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Governing Traditional Medicine in Kenya: Problematization and the Role of the Constitution

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Abstract

After decades of repression and neglect, traditional medicine in Kenya has become the object of increasing official attention in recent years. Initiatives have been proposed by a range of state bodies and civil society groups to regulate practice and to protect the traditional knowledge on which it is based. These are informed by the work of international bodies with which agencies and groups are closely connected. This paper draws on governmentality theory in mapping these developments accounting specifically for international and national influences on the current wave of reform. It argues that initiatives are cast in normative, epistemic and rhetorical terms as responses to problems faced by the Kenyan state. Governance technologies deployed or proposed are oriented to the ‘problematization’ of traditional medicine in terms of health and safety, threats to sovereignty and national development. Kenya’s 2010 constitution provide a crucial normative anchor for each of these problematizations. Its specific provisions allow international imperatives to be re-articulated in terms of the national interest.

Keywords:

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Traditional medicine in Kenya has been the focus of increasing official attention over the past decade. Legislation has been proposed, and some in cases passed, to regulate the practice of traditional healers, to control the supply of medical materials and to protect the interests of local communities in their medical knowledge. The 'quest for governance', identified by Kibet Ngetich (2008), is at last making progress. These initiatives have come in a period of intense political struggles and reform which led to the re-founding of the Kenyan republic. The highpoint of that process was the passage of a new constitution in 2010, which included a number of provisions of direct significance for traditional medicine including the right to health of citizens, acknowledgement that communities have rights over indigenous knowledge and recognition of the contribution that such knowledge can make to national development.

This wide-ranging state engagement contrasts with the colonial period and the early independence years, when traditional medicine was neglected, marginalized and disparaged. Under British rule it was subject to the Medical Practitioners and Dentists Ordinance of 1910 and the Witchcraft Ordinance of 1925. The former limited the practice of 'therapeutics according to Native methods' to the ethnic group of the particular healer.¹ It implicitly privileged western biomedicine, which faced no such restrictions. The latter aimed to suppress important spiritual aspects of healing work including witchfinding and the use of 'witchcraft' to discover crimes. The Ordinance, which is still in force, extended the stigma of sorcery and criminality to the full range of traditional practices, including herbal medicine, as is evident in continued pejorative references to healers as 'witchdoctors'. After independence in 1964 political leaders,

including first president Jomo Kenyatta, denounced healers as frauds (Iliffe 1998:191). Health officials, largely drawn from the medical profession, aspired to eliminate traditional medicine (Ombongi 2011: 362). The late 1970s saw a relaxation of this position under the influence of the WHO's Alma Ata Declaration, which promoted the role of healers in the delivery of primary care and a Centre for Traditional Medicines and Drugs Research was established as part of the Kenya Medical Research Institute (KEMRI) in 1984 (NCAPD 2005: 1). However, this new stance was initially more verbal than practical and signalled above all else a symbolic re-appropriation of traditional medicine as something for Kenyans 'to be proud of', in the words of KEMRI's founder, Professor Kihumbu Thairu (quoted in Ombongi 2011: 364). While Kenya's National Drug Policy of 1994 affirmed the cultural importance of traditional medicine and the need to 'harmonize' it with official health care systems, substantial policies only appeared in the following decade with proposals for practitioner regulation in 2002 and 2003, as well as national policies on medicinal plants and on traditional knowledge and culture in 2005 and 2009 respectively (Mwangi 2013: 23). The legislation already mentioned has proceeded from these initiatives.

What role has Kenya's constitution played in this process? A first glance at the legal literature would suggest: not much. Like its South African counterpart, the 2010 document is understood by judiciary, scholars and much of the Kenyan public primarily as an instrument for political and economic transformation, a response to the long decades of political authoritarianism and economic inequality which marked both the colonial and independence periods (Lumumba and Franceschi 2014: 41-51). Its overriding aim is, thus, to restructure relations between citizens and the state by guaranteeing the fundamental rights of the former and by subjecting the latter to the rule of law (see Musila 2013). There is ample warrant for this pre-eminent objective in

the text and contexts of the constitution. However, as this collection amply demonstrates, the constitution has a broader social reach, engaging with questions of culture, identity and national development. I will argue in this paper that the diverse political, economic and social elements of this constitutional framework provide a crucial normative orientation for the changing state response to traditional medicine. Through its explicit provisions, and its incorporation of international law measures, it also gives form to a series of regimes for the regulation and recognition of traditional medical practice and knowledge. While several of these regimes were under consideration prior to 2010, as the dates above indicate, the new constitution has given them clarity and impetus. I will trace this 'constitutional effect' through recently proposed and enacted legal reforms in the rest of the paper. This new, more intense mode of governance is being realized, I will argue, through the 'problematization' of various aspects of traditional medical practice and knowledge. In the following sections I will set out my framework of analysis, unpacking the notion of problematization and specifying the role of law (both ordinary and constitutional) within it, before going on to examine relevant substantive initiatives. Before that, in the next section, I will locate my work with reference to scholarship on both traditional medicine and constitutional law, as well as setting out the context and methods of my research.

Researching Law and Policy-Making

While there is an abundant legal literature on the regulation of traditional medicine in Africa, this has been preponderantly focussed on questions of intellectual property and administrative regimes controlling access to genetic resources.² The provisions of treaties including the Convention on Biological Diversity (CBD) and the Agreement on Trade Related Intellectual Property (TRIPs) have been carefully studied. By contrast

much less attention has been dedicated to the specific influence of national constitutional provisions on recent reform initiatives. Traditional medicine has been put 'on the constitutional agenda' in ways that were not possible in the 1960s and 1970s by international grassroots struggles over the preservation of cultural heritage and the rights of minorities and indigenous groups as important for sustainable national development (Nnadozie 2012). This article seeks to fill that gap in the case of Kenya and to offer comparative pointers for further research in other jurisdictions. It also augments the considerable literature on constitutions and constitutionalism in contemporary Africa, including Kenya. The latter largely concentrates either on orthodox doctrinal analysis of constitutional texts and the case law in which it is applied or on its implications for political and legal theory regarding human rights, separation of powers and so on.³ To date there have been fewer attempts to develop socio-legal perspectives, which consider the constitution alongside other governance regimes and seek to model the interaction between them. The 'problematization' framework that I develop here seeks to do this in relation to traditional medicine. It will, I hope, also indicate pathways for further study beyond this specific context.

In seeking to answer the question posed regarding the role of the constitution in guiding recent reforms and in attempting to set legal initiatives in a broader political and social context, I deployed three main research strategies. The first involved a close engagement with recent Kenyan and international policy literature and official legal sources regarding the reform of traditional medical practice and knowledge control systems. Considered in light of historical studies of Kenyan politics generally and state health policy in particular, this generated a series of pre-theoretical reflections on the broader aims and orientations of these initiatives. I refined these insights through engagement with social theoretical work influenced by Michel

Foucault on government through the state and beyond the state. The problematization framework for traditional medicine developed through this engagement was pursued through a re-reading of the policy and legal material mentioned above. Given that these measures and indeed the constitution itself were relatively recent, it was evident that the academic and 'grey' literature would not document significant aspects of the debates and struggles over the form and substance of new laws and policies. In light of that I supplemented my reading by conducting semi-structured interviews with a number of key actors involved in the different reform processes, including civil servants, healers' leaders and activists, identified from the literature, and through a further 'snowballing' process. My concern was first to ask them to narrate their own involvement, to identify the values and influences on their engagement and that of others, and specifically to reflect on the relative importance of the 2010 constitution in setting objectives and goals. In addition, I used the interviews to fill informational gaps left by the unavailability of records for important consultation meetings and also to obtain further written sources where these were available. These interviews were intended to be complementary to the desk-based analysis. The research was not intended as a detailed ethnographic study of law and policy making. A further qualification should be added. The study largely engages with official perspectives, rather than those of traditional healers and their patients living and working in rural areas or urban slums, for example. I would refer readers to the important work done on this in medical anthropology and history on traditional medicine in East Africa and beyond (e.g. Langwick (2011); Osseo-Asare (2014)). The focus of this study on official perspectives is intentional given my concern with state-level interventions and discourses. Further work will be necessary to examine the extent to which these measures are effective and how, or to what extent they are merely 'window dressing'.

Governing through Problematization

There is a rich theoretical tradition arguing that 'government is a problematizing activity ... it poses the obligations of rulers in terms of problems they seek to address' (Rose and Miller 1992: 181, emphasis removed). According to governmentality scholars, building on the work of Michel Foucault, this is an active process. Problems aren't simply found, out there, as it were, but rather made. They are produced through a combination of discourses and practical routines (Bacchi 2012). They are defined by expert knowledge and official standards as objects in need of regulation. For Rose and Miller problematizations have three significant dimensions (1992: 178-179):

- 1) Moral: setting out tasks and goals and prescribing fundamental values.
- 2) Epistemic: grounded upon knowledge about the nature of the problem and the target of regulation.
- 3) Linguistic: articulated in a distinctive language which, not only has rhetorical effects, but also renders the field thinkable.

For example, the problematization of childhood obesity is oriented to the collective goal of improving child health, defined by expertise from nutritional sciences and articulated in a statistical idiom (Henderson, Coveney, Ward and Taylor 2009). Policies respond to this problematization by mobilizing 'technologies' (e.g. school health checks) and calling new 'subjects' into being as vehicles of self-regulation (e.g. 'responsible parents'). This 'government at a distance', is achieved by official agencies, but also through the authentic contributions of expert groups, civil society

organizations, corporate actors and, as we will see, international agencies. The state orchestrates this ensemble and contributes to the production of new governance subjects through legal forms (e.g. the corporation, the trust) (Lemke 2007). But it is only one actor among many, not the origin or endpoint of power in society (Rose, O'Malley and Valverde 2006). Governmentality scholarship suggests that the state itself is more usefully seen not as a single entity, but as an ensemble of different institutions (e.g. ministries, research centres, universities) pursuing sometimes convergent, sometimes divergent regulatory strategies articulated in terms of multiple problematizations (Jessop 2007). The state gains its unity then, not from some essential quality or purpose, but from the ongoing elaboration of 'state projects', such as the promotion of economic growth. These lend provisional coherence to the diverse problematizations and related technologies emerging from within, but also from beyond the official state apparatus. They are influenced by, though not reducible to international governance regimes focussed, for instance, on poverty reduction or health improvement (Death 2013: 785).

Ayo Wahlberg has used 'problematization' analysis productively in his survey of the regulation of traditional medicine in Vietnam since the colonial period (2006). He notes that Vietnamese traditional medicine has gone from being condemned or ignored by the French colonial authorities to being today the object of a range of expert knowledges and governance technologies, including ethnobotany, patient safety and drug efficacy regimes (2006: 129). I draw on Wahlberg's framework in the rest of this article, but his analysis needs to be augmented in three ways. First, any specific field of activity is likely to be the object of not one, but multiple problematizations (Dent 2009). A concern with government expenditure, as well as child well-being, may orient policies on obesity. Equally, as will be seen in the rest of this article, traditional

medicine in Kenya is now the focus of three problematizations, i.e. health, sovereignty and development. Second, while Wahlberg's main focus is on initiatives at national level, more attention needs to be paid to the international element in problematizations of traditional medicine. Structural adjustment from the 1980s, saw the ideal of the unitary and self-contained state replaced by a more polycentric model which links ministries and agencies with diverse external bodies, often more closely than with other parts of the national state (Jayasuriya 1999, Tan 2011). In subsequent decades, this transnationalization of the state has widened out beyond financial governance to include sectors under discussion here such as health, intellectual property and the control of natural resources (Sousa Santos 2006: 44). We can expect then that the multiple problematizations of traditional medicine noted above will be significantly shaped by the normative declarations, epistemic frameworks and policy languages of international organizations working in these different fields, each of which helps define the tasks of the state and indeed reconstitutes it in the manner noted above.

Third, while Wahlberg references legal provisions relevant to the regulation of traditional medicine in Vietnam (2006: 136), he does not specify the particular contribution of law to the distinct elements of problematization outlined above. Of course, as already noted, law operates alongside, not above, non-legal technologies and patterns of analysis, for example public health science and economics (Dent 2009). Nonetheless, it retains an important co-ordinating and 'anchoring' role in this pluralistic regime due to its still considerable symbolic resources (Loader and Walker: 2006; Tan 2011: 140). These include constitutionally enshrined values and objectives, which provide the moral orientation for discrete problematizations. Many of Africa's independence constitutions in the 1960s defined these goals in wholly self-referential terms, marking a rupture with external domination under colonialism. By contrast

recent constitutions, like Kenya's, are much more 'internationalized' reflecting the rise of polycentric governance discussed above and a desire to break with the autocratic local regimes which followed decolonization (Thornhill 2016). The constitution can, thus, be seen as a junction-box of the international and the national for each of the key elements of problematization: incorporating and rearticulating international *norms* as national goals; bestowing a local mandate to internationally approved *knowledge and governance technologies*; and giving a national inflection to the *idioms* of global governance. I have argued here that problematizations are plural, internationally influenced and constitutionally anchored. In the following sections I will trace these dimensions through recent initiatives to regulate traditional medical practice in Kenya and to define and protect the knowledge on which it is based.

Health and Safety: Products and Practitioners

The Kenyan constitution follows the model of South Africa and many other states in the global south in guaranteeing social and economic, as well as civil and political rights (see Musila and Biegon 2013). These rights are binding on all state authorities and enforceable against them through court action (Articles 20(1), 22(1)). Two are significant as regards the regulation of traditional medicine. Article 43 recognizes the right of citizens to the highest attainable standard of health, replicating the terms of Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR), a treaty of the United Nations which Kenya has ratified (Mbazira 2013). More distinctively the right of consumers also goods and services of reasonable quality are guaranteed under Article 46 which also requires the state to regulate advertising.

I will argue in the present section that these constitutional measures, which combine national goals and international standards, provide a normative horizon for the problematization of traditional medicine in terms of health.

The health problematization of traditional medicine has two aspects, reflected in the WHO's current global strategy for the sector and in Kenya's National Policy on Traditional Medicine and Medicinal Plants (WHO 2013; NCPAD 2005).⁴ First is its potential to contribute to the goal of promoting universal health coverage when integrated into the conventional system. Second the related need to ensure the safety and effectiveness of traditional practitioners and products. Each finds a normative foundation in General Comment 14 of the UN Committee on Economic, Social and Cultural Rights on the content of Article 12 ICESCR (CESCR 2000). While not legally binding, such General Comments have considerable persuasive force and have been used by the Kenyan courts in deciding on the scope and content of equivalent rights in the constitution, such as the right to health in Article 43 (Harrington 2014). General Comment 14 specifies, among other things, that states should ensure that health care is geographically accessible, financially affordable, culturally acceptable and of sufficient quality (Hunt and Leader 2010). This abstract mix of potential and risk is given concrete expression in policy documents and in the comments of notable stakeholders in reform initiatives.

The WHO strategies lay emphasis on the only partially realized capacity of traditional medicine to augment biomedical provision, which in Kenya as in much of sub-Saharan Africa is overwhelmingly concentrated in urban areas and disproportionately available to those who can pay (Kasilo and Trapsida 2013). As a World Bank-funded study indicated, traditional healers are much more evenly spread across the territory, with a much more favourable ratio of practitioners to patients than

is the case with conventional doctors (Lambert and Leonard 2011). Typically embedded in rural communities, they are also taken to have a unique cultural legitimacy in securing adherence to therapies and in recommending healthy behaviours and lifestyles (UNAIDS 2002: 9-18). Health systems experts ask how practitioners can be 'harnessed' to the official health workforce to deliver individual care and promote public health (Ngetich 2008). Their suitability for these tasks is put in question through a further set of problematizations focussing on quality control and regulation.

The authors of Kenya's National Policy on Traditional Medicine and Medicinal Plants noted the technical shortcomings of indigenous *materia medica* and products when compared with licensed pharmaceuticals (NCPAD 2008: 2). Lack of stability and unclear dosage may undermine the effectiveness of therapy or actively harm patients. Further difficulties are found in the secretiveness of practitioners, their commonly poor relationship with conventional medical practitioners, their maintenance of unsafe practices and frequently exaggerated claims of effectiveness.⁵ These problems, seen as inherent even to genuine traditional healing practice, are greatly intensified in the case of fake products and 'quack healers'. The latter are associated particularly with urban contexts, knowledge cribbed from books and a wholly commercial interest in practice: the salesman who boards a mini-bus with a bag of herbs or the spiritualist promising relief from business and relationship problems on signs affixed to lampposts (Mwangi 2012: 41).⁶ The idiom of such comment calls forth a mood of fear for safety, of course. But this is also mixed with anxiety about the loss of authenticity as practitioners are disembedded from traditional contexts that set normative and practical constraints on their work and the materials which they use.⁷

This direct focus on quality is amplified by a concern with the lack of suitably comprehensive regulation. In so far as healers in Kenya are currently licensed this is done by the Ministry of Culture which requires a testament of good character from the chief in the area where they work and a letter from a medical research institute stating that the herbs which they use are customarily recognized as having medicinal effect (Ngetich 2008: 28). The latter is confirmed only by discussions between the researcher and the healer, no tests for safety or efficacy are currently carried out. Only a small minority of practitioners apply for these licences. Particularly in rural areas most are oblivious to the requirement. Moreover, unless a quack healer is proven to have actually harmed a patient, they are guilty of no offence. On this basis, the sector in Kenya is said to be one of chaos and disorder, by comparison with the often-invoked example of China with its detailed registration, education and quality control systems.⁸ Legislative inaction has been judged against the constitutional provisions on health and consumer rights set out above, the National Traditional Medicine Policy and the detailed benchmarks for the formulation of national frameworks set out in the WHO strategies mentioned above.

In response to these deficits, a diverse set of governance technologies has emerged. They include initiatives such as the Kenya Medicinal and Aromatic Plants project supported by the Japanese Development Agency and the World Bank, in cooperation with the National Council for Population and Development to train around 500 herbalists, identified by two national healers' associations at sessions held in seven different venues around the country (KWG-MAPS 2011). Training was provided in record keeping and hygiene, conservation of plant resources and the regulations for the production and storage of herbal medicines laid down by the Pharmacy and Poisons Board. A further example is provided by the licensing and disciplinary systems

set out in a series of legislative proposals. A Traditional Medicine Practitioners Bill 2014 would have made some form of educational qualification a prerequisite for the inclusion of a healer on a comprehensive national register, itself a requirement of lawful practice. In addition to these substantive norms, governance technologies also include diverse formal modes of engaging healers, such as training workshops, stakeholder conferences, and the detailed forms to be filled for product approval and practitioner registration. As well as the individual practitioner, the Kenyan legislator is the target of standards developed at international level, for example, the WHO Africa Office's tool kits which set out detailed processes for the formulation national policies, as well as model laws and codes of ethics (WHO 2004). The constitution itself has provided further impetus. Since health provision in Kenya was largely devolved to new county level administrations under the 2010 constitution, parliament was obliged to pass new legislation for the whole sector. The resulting Health Act 2017 includes a framework chapter on traditional medicine, committing the state to introduce further, more detailed legislation for 'mapping', 'standardizing' and 'regulating' traditional medical practice.⁹

Problematizations of traditional medical practice call forth at least three distinct ideal 'subjects' through which governance is to be realized as self-regulation. The first is the individual healer, regulating their own practice and trained with reference to standards which are now ideally prescribed and explicit rather than traditional and implicit. Thus, under the WHO Model Code of Ethics they would commit to refer difficult cases to conventional doctors, avoid using stethoscopes, injections or manufactured pharmaceuticals, and exercise restraint in advertising her services (WHO 2004: 42). Set against this ideal the current light touch system of licensing operates at a merely superficial level, failing to reach sufficiently into the practice or character of the healer.

The second subject is the collectivity of healers considered as a professional group. The constitutional principle of stakeholder participation in law-making, set out in Article 118, suggests a straightforward process here of recognizing and engaging with a pre-existing representative group, emerging from civil society as it were. However, in practice healers associations in Kenya are often ephemeral and beset by endemic factionalism.¹⁰ The report of the Medicinal and Aromatic Plants initiative discussed above noted the lack of 'organizational cohesiveness' among healers in some areas (KWG-MAPS 2011: 13). The 2014 Bill failed to pass due to the resistance of middle-ranking members of healers' associations who felt that it took an overly restrictive and punitive approach to regulation. They rejected the advice of their leaders who had been working closely with the National Council on Population and Development to draft the legislation.¹¹ The tendency is for groups with shallow legitimacy and an urban bias, as well as constitutionally suspect governance arrangements, to be called forth in response to new policy initiatives.¹² In recognition of this perhaps, the state is enjoined by WHO guidance to go beyond mere recognition and to take active steps to *create* associations which will establish ethical standards and operate the machinery of professional discipline (WHO 2004: 16). Self-regulation, in other words, requires the prior production of a collective self-regulating subject, in accordance with the constitution and international standards.

The third subject is the state itself which should be meeting its international human rights obligations and keeping up with its peers by promoting access to safe traditional medical care.¹³ An important reason for its failure to do so, according to the National Policy on Traditional Medicine, is the fragmentation and dispersal of state responsibility for the sector (NCPAD 2005: 5). Policies and draft legislation have been proposed over the last fifteen years by the National Council for Planning and

Development, the Ministry of Health and the Ministry of Culture. The latter is currently responsible for licensing, as we have seen. But this allocation is contested by prominent urban-based healers as a relic of the colonial distinction between universal, 'western' medicine (identified with science) and African therapeutics associated with witchcraft and 'tribal' customs (identified with culture).¹⁴ They argue that the Ministry of Health is a more appropriate locus of regulation if the goals of increasing the availability of health care and the attendant system of quality control are to be realized.¹⁵ The plausibility of this demand is underpinned by a further distinction between herbalism (seen as complementary to biomedicine) and spiritualism (a matter of culture and belief). As the leader of a herbalist association put it, 'we will leave the spiritualists behind when we come under Health'.¹⁶ These interventions are a response to the historically hostile attitude of conventional practitioners, dominant in the Ministry of Health, which has frustrated previous attempts to integrate traditional medicine into the official system. The 'move to Health' is clearly a project of elite traditional practitioners who enjoy increasingly close relations with senior medical civil servants and with the WHO in Kenya and the Africa Region. Recognizing that biomedicine is, as Stacey Langwick has put it, 'the obligatory passage point' for securing state recognition, this elite has positioned traditional medicine as supplement rather than a competitor (2011: 75). However, many less well-connected healers, based in rural areas or with less capital-intensive practices might not welcome a shift to what is likely to be a more intrusive regulatory regime under the Ministry of Health.¹⁷

To conclude this section, it must be admitted that the constitutional rights to health and consumer safety have only been in force in since 2010, while many of the normative, epistemic and rhetorical resources for problematizing traditional medicine and the attendant technologies discussed here predate this change in Kenya's

fundamental law. Nonetheless, the salience of the new constitution and of these articles in particular was widely affirmed by interviewees including a senior policy maker at the Ministry of Health, one of Kenya's most prominent healers who also consults for the WHO and a senior researcher on traditional medicine at the Kenya Medical Research Institute.¹⁸ In any case, I am arguing that the constitution did not represent a rupture, but a crystallization of existing tendencies in policy and legislation. Fundamental rights provisions strengthen these tendencies by giving them a clearer, more explicit normative horizon and an idiom which draws force from international health and human rights law.

Sovereignty and Development: Resources and Knowledge

A concern with the potential utility of traditional medicine animated the health and safety problematizations of healing practice discussed in the previous section. This generic concern also informs official engagement with the knowledge deployed and reproduced by healers. It gives a normative charge to twin problematizations of traditional medical knowledge in terms of resource sovereignty and national development which I will consider in this section. The latter are anchored in the express terms of the constitution which commits the state 'to protect ... indigenous knowledge of biodiversity and genetic resources of the communities' (Article 69(1)(b)) and recognizes 'the role of ... indigenous technologies in the development of the nation' (Article 11(2)(b)).

The threat to sovereignty is articulated in terms of national vulnerability to the unauthorized and uncompensated extraction of traditional knowledge and related genetic resources. Perhaps the most notoriously case of this is said to have occurred

in Madagascar in the 1960s when ethno-botanists enrolled local healers who led them to the rosy periwinkle, later used by Eli Lilly to produce highly profitable treatments for childhood leukaemia and Hodgkins disease.¹⁹ No compensation was paid. Such alleged 'biopiracy' is condemned by Kenyan politicians, state agencies and think tanks alike as a new form of 'colonial pillaging'.²⁰ Indeed patented drugs for the treatment of diabetes were developed by the German company Bayer out of bacteria found in Lake Ruiru in central Kenya (McGown 2006: 11). Similarly, enzymes discovered in a microbe, removed without authorization, from Lake Bogoria in the Rift Valley were used by Proctor and Gamble to produce a detergent powder capable of fading jeans (Laird and Wynberg 2008: 123). These appropriations were underpinned by an assumption, inherited from the colonial period, that such tangible and intangible resources were unowned, part of 'the common heritage of mankind' available for exploitation by those best equipped to do so, usually companies from the global north (Timmermans 2003: 747).

The historical resonance of these cases is suggested by Abena Dove Osseo-Asare's recent study of struggles over biodiversity and healing across the continent. Colonial extraction, she shows, was justified as a means of bringing scientifically and economically 'inert' African resources into contact with dynamic and universally valid biomedicine, and, thus, allowing their value to be unlocked (Osseo-Asare 2014: 108). In this spirit Article 6 of the General Act of the Berlin Conference on West Africa (1884-85) extended 'especial protection to scientists and explorers' of whatever European nationality present in colonial territories. Anti-colonial movements and early independence governments in the second half of the 20th century articulated a two-fold response to this regime. Negatively they asserted local sovereignty over material resources. Positively, leaders such as Ghana's Kwame Nkrumah and Tanzania's

Julius Nyerere, framed traditional knowledge as a 'national good', which would build unity through a common culture (Osseo-Asare 2014: 33). They established dedicated research institutions were established, in many countries, to provide the basis for a pharmaceutical industry using local materials and aiming at self-sufficiency through import substitution. Langwick has shown in the case of Tanzania, that this articulation of herbal medicine to state goals has survived the collapse of state-led development models (2011: 68ff). Under the current neo-liberal dispensation policy makers now view traditional medicine as a source of products for export in competition with those from other countries (Langwick 2010). Of course, the important differences between these states should not be neglected. Kenya's post-independence policy always emphasized capitalist development over the autarkic policies advanced by Nyerere and, to a lesser extent, Nkrumah (Hornsby 2012: 147). Nonetheless, as we will see later in this section, in Kenya too traditional medicine is understood and problematized as a 'resource for development' (Langwick 2011: 61).

To date, however, these aspirations have rarely been realized. African governments, including Kenya's, had long failed to secure internal control over their resources or to win international recognition for their right to do so. The Convention on Biological Diversity (CBD) 1992 and the ensuing Nagoya Protocol (2014) represented an important shift in this regard, recognizing the sovereign right of states to exploit their own resources' and outlining a system of prior consent and benefit sharing where outsiders seek access to such material. The terms of the CBD in this regard are reflected in the provisions of the Kenyan constitution mentioned above and they have been implemented since 2006 in regulations administered by the National Environmental Management Agency.²¹ The latter provide for governance technologies including the maintenance of an inventory of biodiversity (reg 6) and a standard

application form for access permits (reg 9). However, as legal practitioners and a major Kenyan ‘think tank’ have noted that the regulations are unclear about who should give consent or with whom benefits should be shared and that, as a result, ordinary Kenyans have gained little from the ratification and implementation of the CBD (IEA 2009: 10).²²

A traditional Westphalian approach, reflected in Article 3 of the CBD, would suggest that the state is the primary bearer of such rights and the appropriate addressee of applications for access (Drahos 2014: 80). However, the Convention was the product of lobbying, not only by post-colonial states, but also by minority indigenous groups around the world, who sought to assert their own ‘sovereignty’ over genetic resources (Oguamanam 2012: 149ff). That influence is evident in the terms of Article 8j of the CBD, subsequently adopted into Article 69(1) of the Kenyan constitution, which requires states parties to respect and preserve the knowledge and practices of indigenous communities and to ensure their involvement in decisions to appropriate and commercialize them. This suggests an alternative problematization, one equally couched in terms of the vulnerability of resources, but which sees the primary claim as lying with sub-state groups, rather than central government. It gains rhetorical force from the notoriously arbitrary inclusion of such groups as vulnerable minorities within post-colonial territories and the often predatory attitude of state authorities to their resources (Antons 2012). The CBD and the 2010 constitution finesse, but do not resolve this difficulty by producing the state as a subject, not only with negative rights, but also as the bearer of positive responsibilities to monitor and protect resources and the communities which hold them.

Deficiencies of law enforcement and substantive intellectual property (IP) law have been an important element of the problematization of traditional knowledge in

Kenya (see NCAPD 2005: 4). On the one hand, traditional medical knowledge in its original state is not capable of being patented given that it is often widely shared and so not 'novel' as required by legislation in Kenya and elsewhere (Timmermans 2003: 752).²³ On the other hand, companies using local remedies as a lead for drug discovery can patent drugs developed 'scientifically' in their laboratories (Dutfield 2012). IP law in effect allows 'corporate enclosure' of financial benefits by creating 20-year monopolies, while preventing 'defensive patenting' to the advantage of those individuals and groups who sustain and transmit traditional knowledge. These deficiencies have been the focus of 'gap analysis' by the World Intellectual Property Organization (WIPO) through the work of its Intergovernmental Committee on Intellectual Property and Genetic Resources, Traditional Knowledge and Folklore (IGC) established in 2004 (WIPO 2008). The Organization has supported strategies to resist enclosure through publicizing traditional knowledge in databases, which would destroy novelty for patent law purposes, or requiring patent applicants to disclose the source of their discoveries (Dutfield 2012). But these have met with limited or no success (Bubela and Gold 2012: 6-17; Correa 2001: 7). More promising has been its proposal to create bespoke or *sui generis* IP rights, tailored to the distinctive nature of traditional knowledge.

Kenya's active participation in the work of the IGC was reaffirmed by a constitutional commitment in 2010 to protect 'the intellectual property rights of the people' and an obligation to pass legislation 'to ensure that communities receive compensation for use of their cultural heritage' (Articles 11(2)(b) and 11(3)(a)). The Protection of Traditional Knowledge and Cultural Expressions Act 2016 seeks to meet these commitments and to fill the gap identified by WIPO (2008) and in the National Policy on Traditional Knowledge, Genetic Resources and Traditional Cultural

Expressions developed under the auspices of Kenya's Attorney General (Government of Kenya 2009). The key impetus for the Act came from senior staff in the Kenya Copyright Board, who have been closely involved in the WIPO process in Geneva, and WIPO staff advised on the drafting of the legislation.²⁴ The Act creates *sui generis* IP rights over traditional knowledge²⁵ which are held and enforced by communities, through their leaders, and sets out requirements for consent and benefit sharing similar to those discussed above in relation to material, genetic resources (ss. 9, 10). But, by contrast with the regulations implementing the CBD regime, the 2016 Act is clear that the primary power of licensing, or refusing to license the use of traditional knowledge lies with the local community (s.10), not with the national or county authorities, though the latter are allocated important supervisory roles (ss. 4, 5). Additionally the 'moral' interest of communities can be protected through their right to seek injunctions in cases where knowledge is misused, misattributed or not attributed to them (ss. 21, 38, 39(1)).

The 'community' is clearly central to the operation of the system of *sui generis* rights under the Act, also appearing as a key term in the constitutional provisions, quoted above, which inspired the legislation. The role and responsibilities of the community as custodian of indigenous knowledge had already been fleshed out in the National Traditional Medicines Policy, as well as through influential non-governmental reports on community rights by the International Institute for Environment and Development and the Kenyan Institute of Economic Affairs (NCAPD 2005; Mutta and Munyi 2010; IEA 2011a). These showcased the work of existing biodiversity management groups in Kilifi and Kakamega Counties and identified 'best practice' for others seeking to protect and profit from their material and intellectual resources, for example, by forming partnerships with research institutes, actively using existing IP

law and creating inventories (IEA 2011b). But the 'community' which was to be the agent of this 'government at a distance' was not clearly defined, a lack of clarity replicated in the Protection of Traditional Knowledge and Cultural Expressions Act 2016. The legislation provides that it may be a group with any of the following: common ancestry, similar culture or language, shared geographic space or collective of interest (s.2). This very broad definition would certainly include small and marginalized communities.²⁶ But it could also extend to Kenya's major ethnic groups, presenting the opportunity for political leaders to pursue competitive 'tribalism' in this sector as they have done in relation to land. The equation of communities with reified 'tribes' was of course the definitive technology of indirect rule in Britain's African colonies and was reflected in the Medical Practitioners and Dentists Ordinance of 1910 which, as we saw above, defined and delimited 'native systems of therapeutics' in terms of 'tribe'.

The salience of these definitional difficulties becomes still clearer given that the Act allows the government to issue compulsory licences for the commercialization of traditional knowledge where it is being 'insufficiently exploited' by its local owners (s.12). Though any ensuing benefits accrue to the community, this allows the utilization of indigenous knowledge for economic ends determined by state authorities. If only in the form of an exception, this gestures at a problematization of traditional medicine in terms of lost potential. If development has been the central task of the independent Kenyan state as Branch and Cheeseman have put it,²⁷ then its obverse is a concern with waste which has 'haunted' capitalist and colonial thought and, indeed, post-colonial policy-making (Parekh 1995: 84).

Pharmacists and botanists, rather than medical doctors, have taken the lead in defining this problem and crafting official responses to it.²⁸ This is evident in the appointment of Professor Julius Mwangi to the Chair of Pharmacognosy in 2012 after

three decades of teaching and research at the University of Nairobi. A healer himself, he focussed his inaugural lecture on the role that traditional medicine could play in Kenya's 'economic and social progress' (Mwangi 2012: 10). He drew on the sovereignty problematization discussed above, but gave it an important developmental inflection. By neglecting its stock of traditional knowledge and allowing resources simply to be 'shipped out', Kenya was failing to grasp an opportunity to develop its own industrial sector (Mwangi 2012: 15, 26). To meet this challenge, the widespread scepticism, at least among educated Kenyans and foreigners, would have to be addressed. Titling his lecture 'Herbal Medicines. Do They Really Work?' he set forth a 'justification' for traditional medicine based on a series of successful cases from his own practice, where biomedicine had originally failed to help patients (Mwangi 2012: 11). Such clinical vignettes are not, of course accepted as evidence of efficacy in themselves. He called on the government to invest in the scientific systems to this end. Admittedly randomized controlled trials, the so-called 'gold standard', would be expensive and difficult given the complex composition of herbal remedies (Mwangi 2012: 19). KEMRI's traditional drug programme, mentioned above, has encountered the difficulty to introducing a promising treatment for herpes. In place of trials, the programme's director, Festus Tolo has argued that long-established usage of a particular herb should be taken as sufficient proof of efficacy instead (2014).

What Professor Mwangi called the 'academic, moral and practical' imperative to make full use of the nation's 'green gold'²⁹ was taken up in the national policy on traditional medicine, which identified commercialization as one of four key issues in the sector and explored obstacles to this, including unsustainable or 'wild' harvesting practices, lack of funds for small-scale investment, weak supply chains and poor packaging and labelling (NCPAD 2005: 9, 20ff). This developmental problematization

is obviously informed by agronomy and business studies, as evidenced in a recent research programme of the Nairobi-based World Agroforestry Centre on cultivation and marketing (see e.g. Muriuki, Franzel, Mowo, Kariuki and Jamnadass 2012). But it is also shaped by economics and law. Thus, the Institute of Economic Affairs attempted a proper valuation of traditional knowledge in Kenya (IEA 2011a: 62-81). The national policy also stated that well-defined access rules and intellectual property rights were a prerequisite to commercialization (NCPAD 2005: 17). The link between IP and development has been explicitly recognized by the Kenya Copyright Board, which drafted the Protection of Traditional Knowledge and Cultural Expressions Act 2016 and which is responsible for its operation (Bunyassi 2011). A 'legally regulated, scientifically driven and commercially informed' traditional medicine is also the goal of the current state-sponsored Natural Products Industry Initiative, established under the government's medium term economic strategy Vision 2030, which aims to exploit massive demand for herbal products in the global north.³⁰

Conclusion

This article traces the expansion of policy-making and recommendations focussed on traditional medicine in Kenya over the last fifteen years. I argued that proposals for the regulation of practice and for the control and deployment of the knowledge on which it draws were shaped by three key problematizations: health and safety, threats to national sovereignty, and development potential. Some general conclusions can be drawn. First, the governance of traditional medicine is an uneven and contested

process. In the case of each problematization, regulation worked through firstly identifying agents that were framed as self-regulating and accountable to government. But there was no even allocation of tasks and rationalities between them. Thus, communities and the state are, to an extent, rival subjects with regard to the conservation and commercialization of traditional medical knowledge. Indeed, the boundaries of subjects are themselves fluid and often incomplete: healers' associations come and go, communities are tiny or vast, and the state itself is in part an effect of international law and governance arrangements. Traditional medicine is, thus, best conceived of as a strategic field, where the normative, epistemological and discursive resources of problematizations and the governance technologies which they have established may be deployed or challenged, not only to the ends of already existing actors, but also in the creation of new actors or subjects. In this spirit the provisions of Kenya's 2010 constitution considered throughout this paper need to be understood, not as the most abstract terms in a fixed blueprint for the sector, but rather as negotiable resources for articulating, implementing and resisting regulatory initiatives.

Second, distinct modes and moods of governance can be identified across the three problematizations. Many initiatives rest on the notion that different aspects of traditional medical practice and knowledge need to be made visible. Healers will be registered, and placed under an obligation to take notes on their meetings with patients, which would then be available for inspection by regulators. IP regimes and inventories will make traditional knowledge known ('patent'). Good manufacturing practice and marketing rules will bring a standard herbal product to the (hoped-for) consumer. Anxiety about the capture of national resources and fear of unsafe healing practice were combined with optimism about the potential contribution to health care

and national development. Such moods are not incidental, but integral to specific problematizations and to their plausibility within the strategic field of governance.

Third, while the Kenyan state does not direct and underwrite all of these initiatives, it retains an important role in orienting and co-ordinating them. As well as the diversity of subjects we noted a range of locales on which problematizations were focussed and to which different governance moods were attached. The village is idealized as the true abode of traditional practice and of the customary law which regulates it. Nostalgia is tinged with regret and apprehension at the loss of this integrity. The city, and particularly the slum, is a zone of mixing and threat. The traditional is introduced to the modern in an unregulated fashion, by quack healers selling unwarranted medicines to random customers. The global north hosts predatory corporations whose neo-colonial objective is to undermine Kenya's hard won independence. The importance of the state lies in the expectation that it can interrupt these disorderly and unproductive links and replace them with systems for the orderly integration of traditional medicine into national health care and the global economy. Such expectations – of genuine sovereignty and equitable development - were disappointed in the long decades from independence in 1963. The constitution of 2010 represents an attempt to restore them in law and politics.

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¹ See further Iliffe (1998: 28-29). This reification of 'tribal' identities in medicine was in contrast to the reality of mobile healers and patients, then and since, see Rekdal (1999).

² See respectively in Wekesa (2009) and Laird and Wynberg (2008).

³ See Gathii (2016), Franceschi, Muthoni and Wabuke (2017), and Kibet and Wangeci (2016).

⁴ The WHO country representative has advised the Kenyan Ministry of Health on the development of legislation to integrate traditional medicine within the official health sector since 2010. Interview with nationally prominent healer, 22 April 2013.

⁵ Interview with senior research officer, Centre for Traditional Medicine and Drug Research, Kenya Medical Research Institute, 21 May 2013; and see Mwangi (2012: 33)

⁶ Newspaper coverage of traditional medicine frequently focusses on such 'practitioners', see for example Mwititi (2011).

⁷ This fear registers among parliamentarians, see for example, *Kenya National Assembly Debates*, 9 December 2009 4442 (Dr Khalwale MP). It is also shared by policymakers and prominent healers, see interviews with former patent inspector, Traditional Knowledge and Genetic Resources Unit,

Kenya Industrial Property Institute, 11 July 2013 and with leader of herbalist's association, 31 January 2013..

⁸ For example, see *Kenya National Assembly Debates*, 9 December 2009, 4440 (Dr Mwiria MP).

⁹ Ss. 74-79 Health Act 2017.

¹⁰ Interview with senior pharmacist, Ministry of Medical Services, Nairobi, 19 February 2013.

¹¹ Interview with former patent inspector, Traditional Knowledge and Genetic Resources Unit, Kenya Industrial Property Institute, 11 July 2013.

¹² Interview with founder of traditional healing NGO, 30 January 2013.

¹³ Thus, in its current global strategy, the WHO urges states to adopt national plans for regulating traditional medicine (WHO 2013: 35ff). This imperative is also reflected in the Kenyan media, see for example, Anon (2012).

¹⁴ Interview with proprietor of herbal medicine clinic, Nairobi, 29 January 2013.

¹⁵ See the comments of stakeholders noted in Ngetich (2011) and Gemson (2013).

¹⁶ Interview with leader of herbalists' association, 31 January 2013.

¹⁷ Interviews with traditional healer, Kakamega County, 31 June 2013; and senior Kenyan research scientist, 26 February 2013.

¹⁸ Interviews with senior pharmacist, Ministry of Medical Services, Nairobi, 19 February 2013; nationally prominent healer, 22 April 2013; senior research officer at Centre for Traditional Medicine and Drug Research, Kenya Medical Research Institute, 21 May 2013.

¹⁹ It should be noted that this plant is available in several locations around the world, and that it is difficult therefore to identify a clear link between the company's successful drug and a specific appropriation of traditional knowledge in Madagascar, see Osseo-Asare (2014: 33).

²⁰ For example, see IEA (2011a passim), Government of Kenya (2009: 6) and also *Kenya National Assembly Debates*, 9th December 2009, 4449, 4452 (Mr Shakeel MP, Mr Maina MP).

²¹ *Environmental Management and Co-ordination (Conservation of Biological Diversity and Resources, Access to Genetic Resources and Benefit Sharing) Regulations* 2006.

²² Interview with intellectual property scholar and practitioner, 1 October 2013; IEA (2009: 10)

²³ The requirements for the issuing of a patent in Kenya are laid down in s.23 *Industrial Property Act* 2001.

²⁴ Interview with former patent inspector, Traditional Knowledge and Genetic Resources Unit, Kenya Industrial Property Institute, 11 July 2013.

²⁵ For purposes of this discussion I will focus on traditional knowledge only, as this is most relevant in the context of medicine. It should be noted, however, that the Act's provisions on traditional cultural expressions are quite similar, and that there is considerable overlap between the two areas, see Oguamanam (2012: 171).

²⁶ The rest of the Act does not offer much further guidance either. The definition of traditional knowledge as that which is 'integral to the identity of the community' (s.6) is essentially circular. Equally, though customary law is relied on to settle overlapping claims to the same knowledge (s.7(6)), it is unlikely to define the communities themselves.

²⁷ See Branch and Cheeseman (2010).

²⁸ Interview with senior pharmacist, Ministry of Medical Services, Nairobi, 19 February 2013.

²⁹ See Mwangi (2012: 10, 32).

³⁰ Interview with senior official, Natural Products Industry Initiative, 25 July 2013.