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Healing traditions in sub-Saharan Africa

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Introduction

Whereas in the early period of colonial imperialism some European observers doubted the existence of religion and medicine proper in African societies, later research by missionaries, medical doctors, and anthropologists discovered sufficient structural and functional analogies with European phenomena to describe many concepts and practices in sub-Saharan Africa as ‘religious’ or ‘medical.’ Yet what the respective experts, in Swahili sometimes called fundi (a term also used for car mechanics), do is far more than what is called medicine in the global north. They offer remedies for success in love matters and business, in school, politics, and sports. Thus, their broad range of practices should not be equated with so-called African traditional medicine, which was only constructed with the influence of biomedicine accompanying colonization, religious missions, and ‘modernization.’

The high diversity of pre-Islamic, pre-Christian, and pre-colonial religious and medical practices—and their further diversification by contact with (and influences from) Islam, Christianity, and secularized European modernity under enormous asymmetries of power—do not allow any comprehensive account of medicine and religion in the fifty-two countries of sub-Saharan Africa. Therefore, the concepts and practices introduced and discussed in this chapter, mainly for a region in East Africa, are only exemplary for the many various phenomena and perspectives that can be encountered. Despite regional variations, the patterns described here may nevertheless be useful in the study of so-called African traditional medicine more generally, as they concern common, fundamental options for understanding disease causation and dealing with illness.

National ministries and the WHO Regional Office for Africa continue to emphasize that 80 per cent of Africans rely on ‘Traditional Medicine’ (WHO n.d.). Although the precise meaning of the term and the empirical origin of this quantification are never addressed, this shows the official understanding that the use of so-called traditional medicine is widespread in this world region. The experts in these types of healing have not always been officially recognized by administrations and they have been marginalized by policies on biomedicine, but these experts have never ceased to be consulted by large parts of the population, be it due to lack of accessible, affordable, and acceptable biomedical services, or due to belief in their abilities.
Differing from the aforementioned accounts by the WHO, by national governments, and by research institutes on traditional medicine, this chapter takes those parts of ‘traditional medicine’ that are not dependent on potentially bioactive substances as the more important constituents. This is in accordance with the results of several generations of anthropological field research that primarily looked at thoughts and actions of the population and not on political claims or the data of ethnopharmacological studies. ‘Traditional medicine’ is thus studied in this chapter as a cultural phenomenon and spiritual resource.

**Invisible forces and spirits**

It is a truism that Cartesian ‘dualistic’ concepts of body and mind cannot be indiscriminately applied to understand concepts in every part of the world. Nevertheless, in a globalized world, thought stemming from European traditions remains an indispensable point of reference for analyzing and understanding other ways of thinking and acting as this allows comparison as well as verbalization. After all, the distinctions made in the North Atlantic region between natural science and supernatural religion were used to divide formerly undistinguishable healing practices in other parts of the world into ‘religious’ and ‘medical’ ones, thus contributing to shaping current understandings of both religion and medicine more globally (Bruchhausen 2018; Lüdeckens and Schrimpf 2018).

One highly influential attempt to describe African concepts by applying European traditions of thought was the book *Bantu Philosophy* (1959) by the Belgian Catholic missionary Placide Temples (1906–1977). Beyond the largely justified criticisms of overgeneralization, of denouncing African concepts as ‘primitive thought,’ of colonial misuse for demonstrating Bantus’ alleged inferiority, and of neglecting the dynamics when treating this philosophy as static and unchanging (Hountondji 1977), several African philosophers would agree that Temples grasped at least some central points (Kagame 1976). One would be the idea of a life force originating in a highest being that runs through all beings in instances such as sexual reproduction, nutrition, or healing and can be mobilized by ‘prayers and invocations’ and by ‘all that is usually called magic, sorcery, or magical remedies’ (Temples 1959: 31). The vital force is behind all life and therefore also behind healing and destruction (Temples 1959: 23).

In many parts of sub-Saharan Africa, such an invisible force is seen as present in all living beings, including animals and plants. This might explain why remedies derived from plant or animal ingredients are much more common than mineral medicines. The use of animal parts distinguishes ‘traditional’ African from European non-biomedical pharmacopeia, which largely limits itself to herbal products. The presence of a life force in all living beings also explains why parts from human bodies, for example, skin or flesh, are sometimes used for consumption or external application, as in the rare criminal cases of ritual murder for gaining body parts in eastern and southern Africa (Becker 2004; Labuschagne 2004). The life force from all these living beings is transferred by swallowing, by inhaling smoke from burned parts, or by bathing with fluids containing such substances (Dias 1967). Thus, not only rituals, but also the substances applied for healing or protection often could be interpreted as religious or spiritual, because they refer to the divine life force, rather than as mere medico-physical acts.

Whereas this force is generally regarded as an impersonal one, without any intention of its own but usable for different purposes, other constituents of the invisible world are beings with wills of their own (Giles 1999). These spirits may be perceived through their physical and mental effects on human beings as well as effects on the non-human world, such as sounds or movements. They can assist in divination by moving hands, sand, beans, bones or food used as oracles, and they can send verbal messages through the mouths of human beings.
Distorting concepts from external observers: demonism, animism, and spiritism

Three European or Western theories have been applied for understanding the African practices related to spirits: demonism, animism, and spiritism, or spiritualism. All these explanations have distorted African concepts to different degrees, but as they are still present in terminology and perceptions, they need to be reflected upon.

A notion of spirits broadly held in Europe as recently as the early modern period and still present in some versions of monotheistic religion is ‘demonism.’ Transferred by biblical and patristic writings from the Middle East to Europe, the idea of spirits as evil allies of the devil strongly influenced European connotations of invisible beings. Accordingly, early Christian missionaries and medical doctors equated the spirits contacted in African rituals with such beings and spoke of ‘devil’s dances’ or ‘devil worship.’ As Africans’ spirits are rather like human beings who are mostly helpful or good and only sometimes malicious, such an evaluation of spirits as always evil by Europeans has grossly misinterpreted what the African rituals meant and thus hindered seeing them as spiritual or religious practice and resources.

‘Animism’ was, in the evolutionist concepts of the late nineteenth century, an allegedly early or ‘primitive’ form of religion and a necessary stage in the development of humankind. According to this concept, everything in the visible world has something like a soul and is influenced by invisible beings. Therefore, incantations can influence other living beings or even physical conditions such as weather or the growth of crops.

‘Spiritism’ or ‘spiritualism’ is the most recent of these three European concepts for explaining spirits and is still present in the anthropological term ‘spirit mediumship’ for the phenomenon of healers using spirits by incorporating them (Beattie and Middleton 1969). The modern term ‘spiritualism’ is translated into Swahili as ‘(belief in) contact with Ḗpē (mizimu, mahoka, etc.),’ that is, the same beings which are contacted in long-standing African rituals (TUKI 2000: 765).

Other European attempts to explain African phenomena are more medical, attributing them to ‘altered states of consciousness,’ largely without any use of psychotropic substances. There were hints to the intake of alcohol, coffee, and cannabis in rituals in the Great Lakes region, but the majority seems to be performed without any such agents, as rhythm and dance are sufficient to induce trance (Heintze 1970: 257). A similarly medical explanation is the reference to either neurological or mental disorders such as epilepsy or neurosis. Only since the 1960s has transcultural psychiatry come to value such states and rituals as effective psychotherapy instead of mainly psychopathology (Kiev 1972; Prince 1980).

What is obvious in the African concepts is that human bodies are far more connected with other beings in their environment than in a modern scientific perspective. These connections mean that unseen or secret forces and beings may enter and change bodies. The concepts of such influences, however, vary largely. In several West African traditions and concepts such as Voodoo in Ghana, Togo, and Benin, or Juju in Nigeria, it is possible to influence others over long distances by using the magic of analogy: for example, harming or treating images or body parts such as a piece of a person’s hair or fingernail to affect that individual (Taliani 2012: 602). Such use of hidden relations due to similarities or former contact was also common in early modern European medicine and survived in folk practices (Frazer 1922: 14, 43). In East Africa, however, those who want to secretly harm or openly heal others are commonly imagined as physically applying the means, for example, by flying to the persons on magical objects, mysteriously entering their rooms through closed doors, and administering substances through the nose or mouth. (Bruchhausen 2006: 191–192). In explaining this difference between West
and East Africa, West Africans’ far longer contact with earlier European and Islamic thought (including Neo-Platonist elements) might have furthered belief in such effects, as Voodoo was a highly syncretistic system already before its transfer into the Caribbean region.

### Unintentional and intentional causes of sickness

 Outsiders are often struck by the observation that their accustomed categories of natural versus supernatural explanations do not accord with many African perceptions. It seems more fitting to (at least) East African thinking to assume three types of explanations. The first type invokes a divine natural order, running against the grain of distinctions between the ‘natural’ and the ‘religious.’ Such disease follows the ordinary course of nature and is called ‘disease by’ or ‘of God’ (ugonjwa wa Mungu), as God created the natural progression and regression of disease as part of the world.

 The second and third types obstruct the ordinary, natural course of things, for example, the healthy growth of a child or the usual healing of a wound or fracture. The second possibility is that disease is caused by living human beings through witchcraft, poison, breaking taboos, or violence, therefore including both ‘natural’ and ‘supernatural’ causes, from a European-influenced perspective. The third possibility is that the disease is caused by spirits, whether former human-like ancestor spirits or non-human spirits like djinns.

 From this perspective, disease is more explained through reference to personal intention than it is in frameworks dominated by scientific, impersonal laws. In the last two causes of disease, that is destructive magic and evil spirits, the source of the disease is a hostile will attacking from outside. A hint of the pervasiveness of this view is the common expression for ‘I was sick’ in Swahili, nilium(w)a. Literally, ‘I was bitten,’ it implicitly attributes illness (or other misfortunes, such as in relationships or business) to an intentional assault from the outside.

 The common attribution of intentional external causes for quite different unwanted states is why many scholars of Africa prefer the term ‘affliction’ to ‘illness’ or ‘misfortune.’ Externally caused health issues are inseparable from other troubles, and the final cause is not just fate but an attack by some other being. Medical anthropologists have called such explanations ‘externalizing belief systems’ in opposition to ‘internalizing’ ones (Young 1976), or ‘personalistic’ as distinct from ‘naturalistic’ systems (Foster 1976).

 The three types of causes introduced here might guide a further account of the ‘explanatory models’ as medical anthropology calls the ‘models of’ explaining disease and the ‘models for’ dealing with disease (Kleinman 1980). At the same time, these three categories of causes—by God/nature, by fellow human beings, and by spirits—determine which way of treatment to be taken: by herbs and bone-setting, by counteraction with magical or physical means (up to the killing of a perceived enemy), or by negotiating with the spirits and satisfying their wishes for sacrifices or dancing. While in the first cause for diseases, nature (as God’s creation) roughly follows concepts of empirical science, whereas the second and third groups of causes (i.e. witchcraft and spirits) need further explanation.

### Witchcraft, sorcery, and destructive magic

 In contrast to the ordinary course of nature, which determines the first bundle of causes for illness, the second and third bundles explain more unexpected misfortunes. For example, when strong men contract fatal diseases, an external cause is suspected. A pioneer of ethnographic field research in north-eastern Africa, Edward Evans-Pritchard, noted that the Azande called this destructive magic the ‘second spear’ (Evans-Pritchard 1976: 69). In hunting, the first spear
usually hurts the game only, but the second takes advantage of its weakness to kill. In human beings, somebody cut by a bush ordinarily limps for a while until the wound has healed. Yet if he does not become better, but contracts fever and becomes increasingly unable to walk, some hostile intention must be the cause.

Evan-Pritchard also introduced an important distinction within destructive magic: the distinction between witchcraft and sorcery (Evans-Pritchard 1931: 35). This use of European words is, of course, not self-explanatory as there are no clear definitions for these English terms, but applied to the Azande, ‘witchcraft’ denotes the inborn or—usually unintentionally—acquired property of a human being to harm others in invisible ways. The Azande believe there is a substance in the abdomen that is responsible for this effect and conducted autopsies to determine whether this substance was present.

‘Sorcery,’ in contrast, is always intentional. It cannot be involuntarily inflicted on other human beings but needs a clear will to harm others by secret means that may have been learned as an apprentice or even bought. Accordingly, this distinction is often highly gendered: witchcraft is more often seen as a negative property of women, not professionally learned and not done for money, but a harmful effect confined to the family and neighbourhood, while sorcery is predominantly male and can be a successful business to make one rich and powerful in society. Evans-Pritchard observed that this distinction could be difficult, but a sudden death was generally attributed to sorcery, whereas in the case of a more chronic disease the common suspicion was witchcraft (Evans-Pritchard 1931: 35).

When, thirty years later, a collected volume discussed the applicability of this distinction for the whole of East Africa (Middleton and Winter 1963), a general equation with concepts of other ethnic groups proved impossible (Turner 1964). Yet some of the differences introduced by Evans-Pritchard were helpful in detecting differentiation in other groups, such as the opposition between malice within one’s group and consciously calculated harm towards outsiders (Bjerke 1989). The distinctions between voluntary versus involuntary, inborn versus acquired potential to harm are also possible, but not necessary, components of other groups’ etiology (Omari 1972).

The major obstacle for a cross-cultural exchange of North Atlantic and Sub-Saharan African thought on witchcraft is their difference in interest. Whereas for post-Enlightenment European thought, the predominant question would be ‘Are these effects possible according to the laws of nature?’ (i.e. a matter of natural philosophy), the main African interest is ‘How, why, and when can people be that malicious towards their fellow human beings?’ (i.e. an issue of moral philosophy) (Evans-Pritchard 1976: 60).

In social settings, however, such logical distinctions and clear-cut attributions in witchcraft as the cause of illness are blurred by the mutual misunderstandings, fluidity of meanings, adaptation of arguments, and non-systematic manner of conversations (Sanders 2003). Recent research and literature on witchcraft in Africa does not reconstruct notions of causation and motivation or relations to health any longer, but rather looks at its appearance in new contexts such as popular media, market economies, independent churches, or technology discourses (Moore and Sanders 2001) or its connections to issues like wealth, sexuality, modernity, religion, and power (Kiernan 2006).

**Spirit possession, shamanism, and adorcism**

The African cases of a manifestation of spirits in human beings tend to be researched in anthropology under the headings of spirit possession or with a widespread word in many Bantu (and other) languages: *ngoma.*¹ Spirit possession is a phenomenon that classically has been
discussed in theology as well as in medicine. The European abolition of this model has led to its categorization as ‘superstition’ and the assumption that it will die out with modernization.

As a diagnosis by traditional healers, spirit possession seems to be a decreasing phenomenon. In the late 1980s, only about 10 per cent of a hundred consultations of healers in the city Dar es Salaam led to the diagnosis of spirit possession (L. Swantz 1990: 114), whereas in its rural periphery before 1970 the figure had been 58 per cent (M. L. Swantz 1970). Yet a low number of possession diagnoses does not mean that possession is less relevant for healing, as spirit possession by healers remains an indispensable part of diagnostic, therapeutic, and protective procedures. Therefore the list of sound ethnographic studies or reviews on cults of affliction, spirit possession, and ngoma is remarkable (Turner 1968; Beattie and Middleton 1969; Caplan 1982; Janzen 1992; Heintze 1970; Giles 1989; Engelke 2001; Thornton 2017), but has not become much longer in more recent years as anthropologists’ interests shifted from ‘traditional medicine’ to biomedical issues and ‘global health.’

A long-standing, though mostly undiscussed question is the relation of these African practices to ‘shamanism.’ Even before Eliade systematically extended the meaning of the term shaman from its North Asian origin to allegedly similar phenomena all over the world (Eliade 1964), many anthropologists of Africa referred to the shaman (Bruchhausen 2006: 215–219). The idea of evolutionism that Stone Age cultures were similar all over the world was behind this transfer of terms. In the interwar period, when cultural historians sought out the diffusion of cultural elements in ‘circles of culture’ (Kulturkreisen) the use of the word shaman for phenomena in Africa was quite common (e.g. Dietschy 1936). In the postwar period, cultural relativists were wary of generalizing equations, limiting the extension of the term shaman (e.g. Leiris 1958). However, since 1970, as the category of shamanism became part of alternative spirituality and healing in the West, academic literature on trance and ecstatic states took up the term in a most generalizing manner once more (Lewis 1971). While scholars have criticized Eliade’s concept of shamanism and ‘other dehistoricising universalizations of the archaic’ (Zinser 1991: 25), the word shaman is sometimes applied to Africans for marketing purposes. For example, a West African in Europe who only passed the ordinary initiation for every male member of his ethnic group without becoming any kind of ritual expert and did not use the term shaman in the French original, is advertised as an ‘African shaman’ in the translations (Somé 1994). Reference to shamanism seems to make African spirit rituals more attractive for Western consumers. Sceptical of both cultural evolution and diffusion theories as well as of esoteric generalization and embracing, most academic authors since the 1980s have reserved the term shamanism to Eurasian regions and the Western world (Jilek 2003), and most anthropologists today do not refer to African practices as shamanism.

There are, of course, some similarities between Siberian shamans and African healers, such as drumming and dancing in trance or acting in the name of a powerful healing spirit (Leiris 1958: 12). Yet the concept of illness and healing seems to be rather different, at some points even opposite. Whereas in North Asia the dominating concept is a loss or robbing of the soul that the shaman needs to retrieve from the other world, the predominant idea in Africa is the intrusion of a foreign spirit, mostly in the head (Heintze 1970: 103). In West Africa, especially in Voodoo, the person is rather seen as the ‘horse’ of the spirit, in East Africa rather as the ‘chair’ (in Swahili kiti), making the term ‘possession’ especially well-suited. Thus, in Africa, there is usually no soul-absence, but rather the presence of an additional soul, although a few exceptions can be found. Accounts of a healing expert’s travels to the realm of the dead, such as one from Dahomé (Dietschy 1936: 1320), are very rare. Another instance some authors point out of ‘authentic shamanism’ in Africa are the ‘Vandau, a small group living among the Thonga’ (Janzen 1992: 134–135).
The most striking difference between spirit possession in earlier African traditions on the one side and the dominant traditions of Europe, Middle East, or monotheistic religion on the other is the evaluative aspect. In monotheistic religion, post-Enlightenment philosophy, and academic medicine, spirit possession is always negative, as it leads the possessed away from God or reason. In Africa, however, most possessed states are desired as spirits are regarded as—at least potentially—helpful beings. In order to mark this difference, authors writing in French introduced a new term to oppose the exorcism of unwanted spirits: adorcism, the contact with wanted spirits (De Heusch 1971: 235). This new term was first found in studies on North Africa and Senegal, but has been applied in other psychotherapeutic, esoteric, and ethnographic contexts, including East Africa (Larsen 1998: 67; Kim 2001: 138, 245–247, 325 n. 2).

Some of such healing cults where powerful spirits are called for their assistance have been researched extensively, especially Zar in Ethiopia and neighbouring countries (Leiris 1958; Lewis 1991). Strong similarities between these traditions and possession phenomena in the coastal zone of Persia (Safa 1988) and in India demonstrate the multiple connections across the Indian Ocean. These ‘positive possession’ or adorcism phenomena are actually much more common in Africa than ‘negative possession’ by intruding spirits.

**Positive evaluations and examples of possession: Zar and Ngoma**

In opposition to the negative evaluation of possession in early anthropology (evolutionism, diffusionism, and structural-functionalism), in Christian tradition, and in psychiatry, anthropologists and scholars of religion since the late 1960s have emphasized other, more positive aspects. Two of them are the arguments that possession cults compensate for marginality, which would explain their popularity with women (Lewis 1971) and that they mainly are a healing strategy (Janzen 1992). After a period of vivid discussion, these arguments’ claims to universality have been partly refuted (Caplan 1982: 41; Giles 1987 and 1989: vii–viii; Boddy 1989; van Dijk et al. 2000). Today, the term possession remains in disrepute due to its negative connotations, but contact with spirits or their embodiment can also be regarded positively as part of integrative or holistic healing (Langwick 2011).

**Ngoma** rituals can be found in many local and cultural variations. All over East Africa, the dance for spirits (ngoma ya majini) is distinct from dancing for fun because of its special drums, special songs and rhythms, and the leadership of ritual experts who also function as healers. It may be organized for special patients, for the initiation of new healing experts and for special occasions, such as before the beginning of Ramadan, a month when such ‘pagan’ rituals are forbidden in some Islamic regions.

Spirits, however, are not only called up by such common rituals of a larger group, but also by individual healers, alone or with assistants, for individual clients. It is an open question whether such individual consultations were practiced in the premodern period or whether they developed and increased with the influence of biomedicine and its more confidential settings and with the prohibition of public witch-finding.

**Popular and public recognition**

African healing as a whole was never entirely prohibited by colonial administrations. In the late nineteenth century, the early period of European colonialism in Africa, European medical doctors hoping for new therapeutic substances like the previous import of quinine and emetine from South America researched African remedies (Bruchhausen and Roelcke 2002). Christian
missionaries encouraged the use of herbal medicine, seeing it as closer to God’s creation than modern pharmaceuticals with their poisonous side effects. The ritual aspects of African medicine, however, have been dismissed by European administrators, doctors, and missionaries as ‘superstition’ (Kalilombe 2008). ‘Witchcraft,’ defined as boasting of or threatening with alleged occult powers for the detriment of others, as well as detecting others as witches, was even explicitly outlawed in British territories (Bruchhausen 2007).

Thus, material and spiritual elements of African healing practices experienced quite different treatment under European domination. These foreign influences with their coercive means promoted the separation of (bio-)medicalized therapeutics, acceptable to colonial administrations and Europeanized publics, from spiritual elements (Bruchhausen 2018). These more spiritual parts of African healing were more and more adapted to a Muslim or Christian repertoire of objects and rituals, like Prophet’s flags, the Quran, the bible or rosaries, and practices, like praying, singing, or glossolalia. Compared to these Islamized or Christianized forms, the more autochthonous versions became marginalized and often regarded with contempt by the more educated followers of the ‘book religions.’

Today, the social status of African healing is as plural as its forms. In eastern, western, and southern African states, it is usually regulated by laws adapted from colonial times. Officially and congruent with legislation at home in Europe, British laws were more tolerant than French ones, but the latter were never rigorously applied. Thus, medical practices without registration or university licensing of doctors have never been strictly forbidden. Mostly, healers are expected to register with the authorities, but formal exams, like those for healing practitioners (Heilpraktiker) of alternative and complementary medicine in Germany, are not required. In some countries, like South Africa, registered practitioners are even allowed to issue certificates for sick leave like medical doctors (Zenker 2011: 157).

Concerning spiritual aspects, healers in Tanzania are outlawed from interfering in any way with issues of witchcraft (United Republic of Tanzania 1998: 2; 2002: 15). This prohibition is due to the social conflicts caused by threats and accusations of witchcraft, not the ‘unscientific’ or ‘supernatural’ character, as spirit practices are not restricted in any way. It is even accepted that for registration with the district office (especially female) healers use the (male) name of their main spirit instead of their own real name (Bruchhausen 2006: 281).

In contrast to governmental recognition, societal practice always demonstrated a broader acceptance of anti-witchcraft practices. Although officially prohibited, local politicians invite witch-finders and have them perform their rituals of detecting and removing witches if popular will demands such action, as in the case of an epidemic. Thus, witchcraft-related practices can be more a question of social expediency (i.e. calming popular unrest), than of orthodox political, scientific, or religious views (Green 2015).

The practitioners and their clients

According to the great variety of practices of so-called traditional medicine in sub-Saharan Africa, its practitioners have different, often quite distinct functions and trainings. They differ in their degrees of professionalization, ranging from unpaid psychosocial support in the neighbourhood to expensive specialists for certain health problems in high demand. They differ in the length of apprenticeship or training, from a few days to many years; in their usage of spiritual and ritual elements, from performing incantations only when giving medicines to spirit possession; and in their social status, from marginalized poor spirit mediums to political authorities or advisors. These enormous differences render any generalizing account of providers highly biased. It cannot even be generally said—as the WHO and their anthropological
advisors predicted in the early 1980s—that mainly the more biomedicalized or professionalized healers or those whose practices are more compatible with biomedical ideas (i.e. those with naturalistic or internalizing belief systems) cooperate and register with the government (Bannermann, Burton, and Wen-Chieh 1983; Young 1983). On the contrary, the majority of healers registered in the district offices of southern Tanzania around 2000 were female spirit mediums, and most of them did not practise healing as their main source of income (Bruchhausen 2006: 36, 283–285).

**Muslim scholars and Muslim healers**

An important professional type in East Africa who practises spiritual healing among other tasks is the Muslim scholar, often called *Mwalimu* (Arabic-Swahili for teacher or scholar). Stout monotheists, these more educated, exclusively male Muslim healers tend to see all spirits apart from God and his angels as evil spirits requiring exorcism. Based on their knowledge of ancient texts such as those analyzed by Schulz-Burgdorf (1994, 1998) they mainly offer two types of treatment based on writing practices, imitated by many healers without such high degrees of formal learning.

The first *Mwalimu* treatment is divination by numerology (*hesabu*, literally ‘calculating’) and astrology (*nyota*, literally ‘stars’). The letters of the mother’s name (as fathers are notoriously uncertain) generate a number, which point the *Mwalimu* to pages in numerological or astrological books where diseases and their treatment are mentioned (Schulz-Burgdorf 1994: 68). Other divination practices like geomancy (*ramli*), interpreting thrown stones or sand, that such scholars had practised in the nineteenth century (Alpers 1984: 686) have been abandoned. Thereby, even in Muslim divination one finds a range from the mechanical-physical, such as the *ramli* described in older texts, to the literary-celestial, that is, towards practices of using letters and numbers that are more congruent with the central roles of writing and the extra-earthly in formal religion.

This tendency is even more obvious in the second writing-based practice used by *Mwalimu* (and others): the use of Quranic verses. One way to perform this is by wearing papers with verses on them as amulets (*hirizi*), often wrapped in leather or stored in small boxes and worn around the neck or tied to the arm. A less durable version of using letters is writing the verses or figures like stars and crescents with ink (previously also rose water with saffron) in a dish (*kombe*) which is filled with water, coffee, or tea afterwards. Clients then drink this fluid as a kind of internal protection. Other uses described in older accounts is writing the verse on paper or tissue, which is burned and the smoke inhaled, or is simply swallowed (Zbinden 1953: 154–155). Such practices are known from Christian and Jewish esoteric or folk medicine in Europe as well (Eckstein 1987: 1055–1058). Usually, such practices are attributed as the Prophet’s medicine (*tibb an-nabi*), based solely on the Quran and Hadith, rejecting naturalistic medicine of ‘pagan’ origin (Schulz-Burgdorf 1998: vii).

Whereas these Quranic experts, who are dressed in white *jellabiya* or *kanzu* and *kofia* (the long robes and caps characteristic for Muslims in many countries), pretend to keep to orthodox Islam, some less formally educated Muslim healers, especially females, combine Sufi traditions with more autochthonous African rituals. They use Sufi songs and their rhythmic breathing prayer *zikri* (from the Arabic *dhikr*, meaning the meditative prayer of Sufi communities), objects like the Prophet’s flag or a Quran in order to call or calm down spirits. Drums are forbidden as pagan in these cult groups, and during Ramadan, calling the spirits is forbidden. Muslim spirits demand white clothes and soft drinks as sacrifices whereas alcoholic beverages, pork, and half-naked dancing are prohibited for them.
Christian pastors and priests

On the Christian side, many pastors of independent or Pentecostal churches (Kuhn 2008: 170–175) and even some Catholic priests (Wilkens 2011) perform protective and curative practices. The rituals in some of the independent churches strongly resemble the *ngoma* rituals: night-long drumming and dancing with trance and fainting. It has to be mentioned, however, that Christian and Muslim congregations, even the most conservative and fundamentalist ones, also embrace biomedical treatment as part of their social activities (Dilger 2014).

Users and economic aspects

The same variety as with the healing experts can be found for the clients of healing providers. There is evidence that the use of traditional remedies and rituals is not confined to the less educated, but is even common in academic circles, and that it can be easily combined with biomedical treatment. Yet there is, of course, a preference for traditional methods in those poorer parts of the population that lack the means for reaching quality biomedical health facilities and getting pharmaceutical remedies. Payment only for successful treatments and payment in kind instead of cash are important advantages of traditional healers in the eyes of the rural poor. It has been noticed that an increase in the user fees at biomedical health facilities leads to a ‘retraditionalization’ of healing, that is an increased consultation of traditional practitioners (Green 2000).

Traditional healing practices, however, can also be far more expensive than a treatment in the hospital or medicine from the drug store. If spirit possession is diagnosed, a series of night-long drum dances might have to be organized, which demand beer or other payment for the drummers and sometimes also the other dancers. For patients unable to finance such ceremonies for themselves, among them some of the most afflicted, another opportunity is living and working in the household of a healer in order to regularly participate, as a kind of assistant, in the rituals organized for others. Cheaper ways out of unwanted spirit disturbances are sacrifices to the angry spirits, such as clothes, drinks, and food. The most expensive types of treatment are amulets written by Quranic scholars, such as those against infertility, as the learned writer needed education and training at a Quranic school for many years (Bruchhausen 2006: 285).

Travels and legitimations of healers, remedies, and blessings

One of the striking features even of supposedly small-scale societies is the exchange of remedies with both neighbouring and distant peoples. In Africa, ritual objects for healing could be traded over long distances even before coastal and intercontinental shipping began increasing the speed of transport in the early modern period. Colonial administrations increased mobility by improving roads, which allowed healers to travel long distances, away from the social control of their local communities who know the details of their training, performance, and reputation. As traveling healers circumvented the established instruments of distinguishing helpful healers from harmful ones and charlatans, colonial governments tended to forbid such practice in their laws and ordinances on health professions. Nevertheless, various healing practices, such as the coastal forms of possession cults with Arabic *djinns*, traveled throughout the African interior.

Today, spiritual healing practices have started to use most recent telecommunication technologies and advertise with them (Janine n.d.). Africans in parts of Africa distant from home
or even in Europe consult healers in their home regions via Skype or WhatsApp. Thereby blessings are transmitted at great distances, even intercontinentally, in real-time, a technical extension of their previous transfer in written amulets. Such healers tend to use common esoteric concepts and language like ‘spirit medium’ or ‘higher self’ thus inscribing African practices into this global discourse of alternative world views and health-related practices, and homogenizing the rich variety of healing at a global and continental scale: ‘Izangoma exist in probably every culture on the continent’ (Mkhize n.d.).

The most profound change of context, however, is the often-mentioned hybridization of rituals with the monotheistic religions of Islam and Christianity as well as with institutions and paraphernalia of biomedicine, for example, white coats, stethoscopes, and thermometers (Semali 1986: 94; Umeh et al. 2014). Perhaps the most astonishing adaptation of African spiritual healing is its ability to survive and develop both as a ‘religious practice’ of two of the ‘world religions’ as well as ‘medically’ in contemporary governmental and private modern health systems.

The perspective of healing practices as (not) religious or spiritual

When international and national health institutions assigned African practices to become part of primary healthcare strategies since the 1970s, their previous conceptualization as religion was de-emphasized in favour of being healing activities (Whyte 1989). Traditional medicine was largely depicted as the application of substances and rituals were seen as extraneous. Thus, in the 1980s, both official documents and medical anthropological literature overlooked their spiritual importance (Pool 1994). Understanding traditional healing practices as religious would have excluded them from growing public recognition and their contributions to health. Those ways of healing officially recognized as religion, for example in the independent Christian churches, were not regarded as related to the healthcare system.

The so-called return of religion in the late 1990s changed this attitude, at least among scholars. An increasing number of northern anthropologists, sometimes criticized by African colleagues, pointed to the spiritual dimension of healing as a central concept (Green 1996; Erdtsieck 1997; Kim 2001). The scientific approach of assuming that effective traditional remedies include bioactive substances, however, dominates large parts of academic research and of international policies on Africa, sometimes in sharp contrast to such work on Asia (WHO 2002: 8). This one-sidedness might negatively impact traditional healing’s fulfilment of religious as well as medical functions. The number of authors in medical publications that acknowledge the spiritual importance of African traditional medicine is still small, but growing (e.g. Homsy et al. 2003).

Note

1 Ngoma, meaning drum in Swahili and other Bantu languages, refers to both the music instrument played and the dances performed in the rituals for spirits (Engelke 2001).

Bibliography


Healing traditions in sub-Saharan Africa


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