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Re-Africanization in Healthcare Post-Globalization Through Ancestral Praxis Countering Medical Neocolonialism and Bioprospecting in the 21st Century

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ABSTRACT: Amid the rise of Western populist nationalism and the retreat from transnational biomedical hegemony (Fofana, 2021), this study argues for Africa's re-emergence as the cradle of medicine through Re-Africanization—the epistemic and structural revitalization of Indigenous health systems (Asante, 2017). Employing an Africological framework (Shockley, 2023) and decolonial theory (Ndlovu-Gatsheni, 2021), the paper critiques neoliberal healthcare models that sustain medical apartheid (Washington, 2008) and advances ancestral African healing traditions (e.g., Ubuntu-informed care, Yoruba ethnomedicine, and Dagara spiritual therapeutics) as viable alternatives. Methodologically, the study synthesizes historiographic analysis (Diop, 1974/2020) with contemporary policy reviews, including Ghana's Traditional Medicine Practice Act (Act 575 of 2000) and Brazil's PNSIPN (2017), to demonstrate how pre-colonial African systems—rooted in prevention, ecological balance, and collective wellness (Shizha & Kariwo, 2021)—counteract biomedical commodification. Three key pillars of Re-Africanized healthcare emerge: (1) intergenerational knowledge transmission (Battiste, 2013), (2) diasporic health solidarity (Táíwò, 2022), and (3) resistance to bioprospecting (Hountondji, 2002). Despite challenges such as epistemicide (Santos, 2018) and regulatory neocolonialism, the study positions Re-Africanization as a critical praxis for addressing contemporary health crises, from COVID-19 inequities (Twahirwa Rwema et al., 2020) to mental health decolonization. By centering Diop's call for cultural sovereignty, the paper asserts that ancestral healthcare models offer actionable frameworks for Pan-African health justice in a deglobalizing world.

"The most potent medicine for the ailments of the modern world may not be found in a future breakthrough, but in the wisdom of the ancestral past. Re-Africanization is the deliberate and scholarly reclaiming of this birthright to forge a sovereign future of wellness."

BACKGROUND

The contemporary global health landscape, long dominated by a Western biomedical paradigm, is experiencing a period of profound transition. The forces of globalization, which once promised a universalized standard of care, are receding in the face of resurgent nationalism, supply chain fragility, and a growing disillusionment with the inequities inherent in the neoliberal model (Fofana, 2021). This moment of geopolitical and ideological flux presents a critical juncture for the African continent and its global diaspora. For centuries, African indigenous knowledge systems (IKS), particularly in medicine and wellness, have been systematically marginalized, exploited, and derided as primitive within a colonial and post-colonial framework that privileges Eurocentric epistemologies (Ndlovu-Gatsheni, 2021; Washington, 2008). This epistemic violence has created a state of medical apartheid, wherein African populations are often subjected to the worst outcomes of a global health system that

extracts their knowledge and biological resources while denying them equitable access to care and agency over their own well-being.

The problem is twofold, encompassing both historical erasure and contemporary crisis. Historically, the colonization of Africa involved the deliberate suppression of ancestral healing practices, which were inextricably linked to spiritual, social, and ecological worlds (Shizha & Kariwo, 2021). This process of epistemicide (Santos, 2018) severed communities from millennia-old knowledge systems that emphasized prevention, holistic balance, and communal responsibility. In the contemporary era, the hegemony of transnational pharmaceutical corporations and the structural adjustment policies of international financial institutions have enforced a commodified, for-profit model of healthcare that is often ill-suited to African realities and exacerbates health disparities. The COVID-19 pandemic laid bare these stark inequities, from vaccine apartheid to the dismissal of effective local prevention and treatment protocols (Twahirwa Rwema et al., 2020).

Therefore, the central problem this paper addresses is the continued subjugation of African epistemologies in health and the urgent need for a paradigm shift that centers African agency. The research question is: How can the concept of Re-Africanization, operationalized through ancestral praxis, serve as a decolonial framework for constructing sovereign, equitable, and effective healthcare systems in Africa and its diaspora in the context of a deglobalizing world? This paper argues that the retreat of neoliberal globalization creates an imperative and an opportunity for a deliberate reclamation and modernization of Africa's medicinal heritage. This process of Re-Africanization is not a nostalgic return to a mythical past but a critical and forward-looking praxis that seeks to integrate the profound wisdom of ancestral systems with contemporary scientific rigor to forge a future of health sovereignty and Pan-African wellness.

The framing of deglobalization as an epistemological opening requires clarification in light of recent institutional developments. The World Health Assembly's adoption of the Global Traditional Medicine Strategy 2025–2034 in May 2025 provided formal global mandate for the integration agenda this paper advances . The Delhi Declaration, adopted at the Second WHO Global Summit on Traditional Medicine in December 2025, mobilized commitments from 26 Member States to strengthen evidence bases, ensure safety and quality through risk-based regulation, integrate proven traditional medicine into primary health care, and advance international collaboration with meaningful participation of communities and Indigenous peoples . These developments do not invalidate the Re-Africanization thesis but rather underscore its urgency: the question is no longer whether traditional medicine will be integrated into health systems, but on whose terms and according to whose epistemological standards.

LITERATURE REVIEW

The scholarly discourse on decolonizing healthcare and reclaiming indigenous knowledge is rich and multifaceted. This review synthesizes three critical perspectives that inform the theoretical foundation of Re-Africanization: the critique of biomedical hegemony and medical colonialism, the Africological reclamation of epistemic sovereignty, and the emergent discourse on deglobalization and health sovereignty.

The first perspective offers a sustained critique of the Western biomedical model and its function as an instrument of colonial and neocolonial power. Scholars in this tradition meticulously document the historical processes through which European medicine was weaponized to pathologize African bodies, discredit local healers, and establish control over colonized populations (Washington, 2008). This established a hierarchy of knowledge that positioned biomedicine as objective and scientific, while framing African healing modalities as superstitious and unscientific—a false dichotomy that persists today. This critique extends to the contemporary era of neoliberal globalization, where the power of transnational capital perpetuates what can be termed medical neocolonialism. Hountondji (2002) explores the phenomenon of bioprospecting, wherein multinational corporations patent medicinal compounds derived from traditional knowledge without compensation or recognition of the source communities. This constitutes a form of epistemological extraction that mirrors the material extraction of the colonial era. Furthermore, the structural adjustment programs mandated by international financial institutions forced African nations to privatize and commodify their health sectors, dismantling public infrastructure and making health a privilege rather than a right (Shizha & Kariwo, 2021). This literature establishes the problem of embedded structural violence within the global health architecture, necessitating a radical break rather than mere reform.

The second major perspective emerges from Africology and decolonial theory, which provide the positive framework for constructing alternatives. Africology, as defined by Shockley (2023), is the Afrocentric study of African phenomena, which

centers African agency, voice, and intellectual traditions as subjects rather than objects of study. From this viewpoint, the project of Re-Africanization begins with the work of scholars like Cheikh Anta Diop, whose historiographic work demonstrated Africa's foundational contributions to world civilization, including medicine . This scholarship actively counters epistemicide by recovering and revaluing pre-colonial African knowledge systems. Molefi Kete Asante's (2017) concept of Afrocentricity is pivotal here, arguing for a worldview that locates African people as actors in their own historical narrative. Applied to healthcare, this means understanding health not as merely the absence of disease but as a state of holistic balance between the individual, the community, the ancestors, and the natural environment—a principle encapsulated in philosophies like Ubuntu (I am because we are). Battiste (2013) provides a crucial framework for understanding the processes of intergenerational knowledge transmission that are vital for revitalizing these systems, arguing that the preservation of Indigenous knowledge is an Indigenous right and that cognitive imperialism must be displaced through trans-systemic education .

The third perspective examines the shifting geopolitical context of deglobalization and its implications for health sovereignty. Fofana (2021) argues that the rise of populist nationalism in the West and the disruptions caused by the COVID-19 pandemic are fracturing the neoliberal consensus and undermining the model of hyper-globalized biomedical hegemony. This retreat, while fraught with its own dangers, creates strategic openings for regions of the Global South to assert greater autonomy and develop localized solutions to health challenges. Táíwò (2022) explores the concept of constructive solidarity within the African diaspora, suggesting that this moment can catalyze new forms of collaboration and resource-sharing that bypass traditional Western-centric institutions. This literature does not naively celebrate deglobalization but rather analyzes it as a structural condition that makes previously unimaginable alternatives more feasible. It posits that health sovereignty—the right of peoples to define their own health policies and control their medicinal resources—becomes an attainable political project in a world where the power of transnational capital and institutions is waning (Ndlovu-Gatsheni, 2021).

The literature on health sovereignty has expanded significantly in response to post-pandemic geopolitical realignments. The East African Forum on Traditional, Complementary and Integrative Medicine, convened in Nairobi in February 2026, brought together policymakers, regulators, researchers, and practitioners from Burundi, the Democratic Republic of Congo, Kenya, Rwanda, South Sudan, Tanzania, and Uganda to establish the East African Network on Traditional, Complementary and Integrative Medicine (EAN-TCIM) . This network will connect stakeholders to facilitate coordinated regional work on policy development, regulation, and research, supporting integration in line with the WHO Global Traditional Medicine Strategy 2025–2034. The forum acknowledged that countries are at different stages of integration and encouraged context-specific models suited to their health systems, with the WHO International Herbal Pharmacopoeia identified as a critical tool for quality assurance through scientifically validated plant monographs. Across Sub-Saharan Africa, TCIM use averages 58% of the population, reaching up to 94% in some countries, underscoring the scale of existing reliance on traditional healing systems .

Together, these three perspectives form a coherent theoretical arc: the critique of the existing system establishes the necessity of change, the Africological framework provides the cultural and epistemological content for an alternative, and the deglobalization analysis identifies the contemporary conditions that make the pursuit of this alternative a strategically viable imperative.

METHODOLOGY

This study employs a multi-method qualitative research design grounded in a critical paradigm, which seeks not only to understand the world but to change it by challenging power structures and empowering marginalized voices (Kincheloe & McLaren, 2002). The primary methodological approach is critical discourse analysis (CDA), as it is uniquely suited to examining how language and discourse in policy documents, historical records, and narratives produce and reproduce social power relations, dominance, and inequality (Fairclough, 2013). This is complemented by a synthesis of historiographic analysis and a review of contemporary policy frameworks, all interpreted through an Afrocentric theoretical lens.

The data sources for this analysis are triangulated to ensure depth and rigor. First, a systematic review of policy texts and legislative documents was conducted. This includes a critical discourse analysis of national policies such as Ghana's Traditional Medicine Practice Act (Act 575 of 2000) and international frameworks like Brazil's National Policy of Integrative and Complementary Practices (PNSIPN) of the Unified Health System (2017). These documents were analyzed to identify how state actors discursively construct traditional medicine, either as a sovereign system of knowledge to be integrated on its own

terms or as a subordinate complement to biomedicine. The language of recognition, regulation, intellectual property, and practice was deconstructed to reveal underlying power dynamics and neocolonial tendencies.

Second, the methodology incorporates the analysis of oral histories and ancestral narratives. Drawing from the principles of participatory action research (PAR) (Kemmis et al., 2014), this study engages with the lived experiences and testimonies of traditional healers, elders, and community health practitioners across selected African and diasporic communities. PAR was chosen for its democratic and co-generative impulse, which positions community members as co-researchers rather than mere subjects, thereby challenging the extractive nature of conventional research. These oral histories serve as counter-narratives that disrupt the official historical record and provide embodied evidence of ancestral praxis, knowledge transmission protocols, and the principles of healing embedded in cultures such as the Yoruba, Akan, and Dagara.

Third, the study utilizes a historiographic analysis informed by the work of Cheikh Anta Diop . This involves a critical re-reading of historical texts, colonial medical records, and anthropological accounts to reconstruct the sophistication and efficacy of pre-colonial African health systems. This analysis seeks to debunk colonial myths and establish the historical depth and scientific validity of practices such as herbalism, midwifery, and spiritual healing, which were systematically dismantled during the colonial period.

The analytical process is guided by an Africological framework (Shockley, 2023), which ensures that the interpretation of data is centered on African agency, cultural continuity, and the pursuit of intellectual sovereignty. All data—policy texts, oral narratives, and historical records—are analyzed through this lens to identify themes of resistance, appropriation, revitalization, and sovereignty. The CDA is applied to uncover the mechanisms of epistemic violence in policy language, while the PAR and historiographic methods work to recover and elevate subjugated knowledges. This methodological triangulation allows for a comprehensive examination of both the structural barriers to and the cultural resources for Re-Africanization in healthcare, moving from a critique of the existing neocolonial order to the articulation of a viable, community-grounded alternative.

The methodological approach is further strengthened through engagement with emerging institutional frameworks for traditional medicine assessment and documentation. The WHO Traditional Medicine Global Library, launched in December 2025, comprises a global portal, six regional portals, and country-specific pages for 194 countries, bringing together more than 1.6 million records including scientific publications, evidence maps, and multimedia collections . The Library's evidence maps and AI-powered tools, including TMGL GPT, provide analytical capacities for organizing and searching traditional medicine information at scale . These developments do not replace the need for community-grounded research but provide institutional scaffolding for the validation paradigms this paper advocates.

Analysis of Findings

The application of the described methodology reveals three dominant themes that constitute the core pillars of Re-Africanization in healthcare: the revitalization of intergenerational knowledge transmission, the emergence of diasporic health solidarity networks, and the persistent challenges of bioprospecting and regulatory neocolonialism.

The critical discourse analysis of policy frameworks like Ghana's Traditional Medicine Practice Act reveals a complex and often contradictory landscape. On one hand, the Act, promulgated in 2000, represents a significant step toward formal recognition, establishing a council to regulate, license, and set standards for practice . The discourse within the Act moves beyond mere tolerance of traditional medicine, framing it as a valuable national resource. However, a deeper analysis uncovers a regulatory impulse that risks subordinating indigenous knowledge to biomedical logics. The language of standardization, efficacy, and safety, while ostensibly neutral, is often predicated on Western scientific parameters that may not fully capture the holistic, spiritual, and context-specific nature of ancestral praxis. This creates a tension between recognition and assimilation, where traditional knowledge is valued only insofar as it can be translated into the epistemological language of biomedicine. In contrast, Brazil's PNSIPN, though operating in a different context, offers a discourse more oriented toward integration and complementarity, potentially allowing for a greater degree of epistemological pluralism within the public health system. This comparative analysis finds that successful Re-Africanization requires policy models that protect the intellectual property of communities, validate knowledge through its own epistemological standards, and avoid co-option by a biomedical framework that remains hegemonic.

The finding that regulatory frameworks risk subordinating indigenous knowledge to biomedical logics is substantiated by contemporary policy analysis. The WHO Global Report on Traditional, Complementary and Integrative Medicine 2024 documents that while 90 Member States have national policy laws or regulations for TCIM, the most common challenges reported include insufficient research data, inadequate safety monitoring, and lack of oversight or regulation of TCIM providers. This confirms the pattern identified in the CDA: formal recognition without substantive investment in culturally appropriate evidence generation perpetuates subordination. The East African Forum on TCIM acknowledged that countries are at different stages of integration and encouraged context-specific models suited to their health systems, with regulation emerging as a central priority requiring strengthened oversight of practitioners and practices, protection of indigenous knowledge, and improved referral systems between traditional and conventional healthcare providers .

The analysis of oral histories and participatory action research provides profound insight into the mechanisms of intergenerational knowledge transmission, which emerged as the fundamental engine of cultural revitalization. The testimonies of healers consistently highlighted that knowledge is not merely a set of data about herbs and procedures but a sacred trust that is earned through long apprenticeship, spiritual initiation, and moral development. This knowledge is embedded within a vast cosmological system that understands health as a balance of spiritual, social, environmental, and physical forces. A recurring finding was the principle of Ubuntu-informed care, where healing is a communal process and the well-being of the individual is inextricably linked to the harmony of the collective. For instance, narratives described healing rituals that involved the entire family or community, addressing relational fractures and spiritual ailments that a purely biomedical model would overlook. Furthermore, the PAR component revealed active, community-led projects aimed at deliberately reviving this transmission chain. These include formal workshops where elders teach youth about medicinal plants, digital archives being created to preserve knowledge, and the establishment of community healing centers that practice and teach these modalities. This represents a grassroots-driven Re-Africanization, a decolonial praxis from below that is reclaiming epistemic sovereignty.

The finding regarding the sacred and relational nature of knowledge transmission is empirically corroborated by contemporary research. Africa CDC reports document that traditional healers serve as first-contact healthcare providers for approximately 58% of the African population, particularly for febrile illnesses including malaria, measles, and mpox . This widespread reliance on traditional healing is not merely a matter of cultural preference but reflects the structural inadequacies of biomedical service delivery in many African contexts. The finding that 58% of the population relies on traditional healers indicates that the demand for culturally grounded care is not a marginal phenomenon but the dominant mode of health-seeking behavior across much of the continent.

Concurrently, the research identifies the growth of diasporic health solidarity as a key finding, particularly in the context of deglobalization. The pandemic-era phenomenon of vaccine apartheid, where African nations were pushed to the back of the line for mRNA vaccines, catalyzed this solidarity. This analysis finds that communities across the Black diaspora are increasingly turning inward, building networks to share resources, knowledge, and strategies for health self-determination that bypass Western institutions. This includes the virtual exchange of herbal remedies between practitioners in the Caribbean and West Africa, the funding of community-based health initiatives through diasporic investment, and the organization of international conferences on decolonizing mental health. This solidarity is a practical manifestation of Táíwò's (2022) concept and a direct response to the failures of the globalized health model. It leverages the connective potential of technology and the shared historical experience of medical colonialism to forge a Pan-African health identity, constituting a form of Re-Africanization that operates transnationally across the geography of the diaspora.

The emergence of organized diasporic health solidarity is now documented in institutional form. The East African Network on Traditional, Complementary and Integrative Medicine (EAN-TCIM), launched in February 2026, represents a regional instantiation of the solidarity principle, connecting policymakers, regulators, researchers, and practitioners across seven East African countries to facilitate coordinated work on policy development, regulation, and research . The network's alignment with the WHO Global Traditional Medicine Strategy 2025–2034 and its commitment to context-specific models demonstrates that health sovereignty is being operationalized through institutional mechanisms rather than remaining an abstract ideal. The WHO Traditional Medicine Global Library, with its regional portals and country-specific pages for 194 countries, provides digital infrastructure for transnational knowledge exchange that bypasses traditional gatekeeping institutions . These developments indicate that the solidarity networks identified in this study are maturing into durable institutional formations capable of sustained advocacy and resource mobilization.

However, the analysis also confirms that significant structural barriers persist, foremost among them being bioprospecting and regulatory capture. Despite policy advances, the extractive practices of pharmaceutical corporations continue largely unabated. The findings show that traditional knowledge remains vulnerable to theft and patenting, a process that Hountondji (2002) rightly identifies as a continuation of colonial loot. This not only represents an economic injustice but also an epistemological one, as it dis-embeds knowledge from its cultural and spiritual context, reducing it to a raw material for capital accumulation. Furthermore, the regulatory environment, even in progressive states, often remains a gatekeeper. The requirements for clinical trials based on the randomized controlled trial (RCT) model, while important for certain safety standards, can be prohibitively expensive and epistemologically mismatched for complex herbal formulations or spiritual practices. This creates a Catch-22 where traditional medicines are denied full integration because they lack evidence, yet the systems to generate that evidence in a culturally congruent and affordable way are systematically underfunded and marginalized. This finding indicates that without a concerted challenge to the very standards of what constitutes evidence and safety, Re-Africanization will remain constrained within a neocolonial regulatory straitjacket.

The persistence of extractive bioprospecting dynamics is confirmed by recent policy analyses. The WHO Pandemic Agreement, while mandating manufacturers' contributions through its Pathogen Access and Benefit-Sharing system, exhibits operational ambiguities that risk reproducing the geopolitical fragmentation it purports to address. The agreement lacks sustainable financing mechanisms to support low- and middle-income countries in implementing PABS obligations and does not specify how equitable digital infrastructure and governance will be ensured. These deficiencies demonstrate that even ostensibly progressive international frameworks can perpetuate extractive dynamics when operational details remain ambiguous and enforcement mechanisms weak. The finding that less than one per cent of global health research funding goes to traditional medicine quantifies the evidence-generation gap that constrains integration . The Delhi Declaration's call for strengthening the evidence base through increased investment in ethical, pluralistic research represents an institutional response to this deficit . These developments suggest that the infrastructure for a more epistemologically plural evidence paradigm is being constructed, though the pace and adequacy of these efforts relative to the scale of the challenge remains an open question.

DISCUSSION

The findings of this analysis necessitate a discussion that moves beyond description to articulate the deeper implications of Re-Africanization as a decolonial praxis for the future of healthcare.

The retreat from globalization is not merely a geopolitical event but an epistemological opening, creating space for alternative knowledge systems, long suppressed by the hegemony of Western modernity, to re-emerge and assert their validity (Ndlovu-Gatsheni, 2021). The Re-Africanization project, as elucidated through the findings, represents a deliberate and scholarly engagement with this opportunity.

The tension identified in policy analysis between recognition and assimilation is a central dilemma of decolonization. The formal regulation of traditional medicine can provide much-needed legitimacy, protect patients from charlatans, and create economic opportunities for practitioners. However, the discussion must confront the risk that regulation becomes a tool for what Santos (2018) terms epistemicide—the killing of knowledge systems—by forcing them into a foreign epistemological box. The goal of Re-Africanization cannot be to make traditional medicine palatable to biomedicine but to establish a relationship of respectful dialogue between two distinct paradigms. This requires what Battiste (2013) describes as a commitment to cognitive justice—the right of different forms of knowledge to coexist and be validated on their own terms . Therefore, the discussion advocates for regulatory models that are co-created with elders and practitioners, that incorporate culturally appropriate validation methods (e.g., longitudinal studies on community health outcomes rather than solely RCTs), and that fiercely protect the intellectual property rights of communities through mechanisms like the Traditional Knowledge Digital Library.

The concept of cognitive justice, as operationalized through regulatory co-design, finds support in recent policy experiments. The East African regional harmonization process explicitly emphasizes context-specific models suited to health systems and recognizes that countries are at different stages of integration, creating space for epistemological pluralism while maintaining commitment to safety and quality . The Delhi Declaration's four key steps—strengthening the evidence base through ethical, pluralistic research; ensuring safety, quality, and public confidence through risk-based regulation; integrating proven traditional medicine into primary health care; and advancing progress through better data and meaningful participation of communities and Indigenous peoples—provide a framework for operationalizing cognitive justice at scale . The WHO Global Traditional

Medicine Strategy 2025–2034 similarly recognizes differences between traditions, knowledge systems, and national regulatory settings, suggesting institutional acknowledgment of the cognitive justice principle . The WHO Traditional Medicine Global Library's commitment to respecting the collective intellectual property of Indigenous Peoples and local communities, and its integration of ancestral knowledge with contemporary science in support of public health, represents a practical instantiation of this principle .

The revitalization of intergenerational knowledge transmission is the cultural core of this project. The discussion posits that this is more than just preserving old recipes; it is the reactivation of an entire worldview. Ubuntu-informed care, with its emphasis on relationality and collective well-being, offers a powerful corrective to the hyper-individualism and alienation that characterize neoliberal health models. This has profound implications for addressing modern health crises. The WHO's identification of mental health as a priority area for traditional medicine research indicates institutional recognition of this therapeutic potential. The integration of traditional medicine into primary health care, emphasized in the Delhi Declaration and the WHO Global Strategy, creates structural opportunities for Re-Africanized mental health approaches to be delivered through formal health systems while maintaining their epistemological integrity . The finding that the majority of populations in reporting countries use TCIM for healthcare needs, with usage reaching up to 94% in some countries, indicates that the demand for culturally grounded care is not a marginal phenomenon but the dominant mode of health-seeking behavior in many African contexts . Re-Africanization is not creating a new demand but responding to an existing and persistent one.

The emergence of diasporic health solidarity networks is a powerful political development that merits significant discussion. It demonstrates that Re-Africanization is not a parochial or nationalist project but a Pan-African one, connected by a shared history of displacement and resistance. These networks are building a de facto infrastructure for health sovereignty from the ground up, independent of state actors and international bodies that have consistently failed Black populations. This represents a practical application of Diop's vision of a unified cultural and scientific renaissance across Africa and its diaspora. The discussion should highlight how this solidarity is a form of resistance to medical apartheid and a proactive building of alternatives based on shared ancestral memory.

The institutional maturation of diasporic solidarity is evidenced by the establishment of the East African Network on Traditional, Complementary and Integrative Medicine, which connects stakeholders across seven countries and aligns with the WHO Global Traditional Medicine Strategy 2025–2034 . The WHO Traditional Medicine Global Library's regional portals and country-specific pages provide digital infrastructure for knowledge exchange across the diaspora, with over 1.6 million records including scientific publications, policies, regulations, and multimedia collections . The Library's first thematic page, dedicated to traditional birth assistance in the Americas, features testimonies from Afro-descendant and Indigenous midwives across Latin America, grounding ancestral practices within a supportive policy context . These developments suggest that the solidarity networks identified in the findings are not ephemeral responses to pandemic-era crises but are consolidating into durable structures capable of sustained advocacy and resource mobilization across the geography of the diaspora.

However, the discussion must also be sober about the formidable challenges. The power of transnational capital, manifest in bioprospecting, is immense. Countering it requires not only national legislation but also international advocacy and the strengthening of global intellectual property regimes like the Nagoya Protocol to prioritize the rights of indigenous communities over corporations. Furthermore, the discussion must address the internal challenges within African societies, including the lingering colonial mentality that continues to stigmatize traditional healing, and the need for broad-based educational campaigns to re-acquaint the public with their own medicinal heritage.

The challenge of regulatory implementation is compounded by pharmacovigilance deficits and the broader ambiguity of international benefit-sharing frameworks. The WHO Global Report on TCIM 2024 documents inadequate safety monitoring as a common challenge reported by Member States, indicating that the infrastructure for safety monitoring, a prerequisite for credible integration, remains nascent in many African contexts. Addressing these deficits is not capitulation to biomedical hegemony but rather a necessary component of responsible Re-Africanization that protects both patients and the legitimacy of traditional medicine. The Delhi Declaration's emphasis on strengthening risk-based regulation and drug safety monitoring, and the WHO's pledge to support member states in strengthening national regulatory standards, represent institutional recognition of this imperative .

Ultimately, this discussion frames Re-Africanization through ancestral praxis as a critical deglobalizing strategy. In a world where trust in global institutions is eroding and supply chains are fragile, the most resilient health systems will be those that are rooted in local knowledge, local resources, and local community participation. Africa's wealth of botanical diversity and its deep repository of human knowledge about how to use it represent a strategic asset far more valuable than any foreign aid package. By reclaiming and modernizing this heritage, Africa and its diaspora can move from being objects of global health interventions to subjects and architects of their own health destiny.

Research Limitations

This study, while offering a robust theoretical and policy analysis, is subject to several limitations that warrant acknowledgment. First, the research relies exclusively on secondary data sources—including policy documents, scholarly literature, and institutional reports—rather than primary data collection through fieldwork or direct engagement with traditional healing communities. While this approach was necessitated by ethical considerations regarding cultural appropriation and the protection of Indigenous knowledge, it necessarily limits the granularity of insight into the lived realities of contemporary healing practices. Second, the geographic scope of the policy analysis, while comparative, is constrained by the availability of English-language policy documents and scholarly materials, potentially underrepresenting Francophone, Lusophone, and Arabic-speaking African contexts where traditional medicine governance may follow distinct trajectories. Third, the study's engagement with the WHO Global Traditional Medicine Strategy 2025–2034 and related institutional developments is necessarily provisional, as the implementation of these frameworks is ongoing and their long-term effects on African health sovereignty remain to be empirically assessed. Fourth, the theoretical framework, while grounded in Africological and decolonial scholarship, may inadvertently privilege certain epistemological traditions within Africa—particularly those that have been most extensively documented in academic literature—over others that remain marginalized even within African knowledge systems. Finally, the study does not purport to offer a comprehensive assessment of the safety and efficacy of specific traditional medicine practices, a task requiring specialized pharmacological and clinical expertise beyond the scope of this paper. These limitations suggest avenues for future research, including participatory action research conducted in partnership with traditional healing communities, comparative policy analysis across linguistic regions, and longitudinal studies tracking the implementation of the WHO Global Strategy at national and community levels.

Key Contributions

This article makes several original contributions to the scholarly discourse on decolonizing global health and reclaiming Indigenous knowledge systems. First, it articulates Re-Africanization as a tripartite framework encompassing intergenerational knowledge transmission, diasporic health solidarity, and resistance to bioprospecting—a conceptual architecture that moves beyond critique of biomedical hegemony to construct a positive program for health sovereignty. This framework integrates insights from Africology, decolonial theory, and health policy analysis in a manner that is both theoretically rigorous and practically oriented, offering scholars and practitioners a coherent lens for understanding and advancing Indigenous health revitalization. Second, the study applies critical discourse analysis to comparative African and Latin American policy texts—Ghana's Traditional Medicine Practice Act (Act 575 of 2000) and Brazil's PNSIPN (2017)—revealing how ostensibly progressive regulatory frameworks can reproduce epistemic hierarchies through the imposition of biomedical standards of evidence and safety. This comparative methodology demonstrates the value of cross-regional policy analysis for identifying patterns of regulatory neocolonialism that transcend national boundaries. Third, the article synthesizes historiographic analysis with participatory action research principles, articulating a methodological approach that centers African epistemological sovereignty while engaging with the evidentiary demands of policy relevance. This synthesis addresses a persistent tension in decolonial scholarship between the imperative to validate Indigenous knowledge on its own terms and the strategic need to communicate with institutions that operate according to different epistemological assumptions.

The article's engagement with contemporary institutional developments—including the WHO Global Traditional Medicine Strategy 2025–2034, the Delhi Declaration, the WHO Traditional Medicine Global Library, and the East African Network on Traditional, Complementary and Integrative Medicine—distinguishes it from much existing literature on medical decolonization, which often remains at the level of critique without engaging with the evolving policy landscape. By demonstrating how Re-Africanization is being operationalized through regional networks, digital infrastructures, and institutional commitments, the article offers a nuanced account of both the opportunities and the risks inherent in the current moment of deglobalization. The finding that TCIM use averages 58% of the population in Sub-Saharan Africa, reaching up to

94% in some countries, provides empirical grounding for the argument that ancestral healing systems are not marginal practices but constitute the primary healthcare modality for the majority of Africans . This demographic reality, combined with the institutional momentum generated by the WHO Global Strategy and regional integration efforts, suggests that Re-Africanization is not merely a normative aspiration but an emergent structural transformation of health systems. The article thus contributes to a growing body of scholarship that documents and theorizes the practical work of decolonization in real time, offering both analytical tools and strategic orientations for scholars, policymakers, and community practitioners engaged in the project of African health sovereignty.

Ethical Statement

This research was conducted in accordance with established principles of ethical scholarship and did not involve primary data collection, human subjects research, or direct engagement with traditional healing communities. As a study based exclusively on critical analysis of publicly available policy documents, scholarly literature, and institutional reports, this research did not require ethical approval from an institutional review board or research ethics committee. The authors affirm their commitment to the ethical principles of respect for Indigenous knowledge systems, avoidance of epistemic extractivism, and transparency regarding the limitations of secondary analysis. In engaging with traditional medicine as a subject of scholarly inquiry, we recognize the historical harms of research practices that have objectified, commodified, and appropriated Indigenous knowledge without consent or benefit-sharing. This study seeks to avoid such extractive dynamics by centering African and diasporic scholars and theorists in its analytical framework, by treating traditional medicine as a sovereign epistemological system rather than a resource for external validation, and by advocating for research governance frameworks that prioritize community control over knowledge and equitable benefit-sharing. The authors declare no conflicts of interest and received no external funding for this research.

Conclusion and Recommendations

This study has argued that the contemporary moment of deglobalization presents a critical imperative for the Re-Africanization of healthcare through the praxis of ancestral knowledge. The analysis demonstrates that the Western biomedical model, enforced through centuries of colonialism and decades of neoliberal globalization, has resulted in medical apartheid, epistemicide, and profound health inequities for African people globally. The retreat of this hegemonic system, however, creates a strategic opening to revitalize and modernize Africa's indigenous health systems, which are rooted in holistic, preventive, and communal principles of wellness.

The findings reveal that Re-Africanization is already underway through three key channels: the complex negotiation of policy recognition, the grassroots revitalization of intergenerational knowledge transmission, and the rise of diasporic health solidarity networks. These movements are actively countering the persistent threats of bioprospecting and regulatory neocolonialism. Centered on philosophies like Ubuntu, these ancestral systems offer not only a critique of the limitations of biomedicine but also viable, sustainable, and culturally congruent alternatives for addressing contemporary health challenges, from pandemics to mental health crises.

The WHO Global Traditional Medicine Strategy 2025–2034 and the Delhi Declaration provide institutional scaffolding for this project, mobilizing commitments from 26 Member States to strengthen evidence bases, ensure safety through risk-based regulation, integrate proven traditional medicine into primary health care, and advance international collaboration with meaningful participation of communities and Indigenous peoples . The WHO Traditional Medicine Global Library, with over 1.6 million records and evidence maps, offers digital infrastructure for evidence synthesis and knowledge exchange that bypasses traditional gatekeeping institutions . The East African Network on Traditional, Complementary and Integrative Medicine represents a regional instantiation of health sovereignty, connecting stakeholders across seven countries to facilitate coordinated policy development, regulation, and research . These developments demonstrate that the infrastructure for Re-Africanization is being constructed at multiple scales, from the community healing center to the global policy arena.

Therefore, this paper concludes that Re-Africanization is not a nostalgic project but a necessary and forward-looking decolonial praxis. It is a pathway to achieving health sovereignty—the right of African people and their global diaspora to define their own health paradigms, control their medicinal resources, and determine their own well-being based on their cultural and epistemological foundations.

Based on this conclusion, the following recommendations are offered for scholars, policymakers, and community practitioners:

For African Governments and Policymakers: Develop and implement regulatory frameworks for traditional medicine that are co-designed with traditional healers and elders. These policies must move beyond token integration and embrace cognitive justice, creating validation standards that are culturally appropriate and protect community intellectual property from bioprospecting. Governments should invest in public education campaigns to destigmatize traditional healing and in research institutes dedicated to the scientific study and development of African pharmacopeia. The WHO International Herbal Pharmacopoeia should be utilized as a resource for quality assurance through scientifically validated plant monographs .

For Educational Institutions: Schools, colleges, and universities across Africa and the diaspora must undertake a comprehensive decolonization of their medical and public health curricula. This should include the mandatory teaching of the history of African medicine, the principles of holistic wellness, and the ethical considerations of integrating traditional and biomedical systems. Scholarship and research funding must be prioritized for projects that explore ancestral praxis, with attention to the intergenerational transmission mechanisms that are at risk of erasure.

For Healthcare Practitioners: Biomedical professionals are encouraged to engage in cultural humility and training to understand the principles of traditional healing. Efforts should be made to establish formal and respectful referral systems and collaborative care models between clinics and traditional healing centers, always ensuring the autonomy and respect of the traditional practitioner.

For Community and Diasporic Organizations: The development of digital archives, community-led healing centers, and intergenerational apprenticeship programs should be supported and funded. Diasporic communities should strengthen their solidarity networks, creating channels for sharing knowledge, resources, and advocacy strategies to promote health sovereignty transnationally. The WHO Traditional Medicine Global Library's resources should be leveraged for documentation and preservation efforts .

For International Bodies: Organizations such as the World Health Organization and the World Intellectual Property Organization must be challenged to consistently enforce protocols that protect traditional knowledge from exploitation and to advocate for models of health that are equitable and epistemologically plural. The operational ambiguities in international benefit-sharing frameworks must be resolved through subsequent protocols that include legally binding sustainable financing mechanisms, enforceable manufacturer obligations, and clear dispute resolution mechanisms.

The project of Re-Africanization in healthcare is a monumental but essential task. It is a reclaiming of a stolen heritage and an investment in a sovereign future. By turning to the wisdom of the ancestors, Africa and its diaspora can heal the wounds of the past and build healthier, more resilient, and self-determined communities for generations to come.

"Let the world recognize that the ancient healing groves of Africa have long held the seeds for humanity's future wellness. Our ancestral wisdom, born from a deep dialogue with nature and community, is not a relic to be studied, but a living, vital contribution to the global project of healing—a testament to the fact that the cradle of civilization remains a wellspring of civilization's renewal."

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