Wilberforce Journal of the Social Sciences (WJSS)

Website: www.nduwjss.org.ng ISSN: 2504 – 9232 Volume 9 No. 1 (2024)

DOI: 10.36108/wjss/4202.90.0140

SOCIOLOGICAL IMPERIALISM AND MEDICAL EXTROVERSION: PROVISIONAL INFLEXION ON COVID-19 RESPONSE AND THE PRAXIS OF MEDICAL IMPERIALISM IN POSTCOLONIAL SOCIETIES

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Abstract

This paper engages medical practice as a human rational response to ill-health that is not generic to all human society albeit in different practices and forms. It examines how the COVID-19 pandemic and response reveal global dynamics in medical research and knowledge production – itself a product of imperial logic. This paper invites a critical re-reading of the COVID-19 pandemic and response to a context of Western-centric or hegemonic (re)production of coloniality in general and extroversion of disciplinary practices in particular by laying out some preliminary basis for interrogation. In particular, this paper attempts to highlight how the association of superiority to (Western) academy is redacted in (medical) practice and manifests as the tension between cultural/local and 'scientific'/global knowledge systems. Through decolonial reflection on literature related to the COVID-19 pandemic, epistemological concerns and imperialism, it argues that Western medical praxis embodies and articulates ingrained cultural assumptions and biases against non-Western medicinal skills and practices.

Keywords: COVID-19, medical imperialism, decoloniality, culture, African value system.

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Introduction

The practice or response to ill health, for better or worse, is known to almost all known human formations (Bleakley, Brice and Bligh, 2008). This is without discountenance to differences in understanding of and complexity in response to underlying ailments across different societies so that different societies have been inclined towards one form or the other such as curative, remedial, restorative, healing, medicinal, therapeutic, and allopathic among others (De, 2020). Though the boundary between these 'varieties' is not water-tight and in practice sometimes overlapping, some

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are historically associated with some societies given their millennial practice. These understanding and response, encapsulated in the now pervasive notion of medicinal practices, frequently accompany these societies as they move from place to place since illness announces no schedule, even as they cross-fertilise as they come into contact with new cultures and experiences. One such practice that has gained traction as it extends to the far corners of the Earth is Western allopathic practice, if it can be so designated. Western medicine and medical practice have been and continue to enjoy limitless export to societies far and wide, especially as sophistication and superiority have been hegemonically made akin to the West (Ani, 1994; Ferguson, 2012). This paper explores, through decolonial inflexions, the discourse in and around discursive events/phenomena such as unequal access to healthcare resources, vaccine production and distribution disparities, ethical considerations in research and clinical trials, and hegemonic Western-centric response predispose or provide the context of COVID-19 pandemic response as medical imperialism. While this discursive phenomenon each reinforces the (re)production of imperialism in the knowledge and practice of the medical profession, the current paper emphasises the latter as its core.

The contention is that COVID-19 response reveals the global dynamics in medical research and vaccine nationalism – itself a product of imperial logic. And, that this global imbalance is further exacerbated by local forces which, in the case of Africa, reflects as and is represented by the perennial tension between Western-imposed signs and local signification. In this case, the gown and the town, representing Western biomedical science and African herbal system respectively. This paper therefore focuses on and invites a critical re-reading of COVID-19 pandemic and response as context of Western-centric or hegemonic (re)production of coloniality in general and extroversion of disciplinary practices in particular by laying out some preliminary basis for interrogation. In particular, this paper attempts to highlight how the association of superiority to (Western) academy is redacted in (medical) practice and manifests as tension between cultural/local and 'scientific'/global knowledge systems. It argues that, Western medical praxis embodies and articulates ingrained cultural assumptions and biases against non-Western medicinal

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skills and practices. To this end, this piece is organised into four parts following this introduction. The first sets the background with a brief examination of the medical imperialism as a sociological thesis. The second section examines COVID-19 pandemic and analyses 'global' – particularly – World Health Organisation (WHO)'s response as an invitation to epistemic issue albeit concerns for systematization and procedural rigour. The third section provisionally explores the valorisation of Eurocentric worldview as scientific knowledge and how it manifests as tension between Western and traditional medicine. The fourth section concludes the study.

A Sociology of Medical Imperialism

Medical imperialism as a theoretical critique draws from a broad base sociological critic – predominantly of American sociological origins – of power and privilege associated with experts' claim which finds systematic articulation in the works of G. B Shaw (Strong, 1979). As a broad array of social critique, it refers to "increasing and illegitimate medicalisation of the social world" with a view to making social problems increasingly professional while shutting 'non-professionals' out (Strong, 1979: 199). Scholars such as Bittner (1968, 2000) and Illich (1975, 2000), are some of the early exponents of this thesis. Bittner (2000), while concurring with Illich (2000), describes medical imperialism as a process of expansion which is dependent on the power of, and under the control of a capitalist ruling class so that the spread of and predominance of Western medical science is but a manifestation of global capitalism at work. The thesis posits a growing reliance on professional expertise to address health challenge as social problems, leading to the expansion of bureaucratic structures and monopolisation of certain services by medical professions. It highlights how medical professions not only provide medical services as universal but also control, discipline and dictate their nature and criteria for evaluation, and thus expanding its influence into domains and societies it barely knows anything about. Additionally, it critiques the perception of social problems as individualistic, neglecting their social causes and processes, thus depoliticising them. Moreover, the medicalisation of social issues, coupled with clients'

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dependency on professional services, perpetuates the expansion of professional empires, often at the expense of addressing underlying social forces contributing to problems.

According to Strong (1979), even though there is no agreement about the nature of the society or societies driven this imperialism or specific society where such expansion occurs, the broad consensus of the thesis can be summed in ten points thus: (i) There is an increasing tendency to assign social problems to professional experts in ever-expanding bureaucracies; (ii) individual professions vie for exclusive control over specific services, excluding other professionals and laypeople i.e., medical doctors may resist non-doctors providing health advice, asserting their monopoly over medical services; (iii) professions not only deliver services but also dictate their nature and standards of quality i.e., medical doctors not only treat patients but also determine what constitutes effective medical care and diagnosis methods; (iv) professions seek to broaden their scope beyond their original domain, defining new problems and solutions. (v) human needs and problems are socially constructed and can endlessly expand, challenging traditional conceptions i.e. health challenges persist despite advances in medical sciences, highlighting the socially constructed nature of needs and problems, and how (vi) professions, with their flexible nature, have the potential for unlimited expansion, encroaching on various aspects of life. Law and religion typify historical expansion of influence to encompass societal norms and governance. It continues that (vii) social problems are often attributed to individual characteristics, obscuring systemic factors i.e., blaming unemployment solely on individual laziness overlooks systemic issues like job scarcity and discrimination, the same applies to certain medical or health condition with systemic origins. (viii) social problems are increasingly medicalised, with scientific professions dominating their handling i.e., mental health issues are often treated primarily by psychologists and psychiatrists, leading to a medicalised approach. This is with little to total disregard that (ix) even medical problems are influenced by social factors, necessitating broader societal interventions, and (x) clients become dependent on professional services, fueling demand for expanded services i.e., with patients demanding more specialised medical treatments,

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contributing to the growth of western healthcare systems like the British National Health Service, since specialisation has been associated with formal education training.

Though this thesis has received its share of critique and backlash – especially as that disciplinary critic of the medical profession inevitably implicates sociology itself as a "fellow profession within bourgeois society" – it nonetheless illustrates concerns of the increasing tendency to globalise medical practice with near disregard for local practices (Strong, 1979: 199). While some scholars have dubbed the case of medical imperialism as a relatively minor phenomenon that poses no major threat (Krause, 1977; Navarro, 1977; Ehrenreich and Ehrenreich, 2002 [1975]), others have argued that it, with emphasis on sociological commitment as a discipline, merely represents professional rivalry/pessimism which can readily harden into doctrinaire cynicism (Strong, 1979: 201). However, these critiques of medical imperialism – especially P. M. Strong's – have been countered as marred by "irrelevant and unconvincing argument" which best represents a "misunderstanding of aspects of the medicalisation thesis" (Conrad and Schneider, 2004 [1980]: 75).

The foregoing notwithstanding, the contention is that the critique, particularly as espoused in Strong's perspective on medicalisation, highlights its limitations in addressing the multifaceted nature of the phenomenon of medical imperialism. While Strong focuses on individual medical practices, he overlooks the broader conceptual and organisational aspects of medicalisation. Medicalisation is not solely about the actions of individual doctors; it encompasses the underlying conceptions used to understand problems and the power dynamics involved in formulating and implementing solutions. Therefore, a comprehensive understanding of medicalisation or its imperialist inclination requires examining its political and definitional dimensions across various levels. Although Strong's analysis has merits, it does not negate the social consequences of medicalisation highlighted by its critics. Instead, it serves as a call for proponents of the medicalisation thesis to refine their arguments, test their ideas with empirical evidence, and

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consider historical, contemporary, and comparative data to enrich their understanding of the phenomenon (Riaz et al, 2021; Bleakley, Brice and Bligh, 2008).

Thus, while drawing on the foregoing understanding, this study deviates to explore the operationalisation of the COVID-19 response as empirics of medical imperialism. It contends that, 'global health' practice carries with it Western value systems which seek to proliferate and obliterate non-Western systems. Key take home from this thesis includes but are not limited to, claim to and monopolisation of 'knowledge', dictating and control of 'knowledge', expansionist tendency or the proclivity to expand, the pursuit of limitless expansion, creation of conditions of dependence on expert knowledge, to mention but few. While the focus of this paper does not cover this broad array of issues, it nonetheless illustrates the penchant of the medical profession to incline towards imperialism by showcasing its expanding control over societal issues and its influence in defining problems and solutions. Through monopolising services, dictating standards, and promoting medicalised approaches to social problems, the medical profession asserts dominance, perpetuating a form of professionalized knowledge without concern of whose knowledge and interests are embedded within it.

COVID-19 Pandemic and Global Response

The novelty of coronavirus, like many other virus outbreaks, not only took the world by surprise but the response to it stretched the capacity and capability of governments and facilities towards managing it globally. This explains the coterie of ad-hoc defensive measures employed by states to contain its spread as well as cushion the socioeconomic impact on citizens. The global response to COVID-19 was characterised by a range of measures aimed at controlling the spread of the virus and mitigating its impact on public health and economies. Governments around the world have implemented a variety of strategies, ranging from public health measures to extreme measures, to combat the pandemic. Initially, many countries focused on implementing public health measures such as mask mandates, social distancing guidelines, and hand hygiene protocols to slow the

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spread of the virus. These measures were accompanied by efforts to ramp up testing and contact tracing to identify and isolate cases (Soludo, 2020; Mohammed, 2020; WHO, 2020; Mohammed and Sakue-Collins, 2021).

However, as the pandemic progressed and infection rates surged, some states resorted to extreme measures to contain the virus. This included imposing strict lockdowns, curfews, and travel restrictions to limit movement and prevent further transmission. For example, countries like China implemented stringent lockdowns in Wuhan, the epicentre of the outbreak, effectively sealing off the city and enforcing mass quarantine measures. In other climes, in addition to lockdowns, some governments deployed surveillance technologies and implemented intrusive tracking and monitoring measures to enforce quarantine and isolation protocols. This included the use of smartphone apps, digital tracking systems, and even drones to monitor compliance with public health measures and identify potential outbreaks. The obstinacy of the virus and its indeterminate nature provide grounds for the state to adopt far-reaching measures towards containment. So that in a bid to find an antidote, there was an accelerated search for vaccines and to accelerate vaccination efforts; some countries have adopted controversial measures such as mandatory vaccination policies, vaccine passports, and incentives for vaccination and, in Madagascar, it was COVID herbal drink (COVID Organic). These measures have sparked debates over personal freedoms, privacy rights, and ethical considerations surrounding coercion and discrimination (Riaz et al, 2021; Murhula and Singh, 2022).

Overall, the global response to COVID-19 has been marked by a mix of public health interventions and extreme measures aimed at containing the virus and protecting public health. While these measures have been instrumental in slowing the spread of the virus and saving lives, they have also raised concerns about civil liberties, human rights, global health dynamics, unequal access to healthcare resources, vaccine production and distribution disparities, ethical considerations in research and clinical trials, cultural hegemony and Western-centric response to global issues, as well as the long-term implications of pandemic response strategies and the need to strike a balance

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between protecting public health and respecting individual and community rights, freedoms, and wellbeing (Bleakley, Brice and Bligh, 2008; De, 2020; Dawes, 2020). It is to this end this piece takes a brief look at global, particularly the World Health Organisation's, response to COVID herbal drink as an invitation to epistemic discourse.

Madagascar's COVID Herbal drink and WHO's response

Madagascar's response to COVID-19 was notable for its emphasis on traditional herbal medicine and public health measures. The Malagasy government promoted the use of a locally produced herbal remedy called COVID-Organics (CVO) as a preventive and treatment measure for COVID-19. In April 2020, President Andry Rajoelina announced the development of COVID-Organics, an herbal remedy derived from *Artemisia annua*, a plant traditionally used in Madagascar for its medicinal properties. This remedy, a mixture which is not uncommon in Africa, relates to the popular *Agboiba* - in the Yoruba language – a variant of *Agbo*, an herbal mixture of medicinal plants that is both a treatment and cure and a staple prescription for chronic flu, malaria and feverish conditions among others by *Balalawo* (Yoruba), *Dibia* (Igbo) and B*oka* (Hausa) – traditional healers (Ayodele, 2002). The government heavily promoted CVO as a cure for COVID-19 and distributed it free of charge to citizens. The promotion of traditional medicine was aimed at leveraging indigenous knowledge and resources in combating the pandemic. Alongside the promotion of COVID-19, Madagascar implemented public health measures such as lockdowns, travel restrictions, social distancing, and mask mandates to contain the spread of the virus. These measures were aligned with guidelines from the World Health Organization (WHO) and other international health agencies.

However, Madagascar's promotion of COVID-Organics faced stern criticism from some members of the international community and health experts who raised concerns about the lack of scientific evidence supporting its efficacy and safety. The WHO, for instance, cautioned against the use of untested remedies and urged adherence to established scientific protocols for evaluating treatments. The WHO, as the leading global health authority, emphasised the importance of

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evidence-based medicine in evaluating potential treatments for COVID-19. In its response to COVID-Organics, the WHO underscored the need for rigorous scientific testing to assess the safety, efficacy, and quality of any proposed remedy (WHO, 2020). It argued against the use of untested remedies, including herbal products like COVID-Organics, without robust clinical trials and scientific evidence, expressing concerns about the safety and efficacy of COVID-Organics due to the lack of scientific evidence supporting its claims. While acknowledging the potential value of traditional medicine, the WHO urged caution and adherence to established scientific protocols for evaluating treatments.

Despite the controversy surrounding COVID-Organics, Madagascar continued to promote its use domestically while also emphasising the importance of adhering to public health guidelines. The government monitored the spread of the virus, conducted testing and contact tracing, and collaborated with international partners to access vaccines and support healthcare infrastructure. Overall, Madagascar's response to COVID-19 was characterised by a combination of traditional medicine promotion and conventional public health measures. While the promotion of COVID-Organics attracted international attention and controversy, Madagascar's efforts to contain the virus underscored the importance of leveraging both indigenous knowledge and scientific expertise in pandemic response strategies. Although the WHO's response to Madagascar's COVID-Organics was characterised by a commitment to scientific rigour, evidence-based decision-making, and collaboration with national authorities, it reveals an often-neglected tension in local/global knowledge on the one hand, and expert cum scientific and cultural cum traditional knowledge on the other hand (Dawes, 2020; Bleakley, Brice and Bligh, 2008). While acknowledging the potential value and importance of conducting rigorous clinical trials to evaluate the safety and efficacy of any proposed remedy, the embedded suspicion of traditional medicine by orthodox medicine cannot be overemphasised. Hence, these concerns bring to the fore the issue of knowledge, science and the dynamic tension of local/global knowledge production.

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Systematisation or Marginalisation?

While it is important to understand WHO's caution against COVID-Organics as an attempt to uphold scientific rigor and ensure the safety and efficacy of potential treatments, it raises concerns about whether without robust clinical trials on its part or enquiry from the source does not amount to inherent distrust or bias by the West for non-Western sources. Moreover, it raises questions about the need for recognition and validation of traditional African healing practices by the West whose claim of monopoly of the invention of science, medicine, the rule of law, and work ethic, Niall Ferguson asserts, prompts her to sit as guardian over the "rest" of the world (Ferguson, 2012). In Civilisation: The West and the Rest, Ferguson (2012), argues that the West's development of key concepts such as science, modern medicine, the rule of law, competition, and work ethic alongside consumerism is responsible for its surge above the Rest of the world and, its exercise of discipline and monopoly is quintessential for its continuing dominance. Thus understood, the WHO caution might not be unconnected with its preference for Western biomedical sciences over traditional African medicine. Moreover, its 'call to order' reflects its preference for Western scientific paradigms as a standard for global health evaluation since it never borders to enquire whether or not 'alternative' processes or procedures have been embarked upon.

Thus, the emphasis on Western scientific standards not only conjures images of historical systems of injustices such as racism, but raises questions about rights to indigenous knowledge systems, the recognition of local contexts and the validation of indigenous healing practices, disregard for the cultural relevance and effectiveness of indigenous knowledge systems, marginalisation of non-Western systems, and cultural hegemony, among others (Bleakley, Brice and Bligh, 2008). Suffice to note that this hierarchisation of knowledge and marginalisation of systems outside Western ontology is not peculiar to the WHO's response but part of a broader logic that treats knowledge, superiority and truth as akin to the West.

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Science, knowledge and Eurocentric worldview

Western philosophical cum epistemic tradition metamorphosed from the platonic formulation of the Academy and continued through Aristotle's Lyceum beholden knowledge produced within its confines as superior (Ani, 1994). In a seminal work, *Yurugu: An African-Centered Critique of European Cultural Thought and Behavior*, Marimba Ani offers a comprehensive analysis of European cultural thought and behaviour through an African-centered perspective. Ani explores how European culture has historically dominated and influenced global societies, shaping systems of power, knowledge, and social hierarchies. Drawing on African philosophical frameworks, Ani critiques Eurocentric ideologies, arguing that they perpetuate systems of oppression, exploitation, and cultural imperialism. Through meticulous examination, Ani deconstructs the origins and manifestations of European cultural hegemony and imperialism and its (re)production through the academy and academic disciplines.

Part of this logic is the association of intelligence with academia (university/college). With this, precisely, the language of intelligence is akin to "academic" and "scientific" terms which, by extension, favours writing over orality as a form of knowledge arguing, part of its logos of linearity, that it is the natural evolution of historical learning processes and as such a higher version of human cognition (or cognitive development). In this regard, Plato not only helped to establish an episteme that would valorise "scientific" cognition over and above other cognitive modes of knowledge; his establishment of the Academy (and Aristotelian reproduction of it in the Lyceum) certified the formal exclusion of other cognitive modes – especially orality – from the broader spectrum of knowledge generation and banishes them to the realm of opinion.

The implication is that the academy, as Platonism personified, not only causes Western episteme to pride in intellectual superiority but causes intellectuals trained in institutions/settings patterned after Plato's Academy legacy to glory in intellectual imperialism. The academy therefore becomes the oven for moulding everything Western and, its products, the active representation of coloniality

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spread across disciplinary boundaries. With the West and the academy as the epitome of intellectual supremacy, it follows that its products trained in the superiority of extroversion see everything outside Western imagination and, anything, not in tandem with Western ontology as inferior, including non-Western medicinal practice. This way, everything is measured against it as the standard. This underscores the logic of describing European/Western-based cultural medication as orthodox or mainstream in societies it is alien to, and local/cultural medication as "alternative" medicine in their locality.

Furthermore, this elucidates how traditional or cultural forms of medication, prevalent in societies outside European cultural practices, face marginalisation, ostracisation, and disdain. This dynamic reinforces the perception of European/Western-based cultural medication as orthodox or mainstream while labelling African medicine in Africa as an "alternative." Interestingly, the term "alternative" isn't merely descriptive, rather, it's deliberately denigrative, relegating indigenous practices to an inferior position compared to Western cultural practices, which are elevated to a superior status. This dichotomy perpetuates a narrative of superiority and inferiority, where Western practices dominate and indigenous knowledge is undermined, as continuing legacies of cultural imperialism (Bhabha, 2004; Sakue-Collins, 2017)

In Africa, these dynamics is evident in various contexts. For example, traditional African healing practices, such as herbal remedies, have been historically marginalised and stigmatised in favour of Western biomedicine. Despite their availability, accessibility, affordability, effectiveness and cultural significance to many African communities, these practices are often dismissed as "alternatives" by healthcare systems heavily influenced by Western medical models (Kasilo and Trapsida, 2010; Mohammed and Sakue-Collins, 2021). This marginalisation not only undermines indigenous healing traditions but also perpetuates dependency on foreign pharmaceuticals and healthcare systems, leading to a loss of traditional knowledge and cultural identity. This attitude

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further impacts healthcare access and treatment options and also contributes to broader socio-economic disparities and power imbalances within African societies.

To put it in perspective, the individual who practices cultural healing method, regardless of the ingenuities and number of lives saved, especially with regards to ailments alien to the Western practices, is considered inferior in so far as such knowledge is not obtained within the confines of a Platonian academy. This is in total disregard for the fact that the bulk of the population lives in rural areas where access to and availability of Western medical care is nearly absent, so cultural practice caters for the lot (Mohammed and Sakue-Collins, 2021; Osain, 2011). The empirics of Western medical facilities vis-à-vis the proportion of the population with access to them speaks to this fact. In Nigeria, the Ministry of Health currently puts the total number of health facilities at 40, 831; 34,675, 5,780 and 166 corresponding to primary health care, secondary health care and tertiary health care respectively. Though the National Institutes of Health puts the figure of people with access to Western medical facilities at 43.3%, a WHO report estimated 80% of Asian, Latin American and African populations use traditional medicine to meet primary health care needs (Ekeopara and Ugoha, 2017), while 50% of the western world and 4 billion of the world's population rely on herbal medicine for primary health concern (Falodun and Imieje, 2013). Mohammed and Sakue-Collins (2021: 584) put the implication of these figures into perspective noting that:

> Although [Western] medical centres and clinics saturate rural areas, their presence has not been appropriated to integrate local knowledge into dispensing health care services. Rather, the transformations have been largely teleguided to favour the development of orthodox medicine at the impairment of indigenous herbal practices. Yet, a preponderance of health challenges in the country is attended to outside the purview of the formal health sector, by a perverse but suppressed traditional medicine that has only recently been accorded the status of an 'informal sector.

Whereas the orthodox-trained who has risen through training the ranks to be certified as a Western medical practitioner (or medical doctor, as they are preferably called) and having no novel invention or method to his/her pedigree is considered superior, both in knowledge and practice,

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for no other reason other than having attended institutions patterned after platonic ideal and disciplined in Eurocentric dictated scientific method. The concern here is the destabilisation of science as an ideological badge of honour distancing those who wear it from their society as though they are alien, and invitation to deploy science as a method. The contention is to address the elephant in the room which, wittingly or unwittingly, bars scientifically-trained personnel from systematically dissecting cultural knowledge systems to develop a coherent praxis. Rather than complement traditional medicine, the Western medical profession has been more or less caught in the habit of perpetual confrontation with an imaginary rivalry – a concatenation perpetuating the alienation of African solutions to local problems.

The 'gown and town' and the 'tension' of praxis

There is an age-long fuss between the university and its host community, represented in the town-gown relations and some societies have evolved amicable ways whereby both are closely connected and complement each other, while in other climes they have remained relatively distanced and separated from each other (Brockliss, 2021; Derounian, 2022). The "gown" and "town" is used metaphorically to represent two distinct spheres or communities within a university on the one hand, and between a university community and the surrounding town or city it is situated. It is used as a referential mark to highlight the relationship between the university as an academic community and its surrounding community. According to Derounian (2022), the "town and gown is a slur for the division that can arise between a university and its immediate geographical community", wherein J. D. Bernal argues, that those in the university or ivory towers act as if they are not citizens instead of to be citizens first and academics second. It describes a state of latent tension between two supposedly distinct entities who find themselves inextricably yoked in a given geographical space and is characterised by the incomprehensibility of each other's world, especially where the problems of one appear not to be of concern to the other (Brockliss, 2000).

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This dichotomy is appropriated to illustrate how the idea of the academy is redacted in the disciplinary practice of orthodox medicine as the gown vis-à-vis its local environment, the town. And, more importantly, how the gown conducts itself like an alien to its host community – in this case, host society. Thus, it is used to illustrate not just how to borrow Brockliss's (2000) phrase, "the university is in the town, but not of it", but also how redacting the association of intelligence to the university and its products, orthodox medicine imposes itself as superior so that it needs not to learn about the society's traditional method. The metaphor depicts the perceived superiority of Western medicine over African traditional healing practices. In this context, on the one hand, Western medicine represents the gown symbolising academic, institutionalised, and scientifically oriented healthcare systems prevalent in Western societies and represented as orthodox medicine. On the other hand, African traditional healing practices represent the town, representing indigenous, community-based, and culturally embedded healing traditions across the African continent.

Western medicine is often viewed as superior due to its association with modernity,[1] scientific advancements, and institutional authority (Ekeh, 2012; Zibima et al, 2024). It lays claims to embodying the principles of evidence-based practice, rigorous clinical trials, and biomedical interventions, all of which are considered hallmarks of academic excellence and medical progress. This, it can be safely asserted, is what is institutionalised as hospitals, clinics, and academic institutions equipped with state-of-the-art technology, well-trained healthcare professionals, and standardised treatment protocols. In contrast, African traditional healing practices are often relegated to the "town," seen as inferior or primitive in comparison to Western medicine. Traditional healers, relying on herbal remedies, ritual rites, and ancestral knowledge, operate within local communities, often outside formal healthcare systems, and with no formal

[1] Modernity is posited, by the Peruvian sociologist, Anibal Quijano (2010) as coloniality, and represents "one and ongoing process underlying all Eurocentric social engineering" (Zibima et al, 2024).

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institutionalised setting or even formal recognition. The irony of the situation is that, while the town lacks formal recognition from the state and as such receives no funding or support, it is equally castigated for lack of institutional framework, systematised procedure, and crude and primitive methods (Ayodele, 2002; Osain, 2011).

The town as African traditional healing is marked by cultural richness, community solidarity, and holistic approaches to health and well-being, deeply rooted in indigenous knowledge systems and cultural heritage. The perceived superiority of Western medicine over African traditional healing is influenced by several factors. First, colonial legacies have contributed to the marginalisation and stigmatisation of indigenous healing practices in favour of Western biomedical models imposed during colonial rule. The colonial encounter introduced Western medical systems, which were often imposed upon African societies, undermining traditional healing practices and eroding cultural autonomy. Second, the dominance of Western biomedical paradigms in global health governance reinforces the narrative of superiority, perpetuating a hierarchy where Western medicine is prioritised over indigenous healing practices. International health organisations, such as the World Health Organisation (WHO), predominantly promote Western biomedical approaches, sidelining traditional healing practices in their health policies and interventions. Third, the emphasis on scientific rigour and evidence-based medicine in Western healthcare systems reinforces the perception of superiority. Western medicine's reliance on clinical trials, pharmaceutical interventions, and technological innovations is often seen as more credible and effective than the holistic and spiritual approaches of African traditional healing (Bleakley, Brice and Bligh, 2008).

Moreover, socioeconomic factors contribute to the perceived superiority of Western medicine, as access to modern healthcare facilities and pharmaceuticals is often associated with higher income levels and urbanisation. In contrast, traditional healing practices may be more accessible and affordable for marginalised communities with limited access to formal healthcare services. Thus,

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the metaphor of the gown and town elucidates the hierarchical relationship between Western medicine and African traditional healing. The perceived superiority of Western medicine reflects historical, cultural, and institutional biases that marginalise indigenous healing practices, perpetuating a form of medical imperialism. Recognising the value of traditional healing practices and promoting cultural diversity in healthcare is essential for achieving equitable and holistic approaches to health and well-being in African societies.

Conclusion

Every knowledge comes from somewhere and serves some purpose. Every knowledge is first local before global, and what counts for global is not its imposition on others outside the local context; but usefulness within a local context and applicability and acceptability across other local contexts. Attempts to universalise medical 'knowledge' while discountenancing the pluriversality of society bespeaks of an attempt to further the perpetual imposition of Eurocentric episteme and exclusion of the vast corpus of restorative knowledge that would benefit the overall human population. It is crucial to recognise that local knowledge and input are invaluable assets in ensuring the success of global initiatives. Communities directly impacted by any challenges cannot be discountenanced as possessing valuable insights into their unique challenges, needs, and priorities. Ignoring or disregarding these perspectives can lead to ineffective solutions, wasted resources, and even exacerbate existing problems. Also, it is essential to acknowledge that while global initiatives often aim to address universal challenges, they must be implemented with sensitivity to diverse cultural, social, and ethical contexts. Rather than imposing Western values, these initiatives should strive for inclusivity and respect for local perspectives. Collaborative efforts that involve stakeholders from various backgrounds can help ensure that initiatives are culturally competent and ethically sound, fostering greater acceptance and effectiveness across different communities. Moreover, fostering a dialogue that acknowledges and integrates diverse viewpoints can enrich global initiatives, leading to more comprehensive and sustainable solutions. Therefore, while being mindful of potential criticisms of ethical imperialism, it is equally important to prioritize

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inclusivity and cultural sensitivity in the development and implementation of international initiatives.

In the end, every organisation that claims to be worthy of membership must be evaluated against how it touches on the lives of Africans economically, socially, culturally, politically, spiritually, psychologically, mentally, and financially. If it does not advance her well-being in any of these regards, then it has to be abandoned by its founders and originators. This valuation must not be mistaken for the reason of what organisations profess or articulate but because of synthesis of how what they profess in their vision and mission statement, what they articulate in active action and interactions, and what they claim to do resonate with what they do and its effect/impact at its destination correspond and or diverge. So, of critical concern at all times should be: is there a coincidence between what is said, what is done, and what is felt? Is there a concurrence or a perfect or near-perfect match between the (policy) intent, execution and implementation, and the outcome or effect of the policy? This is also applicable to all the sciences in terms of our learning and method, its appropriation and understanding of residual knowledge, and how it is used in the service of society.

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