policies and laws is very important. Since policy and law are not a self-contained enterprise, they are dependent on these actors and institutions for formulation and implementation. In the opinion of this author, such actors and agencies function well when they have been created (or designated) by law; as their legal creation or designation makes them legal entities, thereby giving them juristic legitimacy. This legal creation also clothes them with legal authority, in the sense that they have legal backing for their roles and are legally liable for their actions. Such creation being invariably accompanied with legal provisions spelling out their functions and responsibilities, as well as sanctions and penalties for non-performance or wrong performance of these roles.

Kenya has a handful of institutions on traditional medicine, most of which have been established by mere policies, administrative arrangements and executive whim, rather than by law(s); hence are mere administrative entities rather than legal entities. Such entities unlike legal entities (those created by law) lack the legal authority that legal entities have. Neither their existence nor purported mandates and responsibilities are spelt out in the law. For that reason, their powers, functions, duties and roles are and remain amorphous. As already stated in this paper, whereas agencies can be created or designated by such policies, it is better when they are created or designated by the law rather than administratively or by policy alone, or by executive whim. Besides, as also already observed in this paper, these agencies and institutions function well when they have been created (or designated) by the law. This author has identified the institutional entities existing in Kenya on traditional medicine, and has discussed them below. These are of two categories, namely governmental entities and private entities, There are three notable governmental agencies that Kenya has on traditional medicine, namely: (a) Centre for Traditional Medicine and

Drug Research (CTMDR), (b) Department of Culture, and (c) The Pharmacy and Poisons Board (PPB). Apart from these governmental agencies, there are also private associations of traditional medicine practitioners. Notably, these have been created by them for purposes of advertising their vocation rather than regulating their practice. A regulatory outfit will be expected to have rules relating to training, recognition, quality assurance, ethical standards, disciplining wayward members, as well as pricing of their services and products. Those associations lack these attributes. The said entities are discussed below.

4.2.1 The Centre for Traditional Medicine and Drug Research (CTMDR)

The other Government institution/agency with regard to traditional medicine, is the Centre for Traditional Medicine and Drug Research (CTMDR). It was established administratively by the Kenya Government in 1984 at the Kenya Medical Research Institute (KEMRI) (See the KEMRI Website). The latter is a government institution established as a national body responsible for carrying out health research in the country. It is a State Corporation established through the Science and Technology (Amendment) Act of 1977 (Cap 250) as amended in 1979. The Act in its preamble stated that its object was to establish mechanisms through which the Government may be advised on all matters relating to scientific and technological activities and research. It was repealed and replaced by the Science, Technology and Innovation Act of 2013. KEMRI as an institute is headed by a Director, while the said Centre is headed by a Deputy Director of the Institute. The latter was established with a mandate of carrying out research to rationalize traditional medicine in Kenya. It was intended to promote the quality and safe use of traditional medicine, and discharges this mandate through collaboration with traditional healers as well as evaluation of herbal drugs using medicinal phytochemistry, pharmacology and toxicology; and the formulation of herbal remedies.

4.2.2 The Department of Culture

The Department of Culture for its part is a line department of the Ministry of Sports, Culture and Social Services. The Department is tasked with the mandate of recognition and registration of traditional medicine practitioners in the country, and was administratively established under the National Drug Policy of 1994. That policy designated the Department as the one responsible for recognition and registration of traditional medicine practitioners. The categories of its practitioners that the department is mandated to register include the following: Traditional birth attendants (TBAs), bone-setters, traditional surgeons and herbalists (Chebii et al., 2020). Each of these categories of traditional medicine practitioners has a corresponding category of health professionals as follows: TBAs are the equivalent of midwives; traditional bone setters are the equivalent of orthopedic surgeons; traditional general surgeons are the equivalent of medical general surgeons; while herbalists are the equivalent of pharmacists. As for traditional medicaments, registration eligibility criteria included submitting 3 to 6 drug samples, medicinal plant preparations and plant specimens to recognized government and certified research institutions for laboratory analysis (Chebii et al., 2020).

Kigen et al (2013) have reported that most traditional herbalists (and traditional medicine practitioners) in the rural areas are not even aware of this registration process, hence the records on the number of herbalists practicing in the county is not known; and that there are many fake herbalists and fake traditional medicine practitioners. While recognition and registration is plausible, locating this function in the Culture Ministry rather than the Health Ministry is inappropriate, and most likely stems from the misconceived position of perceiving traditional medicine as a cultural artefact rather than a health system. It would have been better if it were located at the Ministry of Health a line ministry in charge of health, which is where health experts are as well as a reservoir for health/medical expertise and information. It is also the generator and nerve of health policies and programmes. The department has generated a Form for the Registration of Traditional Medical Practitioners, coded Form 0001 (GOK, 2010).

4.2.3 The Pharmacy and Poisons Board (PPB)

The other institution that the Kenya Government has tasked with traditional medicine matters, traditional medicines in particular, is the Pharmacy and Poisons Board (PPB). The board is established by the Pharmacy and Poisons Act (Cap 244 Laws of Kenya), a piece of legislation enacted to regulate the manufacture, prescription,

use, and trade in drugs and poisons. The Act has tasked the board with, among other responsibilities, the regulation and licensing of the manufacture of drugs and medicinal substances manufactured or for sale and/or use in the country. Under it a drug is defined as including any medicine, medicinal preparation or therapeutic substance; while a medicinal substance is defined as any medicine, product, article or substance claimed to be useful in the prevention, diagnosis or treatment of diseases- or alleviation their symptoms. These definitions cover traditional medicines as well as biomedicines (pharmaceutical drugs).

In carrying out the aforesaid role, the Board developed guidelines for the registration of herbal and complementary medicines. These have been published into a booklet on the same titled “*Registration of Herbal and Complementary Products: Guidelines to Submission of Applications*” (GOK, 2010). In their preamble, the Guidelines state that they are intended to address, inter alia, the many issues on the quality of herbal and complementary medicines. These include: (a) Misconception amongst herbalists that the documentation demand by the Board (Pharmacy and Poisons Board) is intended to steal their indigenous knowledge; (b) Lack of documented evidence on quality, safety and efficiency of herbal and complementary products; (c) Unethical practices such as adulteration of herbal and complementary products with conventional medicines, advertising of herbal and complementary products in print media, electronic and even billboards; (d) Peddling of products with no therapeutic benefits; (e) Unsubstantiated medicinal claims by herbal practitioners; (f) Dealing with herbal products whose toxicological profile is not known; and (g) Poor standards of preparation as well as manufacture and sale of herbal and complementary products.

Those Guidelines also require an applicant’s application to submit information on the herb or complementary product with regard to: (a) Its name, dosage and therapeutic use(s), (b) The plant or natural part from which it is extracted, (c) Its ingredients and chemical composition, (d) Its pharmacological and pharmaco-toxicological profile, (e) Its ethno-medical profile, including proof of long period of use in the particular ethno-community together with the relevant folklore or other anthropological evidence. Moreover, with regard to traditional medicine, the Board has a specific mandate, namely the registration of herbalists and herbal medicines, not only from Kenya, but from other parts of the world as well. This role has the potential to promote the growth and development of traditional medicine and traditional medicines in the country. Notably, however, it has been reported that currently most of the herbal and complementary products registered by the Board, are those from Asia, and particularly India and China (Kigen et al, 2013). Further, the guidelines focus primarily on products that have been formulated in a commercial manner as opposed to medicinal substances and medicaments produced in rudimentary manner by traditional medicine persons using traditional medicinal knowledge as is the case in sub-Saharan African countries such as Kenya. The other flaw with this registration by the Board is that it focuses on registration of herbalists rather than traditional medicine practitioners generally.

4.2.4 Private Informal Associations of Traditional Medicine Practitioners

As already stated above, apart from these governmental agencies, there exist in Kenya, private associations of traditional medicine practitioners. Notably, these have been created by them for purposes of advertising their vocation rather than regulating it. A regulatory outfit will be expected to have rules relating to training, recognition, quality assurance, ethical standards, disciplining wayward members, as well as pricing of their services and products. Those associations lack these attributes. Being rather informal outfits, these associations are scattered around the country and are undocumented, hence information on them is largely informal and not readily available. These include: (a) An association called *Welfare Association for Stakeholders in Traditional and Alternative Health Care (WAKESTRAH)* (b) An Association called *National Traditional Practitioners Association (NATHEPA)*, (c) An Association called *Central Province Herbalists Association* and (d) An Association in Kwale County called *Muungano wa Waganga wa Kienyeji na Watabibu wa Miti ya Kiasli* (Association of Traditional Witchdoctors and Herbalists). With the foregoing audit of Kenya’s policy and institutional arrangements on traditional medicine, this paper in the part that follows interrogates her existing legislative framework on the same. This is for purposes of firstly establishing whether Kenya has corresponding legislation, and secondly the the suitability and effectiveness of such legislation for the promotion traditional medicine in the country.

4.3. Kenya’s Legislation on Traditional Medicine

For traditional medicine to meaningfully play its role in Kenya's health sector, it requires legal recognition and protection; and needs to be in the policy instruments and law statutes. In a constitutional democracy such as Kenya, the legal foundation is the national Constitution. For Kenya it is the Constitution of 2010; which in terms of Article 2, is the supreme law of the land, from which all other laws derive legitimacy, hence any law that contradicts it or is inconsistent with it, is null and void to the extent of such contradiction or inconsistency. For its part, the constitutional basis for the legal recognition and provisioning for traditional medicine is Article 11 of the said Constitution; which recognizes culture as the foundation of the nation and the cumulative civilization of the Kenyan people and nation. It further directs the State (government) to recognize the role of indigenous technologies in national development (Harrington, 2016; Harrington, 2018). Unfortunately, even with all this constitutional foundation, Kenya lacks a specific statute or legislation on traditional medicine. All it has is a plethora of scattered pieces of legislation which although are on other subjects, nevertheless have some provisions whose application has significance and implications for it. These include following five pieces of legislation, which are discussed below in that order: (a) The Health Act of 2017 (Act No. 21 of 2017), (b) The Public Health Act (Cap 242), (c) The Pharmacy and Poisons Act (Cap 244), (d) The Witchcraft Act (Cap 67), and (e) The Protection of Traditional Knowledge and Cultural Expressions Act (Act No. 33 of 2016).

4.3.1 The Health Act of 2017 (Act No. 21 of 2017)

This Act in its preamble states that it is an Act of Parliament to establish a unified health system; to co-ordinate the inter-relationship between the national Government's and the county governments' health systems; to provide regulation of health care services and health care service providers, health products and health technologies; and for connected purposes. The enactment of this legislation was a milestone in Kenya's health legislation history. With regard to traditional medicine, this fact is in the sense of it being the first legislation in Kenya's legislative history so far, to expressly recognize alternative medicine as a health system in Kenya. It is also Kenya's first legislation to expressly recognize traditional medicine and adopts the World Health Organization's (WHO) definition of traditional medicine already stated in the introductory section of this paper. Part X of the Act is on Traditional and Alternative Medicine. It defines traditional medicine as "including 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." (Section 2).

In section 74, the Act directs the national government to formulate policies to guide the practice of traditional and alternative medicine. Notably, rather than focusing on the promotion of traditional medicine as a health system and acknowledging traditional medicine as a health system in its own right and embedding it in the mainstream health care of the country, the Act only focuses on regulating its practice. The focus is thus on its practitioners rather than on it as a system of health care; on its practitioners only, rather than holistically on its growth and development. Section 25 states that there shall be established a regulatory body by an Act of Parliament to regulate the practice of traditional medicine and alternative medicine. This is a wide departure from other Acts that in so provisioning expressly name and designate or create such agencies. Why didn't this Act itself not create and name the agency? Why leave that to future legislative action? The mere propositioning instead of creating the organ, is to this author, an escapist approach that is rather evasive and shy, instead of being forthright. On the functions of the proposed institutional outfit, the Act further directs that it (the agency) shall be vested with the responsibility of documentation, standardization, prescribing the charges charged to practitioners for registration and licensing; as well as providing for and regulating referrals from traditional medicine practitioners to conventional health facilities. Why not the vice versa? i.e. referrals from conventional health care facilities and health professionals to traditional medicine practitioners.

4.3.2 The Public Health Act (Cap 242 Laws of Kenya)

This piece of legislation in its preamble states that it is an Act of Parliament intended to make provision for

maintaining health. It is called the Public Health Act because it focuses on public health i.e. the health of the whole population (or as large as possible a proportion of the population) rather than the health of an individual—including those who would benefit from but do not seek medical care (Sifuna & Mogere, 2002). This is unlike clinical medicine that is concerned with individual health, especially of those that seek medical care; which explains why public health is sometimes referred to as population medicine.

The author has identified four reasons why traditional medicine should concern any legislation on public health. First, as already stated in this paper, traditional medicine is concerned with diseases as well as the overall health; and the overall well-being rather than just diseases and illnesses. Secondly, just the way public health emphasizes preventive and promotional health, traditional medicine is used for both the treatment and cure of diseases (curative medicine), and to a limited extent the avoidance, avertment and prevention of diseases (preventive medicine). Similarly, traditional medicines are used in curative health care as well as preventive health care (Eddouks et al., 2012). Preventive health care is indeed a key aspect of public health. Thirdly, traditional medicine avoids, averts, prevents, diagnoses and treats several diseases that are of public health importance. Such include venereal diseases, epidemics, as well as those related to hygiene. Sofowora et al. (2013) have for instance discussed the role of medicinal plants in diseases of public health importance (public health diseases). The fourth reason is that a large segment of the Kenyan population (over two thirds) and even the world population (between 70 percent and 80 percent of it), especially in the rural and peri-urban areas rely on traditional medicine for their health care needs.

For the four reasons *inter alia*, traditional medicine can be used to promote public health goals and programmes. It is therefore surprising that despite traditional medicine's implications for public health, Kenya's Public Health Act (Cap 242) which is her primary legislation on public health, neither mentions nor has any specific or any provisions on traditional medicine. This is glaringly anomalous! It cannot be gainsaid that this genre of health care has an important place in public health, especially in the prevention and cure of diseases and illnesses, as well as the promotion of overall health and well-being of society. It for instance therefore would be legitimately expected that the parts of a public health legislation (e.g. the Public Health Act) on diseases should have provisions relating to traditional medicine. Disappointingly, this is not the case as for this Act. The parts on diseases have no provisions on it, and just like the entire Act, do not even mention it. The relevant parts in this regard are: Part IV on Prevention and Suppression of Infectious Diseases, Part V on Venereal Diseases, Part VII on Leprosy, and Part VIII on Smallpox. Apart from these categories of diseases, traditional medicine practitioners and traditional medicines in Kenya are known to treat many other categories of diseases including chronic and even terminal diseases. As already noted in this paper, traditional medicine has been professed to cure virtually all diseases including the chronic and terminal diseases, and even the biomedically incurable ones.

4.3.3 The Pharmacy and Poisons Act (Cap 244 Laws of Kenya)

This is an Act of Parliament to control the profession of pharmacy and the trade in drugs and poison. It defines a drug as “any medicine, medical preparation or therapeutic substance”. Even though this definition would by interpretation and implication include traditional medicines, the Act has no provision on traditional medicine, and neither does it mention the words “traditional medicine” or “traditional medicines”. This is a glaring omission, that future legislative amendment on this Act should consider, as traditional medicine and traditional medicines are a proper province of the object of this Act. Under the Act, a drug is defined as including any medicine, medicinal preparation or therapeutic substance; while a medicinal substance is defined as any medicine, product, article or substance claimed to be useful in the prevention, diagnosis or treatment of diseases—or alleviation of their symptoms. As already observed in this paper, these definitions cover traditional medicines as well as biomedicines (pharmaceutical drugs).

4.3.4 The Witchcraft Act (Cap 67 Laws of Kenya)

In the context of this paper, the term “witchcraft” is used to refer to the malevolent invocation of evil spirits to cause harm to others, by bewitchment, black magic, sorcery, and wizardry (Sifuna, 2021a). In Kenya, traditional

medicine has from colonial times to this date been associated with witchcraft and black magic, which are practices prohibited under the Witchcraft Act (Cap 67), hence illegal. The Act prohibits the practice and promotion of witchcraft as well as the possession of witchcraft articles and paraphernalia. Notably, the only lawful and legally permissible use of traditional medicine is its beneficial use for diagnosis, treatment and cure of diseases and illnesses; and not its harmful use for evil and suffering, such as its employment in witchcraft (witch medicine). In criminalizing the practice of witchcraft, the Act has prohibited and prescribed criminal penalties for the following overt acts: *“holding oneself out as a witchdoctor able to cause fear, annoyance or injury to another in mind, person or property; holding oneself out as being able to exercise any kind of supernatural power, witchcraft sorcery or enchantment calculated to cause such fear, annoyance or injury; a witch-doctor supplying advice or article for witchcraft; using witch medicine with intent to injure others; possession of charms or other article usually used in witchcraft or sorcery; and attempting to discover crime by witchcraft.* For these acts the Act provides for imprisonment ranging from one year to ten years.

Traditional medicine in Kenya can be stifled by the legal prohibition on witchcraft and witchcraft-related conduct (Sindiga et al., 1995). Thairu (1975) has for instance reported that the decline of folk medicine during the colonial era was due to the colonialists associating it with witchcraft and “black magic”. This explains why in Kenya, folk medicine started declining at the onset of colonial rule. Mutungi (1977) has noted that Kenya’s Witchcraft Act has a definitional problem with regard to the term “witchcraft” which it has not precisely defined. Notably, African communities know what may be described as witchcraft, i.e. the invocation of evil powers. Mbiti defined it as the use of mystical power to harm others in society (Mbiti, 1969). The colonialists associated it with the magic of the black African people—variously referred to as “black magic”. Nevertheless, with an overly positivist judiciary together with an overzealous, corrupt, less literate, and socially insensitive police force such as Kenya’s, there is a higher likelihood of this Act being used (actually misused) to stifle folk medicine (Sifuna, 2021 ab).

This is unlike in the neighbouring country of Uganda, whose Witchcraft Act (Cap 108 Laws of Uganda) is so carefully worded as to avoid such a mischief. The Act in its interpretation section states as ‘For purposes of this Act, witchcraft does not include bona fide spirit worship or the bona fide manufacture, supply or sale of native medicines.’ Luckily, a proposal for a review of Kenya’s Witchcraft Act was already made by the Kenya Law Reform Commission (KLRC) and it is long-overdue. Just like the Ugandan Act, a future amendment to the Kenyan Act should similarly expressly exempt the bona fide practice of traditional medicine, as well as the bona fide manufacture and supply or sale of traditional medicines. Such an amendment will not only harmonize the provisions of Kenya’s Witchcraft Act with those of the traditional medicine legislation proposed in this paper, but will also promote and protect the country’s traditional medicine and its practice.

4.3.5 The Protection of Traditional Knowledge and Cultural Expressions Act (Act No. 33 of 2016)

This piece of legislation is intended to protect traditional knowledge (TK) and traditional cultural expressions (TCE) from exploitation by third parties. Such expressions are usually in the form of varied media, for instance folklore. It in its preamble states that it is an Act of Parliament to provide a framework for the protection and promotion of traditional knowledge and cultural expressions; to give effect to Article 11, 40 and 69 (1) of the Constitution (i.e. the Constitution of Kenya, 2010). Article 11 is on culture. It recognizes culture as the foundation of the nation and as the cumulative civilization of the Kenyan people and nation; and enjoins the Government to protect and promote traditional knowledge and cultural expressions by inter alia enacting legislation. It is pursuant to this constitutional edict that the Kenya Government enacted this Act. The Act has definitions of key words and terminology; which include those that are germane to the subject matter of this paper. It defines a community as a homogenous and consciously distinct group of the people who share any of the following attributes: 1) common ancestry, 2) similar culture or unique mode of livelihood, 3) geographical space, 4) ecological space, 5) community interest. It defines the term “customary” as the use of traditional knowledge or cultural expression in accordance with practices of everyday life of the community, such as for instance, usual ways of selling copies of tangible expressions of folklore by local craftsmen. It defines “customary use” as the use of traditional knowledge or cultural expressions in accordance with the customary laws and practices of the holders. It defines “customary laws and practices” as customary laws, norms and practices of local and traditional communities that are legally

recognized.

The Act provides for equitable sharing of the benefits accruing from traditional knowledge. It gives the community exclusive use rights over their traditional knowledge, and allows the owners of such knowledge to enter into agreements with others. With regard to traditional medicine and traditional medicinal knowledge, one area in which this may be manifested is negotiation and execution of use agreements between traditional medical practitioners and their counterparts in the conventional medicine system, or even the government and other non-governmental actors such as pharmaceutical companies. Under the Act, the following acts are prohibited, and penalties prescribed for infraction: 1) The derogatory treatment of traditional knowledge and their holders 2) Misappropriation, misuse, abuse, as well as unfair, inequitable or unlawful access and exploitation (use) of traditional knowledge and cultural expressions 3) The use of traditional knowledge without the prior informed consent of its owners. For infractions, the Act imposes punishment of imprisonment ranging from 5 to 10 years; and fines of up to Kenya Shillings One Million (Approximately 10,000 US Dollars). The next part is the conclusion and recommendations section that summarizes the theme and major findings of this study, and recommends certain institutional and legislative reforms.

5. Conclusion and Recommendations

5.1. Conclusion

Commentators have in previous reports and studies over the years either reported that Kenya had no policies, institutional arrangements, and legislative framework on traditional medicine, or that there was a glaring disconnect among these three aspects of Kenya's traditional medicine regulatory regime. Years later, a study that this author undertook for this paper, arrived at a remarkably different finding. That far from that, Kenya indeed has an avalanche of policies, institutional arrangements and legislative framework on traditional medicine. This new finding can be attributed largely to effluxion of time, that has led to marked developments in Kenya's policy-making and legislation- with new policies having been made, and new legislation having been promulgated, and some of the then existing legislation having been amended. The earlier situation, and which has as already stated changed, was perhaps attributable to the nascent stage of tradition medicine policy and legislation at the time. The latter developments and the present situation are plausible, given that traditional medicine is a crucial and integral part of the country's health care system, with over two thirds of the population (mainly in the rural and peri-urban areas) relying on it for their health care needs.

The study has further established however, that Kenya's regulatory regime (i.e its policies, institutional arrangements and legislation) fragmented and scattered over several sectors and line ministries and touching on one or other aspect of traditional medicine. Further that although their operation can in a way still promote or impact positively on traditional medicine, they are bedeviled by lack of coordination and harmonization. This fragmented, disjointedness, lack of coordination and lack harmonization is undesirable, because given the inter-disciplinarity and inter-sectoriality of traditional medicine, inter-sectorial co-operation is required. Notably, that undesirable state of affairs compounded by the fact that Kenya lacks a specific institution and a specific legislation exclusively devoted to traditional medicine. Which anomalous state of affairs has curtailed and clawed back on the adequacy and sufficiency of the existing regulatory regime and impacted negatively on its effectiveness in the protection, promotion and development of traditional medicine in the country. To attenuate this anomaly, there is urgent need for the Kenya Government to undertake the reforms discussed in the part below.

5.2. Recommendations

To streamline Kenya's regulatory regime (policy framework, institutional arrangements and legislation) on traditional medicine and enable this system of medicine meaningfully play role in the country's health care, this paper recommends three actions that the Kenya Government should take, namely: (a) Establish an inter-ministerial committee to coordinate the traditional medicine agenda among the relevant ministries, (b) Enact, through Parliament, a framework legislation (Act of Parliament) to coordinate specific Act exclusively on traditional medicine, (c) Amend the existing related pieces of legislation that touch on traditional medicine, to create harmony

between them and also align them with the proposed framework legislation (Act of Parliament) so as to manage and coordinate matters and actions relating to traditional medicine.

(a) Establish an Inter-Ministerial Committee on Traditional Medicine

Traditional medicine transcends several disciplines and sectors. This inter-disciplinarity and inter-sectoriality begs for a framework coordinating legislation that retains the existing fragmented pieces of legislation, while creating a new legislative statute to co-ordinate and create harmony among the respective sectoral pieces of legislation to streamline the provisions that relate to traditional medicine to avoid both intra-legislation and inter-legislation conflicts. This inter-disciplinarity and inter-sectoriality of has engendered the need for coordination and harmonization, to co-ordinate and harmonize efforts by actors in the various respective sectors and line ministries; in order to avoid conflict and duplication of efforts, as well as inaction, and ensure collective and concerted action by all. With this approach the respective ministerial actors will play complementary roles and avoid taking contradicting positions or actions on issues or agendas that are cognate to traditional medicine. This is because where there are overlapping responsibilities there is likely to be inaction as one ministry expects/looks to the other to take action. This author recommends that for that inter-disciplinary and inter-sectoral approach to work well, the Kenya Government needs to establish an inter-ministerial committee on traditional medicine, whose mandate will be: (a) To ensure co-operation between relevant ministries on matters relating to traditional medicine, (b) To co-ordinate traditional medicine efforts and actions among the respective cognate ministries. (c) To deal with cognate matters and issues with regard to traditional medicine, (d) To harmonize traditional medicine actions, efforts, and agenda within the cognate ministries.

This committee can be coded “**The Inter-Ministerial Committee on Traditional Medicine**” (IMCM), and will be a forum for coordinating and harmonizing traditional medicine actions and agenda within participating ministries. The Committee can draw membership from the following ministries in Kenya’s Cabinet structure: (a) Ministry of Health (b) Ministry of Sports, Culture and heritage (c) Ministry of Environment and Forestry (d) Ministry of Tourism & Wildlife (e) Ministry of Devolution (f) Ministry of Sports and Gender (g) Ministry of Interior and Coordination of National Government, and (h) Ministry of National Treasury and Planning.

(b) Enact a Specific Act Exclusively on Traditional Medicine

There is need for Kenya’s Parliament to enact a specific statute (an Act of Parliament) on traditional medicine. The need for such a specific or specialized new enactment is that with almost two-thirds of the Kenya’s population (especially in the rural and peri-urban areas) relying on traditional medicine for their health care needs, traditional medicine is an integral and invaluable component of Kenya’s health care system. The Kenya Government needs to accord it more attention than it has accorded it so far. There is need for the government to mainstream traditional medicine in its the Universal Health Coverage (UHC) programme currently being undertaken. Infact given its relative affordability and accessibility compared with allopathic health care (Banquar, 1995; Githae, 1995), this genre of medicine squarely fits in the UHC objectives and agenda, pretty much like hand in glove. This has made it an important and critical health care system, that if Kenya leaves unsupported or unregulated, may have undesirable and even catastrophic consequences for the population’s health as well as the country’s health care at large. This awareness together with the infirmities that this author has in this paper identified in Kenya’s legislative framework, provides ample justification for enactment of a new statute as proposed above.

Such a legislation could either be a comprehensive statute exclusively on traditional medicine, or as proposed in this paper, a framework statute (framework legislation) to manage and co-ordinate efforts on matters related to traditional medicine. If a comprehensive (composite) statute it can be named “The Traditional Medicine Act”. If a framework legislation it can be named “*The Traditional Medicine Coordination Act*”. This author has in recently published journal paper configured it as a framework legislation and extensively set out a preferred structure for it (See Sifuna, 2022). Admittedly, the inter-disciplinarity and inter-sectoriality of traditional medicine begs for such a framework coordinating legislation that retains the existing fragmented pieces of legislation, while creating a new legislative regime to co-ordinate and create harmony among the respective sectoral pieces of legislation to streamline the provisions that relate to traditional medicine. This is intended to avoid both intra-legislation and

inter-legislation conflicts as the ones existing in the current legislative outlay. The author posits that the name and structure of such legislation may be the subject of further debate and research, now hence.

(c) Amend the Existing Cognate Pieces of Legislation, to Align them with the Said New Legislation

In order to ensure efficacy, sanity and order, the author recommends that upon the enactment of the aforesaid new legislation, the existing traditional medicine-related pieces of legislation already discussed in this paper (The Health Act of 2017, The Public Health Act, The Pharmacy and Poisons Act, The Protection of Traditional Knowledge and Cultural Expressions Act of 2016, The Industrial Property Act of 2001, and The Witchcraft Act) be amended to include provisions on traditional medicine and traditional medicines. This is because traditional medicine as already observed in this paper is inter-disciplinary and inter-sectoral in character, hence can neither be divorced nor isolated from the cognate sectors and line ministries aforesaid, as these others have each the pool of experts and expertise in the respective sector.

Declaration on Conflicts of Interest

The author declares that there is no conflict of interest regarding the publication of this paper. Further, the research leading to it was his individual scholarly enterprise devoid of any economic gain or prospect thereof, and was not funded by any organization, institution or entity.

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