Preliminary communication UDC 165:60(292.6)(045)
doi: 10.21464/sp33106
Received: May 11, 2018

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Western *versus* African Medical Knowledge Systems

A Comparative Epistemological Analysis

Abstract

The epistemic foundation of reality, especially Western-derived knowledge, is often portrayed as universal and, therefore, as a given, while other forms that do not subscribe to the logic of Western paradigm are challenged and summarily dismissed as inferior to Western form and unworthy of any scientific investigation. The rhetoric of Western versus non-Western knowledge (especially those of African tradition), seems to be characterised in patronising ways that suggest a knowledge form that is inferior to mainstream knowledge system of Western rationality. This rhetoric and ideological orientation are deeply entrenched in academic discourses regarding knowledge production and utility. For the most part, they have become entrenched in Western education and have remained dominant for centuries. The underlying assumptions of the discourse, however, remain unsubstantiated primarily because they are grounded in a scientific tradition that is antagonistic towards other forms of knowledge systems. We argue in this paper that the real difference between Western and African medical knowledge systems is not so much the outcome of the knowledge derived, but in the epistemic foundations that give rise to these knowledge systems. We contend that all forms of knowledge are contingent on specific contexts, and the evaluative criteria designed to measure their universal truth do not serve any useful function except to propagate a false hegemonic narrative for the sole purpose of domination and exploitation. We conclude by advocating for the expansion of mainstream medical knowledge by researching other forms of epistemology without prejudice.

Keywords

African medicine, African medical knowledge, African healing, knowledge production, Western medical knowledge

Introduction

The dominance of knowledge production by the global North, framed as scientific and, therefore, universal is rooted in the historical encounter between the West and non-Western societies, and the need to maintain that dominance perpetually. Thus, the entanglement of African, Asian, North American, and European histories still shapes contemporary global politics, economy, and social relations. This dominance is especially pronounced on the African continent due to various political, economic and cultural interests of the West. As noted rightly by Schwab, the nascent political independent states of Africa starting from the late 1950s

> "… became clear almost immediately that Africa would not be left alone to sort out its problems. Europe, the Soviet Union, the United States, and even the United Nations impinged on political and economic developments, harming Africa's ability to cope with change." (Schwab, 2002, 5)

The result of that interference is that by

> "… the 1990s many African states had all but ceased to exist as coherent and organised entities, with some spiralling into complete disintegration (…) pushed into raucous tyranny, others collapsed into civil war and/or ethnic conflict (…)." (Schwab, 2002, 5)

Knowledge production was also not immune to the interference of Europeans in African affairs since their first encounter. It suffered as much as the political, economic, and social chaos that the actual engagement produced, and Africans still suffer from it in the second decade of the twenty-first century.

In the literature, the term African Indigenous Knowledge, African Traditional Medicine, or African traditional healer, is used somewhat derogatorily to refer to all forms of medical knowledge and practices that have their roots in precolonial Africa. Collectively, they connote a high degree of illogicality and unscientific knowledge and practice that are inferior to other forms of medical knowledge. This arrangement is usually gauged against Orthodox medicine that is grounded in Western logic, which is still the framework for researching African medical system both by Western scholars and most African researchers. These forms of "scientific" research use African medicine as the base for preclinical trials by subjecting it to experimentations in randomised clinical trials with the sole aim of isolating the active properties of the plants of African medicine while deriding other aspects of the healing process as demonic and nonsensical (Gibson, 2011). This dominant narrative, notwithstanding, some scholars have also begun to challenge this position (Laplante, 2014; Ngubane, 1977; Mazrui, 1986; Van Sartima, 1984). Contemporary efforts by various African governments, motivated by the World Health Organization (1978, 1984, 1995), to officially recognize African medicine can best be understood against the backdrop of promoting African indigenous knowledge and medicine but still framed along the ethical codes of Western medicine that is characterised by "scientific proof", standardization, and tight regulations (Appiah, 2012). The contestation by Africanist scholars of this dominance that is underpinned by a metanarrative that frames reality from one monolithic perspective and a universal science of knowing takes different research course such as those that focus on methodologies (Turner, 1968; Kleinman, 1980). Others include the integration of both Western and African forms of medical practice (Van Andel et al., 2015; Gowon and Goon, 2010), to those who advocate for separate and authentic research and development of African medical knowledge and health system (Barnett, 2000).

In this paper, we explore the epistemic foundations of Western and African medical knowledge. We review the basis of Western knowledge and the underlying assumptions of its evolution. Furthermore, using practical medical experiences we interrogate the ontology of Western and African medical realities and how the narrative of what we know and can know is a product of social constructions and how such constructions constrain our understanding of the world around us. The goal of the paper is to initiate a discourse that challenges hitherto taken for granted medical knowledge framed as "scientific" while other forms are regarded as unscientific and, therefore, unworthy of attention in mainstream scholarship. The ultimate purpose of the article is to draw the attention of African intellectuals and Africanist scholars, generally, to engage more with the African reality and develop appropriate theories that will explain that reality and advance endogenous ways of knowing.

Western Knowledge:
Its development and nature

Through the centuries Western scholars have preoccupied themselves with the nature of knowledge, but this endeavour became a more critical enterprise at the turn of the nineteenth century as Western empires sought to expand and entrench their political power and influence around the globe. To fully establish their domination, Western scholars propounded theories of knowledge development that were grounded in the progression of humankind starting with the Greek civilisation and reaching its apogee in the modern scientific endeavour of the West. Early sociologists and contemporary positivists are convinced that there is a universal way of knowing premised upon objective laws that supposedly undergird all natural phenomena and human societies (Mill, 2009). Even though it is acknowledged that each scientific enterprise has its subject-matter, the theoretical position of Western scholars is that practical ways of deducting and applying facts are the same (or should be the same) and applicable in all circumstances and all human societies. The shortcoming of this way of thinking is the limitation positivism imposes on its mode of knowing, which is embedded in its framework of investigation that concerns itself only with observable entities that are perceived directly through the five senses and subjected to Western experimentation.

Auguste Comte (1798–1857), one of the earliest sociologists, foregrounded his positivistic knowledge and "law of three stages" on the assumption that Western rational knowledge is the product of evolution with his precipitous three stages of human development characterised by his claim that the basest level of knowledge is the theological followed by the metaphysical. Both of these "lesser" stages, Comte reasoned, were characterised by knowledge systems that ascribed spiritual and abstract forces to human and natural actions (Giddens, 2016, 12–13). For positivists, reality can be proven only by reference to Western rational science based on empirical evidence while other kinds of explanation of reality that do not subscribe to the positivistic mode of knowing must be rejected as false and summarily dismissed. Underlying this line of thinking is the prescription that all modern societies that do not apply and subscribe to positivistic knowledge must be regarded as primitive and inferior to those that do. The only rational thing to civilise them is to bring such primordial societies to a level of sophistication and civilisation accomplished by teaching them the logic and rationality of modern science. The framing of standard development theories exemplified in global policies, education, economics, health, and politics is guided by this firm conviction and has remained unchallenged since the ascension of Western science as the dominant way of knowing and in the establishment of the Bretton Woods Institutions after the end of WW II (such as the World Health Organization and the World Bank). Hence, the ideas of the nineteenth century are still pervasive and enduring in the twenty-first century, and in all likelihood, will continue to shape future directions of global politics and social relations.

Auguste Comte's evolutionary idea of knowledge, with its modern variants, is dubious as it suggests that the trajectory of understanding is unilineal. The stages of human experience, from a Comtean perspective (and by extension contemporary Western ideology and policies), suggest a progression that leaves a clean break of one stage to another and the adoption of a new form of knowing and understanding. It is not only considered a paradigm shift but an entirely new way of thinking and a new way of knowing. While this may be true in a sense, it is not the complete picture. Indeed, the enterprise of

knowledge production is far more complicated than the monolithic prescription by Western scientists. Knowledge is not evolutionary in the Comtean sense but the product of cumulative experiences, experiments, and revelation. Thus, positivistic mode of knowing has in its form and structure the essential characteristics of other forms of knowing including experiential, experimental, and transcendental. The same is also true of different types of knowledge production: the so-called theological and metaphysical stages of knowledge incorporate in their structure of knowing elements of positivism. For example, the belief in animism and spirits has only transformed, not in its contents, but in ways they are now constructed. So that rather than animals we now believe in human capacities, and instead of supernatural forces (however they are defined), modern scientists now believe in atoms, electrons, and social forces (or what in Sociology Emile Durkheim refers to as "social facts"). In themselves these forces remain constant, it is only our construction and use of them that inform their utility.

By the mid-nineteenth century, especially after the publication of Charles Darwin's *On the Origin of Species* in 1859, the dominant notion of the evolution of knowledge, and by extension of the human species, became firmly established. Darwin's theory of human (and cultural) evolution, which Carleton Coon (1963) further developed into the five stages of human development became the standard framework for the analysis of human condition. Darwin's general theory of evolution and Coon's notion of the Caucasian race evolving first into *Homo sapiens* and other races following afterwards significantly shaped Western anthropological scholarship with specific reference to European and non-European groups. Scientific developments in Western societies were, thus, interpreted as to imply the superiority of all forms of the Western knowledge system. With this idea of superiority, the early missionaries to Africa also used Western medical knowledge system for ideological purposes whereby the establishment of missionary hospitals was partly intended to demonstrate the healing power of Jesus Christ among the Africans they came in contact. Underlying this demonstration of Jesus' power was the covert demonstration of the validity of Western rational explanations of reality over what missionaries and their colonial counterparts saw as unintelligible African superstitions. These cultural encounters became the fermenting grounds that framed the grand narrative of Western scholarship.

Thus, in an attempt to articulate what he regarded as rational knowledge or belief, Lukes (1970) painstakingly discussed the nature of knowledge and its rationality. For him, knowledge is irrational and should be rejected if it is inadequate in specific ways such as: (i) if they are illogical or inconsistent or self-contradictory, consisting of or relying on invalid inferences; (ii) if they are partially or wholly false; (iii) if they are nonsensical; (iv) if they are situational, specific, or ad hoc; (v) if the ways in which they come to be held or the manner in which they are held are seen as deficient in some respects (Lukes, 1970, 207). Lukes' criteria in determining rational knowledge, although useful in analysing Western knowledge production, is inadequate for the analysis of all forms of knowledge. In the first place, the underlying assumptions of Lukes' criteria are hinged on Western binary ways of knowing, which construct reality from a reductionist perspective. Thus, Lukes' criteria are framed purely from a Western paradigm and cannot apply to all forms of knowledge as shall be presented in this paper.

African indigenous medical knowledge and practice

African medical knowledge has often been misunderstood by Western-trained scholars who view African medicine as one collective whole and analysed under the derogatory term of African Traditional Medicine. Under this broad and amorphous categorisation is the typical portrayal of African medical knowledge system as nothing but an oasis of superstitious beliefs and deriding African pharmacology as vague primitive terms associated with people of low mental faculty (Gibson, 2011). It is worth noting, however, that some African scholars (for example, Mazrui, 1986; Mutwa, 1996), have challenged this uncharitable view. They have demonstrated in their arguments that scientific theories such as those of relativity and plant telepathy were already known among Africans long before the advent of Christianity and colonialism, which promoted a medico-epistemological arrogance that portrayed African medical knowledge system as demonic and irrational.

In our preliminary investigation of African medicine and healing system in South Africa, we attempt to understand how indigenous doctors diagnose diseases and examine health conditions and explore the philosophy behind their healing methods by interviewing practitioners and patients who benefitted from the former's expertise. In this section, we present some types of indigenous medical diagnosis and some of the key features of each type as a framework for discussing African medical knowledge relative to the Western medical knowledge system.

At least two types of African indigenous medical diagnosis exist, and they are distinguished by the diagnostic apparatus. Generally, traditional healers who rely on patients' narratives and the physical examination of the ailment in diagnosing the health condition of patients are herbalists (or *nyangas* in South Africa; *onisegun* among the Yorubas of Nigeria). Their expertise is demonstrated in their examination and diagnosis of "natural" ailments such as headache, ulcers, stomach pain, insomnia, diabetes, high blood pressure, including complex neuro-psychosomatic disorders such as depression and bipolar disorder. Through years of practice, and based on the training obtained, *nyangas* have a compendium of symptoms that are used to diagnose various forms of diseases, which will be corroborated by patients' narrative. This diagnostic type shares common features with biomedicine as it can be objectively assessed based on the symptoms that are collectively agreed upon. This aspect of African medicine has been widely demonstrated to be reliable, effective, and amenable to external validation by employing clinical trials in assessing the diagnostic process and treatment. Western-trained scientists, in conjunction with pharmaceutical industries, have collaborated with *nyangas* to identify and extract the compounds of various herbs used in the treatment of diseases to isolate the active ingredients of medicinal plants. As noted by Lauer:

> "… biomedical and pharmaceutical research depends upon indigenous African herbology for the success of multi-national explorations of tropical bio-diversity in the search for new anti-carcinogenic and anti-viral therapies, nutritional supplements, and food processing ingredients." (Lauer, 2003, 10)

Specialised journals such as the *African Journal of Traditional, Complementary and Alternative Medicines* have also been established to publish the results of research in the field of traditional African medicine. The key challenge of this form of traditional medicine is the debate around intellectual, cultural and property rights and those who stand to benefit commercially from the

knowledge and information obtained from *nyangas*. To protect these rights, the World Health Organization (WHO, 2013) has called on African governments to develop a framework where the issue of intellectual property rights is unambiguously explained in order to protect cultural knowledge and practices. If governments, scientists, and pharmaceutical industries, demonstrate a genuine faith and respect for the knowledge of indigenous peoples, *nyangas* will continuously support the efforts of governments in promoting indigenous wisdom towards achieving universal health care.

On the other hand, is the category of African medical practice that transcends positivistic logic and, therefore, not easily amenable to Western rationality and its system of validation. Its diagnostic process is not only illogical to Western methodology, but it defies the Western mode of knowing. The diagnosis of diseases in this category takes the form of dream interpretation, consulting with the ancestors through the use of "bones" (the term used by South African traditional healers to refer to their divination repertoire), extrasensory perception, the reading of smoke, and other ways of diagnosing health conditions. At this level of diagnosis, the healer differentiates between "natural" and man-induced ailments. The traditional doctor (*sangoma* in South Africa, *babalawo* among the Yorubas of Nigeria), recognises, for example, the physical symptoms of stroke which include speech, limbs, and vision impairment, among other symptoms. But what seems to differentiate natural stroke from man-induced stroke is vomiting. Once the patient is confirmed to have vomited, the African healer is quick to diagnose some other underlying explanation for the ailment. To further confirm their hunch, the vomit is analysed and interpreted. Where this is not practicable divination is performed to understand what led to the social problem and those that might be responsible for the health condition. After the diagnosis is completed, the healing process is then initiated. *Sangomas* who treat stroke patients admit that they do not normally cure patients with natural stroke but refer them to the hospital for Western treatment. They also lack the knowledge in explaining the physiological process and causative factors of stroke such as the blockage of veins and the inability of the brain to function ones the supply of blood is cut off. Thus, "unnatural" ailments, including various types of mental illness, are diagnosed not only by physical symptoms such as vomiting but by divination. In diagnosing the ailment, the patient may or may not be physically present for the practitioner to make a complete diagnosis. All that is needed is the full names of the patient for the diagnosis to be made.

It is at this level of duality between "natural" and "artificial" ailments that African medicine becomes a suspect from a Western perspective. Can diseases and health condition be induced by the machination of humans and other elemental beings such as ancestors and spirits? How can we explain the rationality of diagnosing health conditions by mere throwing and "interpreting" "bones" or smoke? These questions cannot be answered from Western rational reasoning due to its limitation in conceptualising realities beyond the five human senses. However, do we dismiss this alternative claim to knowledge because it does not fit into the Western paradigm? Or can it be treated as another way of knowing that will help to expand our knowledge and understanding of the complex nature of reality? Our interviews with patients who were diagnosed and healed with this method all claim to be real and efficacious. Two examples from our respondents are given below.

A man consulted a traditional healer to ward off any ill luck, ill fortune and evil spirits from a newly bought apartment. In the process of divination, which

involved the slaughtering of a chicken and interpretation of its entrails, the *sangoma* informed her client that his primary concern should be his health besides his newly acquired home. She informed him that the divination revealed that his liver was damaged due to heavy drinking and smoking. Her client confirmed that he had been told by his medical doctor after his check-up the previous month. He must quit smoking and drinking, the *sangoma* advised her client, and he must start treatment (either Western or African) immediately if he wanted to be alive by the end of the following year.

A second case involved a community development worker. She described herself as a sociable and vibrant young lady who "did not get involved in anything 'traditional'". She found out a year ago (2017) that she was constantly having abdominal pain and went to the hospital for a routine check-up. Her doctor could not diagnose the ailment but prescribed some pain relieving tablets. A week later, she noticed a lesion at the lower section of her abdomen and went for a scan. The doctors found nothing. According to her, she could feel a physical movement in her abdomen and the increased swelling of the lesion. The pain became excruciating. She was referred to a traditional healer who diagnosed the ailment through divination and told her she had been "called" by the ancestors to be a traditional healer. According to her, once she accepted her calling and started the initiation process, the pain stopped and the swelling "disappeared" without her taking any medication.

For this paper, two issues from the above narratives will be highlighted. First is the method of diagnosis among African healers, and second, is the outcome of their treatment. From a Western rational perspective, and using Lukes' criteria specifically, it is illogical to diagnose a state of health through the interpretation of a slaughtered chicken entrails or through "bones" divination, or the "interpretation" of the smoke of incense without having any physical contact with the patient or asking the patient what the ailment might be. To the uninitiated, or the Western rational mind, there cannot be any remote possibility for these forms of diagnosis to be regarded as "true", yet these are standard modes of diagnosing ailment among African medical doctors. The outcome of their determination is undisputable as it always confirms the results of another type of diagnoses such as those associated with Western practice or the patients confirming the diagnosis themselves.

While it is true that African medical diagnostic method can diagnose some ailments, it is equally valid that it is limited in diagnosing some form of ailment, especially modern ailments such as HIV/AIDS. The same is also true of Western diagnosis – some ailments seem to defy Western diagnosis – such as the one narrated above. What appears to be clear from this preliminary analysis is that illnesses may not only be regarded as culture-bound, as they are specific to the cultural reality of the society of the patient and doctor but also ways of diagnosing ailments are limited and may not be universal as scientists often present Western medical knowledge. For the *sangomas* and their patients, their experiences are real to both of them even if Western science is inadequate in explaining that reality. Their world may not be recreated elsewhere, but it does not negate the fact that it is real to them and that they respond positively to that reality.

What is clear from the above discussion is that while the results of African medicine are undisputed by Western-trained health practitioners (through scanners, x-rays, and other medical gadgets) what seems to be disputed is the method of diagnosis merely because it cannot be subjected to Western rationality nor amenable to its experimentation. Thus, the bone of contention is

not the outcome of African medical knowledge *per se* but whose knowledge of knowing and to what authority knowledge is ascribed. An acknowledgement of other forms of understanding by Western scientists is to undermine the Western authority and to alter the power relations that were historically constructed. Hence, the politics of knowledge production is not an objective framework but a process that is influenced by historical antecedents to leverage power in favour of the global North whose principal interest is to manipulate and subdue. In challenging the Western hegemonic narrative of knowledge production, we submit that because the results emanating from African medical knowledge system cannot be ascertained by Western logic, it then follows that its method of diagnosis and the healing process that follows are valid but may not be subjected to Western scientific rationality. Thus, we may conclude tentatively that Western epistemology is inadequate in comprehending and explaining some realities and, therefore, cannot be universal in its application. The point being made here is that no one way of knowing is superior or inferior to another. African and Western approaches to the construction of knowledge are merely different ways of arriving at the same outcome. In the African tradition, embedded reasoning provides the necessary platform to explore both the visible and the invisible worlds that are inhabited respectively by humans and elemental beings in achieving diagnosis and treatment. The same goal, however, may be achieved by an exclusionary Western orientation that takes only a positivist approach. We may then submit that there are multiple realities and the real and the unreal are a matter of degrees and methods of enquiries. These multiple realities make a distinctive difference between Western science and African medical knowledge (at least some aspect of it). Thus, it is in the arena of the means of enquiries and not the outcome that makes the difference. What follows in the next section is a discussion of the ontological and epistemological basis of African medical knowledge, and the production of knowledge more broadly.

African versus Western medical knowledge epistemologies

African doctors uphold that the causative factors of diseases and ill-health are not separate from the individual as opposed to the epistemological persuasion of biomedicine framed by the germs theory that considers the aetiology of diseases to be traced mainly to an external intrusive agent such as bacteria. From this position, biomedicine considers the patient and disease to be two separate and independent entities. Hence, the ontological position of biomedicine is dualistic in nature and form. African medicine, on the other hand, believes that diseases and the individual are embedded – that is, they are inseparable. This mode of medical knowledge is grounded in the notion of "life-world embeddedness" whereby perceptions about the individual and their health are inextricably bound to a stream of experience or life events. These life events have both natural and supernatural features. The natural elements reflect our perception of the physical world, the meaning we attach to it, and how we respond to that world. The supernatural characteristics reflect that we are sometimes influenced by the unseen world that is made up of ancestors, elemental beings, and other transcendental agents, including social forces. In a sense, the supernatural is an objective reality since it may reflect an inter-subjective reality that can be shared by the healer and the patient. However, this ontological position of African medicine, from a Western perspective, may seem vacuous, but it is not as shall be made apparent shortly.

African doctors are not only guided by the notion of embeddedness, but they also acknowledge and accommodate the objective reality of the world of germs and how such external agents can lead to ill-health. The recognition of this reality is the practical reason why there are African doctors who specialise in child-birth, orthopaedics, mental health, and those who provide the necessary herbal mixture to remedy ill-health conditions. Thus, when it comes to health and healing African peoples do not separate between "Western" or "modern" healthcare system as opposed to indigenous African health system because the African approach to health and healing is holistic in the sense that the material and the spiritual are understood as inseparable from each other. It is precisely for this reason that many Africans do not find it difficult to patronise Western medicine. However, the spiritual dimension of health (which is not captured by biomedicine), also facilitates the simultaneous use of Western medicine with indigenous medicine among many Africans (Sibanda, Nlooto and Naidoo, 2017). For example, it is acknowledged that depression may lead to mental illness, which is an objective physical reality, but the African doctor may provide a supernatural explanation of why the depression occurred in the first place. In treating the patient both the immediate cause (the objective reality of depression) and the remote cause (the supernatural cause of depression) will be the concerns of the healer if she is to cure the mental disease and prevent further occurrence of the malaise. Hence, the value of the African medical system is fundamentally to enhance the understanding of the objective and subjective worlds of the patient and how to provide permanent cure to the sick. However, like all fields of knowledge, there are limitations to the full understanding of both worlds and the methods of accessing those worlds are also limited. In their humility and an acknowledgement of their limitations, African healers ascribe all knowledge to "God Almighty" who is regarded as the "Great Healer", "The Wise One", and "The Omniscience".

From an epistemological position, African doctors do not only attempt to build their medical knowledge on a reality that exists beyond the human mind, but they also access that realm. They do so by employing various artefacts including leaves, animal entrails, smoke, sand, snuff, cowries, bones, and the mobilisation of elemental beings. At one level of knowing, African healers recognise that the knowledge they have reflects the ultimate goal of healing, which is within the framework of their culture, experience, and history. African healers intentionally constitute knowledge, but at the same time, they are purveyors of that knowledge through their positions as interpreters of the natural and supernatural causative factors of ill-health as well as in the healing process. In other words, they use appropriate cues, anecdotes, and linguistic symbols to make sense of the dual world to the patient, recognising that their sense-making activities occur within the framework of their life-worlds and the ultimate goal of healing the patient. Thus, the diagnostic and healing practice constitutes a cognitive process through the construction of the world of the patient that is mediated by the healer.

As suggested earlier, the examination of African medical system does not in any way confer a claim of infallibility. Indeed, as far as our preliminary research suggests, all our respondents recognise and point to the inherent limitations of the knowledge they access. They understand fully well that their frailty as humans, their personal experiences and idiosyncrasies as healers, impact on the intricate work they undertake on behalf of their patients. For instance, one participant claimed that she had difficulties interpreting the symbols presented to her by the ancestors in her attempt to explore the aetiology of HIV/AIDS. For her, there is a pattern that seems to explain the behaviour

of the virus but, according to her, she cannot crack the code as presented symbolically. She has no doubts, however, that through a methodical probe, it is possible to gain insight into the origin and structure of the virus and, there after, prepare the necessary ingredients for its cure.

Similarly, African healers have developed theories to explain different health conditions and these have been used successfully to cure various ailments, though in some instances, some theories have been modified to reflect the dynamism of the disease, and in some instances, some theories have been abandoned as they no longer satisfy the healing purpose. Thus, the fundamental difference between African and Western medical knowledge systems is in their methods of knowing. For the Western-trained doctor, the medical artefacts of diagnosing diseases are the products of the scientific preconception of the physical world guided by the germs theory and grounded in the logic of positivism.

On the other hand, the repertoire of the African doctor, even though a part of the physical world, are not necessarily contingent on the knowledge, or previous experience of the healer. However, the artefacts of both methods of knowing are not infallible. From the point of view of the African medical practitioner, the artefacts of Western medicine do not approximate the reality or lead to the lived experience of the patient as is commonly associated with mental health in Africa, for example. Similarly, the methods employed by the African healer may correspond to the truth, but the process of interpretation may be flawed. Since the African process speaks to both the physical and metaphysical worlds, it becomes difficult to assess the accurate measure of its reality using the Western paradigm of positivism. At the metaphysical level, it is impossible to articulate and verify the validity of any claim made by the healer even though those made by the patient can be verified empirically. While the former may be difficult to articulate by the layperson, those with the cognitive authority may, nevertheless, claim that the knowledge they have acquired via the supernatural is defensible. The idea is that fellow practitioners with similar insights into the working model of the supernatural can examine the evidence of the healer, the methods employed, the context in which the knowledge was derived, and the healer's life-world. From this body of evidence, a conclusion may be drawn by other practitioners that the claims made by the healer are reasonable, authentic, and accurate to the cognitive framework of that reality. From this perspective, the logic and validity of the African healer's claim to knowing may only be verified by those who understand the logic of that reality and not by Western scientists whose epistemic foundation is radically different and inadequate in assessing that realm of knowing.

As African doctors subscribe to different aspects of the cosmos (air, water, earth, and so on), they may not necessarily agree with the healer's claims, but they may concede that the healer's conclusions are reasonable and plausible, at least from the subjective perspective of the healer. In any event, within the guild of healers generally, specific criteria that measure some objective reality external to the healers will need to be explored further. This exercise is vital for the sake of developing independent measurement scale towards the scientific study of African medicine. By "scientific study" I do not necessarily prescribe a Western paradigm for the study of African medical system. Rather, I propose an appropriate African science with the appropriate epistemic foundation that captures the African reality. The development of such science that accommodates an exploration into the metaphysical will provide

the ground for a meaningful understanding of the complex nature of African medicine. Thus, the validation of African medicine (at least some aspects of it) cannot be achieved by using the Western scientific paradigm and method of knowing. The validation of Western scientific knowledge although it is well established and widely published in academic journals, the same cannot be said of African medical knowledge, due to its complexity as discussed above. Different notions of validity regarding African medicine are espoused precisely because healers subscribe to different ways of knowing and in the interpretation of health conditions. In other words, different aspects of the cosmos may be more usefully applied to evaluate different types of illness. Indeed, some notions of validity seem to be associated with specific health conditions. For example, mental illness, rather than just defined as an objective manifestation of depression, is closely connected with some breach of taboos, ancestral curse or "ancestral calling", or the handiwork of malevolent spirits orchestrated by fellow humans. Such complexity provides the basis for the argument that African medicine represents a form of science, and therefore, of knowledge that is worth investigating by using its framework of knowing rather than force it to conform to some other forms of knowing that is inadequate to capture its reality.

Conclusion

Preliminary analyses of our research into African medical knowledge and healing system suggest that the African healer operates within a cognitive framework that believes in both an objective and subjective reality that exists over and above the human mind and a world and experience that are socially constructed. There is an aspect of an African healing system that appeals to Western science and rationality and another aspect that is fuzzy and speaks to the intangible, the metaphysical, and the transcendental. In practice, the line that separates these realities are well defined, and yet, at another level, both aspects are fused into one cosmic whole. Contrary to the idea that African doctors possessed infantile minds and at best are fraudsters who hoodwink their patients by claiming expertise in all aspects of medicine by invoking the supernatural is unfounded. The authentic healers demonstrate a high degree of knowledgeability regarding the complex interaction of germs, the human condition, and the visible and invisible worlds of the patient. But they also acknowledge their limitations, and this humility is affirmed by their appeal, through rituals and other performances to the ancestors and other elemental beings to help them with their fallibility. Even at this level of interaction, they are sometimes limited in the interpretation of the symbols they are privileged to access.

Nevertheless, the ultimate goal of African medical doctors, like that of their Western counterpart, is to heal the sick and restore the patient to normalcy. Both forms of medical knowledge and practice have their strengths and weaknesses, and neither should be regarded as inferior or superior to the other. They both provide humanity with different types of knowledge and understanding of diseases and illness. Moreover, both medical systems have different strengths and weaknesses depending on the general contexts that guide the framing of various medical conditions. Though the differences may be compelling, we need to celebrate them as they underpin the value of science and scholarship more broadly. The differences should be explored, but the knowledge derived should not drive a wedge between medical practitioners

of different persuasions. The challenge is to explore how we can gain a deeper understanding of other forms of medical knowledge and harness them for the progress of humankind. In our view, such an undertaking is a more useful way of facilitating access to new ways of dealing with diseases and ill health, especially in resource-poor countries (in terms of financial and Western-trained medical personnel) such as those in Africa. To achieve accessibility, we must move beyond the rhetoric and hegemonic discourse of Western versus African medical knowledge systems; instead, we should see the underlying unity in both medical systems towards ameliorating health conditions globally.

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Alex Egodotaye Asakitikpi

Zapadni *versus* afrički sustavi medicinskog znanja

Komparativna epistemološka analiza

Sažetak

Epistemička osnova zbilje, naročito znanje Zapada, često se opisuje kao opće i time kao dano, dok se oblici koji ne odgovaraju paradigmi Zapada izazivaju i odbacuju kao inferiorni i nevrijedni znanstvene analize. Retoriku zapadnog vs. ne-zapadnog znanja, naročito u okviru afričke tradicije, čini se da karakterizira patronistička sugestija da je ne-zapadno znanje inferiorno sistemima zapadne racionalnosti. Ta je retorika i ideološka orijentacija duboko ukorijenjena u akademski diskurs kada je u pitanju proizvodnja znanja i alata. Nastanila se u zapadnjačko obrazovanje i ostala dominantna stoljećima. Podtekstualna pretpostavka takvog diskursa nepotkrijepljena je jer se zasniva na znanstvenoj tradiciji koja je antagonistička prema drugačijim oblicima znanja. U ovom radu argumentiramo da je prava razlika između zapadnog i afričkog sustava medicinskog znanja ne toliko u rezultatima, koliko u epistemičkoj osnovi koja ih oblikuje. Tvrdimo da su svi oblici znanja kontingentni prema specifičnim kontekstima te evaluacijski kriterij dizajniran da vrednuje njihovu univerzalnu istinu nema korisnu funkciju osim promicanja lažnog hegemonijskog narativa s jedinom svrhom da dominira i eksploatira. Zaključujemo tako što zagovaramo proširenje glavnog medicinskog znanja istraživanjem drugih oblika epistemologije, bez predrasuda.

Ključne riječi

afrička medicina, afričko medicinsko znanje, afričko liječenje, proizvodnja znanja, zapadno medicinsko znanje

Alex Egodotaye Asakitikpi

Westliche versus afrikanische medizinische Wissenssysteme

Vergleichende epistemologische Analyse

Zusammenfassung

Die epistemische Grundlage der Realität, insbesondere das Wissen des Westens, wird oftmals als allgemein und mithin als gegeben erläutert, während Formen, die dem westlichen Paradigma nicht entsprechen, herausgefordert und als minderwertig sowie einer wissenschaftlichen Analyse unwürdig verschmäht werden. Die Rhetorik des westlichen vs. nicht westlichen Wissens, namentlich im Rahmen der afrikanischen Tradition, scheint durch eine patronistische Suggestion gekennzeichnet zu sein, das nicht westliche Wissen sei den Systemen der westlichen Rationalität unterlegen. Diese Rhetorik und ideologische Orientierung ist im akademischen Diskurs tief verwurzelt, wenn es sich um die Herstellung von Wissen und Werkzeugen handelt. Sie etablierte sich in der westlichen Bildung und blieb jahrhundertelang vorherrschend. Die subtextuelle Voraussetzung eines solchen Diskurses ist unbekräftigt, da sie auf einer wissenschaftlichen Tradition fußt, die gegenüber andersartigen Formen des Wissens antagonistisch ist. In diesem Beitrag argumentieren wir, dass der tatsächliche Unterschied zwischen den westlichen und afrikanischen medizinischen Wissenssystemen weniger in den Ergebnissen als in der epistemischen Basis liegt, die sie formt. Wir behaupten, alle Formen des Wissens seien kontingent gegenüber spezifischen Kontexten und das zur Bewertung ihrer universellen Wahrheit entworfene Evaluationskriterium habe keine andere nützliche Funktion als die Förderung eines falschen hegemonialen Narrativs, mit dem alleinigen Zweck der Dominanz und Ausbeutung. Wir schließen ab, indem wir die Erweiterung des medizinischen Hauptwissens durch eine vorurteilsfreie Erforschung anderer Formen der Epistemologie befürworten.

Schlüsselwörter

afrikanische Medizin, afrikanisches medizinisches Wissen, afrikanische Behandlung, Herstellung von Wissen, westliches medizinisches Wissen

Alex Egodotaye Asakitikpi

Systèmes occidentaux du savoir médical versus les systèmes africains

Analyse épistémologique comparative

Résumé

Le fondement épistémique de la réalité, et spécialement celui du savoir occidental, est fréquemment décrit comme général, et par là même comme quelque chose de donné, alors que les formes qui ne correspondent pas au paradigme de l'Occident sont évoquées et rejetées comme étant inférieures et indignes d'être analysées scientifiquement. La rhétorique de l'Occident vs. le savoir non-occidental, principalement dans le cadre de la tradition africaine, semble être caractérisée par une attitude condescendante qui suggère que le savoir non-occidental est inférieur aux systèmes de rationalité occidentaux. Cette rhétorique, avec son orientation idéologique, s'est profondément enracinée dans le discours académique lorsqu'il est question de la production du savoir et de ses outils. Elle s'est installée au sein de l'éducation occidentale et demeure dominante depuis des siècles. La présupposition sous-jacente d'un tel discours n'a pas été démontrée car elle se fonde sur une tradition du savoir qui se pose de manière antagoniste envers les autres formes de savoir. Dans ce travail, nous démontrons que la réelle différence entre le système occidental de connaissances médicales et celui de l'Afrique ne situe pas tant dans les résultats, que dans le fondement épistémique qui les façonne. Nous affirmons que tous les systèmes de connaissances sont contingents et dépendent de leurs contextes spécifiques, et que le critère d'évaluation élaboré visant à valoriser leur vérité universelle n'a aucune fonction d'utilité, mis à part promouvoir un discours hégémonique fallacieux qui a pour seul but de dominer et d'exploiter. En conclusion, nous défendons l'idée selon laquelle il faudrait élargir le savoir médical principal par le biais d'une recherche sur d'autres formes d'épistémologies, sans préjugés.

Mots-clés

médecine africaine, savoir médical africain, soins africains, production du savoir, savoir médical occidental