



Indigenous Health Care Practices And Role Of Child To Parent Communication Strategy

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Abstract

This research paper presents a critical point of view on indigenous knowledge and child to parent communication technique as an unexploited source for sustainable development. By acquiring health related knowledge, children can be empowered to pursue a healthy life and to work as an agent of change for the health of their communities. Therefore, the study aimed to identify the indigenous health care practices being followed and their rationality as perceived by respondents and to study the effect of child- to -parent communication technique on awareness related to health of parents.

The present research was conducted in two Junior Basic Schools in Naugarh block of Chandauli district, U.P. All the student of 5th standard i.e 22 students and their 44 parents were selected as purposive sample and divided equally in experimental and control group. Before and after with control experimental design was followed to see the difference.

Some indigenous practices were found scientifically relevant. Such practices need to be educationally promoted and shared in the larger communities. Both children and parents learn better when they share the language, culture and social situation with their teacher. Thus, in teaching-learning process communication through children to parents is an applicable strategy.

Key Words : Indigenous knowledge and health care practices, Traditional Knowledge(TK), Traditional medicine (TM), Child to parent communication strategy.

Introduction

The Knowledge, innovations and practices of indigenous people is the foundation of much of the world's modern science and continues to provide a significant and valuable source of inputs. It is increasingly recognized that unlocking the potential of traditional Knowledge can help modern society address significant challenges ranging from climate change and sustainable agriculture to new pathways for sustainable development for ensuring the livelihoods of indigenous and local communities. (Henrietta.AM,2019) Yet, traditional Knowledge is rapidly disappearing. UNESCO estimates that at least 43% of 6000 languages spoken in the world are endangered most if not all of these are

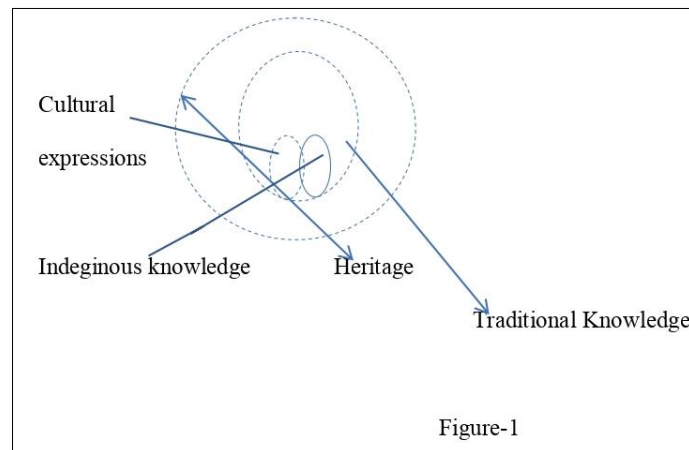
indigenous languages and represents a great loss of TK.(Ethnologue 2019) The theme of the 2019 session of the United nations programme forum on indigenous issues was the generation, transmission and protection of traditional Knowledge. Traditional Knowledge refers to the Knowledge, innovations and practices of indigenous peoples. Developed from experience gained over the centuries and adapted to the local culture and environment, traditional is often transmitted orally from generation to generation. It tends to be collectively owned and can be expressed in stories, songs, folklore, proverbs, cultural values, beliefs, rituals etc. It is also the source for the traditional use and management of lands, territories and resources with indigenous agricultural practices that care for the earth without depleting the resources. Indigenous peoples follow oral traditions with dances, paintings, carvings and other artistically expression that are practiced and passed down through millennia.(United Nations2019). Traditional medicine (TM) is an important and often underestimated part of health services. TM has a long history of use in health maintenance and in disease prevention and treatment, particularly for chronic disease. 80% of the population in Africa and 65% in India depend on TM to help meet their health care needs.

Child to-Parent (C-to P) programme was conceived by the Institute of Child Health, London —to mark the International Year of the child, 1979. The concept has grown from the recognition of. the central role of older children in caring for younger siblings. Thus, began the formulation of an approach to health education which could be used with the help of children. The purpose is to teach children in primary school (6-12 yrs. Age group), basic health and development concepts with the aim of improving their knowledge and in turn those of their parents and community. However, over the last decade, the. concept of child-to-parent communication r has evolved and broadened from sibling care to "child power". Education for health is a fundamental right of child. Health is inextricably linked to educational achievement, quality of life and economic productivity. By acquiring healthrelated knowledge, values, skills and practices, children can be empowered to pursue a healthily life and to work as an agent of change for the health of their communities. The goal can be achieved if we have the will. (WHO 1992a: 1). Therefore, the present research work was designed with the following objectives-

1. To know the socio personal charecteristics of the respondents.
2. To identify the indigenous health care practices being followed and their rationality as percieved by respondents.
3. To study the effect of child- to -parent communication technique on awareness related to health of parents

Review of Literature

Difference between Traditional Knowledge, Indigenous Knowledge and Traditional Cultural Expression



WIPO's (World Intellectual Property Organization, 2020) focus is on "traditional knowledge". TK is created, originated, developed and practised by "traditional knowledge holders". "Traditional Cultural Expression" (TCE) are a subset of "TK". Over centuries, people have learnt how to grow food and to survive in difficult environment. They know what varieties of crops to plant, when to sow and weed, which plants are poisonous, which can be used for control of diseases in plants, livestock and human beings. Indigenous knowledge is passed from generation to generation usually by word of mouth and cultural rituals, and has been the basis for agriculture, food preparation and conservation, health care, education, and a wide range of other activities that sustain a society and its environment in many parts of the world for many centuries. (Atoma CN, 2011)

The WHO TM strategy 2014 - 2023 was developed in response to the WORLD HEALTH Assembly resolution on traditional medicine. (WHA62.13) The strategy aims to support members states in developing proactive policies and implementing action plans that will strengthen the role TM plays in keeping population healthy. (WHO, 2013) .

Recognizing the importance of traditional Knowledge, the right of indigenous people to promote, maintain and safeguard their traditional Knowledge is enshrined in several international normative and policy instruments. The U.N Declaration of the rights of Indigenous people (UNDRIP) emphasizes the protection of indigenous peoples rights to their traditional Knowledge -Article-31 (UN2019) There has mass implications of indigenous Knowledge in sustainable development. Indigenous Knowledge plays role in conserving the nature, food production, forestry development, medicine, sustainable practices, land and resource management and ecotourism, climate change and disaster risk reduction. (Sultana R., Muhammad N. 2018).

Preserving and safeguarding TK has assumed great significance in the recent past and a variety of initiatives are being made across the globe towards achieving it. In view of the wider misuse of TK, preservation and protection should work hand-in-hand. Documenting non-codified knowledge is not very successful in a larger perspective because of the variety of issues involved. However, urgent measures are required to

preserve oral knowledge as it faces a greater risk of loss and misappropriation. Also, documentation of medicinal knowledge has gained prominence in many countries in their fight against bio-piracy. However, TK involves various sectors such as agriculture, environment, architecture, culture, heritage, etc. that are interlinked and applied to daily living. All this knowledge needs to be preserved in order to achieve inclusive development(Dubey, K.2018).

The IKS division was established by the government at the All India Council for Technical Education in 2020 to promote interdisciplinary research on aspects of indigenous Knowledge. (IKS,2020).

Child to Parent Communication strategy

Children can be taught to participate in a community collaboration to promote health care in their community(Commendador, K., Flood, J.2016) 'Child-to-parent' denotes an approach and methodology rather than a program with a specific structure and predefined components. It introduces the possibility of health education for both school-going and out-of-school children. Its principal objective is to develop children's knowledge, attitude and behavior necessary to manage their own health, as well as the skills to help their parents and others. The distinguishing feature of the child to parent (C-to-P) approach is its insistence, that learning should be activity-based, so that the child could be a participant in the learning process. 'Little teacher' appear to have a significant effect on the ability of preschoolers to recall health messages, and that performing the role of a little teacher resulted in a significant increase in their own ability to recall health messages.(Pridmore, 1996) Child-to-child has been successful in displacing passive pedagogy, at least during child-to-child lessons, and here is versatility of the approach in, diverse social, cultural and economic situations. (Somerset, 1987) Educating children at school on health should be the highest priority, not for health per se but also from the perspective of education since if they are to learn they need to be in good health, (WHO, 1992a) Investment in schooling and health poverty and efforts to promote the rights and status of women are now considered to be the key for transforming vicious cycles of poverty, malnutrition, disease: from ignorance into 'virtuous cycles' of health, equity and sustainable development (World Bank, 1993) In research work an attempt was made to compare the effect of the child-to-parent communication technique and conventional communication, on practices related to health.

Research Methodology

The present research was conducted in two Junior Basic Schools (J.B.S.), namely J.B.S., Aurwatand and J.B.S., Semar in Naugarh block of Chandauli district. The schools are situated in Kaimur range of plateau. These schools were grouped into two, one comprised of those students who were exposed to C-to-P communication technique and the other one was not exposed to C-to-P communication technique. The health education package was given equally to the students of both groups. All the students of 5th standard i.e. 22

students and their 44 parents were selected as purposive sample and divided equally in experimental and control group. Informal experimental research design i.e. before and after with control design was followed to see the difference.

Interview schedule consisted of 51 items and observation schedule containing 19 items formed different aspects of indigenous health care practices like, food and nutrition, personal health and hygiene, home sanitation, addiction of tobacco- alcohol, stimulants and their consequence based on the simply observable local health problems was subjected to pre-testing before providing health education & final data collection. Experimental group children were taught by different participatory methods, and they were guided to convey these messages to their parents. On the other hand lecture method was used for teaching control group children. The scoring of each item was done on a scale with four point continuum based on the degree of correctness of the knowledge held. The effectiveness of techniques was obtained as differential score before and after health education. The level of awareness related to health practices was categorized as high ($>M+SD$) Medium ($M\pm SD$) and low ($<M-SD$). Data was interpreted through mean, S.D. and computed 't' values.

Hypothesis

1. There is no difference in awareness related to health of the children of experimental group before and after the exposure of health education.
2. There is no difference in awareness related to health of the parents of experimental group before and after the exposure of health education.
3. There is no difference in awareness related to health of the children of control group before the exposure of health education.
4. There is no difference in awareness related to health of the parents of control group before the exposure of health education.

Findings & Discussion

Socio-personal characteristics of the respondents were studied to gain background information about the respondents.

Table-1 Distribution of respondents according to their age, sex, caste and size of land holding

S.No.	Characteristics	Categories	Experimental Group(N=33) Frequency	Control Group (N=33) Frequency

1.	Age	(a) 10-22years (b) 23-24years (c) 35-45years	11(33.33) 06(18.18) 16(48.48)	11(33.33) 08(24.24) 14(42.42)
2.	Sex	(a) Male (b) Female	19(57.57) 14(42.42)	20(60.60) 13(39.39)
3.	Caste	(a) General (b) O.B.C. (c) SC/ST	03(9.09) 21(63.63) 9(27.27)	02(6.06) 20(60.60) 11(33.33)
4.	Size of land	(a) >1 hectare (marginal) (b) 1-2 hectare(small) (c) 2-5 hectare (medium) (d) < 5 hectare	18(54.54) 09(27.27) 03(9.09) 03(9.09)	15(45.45) 09(27.27) 06(18.18) 03(9.09)

Figure in parentheses indicate percentage

Majority of the respondents in both experimental and control groups belonged to 35 to 45 years age group. 63.60 and 60.60 percent respondents are of Other Backward Caste and most of the respondents had marginal and small holdings.

Table-2 :Distribution of respondents according to their parental education

S.No.	Categories	Experimental Group(N=33) Frequency	Control Group (N=33) Frequency
1.	Illiterate	10(45.45)	8(36.36)
2.	Up to Middle	8(36.36)	7(31.81)
3.	Up to Intermediate	2(9.09)	2(9.09)
4	Graduate	2(9.09)	2(9.09)
	Total	33	33

Figure in parentheses indicate percentage

Majority of the parent respondents in both experimental and control group were in categories of illiterate (45.45 and 36.36% respectively).

Indigenous health care practices

Indigenous practices refer to traditional practices, folk knowledge of wisdom of elders existing within a particular geographical area. Respondents especially were acquainted with a number of herbal treatment methods. They shared different local practices for better care of health and diseases. Though they complied with the fact that, now a days

people believe more in allopathic medicines and these are easily available yet they couldn't deny use of the traditional one. An effort had been made to note down some of their valuable knowledge for acquiring better health in different physiological conditions.

(1) Health Care of Mother after Delivery:

A number of dietary and other practices were popular in the study area. Some of these are discussed below:-

- (a) Deshi alcohol (Preferably made by mahua or grapes) was filled in a hollow vessel and mother sit in it immediately after delivery. Women believed that this practice help in setting the reproductive organs in appropriate manner, reduce pain and would provide strength so that mother could start their routine work after twelve days of giving births.
- (b) Mother took 2-3 gm alcohol two times a day.
- (c) Massage or rubbing mustard oil on the body was necessary till 6 days and might be continuous as long as required.

(d) Dietary Practices:

A number of dishes were prepared especially for lactating mother. Some special recipes are presented below:

(i) Aacchhavani

Ingredients	Measurement
Long Peppar (Piper Longum Linn.)	50 gm
Wild Asparagus(Satavari, Asparagus racemosus wild)	50 gm
Poppy seeds	50 gm
Coconut	100 gm

Makhana(Euryale ferox Salisb)	100 gm
Almond	100 gm
Chhuada	100 gm
Other nuts and seeds available	100 gm

Method:-

All the listed material was ground into a powder, roasted and taken with milk.

This preparation was necessarily taken upto 6 days and thereafter might be continued till one month.

(ii) Chauhaddi

Ingredients	Measurement
Cardamomum (Elaichi, Amomum Subulatum Roxh.)	5 gm
Long Peppar (Piper Longum Linn.)	5 gm
Dry Ginger Root (Sounth, Zingiber officinale)	50 gm

Vanshlochan (Bamdusa Bambos Druce)	5 gm
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Method:-

All four items were ground together into a powder, sieved and kept. This food item was taken at second day after delivery. It is used in the morning after giving teeth a brush. The mixture (3gm) is blended with 2 gm honey and licked.

Chauhaddi was taken after 15 minutes of eating Achhavani for one month.

(iii) Harira :

Ingredients	Measurement
Turmeric (Huldi, Curcuma Longa Linn.)	10 gm
Ginger	10 gm
Thyme(Ajvayan, Carum Copticum.)	10 gm

Method:-

The three spices were ground together into a powder and fried with ghee. Jaggery and water was added and stirred for about 3 minutes. This solution was taken (500 gm) two times a day for 3 days.

(2) In Case of Fever

(i) Typhoid, Malaria and Cough:

Ingredients	Measurement
Basil leaves (Tulsi, Ocimum Sanctum Linn)	: 20-25 leaves
Black Pepper (Kali Mirch, Piper Nigrum Linn.)	5- 10 seeds
Black Cumin Seed (Shah Jeera)	3 gm.
Makoh leaves (Kakamaci, Solanum Nigrum Linn.)	50 gm
Root of Bhatakatiya	25 gm
Guduch (Kantkari)	50 gm
Nitora leaves	25 gm
Parijaata leaves (Nyctanthes arbortristis Linn)	25 gm
Salt	5 gm

Method:-

All ingredients were mixed for grinding and taken in a new earthenware. 1 kg water was added and boiled on the fire of gohari (using dry cowdung as fuel). Simmering was done till 50 gm water remain. Salt was added and solution was taken as Kadha (decoction).

(ii) Jaundice:

Ingredients	Measurement
Root of Gadarporna : (Boerhaovia diffusa Linn)	5 gm
Black Pepper (Kali Mirch, Piper Nigrum Linn.)	5 gm
Honey	5 gm

Method:-

Both the materials were ground and juice was extracted. The juice was rubbed on iron pan, mixed with honey and licked.

(iii) In fever and cough, kerosene oil was rubbed on palm and sole.

(iv) Parijaata leaves were boiled in tea.

(v) Aesfoetida, turmeric, lime (Citrus medica var acida), Ajvaine, Neem (Azadirachta indica ajws), Tulsi etc. were used in any form.

(3) Pain**(i) Headache:****(a) Doodh-Jalebi**

Ingredients	Measurement
Cow's milk	400 gm
Jalebi (Refined flour sweet product)	50 gm

Method:-

Jalebi and cow's milk was taken in a vessel and Kept in dew. Half of this was eaten in the morning after brush without taking any food and rest half was used on sun rising. This was taken for 3 days.

- (b) New bamboo leaves or thyme or cinnamon is ground as a paste and kept on the forehead.

(ii) Pain at Any Part of the Body:

- (a) Cactus plant was kept in earthenware. An earthen plate was taken and a hole was made at the mid point. This plate was stuck over the pot with paste of flour. This earthenware was placed on the fire of gohari (dry cowdung used as fuel). On cooking water separates. This water was taken and boiled with mustard oil. This solution could be applied anywhere in the body.
- (b) Raw turmeric and musabbar (excreta of new born ass) was ground into a paste and set as required.
- (c) Women said that special oil or cream prepared by different animals and plants had an unfailing and lasting impact. These oil or cream were prepared by a family or special caste people and the techniques were inherited by ancestors. These unfailing treatments were provided to the needy people at low cost. But the techniques were kept confidential. It was considered a boon or a supernatural occurrence which was only for the welfare of mankind.
- (d) Gohiya oil was a medicine prepared by musahar caste and given in gout.
- (e) Oil of "Dhanish bird" was prepared by fowlers who were familiar with the special type of birds.

- (f) Saihjan (*Moringa pterygosperma* Gaertn.) leaves and madar leaves were tied on the effected place

(iii) Liver Problem and Stomachache (Barvat)

(a) First Urine of the she-calf was collected at the dawn and was given immediately to the child. This method was generally used for infant care.

(b) 2 gm aesfoetida was heated with half spoon water and applied around the navel.

(4) Diarrhoea

(a) Sometimes in case of loose motions people considered it as "Nara Ukhadna" due to lifting heavy objects. Women said that this can be treated by the person who knew the method of "Nara Baithana". In this method affected person was said to sit in a different style.

(b) Onion Juice is given – 5 gm to child and 10 gm to adult.

(c) Mint (*Mentha Vindis.*) leaves and bail (*Aegle mamelos* Corr.) fruit leaves was used in any form.

(5) Sunstroke

(a) Raw mango (*Mangifera indica* Linn.) was roasted and mashed, then pasted on the sole and palm. Paste of barley flour and onion was also used.

(6) Itching

(a) Cardamom and camphor (both 5 gm) was ground and blended with butter (50 gm) in a paste. This paste was applied on the effected area.

(b) Bark of neem tree (*Azadirachta indica* Ajws.) and pepper was crushed and mixed with mustard oil. This paste was stuck on the body part.

(c) Jasmine (*Jasmin official* Linn) oil was also used.

(7) On Burned Place:-

Raw potato was ground into a paste and stuck on the effected body part.

(8) Minor Injuries

The Juice of marigold (*Genda, Tageteserecta* Linn) leaves was kept over the minor injuries. Most of the indigenous practices were found to be scientifically relevant.

Table 3: Distribution of respondents according to sources of information about the medicines to be taken.

	Generally		Emergency	
	Number	Percentage	Number	Percentage
Doctor	17	25.75	46	69.68
Medical shopkeeper / Any Person	49	74.25	20	30.32
Total	66	100	66	100

The most striking point noted was that majority of the respondents were using allopathic medicines without any consultation with doctor. In case of headache, fever, or any pain they directly asked the name from medical shop keepers or any other persons who had used it and took it without hesitation. This practice can prove dangerous. Respondents believe that there was no harm in taking medicine on the basis of information gained from medical shopkeepers and any person who had used the same medicine or had knowledge about it. 74.25% households of the selected sample were using this practice frequently.

Child to Parent communication strategy

Table -4. Differences in awareness related to health among respondents before and after the exposure of C-to-P communication technique

S. No.	Characteristics	Mean	S.D.	T. Computed "t" value
1.	Awareness of experimental children (a) Before C-to -P exposure (b) After C-to-P exposure	76.45 168.82	5.28 6.48	32.9842**
2.	Awareness of experimental parent (a) Before C-to-P exposure (b) After C-to -P exposure	80.18 153.32	12.13 9.34	57.0005**
3.	Awareness of control group children (a) Before health education (b) After health education	70.30 154.50	5.58 10.04	36.3237**
4.	Awareness of control group parents (c) Before health education (d) After health education	85.50 96.50	10.86 9.67	13.7274*

*significant at 5 percent level of probability.

**significant at 1 percent level of probability.

Awareness of children in experimental group

It was evident from first part of the table.4 that the computed “t” value (32.9842) was found greater than tabulated “t” value with 10 d.f. at 1 percent level of significance. Hence, the hypothesis which was formulated for the study was rejected and the empirical hypothesis was accepted that there was a significant difference between the mean scores of children before and after the exposure of C-to P technique with respect to their health awareness . Therefore, it could be revealed that the awareness related to health of the experimental group children was increased during the exposure of C-to P communication technique. Further, the mean scores obtained by the respondents their awareness related to health before and after the exposure of C-to P technique were found to be 76.45 and 168.82 respectively.

Awareness of parents in experimental group

From part B of the table.4 it was clear that the computed “t” value (57.005) was found greater than tabulated “t” value with 21 d.f. at 1 percent level of significance. Hence, the hypothesis which was formulated for the study was rejected and the empirical hypothesis was accepted that there was a significant difference between the mean scores of experimental parent respondents before and after the exposure of C-to P communication technique with respect to their awareness related to health . Therefore, it could be revealed that the awareness related to health of the respondents was increased during the exposure of C-to P communication technique. This may be due to the nature of health education course content wherein individual children has to be well-read about various health practices. Further, the mean scores obtained by the respondents for their awareness related to health before and after the exposure of C-to P technique were found to be 80.18 and 153.32 respectively.

Awareness of children in control group

It was evident from ‘C’ part of the table.4 that the computed “t” value (36.3237) was found greater than tabulated “t” value with 9 d.f. at 1 percent level of significance. Hence, the hypothesis which was formulated for the study was rejected and the empirical hypothesis was accepted that there was a significant difference between the mean scores of children in before and after the exposure of classroom health education programme with respect to their health awareness . Therefore, it could be revealed that the awareness related to health of the control group children was increased during the exposure of classroom health education programme. Further, the mean scores obtained by the respondents for their awareness related to health before and after the exposure of health education programme were found to be 70.30 and 154.50 respectively.

Awareness of parents in control group

From the last part of the table.4 it was clear that the computed “t” value (13.7274) was found greater than tabulated “t” value with 19 d.f. at 5 percent level of significance. Hence, the hypothesis which was formulated for the study was rejected and the empirical hypothesis was accepted that there was a significant difference between the mean scores obtained by the parents in control group before and after the exposure of classroom health education programme for children. Further, the mean scores obtained by the parent respondents for their awareness related to health before and after the exposure of classroom health education programme were found to be 85.50 and 96.50 respectively.

Conclusion

Some indigenous practices were found scientifically relevant. Such practices need to be educationally promoted and shared in the larger communities. Both children and parents learn better when they share the language, culture and social situation with their teacher. Thus, in teaching-learning process communication through children to parents is an applicable strategy. The classroom health programme was effective in increasing the level of understanding of experimental (C-to-P) and control group (non C-to-P) children, but it was no more helpful in changing the level of awareness of control group parents in comparison to experimental group parents. As far as the difference between C-to -P and non C-to -P parents regarding their awareness and practices related to health after the exposure of health education was significantly differed during the exposure of C-to-P communication technique. The study highlights the importance of local adaptation of health education initiatives being informed by a detailed and sensitive understanding of the social, cultural and environmental contexts within which programmes are being implemented and depicts the way in which the acceptability of children as health educators within their family and community needs to be strengthened. A more relevant indigenous pedagogy needs to be developed that takes more account of a child’s traditional upbringing and worldview.

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