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Review Article

African Traditional Healthcare Practices vs Conventional Medicine: Future Directions for Healthcare in Africa

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Abstract

The paper revisits the field of traditional and conventional medicine, an area that is dominating health and medical sciences today. Despite substantial evidence on the potential contribution of traditional and complementary medicines to health and wellness, several questions remain unanswered. One of the questions is whether the extensive use of African Traditional Medicine (ATM), in the prevention and cure of various pathologies are compelling enough to warrant a radical paradigm shift in healthcare. On the one hand, Conventional Medicine (CM), influenced by the classic biomedical model (BMM), function as 'biological garages' that are intrinsically interested in the biomedical markers of disease and illness. On the other hand, the emerging Biopsychosocial-Spiritual Model (BPSSM) acknowledges the possibility of patients having medically unexplained subjective experiences that influence how they experience and respond to treatment plans. Despite resonating deeply with ATM, the BPSSM struggles for broad acceptance and recognition by CM in Africa. The continued existence of multi-health seeking behaviour in Africa calls for purposive therapeutic collaboration between ATM and CM.

Keywords: African traditional medicine; Biomedical model; Biopsychosocial-spiritual model; Conventional medicine

Introduction

Religion has always been part of the healing process from time immemorial. In the ancient Near East, there was an intimate connection between the office of the priesthood and the medical profession because illness and healing were religious concerns. The separation of religion from medicine only took place only within the last 200–300 years, courtesy of the 18th century Enlightenment that promoted critical thinking and displaced religion from the centre of natural philosophy ("science") [1]. Although religion and medicine have a long history, empirical research on religion and spirituality in the context of health is a relatively new field of increasing importance. The World Health Organization (WHO) cemented the place of spirituality in healthcare 20 years ago when it recognised that spirituality was an integral part of patient well-being [2]. Evidence from two decades of research on the links between religion and health (R&H) has shown that spiritual and religious practices are central to a patient's Quality of Life (QoL), thus increasing personal satisfaction and reducing anxiety and stress. As a result, religion and spirituality positively affect health and well-being. Spirituality is essential for patients and Biomedical Practitioners (BMPs) who have admitted that religiosity and spirituality affect patients in clinical care. Recent studies on the brutal global Coronavirus 2019 (COVID-19) pandemic indicate that people are increasingly turning to religion and spirituality in the face of crisis.

Medical, public health, and social science experts have long recognised the need to shift from the classic Biomedical Model (BMM) to a more spiritually sensitive and patient-centred biopsychosocial-spiritual model (BPSSM). However, despite resonating deeply with the traditional African concept of health and well-being, the BPSSM struggles for broad acceptance and recognition by Conventional Medicine (CM). The continued existence of multi-health seeking behaviour in Africa calls for purposive therapeutic collaboration between traditional healthcare and CM.

Traditional African Healing and Conventional Medicine

Africa is a continent with several religious traditions central to the people's social, economic, and political lives. Levels of religiosity in sub-Saharan Africa are incredibly high, giving weight to Mbiti's declaration that 'Africans are notoriously religious' [3]. In African Traditional Medicine (ATM), healing revolves around religious and cultural cosmologies that define illness, its causes, and the treatment processes. Dzoyem et al. define ATM as 'a holistic discipline that uses indigenous herbalism combined with some aspects of spirituality; it is deeply rooted in a sociocultural milieu that varies from one community to another. … influenced by factors such as culture, history, personal attitudes, and philosophy' [4]. ATM has three distinct, but overlapping categories: divination, spiritualism, and herbalism, and these categories seek to address all potential symptoms (physical, psychological, spiritual, social, and existential), worries, and fears of the patient [5].

At the centre of ATM is the Traditional Health Practitioner (THP), sometimes known as the traditional healer, 'who provides medical care in the community that he [sic] lives, using herbs, minerals, animal parts, incantations, and other methods, based on the cultures and beliefs of his [sic] people. He [sic] must be seen to be competent,

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versatile, experienced, and trusted'. ATM is one of the oldest and most diverse medicine systems and much more prevalent than conventional medicine [6]. Several reasons explain the longevity and resilience of ATM, and one of them is the belief that the patient's symptoms and fears are taken seriously and given sufficient attention. Another reason is that the patient is addressed as a whole and not split into different entities. ATM does not isolate the patient from his/her context but incorporates the family and the larger community into the diagnosis and treatment process [7].

African conceptualisation of illness and health flows from cosmologies that posit multiple deities (a Supreme Creator Being in some cultures), ancestral spirits, human spirits, nature spirits, and the community of the living-dead [8]. These cosmologies are integrated into all spheres of life but exert considerable influence on traditional African healthcare with a distinct concept of the aetiology of illness. This system understands illness as an imbalance of the body and one's socio-spiritual life and is treated by involving the interaction of physical and spiritual therapies (e.g., divination, incantations, animal sacrifice, exorcism, herbs) with no single dominant therapy [9]. Since illness results from supernatural interventions, the prescribed healing and curative therapies are tailor-made to meet the needs and expectations of the patients and their families. The highly personalised and interactive traditional healing process regards participants and not observers in the diagnostic and treatment process, and the THP are simply facilitators [10]. Unlike allopathic medicine, ATM is communal rather than individualistic.

The Biopsychosocial Model (BPSM) was conceptualised by G.L. Engel nearly four decades ago. Analysing the historically dominant model of medicine, Engel noticed that it does not suffice. To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he [sic] lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system [11].

The nature of this pathology-focused BMM is that it is scientific, mechanical, individualistic, dualistic and reductionist [8]. Its concept of health as contingent on the presence/absence of diseases does not correspond with the WHO definition of health as 'complete physical, mental and social well-being and not merely the absence of disease or infirmity' [12]. Engel then offered a new paradigm, a new medical model; he called a biopsychosocial model whose scope is determined by the historic function of the physician to establish whether the person soliciting help is "sick" or "well"; and if sick, why sick and in which ways sick; and then to develop a rational program to treat the illness and restore and maintain health. The boundaries between health and disease, between well and sick, are far from clear and never will be clear, for they are diffused by cultural, social, and psychological considerations [11].

According to him, rather than giving primacy to biological factors alone, a BPSM evaluates all the factors contributing to a patient's illness, thereby making 'it possible to explain why some individuals experience as "illness" conditions which others regard merely as "problems of living," be they emotional reactions to life circumstances or somatic symptoms' [11]. According to Borrell-Carrió et al., the BPSM, 'Philosophically, it is a way of understanding how suffering, disease, and illness are affected by multiple levels of organisation, from the societal to the molecular. At the practical level, it is a way of understanding the patient's subjective experience as an essential contributor to accurate diagnosis, health outcomes, and humane care' [13]. The BMPs enthusiastically embraced this new medical paradigm and were eager to incorporate human warmth, care, compassion, and empathy into clinical practice [13].

In recent years, researchers have been calling for the expansion of the BPSM to include the spiritual dimension as well in order to address holistic health care that understands the whole patientmany researchers think the biopsychosocial model should be expanded to include the spiritual dimension as well. However, "spiritual" is an open and fluid concept, and it can refer to many different things. This paper intends to explore the spiritual dimension in all its meanings: the spirituality-and-health relationship; spiritual–religious coping; the spirituality of the physician affecting his/her practice; spiritual support for inpatients; spiritual complementary therapies; and spiritual anomalous phenomena. In order to ascertain whether physicians would be willing to embrace them all in practice, each phrase from the Physician's Pledge of the World Medical Association Declaration of Geneva. As the argument goes, BPSM, 'pays attention to the bio-physical, the psychological, the spiritual and the social aspects of the health of the individual … combines all the elements of the medical, social and the holistic models and is built on the premise of the interaction between all of them' [8]. The BPSSM is not a novelty in Africa because ATM has always incorporated the psychosocial-spiritual aspects of illness and disease in the healing process [14]. The two health systems, ATM and BMM, represent two diametrically opposing cosmologies. Whilst the strength of the BMM lies in its curative prowess, ATM is peculiar in that it blends cultural practices and religious beliefs that give it a holistic and comprehensive outlook. The paradigmatic differences in disease causation are apparent in that '…Curing is a largely biological process that results in the clearing of disease from the body. In traditional healing, illness is generally viewed as a more psychosocial condition involving spiritual or mental health aspects in need of healing' [10].

Reviewing the application of the BPSSM in psychiatry, Papadimitriou wrote, 'The biopsychosocial model, despite the criticism it was subjected to, continues to offer valuable clinical, educational and research services, as well as to provide an important contribution to the formation of health policies, not only for psychiatry, but for the whole of medicine as well' [15]. The BPSSM has been given extensive coverage in the medical community that believe that this new model would bring remarkable transformations to the concepts of health, disease, treatment, and cure [8,16]. Like the ATM, the BPSSM contextualises illness and healing and considers the patient's transcendental dimensions [17]. However, for the BPSSM to displace the BMM's deeply rooted dualistic mental philosophy, there is a need 'to include a specific acknowledgement of the central role that cultural beliefs and practices can play in understanding mental health difficulties' [18].

Psychosocial-spiritual healing has heightened focus in sub-Saharan Africa with the emergence of faith healing practitioners (FHPs) who claim to solve all human ailments from infectious diseases to chronic conditions. Although most of these FHPs profess Christianity, who claim to be empowered by the Spirit of God, some of them are avowed traditionalists who derive their power from ancestral spirits [19]. The FHPs ability to offer something the BMM cannot, i.e., an integrated approach to pain and healing, may partly explain the growing popularity and demand for FHPs in Africa. Peprah et al. seem to agree

with this perception when they wrote, 'In treating patients, faith healers view health and diseases through the integration of mind, body and spirit largely within the context of family and community. This implies that the healers deal with the complete person aside providing treatment for physical, psychological, spiritual and social symptoms' [20].

Those who subscribe to faith healing (FH) believe that the divine power, activated by faith through prayer and other rituals, brings about healing and wholeness [20]. The perceived effectiveness of FHPs explains why healing services have become part of most Christian services in Africa, especially among Pentecostal and charismatic churches [21]. Since Africans have a deep-rooted belief in the supernatural, Traditional Medicine (TM) and FH are the preferred choices of treatment modalities before any contact is made with a Conventional Health Provider (CHP) [19]. Studies have confirmed that Africans do not reveal their engagement with ATM when approaching a CHP [6]. This medical syncretism has highlighted the need for progressive and mutual collaborations between CM and TM, strategies encouraged by several WHO resolutions and guidelines since 1978 [22].

In Africa, one of the barriers to the institutionalisation of ATM is the demand by BMPs for THPs to acknowledge the perceived medical and scientific supremacy of CM and raise their standards to match the scientific standards of CM. Whilst THPs sometimes engage in practices that broaden and deepen their knowledge of CM, BMPs are sceptical about the authenticity of ATM, which they view as unscientifically unfounded and superstitious. Another problem is that though THPs are willing to refer their patients to CHP, BMPs do not reciprocate this practice. In some contexts, BMPs favour collaboration with one category of THPs, i.e., herbalists who are easily subjectable to rigorous scientific examination, unlike the spiritualists whose practices lack objectivity. There is fear among THPs that CM will appropriate indigenous therapies and resources without giving them due credit, and this phenomenon has stood in the way of mutual collaboration between the two systems [14].

Over the past decades, Africa has experienced a steep rise in the rural-to-urban diffusion of ATM. The increased use of ATM is mainly due to urbanisation, low cost, affordability, availability, acceptability, and dissatisfaction with conventional treatment outcomes of some pandemics and chronic health conditions. There is a significant public interest and demand for natural or herbal therapies globally, with herbal pharmaceuticals becoming a multimillion-dollar industry to be US$ 83 billion in 2019 [23]. As Kofi-Tsekpo wrote, 'Naturally, the many centuries-old alternative sources of health care have become handy, often in desperate situations' [24].

In fact, according to research, about 80% of Africans today rely either totally or partially on ATM for disease prevention and care [25]. For example, in South Africa, 'in 2009, it was estimated that there is 500 THs for every 100,000 people as opposed to 77 medical doctors for the same population' [26]. Whilst many African governments have made much progress in incorporating ATM in mainstream health care, some African scholars object to the idea, that African TM needs to be incorporated into, and subjected to the canons of Western scientific medicine. Such a suggestion … is a prescription for invasion, colonisation and exploitation so characteristic of the relationship between Africa and the Western world. However … African TM is quite compatible with Western scientific medicine [27].

The poisonous atmosphere of mistrust and suspicion between TM and CM appears to be eternal and indelible. Others are uncomfortable with the characterisation of ATM as Complementary or Alternative Medicine (CAM), arguing that, 'the term "African traditional medicine" is not synonymous with "Alternative and complementary medicine" which is a misnomer which is sometimes used. African traditional medicine is the African indigenous system of health care and therefore cannot be an alternative' [24]. African governments have made some half-hearted and ill-executed attempts at mainstreaming TMs, but this tacit recognition has not done much to make ATM a significant contributor and a key player in health care delivery in Africa. The amelioration of this lacuna can only occur if there is policy-relevant data, a comprehensive knowledge base on TMs, and a proper legal framework to support their use in health-seeking communities.

Although many African countries have made significant progress in creating policies and legal frameworks facilitating the integration of ATM and THPs into national health systems, lack of financial support and political will have hampered the implementation and effectiveness of these strategies. Most of the policies and frameworks on the institutionalisation of ATMs have even not seen the light of day. Until such time, the WHO dream of realising universal health coverage will always be a utopian pipe dream for the marginalised populations in Africa.

Towards a Plural Healthcare System in Africa

The plural health care system in Africa typically refers to the coexistence of two systems: Western Biomedicine (WB) and ATM. The former is based on the medical model, which focuses on the diagnosis and treatment of specific health conditions using pharmaceuticals and medical procedures. The latter, on the other hand, is a holistic approach that considers the social, psychological, and spiritual aspects of health and illness. This approach often includes the use of traditional herbs, rituals, and community support to promote health and wellness. Both approaches have their own strengths and limitations, and many people in Africa may use a combination of both approaches to address their health needs. The most important thing is to find the approach that works best for everyone, in order to ensure optimal health and wellness. The combination of these two systems can provide a comprehensive approach to health care in Africa.

The development of a plural health care system in Africa, one that incorporates both WB and ATM, could be beneficial for a number of reasons. One of the benefits is that a plural health care system can help to improve health outcomes in Africa by incorporating a variety of different perspectives and approaches to health care. This can help to address the unique health needs of different populations and communities and would allow individuals to choose the approach that works best for them and could potentially lead to better health outcomes. Implementing a plural healthcare system in poor African townships could also help to address some of the challenges currently faced by the health care system in Africa. For example, a lack of access to CHPs and Western-trained healthcare personnel (HCP) can make it difficult for many people in the townships to receive the care they need. Incorporating traditional African approaches to health care could help to ensure that people have access to a wider range of health care options, including both traditional and modern approaches. This could be particularly beneficial for people who prefer ATM or who may not have access to WB.

Furthermore, a plural health care system could help to preserve and promote knowledge and practices of ATM, which are an

important part of many communities' cultural and spiritual heritage. This could help to maintain the cultural identity of these communities and ensure that traditional knowledge and practices are not lost and can continue to benefit future generations. There are many ways to bridge the gap between WB and ATM. One approach is to integrate ATM and practices into the WB, recognizing the value of both approaches and the unique insights that each can provide. This could include training Western health care providers in ATM, as well as incorporating traditional healing practices into CHPs.

Exposing healthcare practitioners to traditional medicine

Exposing HCPs and medical students (*Meds)* to ATM can be a valuable way to enhance their understanding of and ability to provide care to patients from African cultures. Since ATM is an important part of the cultural heritage of many African communities, this exposure can help broaden their understanding of different cultural approaches to healthcare and may also allow them to better serve patients from African communities who may hold traditional beliefs about health and illness.

There are several ways that HCPs and *Meds* can learn about ATM. In the first place, it is important for medical schools and other healthcare training programmes to offer educational programmes or workshops focused on ATM, herbs and other natural remedies, and spiritual and holistic approaches to healing. These programs may include lectures, discussions, and experiential learning opportunities, such as observing or participating in traditional healing practices. These can provide a comprehensive overview of the various practices and beliefs that are prevalent in different African cultures.

Again, CHPs and training programmes offer opportunities for *Meds* and practitioners to work with THPs or to participate in traditional healing practices. These training programmes can help HCPs learn about the cultural beliefs, values, and practices of different groups, including those from African communities. This can also be a valuable way for students to gain first-hand experience and understanding of these practices.

And lastly, HCPs and *Meds* may also have the opportunity to learn from traditional healers in African communities through partnerships or collaborations. These partnerships can provide valuable insights and first-hand knowledge of traditional approaches to healthcare and can help bridge the gap between traditional and biomedical approaches to health. They may also be opportunities for students and practitioners to engage with communities and learn about traditional healthcare practices through outreach and engagement activities.

It is important for HCPs and *Meds* to approach ATM with an open mind and a willingness to learn. It is also important to respect the cultural values and beliefs of the communities they serve, and to strive to provide culturally sensitive care. There is need for HCPs to have a broad understanding of the diverse approaches to healthcare that exist, in order to better serve patients from all cultural backgrounds.

Towards the institutionalisation of traditional medicine

There has been a push in recent years to institutionalise ATM. This includes providing training and education to THPs in order to improve their skills and knowledge, as well as incorporating modern medical techniques and technologies into their practices. This can help to improve the quality and effectiveness of healthcare in Africa, while also preserving and promoting traditional practices. In addition, efforts are being made to integrate THPs into the mainstream healthcare system, in order to provide more comprehensive and accessible healthcare services to communities across the continent.

There are several ways that THPs can be institutionalised:

- THPs can be trained in the use of modern technology and techniques, such as diagnostic tools and advanced treatments, to improve their effectiveness and accuracy in treating patients
- THPs can work together with modern medical professionals to develop standardised practices and protocols that are based on the best available evidence, to ensure that patients receive the most effective care
- Governments and other organisations can invest in research and development to better understand the effectiveness of ATM, and to develop new treatments and therapies that are based on traditional knowledge
- THPs can be provided with education and training to improve their knowledge and skills, and to ensure that they are able to provide safe and effective care to patients
- Governments and other organisations can work to recognise and value the contributions of THPs, and to integrate their practices into the broader healthcare system. This can include providing legal recognition and support and ensuring that THPs are included in policy decisions and healthcare planning
- THPs can work closely with HCPs to share knowledge and expertise, and to develop integrated approaches to healthcare that combine the best of both worlds
- THPs can play a key role in promoting awareness and understanding of TM among the general public, and in helping to dispel myths and misconceptions about these practices
- Governments and other organisations can support the sustainability of THPs by providing funding and resources to help THPs continue their work, and by working to protect and preserve the knowledge and traditions of these practitioners
- THPs can benefit from building networks and communities with other practitioners and modern healthcare professionals, to share knowledge and experiences, and to support each other in their work
- THPs can advocate for their own rights and for the recognition and value of their practices, to ensure that they are treated with respect and dignity, and that their contributions to healthcare are recognised and valued

Conclusion

The article makes a single claim: the need for healthcare systems in sub-Saharan Africa to create a plural system of healthcare that merges the dichotomous biomedical and healing paradigms. A plural healthcare system can be beneficial in an age of pandemics, such as the current COVID-19 pandemic, as it allows for greater flexibility and capacity to respond to the needs of the population. The COVID-19 pandemic has highlighted the challenges and strengths of plural healthcare systems in Africa. One thing that has to be emphasized is that ATM must not be understood simply as an alternative to CM but a standard treatment in its own right. Although no system

can completely substitute the other, both could become 'co-wives' in providing culturally-and-spiritually sensitive health care to medically underserved Africans. The plural health-seeking behaviour exhibited by many Africans could be a sign that CM is depriving patients of spiritual support and comfort, crucial to their health and well-being and thereby aggravating the already widening health disparities in Africa.

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Conflicts of Interest

There are no conflicts of interest.

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