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Adventist Mission and African Traditional Medicine: Breaking the Silence

Africans have used and still continue to use African Traditional Medicine (ATM) for treating physical, socio-psychological, and spiritual conditions. However, the arrival of Christian Medicine (CM) has resulted in contentious episodes between practitioners of these two parallel systems. A significant number of Christian converts have also shown resolute commitment to both ATM and CM, raising issues of dual allegiance and syncretism. Can Christians find healing from both systems and still be considered faithful to their God? This article seeks to open avenues towards dialogue between ATM and CM. It briefly traces the historical developments that led to the status quo and looks at the nature of ATM. It also seeks to find common ground as a basis for dialogue between CM and ATM. It is not the purpose of this paper to argue for the unrestrained embrace and use of ATM by the Christian church. However, I do call for a better understanding and examination of ATM for possible applications where appropriate.

This article is important for two main reasons. First, it should be noted that even to this day, the two parallel systems still operate in sub-Saharan Africa. Caught in the cross hairs of this schema is the African Christian patient, who has to decide whether to consult either a Christian or a traditional practitioner, or both (unfortunately many Westerners chose to “throw the baby out with the bath water” when they rejected ATM in its totality). Pragmatically, the choice for Africans may not be as easy as it sounds. As will be discussed later in this article, loyalties are at stake. Socio-cultural issues such as fear need to be addressed, the potential of being judged, blamed, shamed, ostracized, and even removed from church membership is ever present. Second, the Adventist Church in sub-Saharan Africa runs a network of at least 225 hospitals, clinics, and other forms of healthcare facilities (Office of Archives 2013) serving

a population of over 6.2 million Adventists (Office of Statistics 2011). It is in this very region that “80 percent of the population depend on traditional medicine for primary health care” (WHO 2013). Certainly, the Adventist Church needs to provide direction in the use or non-use (of some aspects) of ATM.

A Definition of Traditional Medicine

There are various definitions of traditional medicine, two of which best fit the purposes of this article. Traditional medicine is defined as the “total combination of knowledge and practices, which are used in the diagnosis, prevention, or elimination of a physical, mental, or social disease and which may depend solely on previous experience and observation that has been handed down from one generation to another either verbally or in writing” (Safowora 1993:2). It is also defined as “the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses” (WHO 2000:1). In the African context, traditional medicine contributes significantly to primary healthcare.

Collision Course: Christian Medicine and African Traditional Medicine

The resilience of ATM cannot be underestimated. For example, Christianity in Ethiopia was introduced about the first century and assumed the status of a state religion some 400 years later. “The new religion was thus superimposed . . . upon the native culture, and elements of that pre-Christian culture—such as the belief in sorcerers and the power of black magic—survived within the framework of Ethiopian Christianity” (Haile 2007:633). Not surprising, the same can be said when Christianity—coupled with Christian medicine—was introduced to the rest of Africa during the colonial era. From the onset, Christian mission confronted an array of immediate challenges. One of the most formidable was the African Traditional Religion (ATR). Invariably, Christian Medicine faced off with African Traditional Medicine. In as much as the gospel missionary and the medical missionary were the face of Christianity, so were the traditional priest and traditional doctor to ATR. As will be discussed later in this article, the duos of missionary/medical missionary and that of traditional priest/doctor worked in apposition to one another, and unfortunately never found any common ground.

Many theories and their attending explanations have been postured for this debacle, including the initial attitudes of Western missionaries towards ATR. Enough documentation exists that alludes to the missionaries' failure to approach ATR with cultural sensitivity (Mbiti 1990:159; Idowu 1973; Comaroff and Comaroff 1991; Mugambi 1989; Dickson 1984). In a nutshell, the early missionaries plunged into the Christianization of Africans without an informed socio-cultural and anthropological understanding of the people. This led to biases against both ATR and ATM, leading to conflict between CM and ATM. In addition to the colonial missionary oversight, modern medical anthropology has fallen into a similar trap (Rekdal 1999:459).

Taking a critical look at select reasons as to why and how colonial Christianity in sub-Saharan Africa missed the "grand opportunity" to establish itself more firmly helps give a better perspective of the situation. The key explanation lies in two diachronic worldviews held by Westerners—Cartesian dualism (Hiebert 1985:111-112) and positivism (Trigg 2003:685). In simple terms, Cartesian dualism makes a distinction between the body and the mind (or soul) as two discrete entities. On the other hand, positivism is enshrined in empiricism, which "hold[s] that knowledge can only be obtained from direct experience" (685). It asserts that knowledge and experience can be derived through scientific observation, measurement, and verification.

Nevertheless, science operates only in the realm of physical matter, and categorically excludes the metaphysical or supernatural. This effectively separated religion and science into two compartments: faith and matter. This meant that anything in the sphere of spirits or ancestors, which are central to the ATR, could not be "proven" by positivism. So when Western missionaries came to Africa and heard the "tribal people [who] spoke of fear of evil spirits, they denied the existence of the spirits," something which Paul Hiebert refers to as the "excluded middle" (1994:196-197). "From the standpoint of an African worldview, the natural and supernatural are inextricably interwoven, and spirituality and health are strongly connected to the point where the human body and the soul are not viewed as separate entities" (Juma 2013:102).

Thus CM did not consider treating those who had spirit illnesses, as these fell outside the realm of rationality, measurement, and observation. This difference between Christianity and ATR, and CM and ATM, has had serious missiological implications in the quality and growth of the church in Africa, and in the rendering of primary healthcare to Africans.

Ontology of African Traditional Medicine and Healing

ATM is a part of the African culture; as such culture defines ATR. In other words, in the African tradition there cannot be a separation of the secular and the sacred as observed in Western worldviews. For this reason, Africans may be viewed as “notoriously religious” (Mbiti 1990:1). Thus African medicine may not be understood “except as seen in the light of religion” (Idowu 1973:189).

African religiosity revolves around the following pillars of ATR: “the belief in God, belief in the divinities, belief in the ancestors, and the practice of magic and medicine” (Kamara 2000:508), or specifically: God, spirits, man, animals and plants, and natural phenomena form categories of African ontology (Mbiti 1968:9). The hierarchy of deities in African cosmology range from the “living dead” (ancestors), spirits, and ultimately, God the Creator. According to Mbiti, the living dead are the recently departed that are still memorialized in the minds of their surviving loved ones (Mbiti 1990:159). The living dead are supposedly able to communicate with the living, directing, cautioning, and protecting them from the malevolent sprits. However, if the living dead are unhappy with a family member, they may be appeased through some form of animal or crop sacrifice. By so doing health would be restored to the troubled family or individual.

The mention of *evil* spirits suggests that there are good ones, which according to ATR are able to communicate with the ancestors, who in turn communicate with God on behalf of the living people. Evil spirits however, are the overlords of the sorcerers, witches, wizards, and bad human spirit mediums. These spirits work in cohorts with their human counterparts to bring hurt, ill health, and even death to unsuspecting humans for explicable or inexplicable reasons. This is the chief explanation for the fear that many Africans contend with in their day to day lives. This fear feeds the desire to seek protection of some sort. Thus the average African will strive to maintain a degree of harmony between himself or herself, the environment (Africans believe in the sacredness of the natural), and beings in the spirit world. When harmony is achieved, the African is said to be truly happy, safe, and healthy. Standing between the people and the spirit world is a select individual, who could either be male or female, a person who is trained in the ways of ATR—the traditional priests and doctors, diviners and shamans. It is to these individuals that Africans turn to for restoration of harmony, peace, and healing.

Notice a key tenet of African traditional healing that distinguishes it from Christian medical healing (as observed today).

The African conception of health and illness . . . [involves] the whole human body—not merely certain parts of the body—that is considered either well or in a state of disease . . . Unlike in the West, where a patient consulting a physician often hints as to what part of the body he/she thinks is afflicted, the traditional African (except in the case of easily identifiable anatomical parts of the body or where there are external injuries due to an accident) is generally non-specific as to the part of the body afflicted by disease. (Sogolo 1998:181-182)

Two things to note here are that (1) the incorrigible difference of Western dualism and African traditional holism are at play and (2) an African patient would naturally be drawn to a holistic health-oriented practitioner more than to the physical-oriented Western doctor. But because Africans believe a “culturally distant” doctor is more powerful than the local one, they will consult both the traditional doctor and the Christian doctor in order to maximize their chances of healing (Rekdal 1999:458).

African Traditional Religion, African Traditional Medicine and Healing

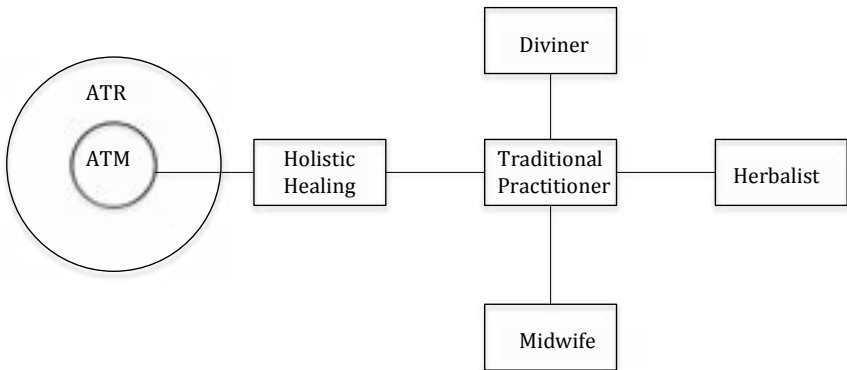


Figure 1. Relationship between ATR, ATM, and the African traditional practitioners.

The African traditional diviners/priests generally are spirit mediums that operate in the realm of the spirit world. Practitioners of this nature are *called* into their practice by a voice from the spirit world, through some serious sickness, through dreams and visions, or by another experienced elderly diviner from whom they would receive an apprenticeship. Diviners are believed to communicate with the spirits, ancestors, and even God on behalf of their people. One of the important outcomes of the shaman, priest, or diviner’s connection with the spirit world is that “the spirits give healing information” (Escobar 2007:613).

Thus to the African, the diviner has the important functions of mediation between people and the spiritual powers, seeking revelations, divination, and healing. This practitioner heals people with sociocultural and psychosocial ailments or concerns. The diviner may demand the slaughter of an animal as a sacrifice (or crop offering) in order to appease the ancestors. Diviners may use herbs and rituals for the healing of their patients (Juma 2013:100). Therefore, the diviner is believed capable of protecting people from harm that may come from evil or offended spirits, witches, sorcerers, enemies, disease, and misfortune. Thus the “traditional healer . . . is not only a medicine man. He is also a religious consultant, a legal and political adviser, a police detective, a marriage counselor, and a social worker” (Staugård 1986:52). It is this group of practitioners that has drawn the ire of Western missionaries and doctors. Though this paper is not addressing the theological dissonance and relevance of ATM with Christianity, one can figure out why missionaries perceived African traditional priests and doctors as conduits of idolatry, evil, and mysticism. For this reason, the Westerners threw the baby out with the bathwater when they rejected ATM in its totality.

The second type of healer in ATM—the herbalist—acquires his or her skills through apprenticeship from an experienced grandfather, uncle, or other individuals; the skills and knowledge are passed on from generation to generation. As such, “the herbalist or *inyanga* is not mystically defined” (Dauskardt 1990:277). This means that such a herbalist “freely give[s] herbal medicine without any religious connotations” (Gehman 1989:78). The primary task then of the African traditional herbalist is to provide herbal medicine for the healing of physiological and psychological diseases. While the herbalist has herbs and plants as his/her *materia medica*, the diviner-herbalist “combines the art of making a diagnosis by means of the ‘holy bones’ with that of treating the diagnosed disease with herbal preparations” (Staugård 1986:56).

The last, but not least type of healer in ATM is the Traditional Birth Attendant (TBA), or the Traditional Midwife (TM). Sandra Anderson and Frants Staugård reveal that “over two-thirds of the births throughout the world are conducted by traditional midwives who are not trained in modern medicine but are experienced in the traditional birthing system” (1986:23). Though most TMs are older women past the menopause stage, it has been known that in some West African countries like Ghana and Nigeria, men also serve as midwives (26). TMs get their skills through apprenticeship from an older family member or another experienced TM. They have a good knowledge of plant medicines, which they administer to pregnant mothers.

This section cannot be complete without the mention of African Faith Healers (AFH), who though they are not part of the original ATM rubric, make a significant contribution in ATM because of their nature. AFHs are usually leaders or prophets of African Independent Churches (AIC). AICs were formed when African church members became dissatisfied with the treatment and the services they received from mainline (missionary) churches (Kelalotswe 2004:205). Africans felt that their traditions and culture were systematically excluded from their worship experience, to the extent that they were forbidden to worship in their African way.

A key feature of AICs is that they characterize themselves as Christian, yet they fully commit themselves to ATR. "Nearly all AICs are similar in their incorporation of key tenets of Pentecostalism, including belief in the healing power of the Holy Spirit . . . , which are then combined with the continued acceptance of local African spiritual explanations for misfortune and illness" (Pfeiffer 2002:178). Thus the prophet healer or spiritual healer uses similar healing methods as the diviner and herbalist, except for the additional use of Christian prayer. AICs have become the first Christian entity to apply a high level corrective to the "flaw of the excluded middle," however, by doing so they have become hyper-contextualized. AICs then, by this standard are notoriously syncretistic. AICs have not received any recognition from Western medical practitioners or the mainline (mission-oriented) churches, though they might work closely with the African traditional healers.

Having discussed the nature of healing in ATM and its attendant practitioners, the next section discusses the reasons why Africans incessantly seek traditional healing.

Quest for African Traditional Healing: Missiological Implications

With 80 percent of sub-Sahara African people depending on ATM, there are several reasons for this phenomena. ATM is affordable and easily accessible compared to the skyrocketing costs of public health facilities, let alone the private health sector. In most of rural Africa there are no adequate medical facilities, and if they do exist, they are often at too great a distance for poor people to afford to travel to them. In addition, "medications and treatments that Western pharmaceutical companies manufacture are far too costly and not available widely for most Africans. . . . Therefore, healers are their only means of medical help" (Russell and Cohn 2012:10).

The ubiquitous presence of ATM practitioners makes their availability more convenient compared to the scarce and distant CM counterparts. Besides, the ATM practitioners live among their patients, know their culture and their needs whether spiritual, social, physical, or emotional.

Therefore, Africans would naturally consult a practitioner whom they believe understands their situation better than the stranger, who most times is alienated by that same culture.

Given the scope of this paper, it is not possible to discuss all the reasons why people use ATM; however, there is one fundamental drive—the African worldview of healing. The African healer has a holistic approach to illness and suffering that gives him or her a competitive advantage over the CM counterpart (Rekdal 1999:466). Traditional medicine offers a diagnostic solution to the questions of social causation of disease, curses, misfortune, and even death (Westerlund 2006:7). For Africans, causal attributions are a critical part of healing; local practitioners stand ready to do just that.

The insatiable quest for African traditional healing has significant missiological implications and challenges. This quest for ATM is so strong that African Christians are not exempt from its drawing power. “It is not a secret that many African Christians who come to church most Sundays [and Saturdays] at the same time consult traditional healers about the causes of their problems before approaching their priests, ministers, or pastors” (Juma 2013:95). Perhaps the more liberal in doctrines and theology a church (and by extension its medical counterpart) is, the freer its members would be to consult traditional healers. However, conservative churches also experience church members surreptitiously consulting traditional practitioners.

A good example of a church that has a rich orthodoxy is the Seventh-day Adventist Church. In research on the use of ATM by Adventists, one researcher found that “the use and practice of African traditional medicine among Seventh-day Adventist in Remoland [Nigeria] is real”; however, a significant number of the church members did not know if the Church approved of it or not (Amanze 2011:89, 292). This ambiguity might indicate that the church may not have a clear position on the use of ATM, in which case there is a need to develop a theology of healing to address this issue. With no guidance, church members face the very real risk of falling into syncretism and idolatry.

ATR and ATM have a holistic approach to healing. The Adventist Church holds the same view, even though it uses a different model. The Church also endeavors to serve and restore humanity in the emotional, mental, physical, social, and spiritual spheres. However, the reality that some of its members find it necessary to consult traditional healers about the causes of their problems before approaching their pastors or mission doctors might suggest a degree of inadequacy in the church’s mission and ministry and in its theology of healing.

Is there anything that the ATM and CM can learn from each another? Are there any possibilities of cooperation or corroboration between these two health systems? The Adventist Church in Africa has been silent on this question for too long, and seems unwilling or incapable of dealing with it. It is time for the Church in Africa to take the necessary steps to address this issue.

Toward a Missiological Dialogue: Christian Medicine and African Traditional Medicine

ATM certainly does have its own limitations: a lack of documented regimens for the use of its medicines, some unhygienic practices in administering treatments and surgery (Isola 2013:323), unstandardized dosages of herbs or medicines prescribed, and so on. However, a basic principle in dialogue is to begin with a common ground (see figure 2). There is enough shared commonality for CM and ATM to cooperate in certain areas and learn from one another.

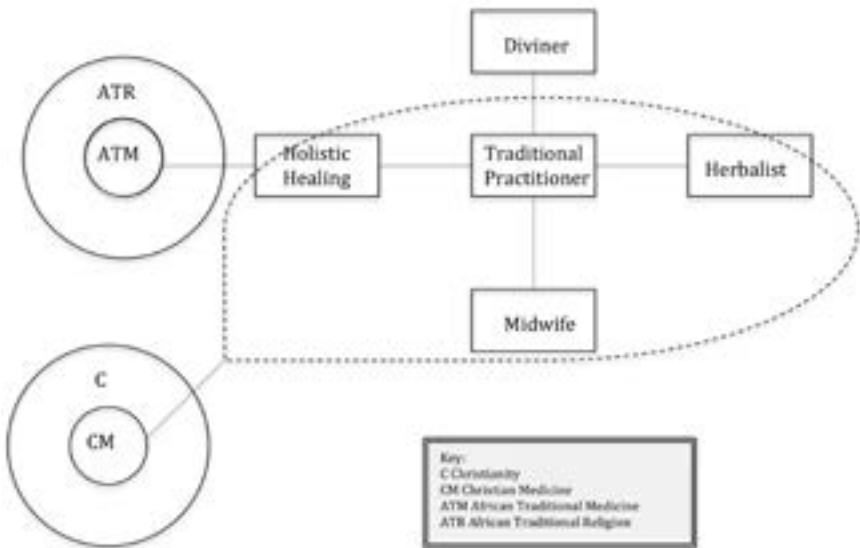


Figure 2. CM and ATM—The dialogue bubble shows common ground.

To begin with, both systems do have a holistic approach to healing. This should allow some ground for dialogue, as this is a principle that is akin to both parties.

“About 25% of modern medicines are descended from plants first used traditionally” (WHO 2002). This should be of pharmacological interest to CM, providing common ground to work with herbalists to improve the efficacy of the herbs they use. Besides, “with proper guidance, these same plants may still protect one from more mundane afflictions such as headache, indigestion, rheumatism and many other complaints” (Bianchini and Corbetta 1977:13). Because of plural medicine, a situation where a patient consults different forms of medical systems, there is a danger of using prescriptions that have not been co-managed—to the detriment of the user. As such, CM doctors and herbalists need to work together so that they do not administer medicines that work at cross-purposes.

Finally, but not least, the traditional midwife is widely used all over Africa. CM needs to consider working with these African specialists, especially in helping them with training and family welfare education.

Conclusion

African Traditional Religion does have a missiological impact on African Adventist Christians. It shapes and influences how members worship, and how they seek to address disease, misfortune, and even death. In essence, the African worldview is no small matter that can be ignored. The inherent fear that Africans experience, the need of assurance of protection from a perceived and sometimes unseen harm, their quest for a holistic approach to healing and life in general—all point to a need for a theology of healing for the church in Africa.

There are many factors that point to this—Christian medicine is just one of them. As far as the question of fear of evil is concerned, CM has the provision of chaplains and pastors to care for people in the local communities. However, for as long as these tasks are limited to the clergy, to the exclusion of the rest of the medical staff, fear may remain in the hearts of the people. Members whose faith is biblically rooted and who have a worldview that has been shaped by biblical principles will be better prepared to face the uncertainties of life in the African setting.

The Adventist Church in Africa does need to consider having a serious dialogue with ATM practitioners. The non-mystic herbalists and traditional midwives are certainly the practitioners to consider opening that dialogue with.

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