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CONTINUITY, CHANGE, AND CHALLENGE IN AFRICAN MEDICINE

Health and healing practices in sub-Saharan Africa have evolved over three millennia in constant interchange with those of other world regions. The medicine of Ancient Egypt shaped ideas of the civilizations around it, including the medicine of classical Greek and Roman Antiquity. This complex in turn spread to African regions, through the influence of Islamic medicine. Another dimension of Islam, “prophetic medicine”, brought notions of health and healing to Africa from Persia and Arabia.¹ Christian faith healing, which spread first with early Christianity across North Africa and Ethiopia, later was part of European colonial expansion to sub-Saharan Africa. Post-Enlightenment scientific medicine, building upon ancient medicine, brought its ideas of public health and curative medicine. All these perspectives coexist in the early 21st century with African perspectives on health, sickness, and healing.

What then is African healing and medicine? Africa is of course a vast continent with a multitude of societies of great diversity, and we admit a certain hubris with the very idea of generalizing about it. We will focus our attention on the ethnolinguistic group known as Niger-Congo, within which we have ourselves had most of our experience.² This group of societies is geographically widespread and numerically large, covering sub-Saharan Africa from the Wolof of Senegal to the Swahili of coastal East Africa, and down to Southern Africa. The Niger-Congo grouping relates the Bantu-speaking peoples of the Congo basin and southeastern Africa historically and culturally to the dense population of West Africa. All of these societies share, in addition to historically related languages, “attitudes about God, religion, kinship, the nature of the world, and life” (Murphy, 1972: 179), and within them, health-related practices and beliefs.

TOOLS AND PERSPECTIVES FOR THE HISTORICAL STUDY OF CHANGING HEALING TRADITIONS

Ecologically distinctive zones of the rainforest, savanna, and desert have shaped both health and adaptive responses by human communities. The modes of

living – hunting and gathering, cultivation, herding, and then urban societies – also shaped the underlying determinants of health.

Hunter-gatherers, for example, such as the remaining Khoisan speakers of Southern Africa in the early 20th century, practiced infanticide for population control and birth spacing of up to four years between children. They also picked up camp whenever diseases broke out, in order to reduce deaths in the settlement. Given their small population concentrations, contagious diseases did not have a chance to take hold and become endemic. The health of the band was promoted through spirit healing ceremonies led by healer-singers (Katz, 1982; Katz, Bieseke, and St. Denis, 1997).

Both the West African and the Bantu-speaking civilizations, defined primarily by sedentary agriculture, have also been cattle herders and pastoral nomads throughout their histories. Where the tsetse fly has been absent – as across the Sahel, the eastern Sudan, in the lake region of East-Central Africa, and into moderate Southern Africa – pastoralism has brought with it a distinctive set of ideas about health, sickness, and medicine.

As livestock herding spread southward about six millennia ago, it skirted the rainforest area. This created at the center of the African continent a vast population without domestic large animals. As a result, this population is unable to digest animal milk – a condition known as lactose intolerance. The boundary between pastoralist and non-pastoralist societies has historically been that between rainforest and wet savanna on the one hand and the dry savanna and the desert on the other. On the one hand, the pastoralists have had to manage their herds, concentrating on good breeding, learning the politics of being good neighbors (or superior raiders) on their annual transhumance treks to find seasonal pasture, and understanding the danger zones of the tsetse fly's habitat. On the other hand, the cultivators without large livestock have had to emphasize crop fertility, soil fallowing, irrigation and water management, and the importance of rainfall.

In West Africa, the domestication of plants and animals in sedentary settlements was well underway by 4000 BC. Urban centers and stratified societies emerged in the West African and the Sudanic savanna by the early centuries of the first millennium AD, and trade routes linked West Africa with the Mediterranean and Europe. By the early second millennium AD the influences of Islam and Arabia were felt in the savanna, but pre-Islamic healing rituals or therapeutic practices were not fully supplanted.

The spread of food cultivation and sedentary social modes southward through and around the equatorial rainforest has come to be associated with the spread of the Bantu, Cushitic, and Nilotic cultures and languages. Perhaps as early as 1000 BC the Bantu languages had begun to spread from the region that is now Cameroon and Nigeria. These languages ultimately came to be spoken throughout the whole of Central, Eastern, and Southern Africa, facilitating exchange of ideas and practices, including those related to healing. Food production and iron working spread rapidly through this area during the first millennium AD. The sedentarization of community life in sub-Saharan Africa and the domestication of food plants and livestock provided a moving threshold

that also affected health and healing. With the transition to cultivation and larger, sedentary communities, new diseases appeared. There was sleeping sickness (endemic in the rainforests, a major threat to pastoralists), malaria (endemic in rainy forested areas), and smallpox (endemic once population concentrations emerged). Together with widespread environmental risks such as poisonous vipers, these diseases offer examples of health threats that encouraged the creation of “medicines” directed at them. They also show the vocabulary of health-related terms and concepts in a common linguistic and cultural background.

Language history – along with archeology and the study of the distribution of cultural practices including uses of plants, animals, and other natural substances – offers one of the most promising avenues for the study of the history of African medicine and health related practices (Ehret, 2000; Janzen, 1992; Schoenbrun, 1996; Vansina, 1990). Analysis of the words and their meanings and uses by language family permits the determination of which concepts, practices, terms, and phrases are part of the institutional infrastructure of these varied adaptations. Language analysis assists in determining which are inventions along the way, and which are borrowed from elsewhere. Language history also allows the reasonable dating of the origin and spread of specialized institutions, practitioners, techniques, concepts and ideas, and *materia medica*.³

Terms for suffering (*-*duaad*-), healer (*-*ganga*-), medicinal plant (*-*ti*-), the power of words and will to affect health in social relationships (*-*dog*-), and song-dance ceremonies of trance and healing (*-*goma*-) are part of the common vocabulary of the Bantu expansion from about 1500 BC. They are found throughout Equatorial, Central, East and Southern Africa (Janzen, 1992; Vansina, 1990).⁴ Such a constellation also characterizes medicine on the Guinea coast and West Africa. As this cultural complex moved eastward to the Great Lakes region, the basic term for healer became bifurcated and the root term for “big man” or chief (*-*kumu*-) came to be applied to diviner (*-*mufuumu*-), suggesting the importance of the diviner in social control (Schoenbrun, 1997).

Profound transformations were brought to African medicine by the mercantile trade of the 16th to the 19th centuries, and then by 19th and 20th century European colonialism. Foreign trade, technology, ideologies, and social forms were often imposed by force. New ideas about health were part of this colonialism, ideas that discredited African medical systems. Missionaries and colonial regimes came to evangelize Africa. Just as Islamic crusaders had attacked “pagan” African forms of healing and religion, so Western Christian missions discredited the basis of knowledge as the overall approach to ritual healing. At a time when early positivist science was analyzing the causes of contagious diseases and public health campaigns were being waged to make Africa safe for “progress”, assumptions that social dynamics could cause sickness were dismissed as witchcraft. Since they had cures for diseases such as yaws, leprosy, and later malaria and dysentery, Christian missions and their hospitals contributed to the conversions of many Africans. Although Christianity gained widespread following in sub-Saharan Africa, many of the marks of the African worldview of misfortune have been reincorporated or persisted quietly in

Medicine Across Cultures

History and Practice of Medicine in Non-Western
Cultures

Selin, H. (Ed.)

2003, XXIV, 417 p., Hardcover

ISBN: 978-1-4020-1166-5