CAUSATION OF ILLNESS IN AFRICAN TRADITIONAL MEDICINE

by

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THE PROBLEM

The attribution of illness to multiple causes has been noted in medical anthropology from the beginning of this century and even before. Most scholars who have studied and written about ethnomedicine have, in attempting to discuss how societies cope with disease, usually included the concepts of causality and especially the notion of multiple causality. Though a lot of literature on this subject exists, causation of illness among non-Western societies is still far from clear. Fabrega has aptly noted that this is because, 'Social scientists and even psychiatrists, when they study problems of illness cross-culturally seem fixed on the view that only psychological and perhaps socio-interpersonal factors are sufficient to explain medical phenomena' (1974:41). I should also add that until recently, illness has been regarded by most social scientists who have worked in non-western societies, as just any other misfortune, explainable by referring to certain 'powers' or 'forces' believed in by various societies. This is evident from the works of Rivers, Clements, Paul and Ackerknecht, scholars who have written on causation of illness in general. These writers precede historically the second group of writers who have usually tended to focus their attention on specific societies. For Africa, to mention only a few, I have in mind social anthropologists like Evans-Pritchard Victor Turner, Monica Wilson, Jean Buxton, R. Le Vine, H. Ngubane and A. Harwood. Both sets of scholars share many weaknesses in their approach, the most significant of which is a failure to see causation as a dynamic process operating across various dimensions (or realms of reality) which are closely related.[1] I am not suggesting that the dimensional process idea has not been noted. Actually Evans-Pritchard discusses the idea and Turner and Buxton allude to it. Ironically, most writers following Evans-Pritchard's Azande study have largely failed to relate the causation of illness to the concept of planes, which is very common among many African societies.

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1. These dimensions will be referred to as "planes" in my argument.

Most literature on causation of illness up to now has focussed on the exotic (usually regarded by the writers as 'mystical') aspects. In other words, too much attention has been paid to what I shall call the second and third planes of causation which involve the inter-personal and spiritual aspects of illness. Little attention has been paid to the equally, if not more, important plane of causation, the first one in my scheme, which pertains to the physio-chemical process in a patient and how a society conceives of the same.

This failure to elucidate the notion of planes of causation has been coupled with an insufficient concern with the concept of 'health' and I propose that this accounts for most of the misunderstanding as far as theories of causation of illness in African societies are concerned. Why one plane of causality should be selected explaining an illness and not another in a particular society at a specific time is a question that requires more research - yet the evidence contained in the aforementioned studies indicates that the specific 'chain of events' which is relevant when explaining a case of illness can change as the illness progresses and as different people assess the situation. It is also possible to claim that the patient's life history and that of his society are important when analysing the chain of events considered as the 'causes' of a particular illness. The four societies I am dealing with, show in their beliefs and practices that an illness may be regarded as being brought about by physio-chemical, interpersonal and spiritual factors, separately or in combination. Various combinations of these factors are possible both at the inter-plane and intra-plane dimensions. Though the writers mentioned show an awareness of this, they have usually presented reductionist views of causation while at the same time acknowledging the possibility of various planes of explaining illnesses as these are understood by the actors. This has resulted in too much emphasis on ultimate as against immediate explanations of causation because the former are usually coined in a mystical idiom, and therefore appear more bizarre and therefore attractive to many Western social anthropologists. This has been done in spite of ethnographic evidence pointing to the fact that the concept of health as found among many African societies necessitates the consideration of both the immediate (how) and ultimate (why) levels of causation. Most writers on this subject have tended to emphasize the latter at the expense of the former.

The justification for this paper lies in the fact that allegations have been and are being made that traditional beliefs regarding the causation and

treatment of illness are a major hindrance to the 'acceptance' of modern medicine in Africa. Herein lies a false assumption that the basic premises of traditional and Western medical practice are totally conflicting - so beliefs in the former should be dropped to give way to acceptance of the latter. The argument presented here is meant to provide the evidence that in both traditional African and Western medicine, the causation of illness is perceived first and foremost as physiological pathology (except of course for some psychological problems). African traditional medicine goes further than physiological pathology and embraces other realms of existence.

The Zulu, Nyakyusa, Gusii and Mandari are used in this paper to illustrate the argument. To understand causality of illness, it is necessary to understand what people consider as health - to this I turn below.

THE CONCEPT OF HEALTH

If a society seeks to explain what causes illness, this implies that the society has certain expectations, should I say ideals, about what 'health' entails. A partial or total absence of these expectations would then evoke a desire to find out why health as a condition no longer exists. I think that one can justifiably claim that an understanding of the concept of health is essential when seeking to discover what factors are considered by a society as responsible for illness - for, in explaining the cause or causes of an illness, the people try to point to the factors which reduce, or remove altogether, the conditions which must be present for a healthy situation to obtain.

Before discussing the concept of health as perceived by the four societies, let me point to a distinction which needs to be made at the outset to avoid confusion, one between disease and illness. Depending on cultural background, a disease may not be regarded as an illness. Illness is culturally specific while disease may be regarded as a universal condition - a pathological abnormality indicated by a set of symptoms. This distinction has been made by G. Lewis, among others. He says, 'I wish to contrast, on the one hand "disease" defined by criteria of a biological nature, and applying generally to the human species, with, on the other hand, "illness" which will be determined by views of particular individuals or cultures - it is of a social and psychological nature' (G. Lewis, 1976: 90).

In Western medicine, at least until recently, the tendency was to

concentrate on the physio-chemical aspects of illness. In the four societies I am considering, as among many others with what Gluckman has called multiple relations, there is a more or less unified view of illness. In these societies, ethnographic evidence suggests that health is not an isolated phenomenon but part of the whole socio-religious fabric; it is more than an absence of disease. Health is bound up with the whole interpretation of life, which means that considerations like peaceful living together, keeping religious and jural laws, are just as essential to a healthy life as absence of malfunction in the physical body. When the Gusii say, for example, orogongo rwasarekire (lit. 'the place is spoilt') they mean a variety of conditions, all of which may exist at the same time. The statement may refer to:

(1) general physical illness;
(2) disharmony among the members of a group;
(3) an upset spiritual environment.

Usually it is believed that a presence of conditions two and three provokes condition one, or if this were already existing, worsens it. The Zulu have the same view, as Ngubane has this to say, 'For a Zulu conceives a good health not only as consisting of a healthy body, but as healthy situation of everything that concerns him. Good health means the harmonious coordination of the universe' (Ngubane 1977: 27-28). The Mandari have a similar view of health which usually embraces the individual, morality and religion - because medicine is closely interwoven with other institutions of society (Buxton, 1973). Among the Nyakyusa 'good company implies co-operation between members of an age village, the sharing of food, good-natured conversation etc. At another level, the Nyakyusa believe that such inter-personal relations also reflect the physical health of a society. This is symbolically expressed by the claim that cleanliness of body (implying absence of illness) is learned from inter-personal inter-action. A healthy community is one in which the people are physically, morally and spiritually 'clean' (Monica Wilson 1963).

'Health' as understood by the four societies then approximates to the proposition in the WHO constitution that 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[2], and ideal though this may be, it is the sort of condition that many non-Western societies regard as health. Let me expand on this concept before

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2. World Health Organisation Constitution.

I deal with the issue of causation, or the reduction of health. Since health is believed to involve various realms of reality, a disturbance in one of these has a bearing on the others. The sequence of events that are believed to lead to non-health, or illness, is confused in existing literature. Some writers seem to suggest that where the people allude to external factors- spiritual and inter-personal - as causes, there is an absence of the notion of illness as a process internal to the person. I argue that since 'health' seems to imply internal and external conditions from the point of view of the patient, causation should also be regarded as embracing these two aspects - the internal, referring to the physio-chemical processes, and the external to spiritual and inter-personal factors.

It is not difficult to understand why such a view of health and illness should prevail. For most African societies, the original concept of nature includes, at the same time, the physical world, the social environment and the meta-physical forces of the universe. This view of life affects the concept of health, for a state of illness transcends the merely biological and physical consequences of organic malfunction and affects social/spiritual life in significant ways. This view is possible because according to African traditional religions, man lives in a religious universe, with him as the centre of this universe. The social, spiritual and physical aspects of the universe dovetail into each other, 'to the extent that at times and in places one is apparently more real than, but not exclusive of, the other' (Mbiti 1969: 57).

In trying to understand causation, one needs to look at these aspects of the universe in their interrelationship. A cause on one of the planes (physical, inter-personal, spiritual) may, and does often, not exclude causes on other planes. Explanations of causes complement one another and therefore care should be taken so as to avoid giving 'lists' of causes, some referring to the 'how' others to the 'why' of an illness since as has been noted, the two planes, are not at par. A 'how' explanation may not necessitate a 'why' explanation but the latter usually assumes the existence of the former. I hope that I have now broken the ground for my argument about dimensional causality. The four societies regard health as ensuing from a converging of physical, inter-personal and spiritual well-being. In what follows, I want to develop the argument as to the possible chain of events that are regarded as leading to a situation of reduced or complete absence of health, i.e. illness.

POSSIBLE PLANES OF CAUSATION

Process

In discussing how people conceive illness is caused in Africa, various writers distinguish three main categories of cause:

(1) the physio-chemical (usually referred to as natural) which may include psychological factors;
(2) inter-personal;
(3) spiritual.

All three categories of cause are regarded as operating independently of each other. I suggest that this is a superficial view, because causation at any of the three planes does not mean the same thing.

For most illnesses, people seek to understand how the condition has originated, i.e. the immediate factor responsible for the patient's debility. At this plane, the patient and those around him may refer to environmental factors like coldness, aging, worms, bad food, medicine taken or psychological stress. These factors, possible causes for the patient's debility, are regarded in a matter-of-fact way. It is known that human beings are prone to fall sick as part of the natural process of growth, degeneration, and death. If one is bitten by an insect or snake or steps on a poisonous thistle, the people know that all these can somehow work upon the person concerned so that normal metabolic reactions are impaired, leading to a malfunctioning of an organ or organs, or indeed, the whole body. Ethnographic evidence suggests that African societies recognize the fact that a disturbance of bodily parts by harmful substances or organisms may lead to illness. When the first symptoms of an illness are reported or noted, there is usually an attempt to seek the immediate factors or substances which may be regarded as responsible for the condition. This does not mean that a 'perfect' understanding of germ theory exists among the four societies. The point I am making is that members of the four societies attempt, as a first step, an empirical observation of the patient and his physical environment to try to attribute the illness to some familiar factor. It is also true that on this empirical plane, a wrong explanation may be offered, but yet this is regarded as natural enough not to necessitate other explanations on the inter-personal and spiritual planes.

Physio-chemical plane

Various biological factors may be called forth to explain an illness. For example, vomiting may be attributed to some wild fruit chewed, or a swelling to an insect bite. The details of how the harmful substances react with the body to cause illness may not be clear. Common illnesses, like malaria, may be be wrongly blamed on uncooked food, but the point for this argument is that the people know that insufficient food may lead to illness - hence the attempt to provide a special diet for a person who has lost much blood. It is also known that illnesses can be transmitted physically from person to person, for example venereal disease.

It should be noted that on this empirical plane, there may be a number of factors given as causes for one illness, all operative at the same time. A stiff neck may be blamed on bad food, an insect bite, a fall from a height or any such factors as are regarded as natural, i.e. expected as part of normal life. Of course, the causes believed to be operative may have nothing to do with an illness, but the fact that people blame the illness on the factors shows that their concern is with the how of the case as against the why. At the intra-plane level, multiple causality of an illness can be believed to exist. Explanations on this plane are significantly different from explanations on the other two planes I shall consider later. On the 'how' level, where causation is perceived in the sense of physiological pathology, it may be unifactorial or multifactorial, i.e. as an illness progresses in time and intensity, any of the factors already mentioned may be thought to be involved.

Inter-personal plane

As noted above, explanations of an illness at the inter-personal level imply causation but of a different nature. Here there is usually an attempt to fix responsibility upon some member of society or the patient himself. An action, or failure to perform one, may also be believed to lead to a worsening of an illness. On this plane, the society moves from the 'how' of an illness to the 'why' and especially its particularity. This plane is usually preceded by a 'how' explanation. As an illness becomes serious people start seeking to account for the reasons which have made the patient the victim of the illness. It is this understanding which I wish to stress. Most writers give factors like sorcery, breach of taboo, the curse etc. as 'causes' of an illness. In what

sense are these causes, comparable to the causes in the physio-chemical plane? I propose that the two planes be viewed separately by referring to ultimate and immediate causation; the former being the domain of the second and third planes of causation, while the latter is that of the physio-chemical plane. Forces, agents or persons on the second and third planes of causation are believed to direct or focus whatever agents are responsible for the patient's pathological condition. On this plane, explanations are vividly symbolic and must be so regarded if a distortion of beliefs is to be avoided. The distinction between the first plane, the 'how' explanation, and the other two planes, the 'why' explanations, is clearer when one considers treatment, which I shall do later. On the inter-personal plane, a society seeks to find why an individual should be afflicted by illness and which human relations are responsible for this. This has a bearing on questions of morality, corporate responsibility and punishment for unacceptable behaviour.

Explanations of causation on the interpersonal plane are often superimposed on that of the physio-chemical. Here we have what may be described as double-plane multiple causality or just interplane multiple causality. The factors involved arise from inter-personal relations, which involve moral considerations. There is not necessarily a supernatural element, though this may be assumed for some cases. The main aim on this plane is to impute responsibility for the illness. It is believed that the social environment does affect physical health. On this plane any of the following may be held responsible:

(1) Sorcery (as defined by social scientists, the use of medicines with or without spells);
(2) the evil eye - referring to attributes like jealousy, greed, etc;
(3) the curse as a stylized pronouncement directed at an individual which is intended to harm because of its form and because of the relationship which links the parties;
(4) breach of taboo - though this is believed to be punished by spiritual powers there is a personal responsibility on the side of the victim, but usually the punishment is meted out to a person/persons in a certain relationship with the person breaking the taboo[3];

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3. These usually involve the third plane at the same time.

(5) witch-craft-tapping of mystical power by human beings to debilitate health;

(6) ancestor 'punishment' - ancestors are sometimes placed in the inter-personal rather than spiritual domain.

There are many other factors arising from inter-personal relationships which may be seen as affecting one's health, but as indicated earlier, not in the same way as do factors on the physio-chemical plane. Sometimes people may not be clear when talking about causation and it may not be understood, for a particular illness, what difference there is between immediate and ultimate causes. One needs to take the whole life view, in relation to health, to understand what is meant by statements pertaining to causality. It may be necessary at times to follow a person's and his society's life history, in relation to its cosmology, in order to grasp the idea of planes in causality. In literature, one finds a list of 'causes' of illness like: 'natural', 'sorcery', 'ghost visitation', 'the curse'. Such a list does little by way of clarifying the concepts of causality; because these four factors belong to different planes of explanation. It is true that, at times, people may seem to claim that something like sorcery or a curse is the immediate cause of an illness. This is an exception, I dare say, rather than the rule; it is usually a result of superficial enquiry, and this is seen, for example, in Le Vine's work (Nyansongo), where he fails to make distinctions which the people make both in theory and practice.

By referring to the inter-personal factors which are believed to cause illness, the people imply the stresses, guilt and emotional disturbances which are consequences of sins or crimes committed by the patient or his fellowmen. According to the notion of corporate responsibility, someone may suffer affliction because of a curse invoked upon a grand-father or some other relative. Ancestors may be believed to be capable of punishing any or even all of a group of kinsmen. I am not concerned here with the mechanisms of these factors: rather, I wish to stress that forces believed to emanate from the social environment may be seen to bear on an illness. The people express this by using analogy, that is, by referring to common experiences, familiar concepts are made to stand for a complicated set of phenomena which may or may not affect the patient's pathological condition. By stressing the sociological implications of these beliefs, for example witchcraft accusations, anthropology

has obstructed an understanding of the concept of causality in African traditional medicine. Some writers have attempted to elucidate the notion of dimensional causality, embracing, among others, the inter-personal plane. Evans-Pritchard had this to say in 1937: 'Zande belief in witchcraft in no way contradicts empirical knowledge of cause and effect... The attribution of misfortune to witchcraft does not exclude what we call its real causes but is superimposed on them and gives to social events their moral value' (Evans-Pritchard 1937:72-73).

The same warning is echoed by Gluckman who says, 'witchcraft as a theory of causation does not deny that men may fall ill from eating certain foods, but it explains why some of them fall ill at some times and not at other times... for example when a Zulu said that his son was killed by witchcraft, he meant that a witch caused a snake to bite his son so that the latter died' (Gluckman 1960: 83, 90). Though these two writers make the point explicit that there are different planes of causality, few others, even those writing afterwards, have developed the dimensional analysis, besides just mentioning its possibility. Yet, ethnographic evidence suggests that where multiple causality is involved, different planes are discernible.

The Spiritual Plane

Among the Gusii, Zulu, Mandari and Nyakyusa, there is the belief that spiritual forces, non-human in nature (though not necessarily in origin) may also be involved in an illness at the 'why' dimension. Though the inter-personal plane is also concerned with ultimate causality, the spiritual plane is usually believed to be the 'highest' in the causal chain. The Mandari believe that the creator (Nun) permits all illnesses to happen. Yet, in specific illness cases they may refer to physio-chemical and inter-personal factors as causes. According to Mandari cosmology, Creator is involved in illness, though the same illness may be blamed on other causes. Buxton makes this point very clear and implies that Creator is at the most ultimate level of explanation. Usually for illnesses where the two 'lower' planes are difficult to understand, the people refer to Creator as the 'cause'. It does not mean here that the people are claiming that Creator is in the patient and thus causing the malfunctioning. It is a symbolic way of 'resigning' from attempts to explain an illness on the 'how' plane. The people console them-

selves with a 'why' explanation. On the spiritual plane, the forces are believed to be extra-human and celestial. These forces can be:

(1) Creator and his representatives;
(2) ancestor spirits (or ghost spirits);
(3) evil mystical beings, e.g. Jok among Mandari, ebirecha among the Gusii.

For the four societies, this plane usually works in conjunction with the second. For example, breaking taboo is believed to evoke divine punishment. When a curse is cast upon someone it is believed that Creator or the ancestor or both may harken to the person (or people) cursing to punish the offender. There may be one or several spiritual forces in one episode of illness and there are certain cases of illness which are believed to be due to all the three planes of causation. A causal chain is believed to be operative - the people move from the how to the why levels of explanation because of the particular circumstances surrounding the patient.

A consideration of the procedures of treating illness in African societies may clarify the people's perception of the causation of illness. To this I turn below.

TREATMENT

Perhaps the amplest evidence for the planes of causality is available from the material regarding the treatment of sick people in African societies. Therapy is usually applied at the physical, sociological and spiritual realms of reality. This has been reported for the Chiga of Uganda (Edel 1957), the Zulu and Mandari. Among the Gusii, okogwenia (to cause recovery) may involve the following; emete (trees, i.e. medicine), okoosia (appeasement), ekeng'wanso (sacrifice/purification). For simple sicknesses emete, material medicines, are given without any rituals. This stage may also involve physio-therapy by a medical expert. If, however, the sickness becomes serious, the elders may suggest okoosia. This involves an assembly of the kinsmen and neighbours of the patient. Food is eaten together and all adult men and women 'bless' the sick person and proclaim publicly that they have no ill wishes against the victim. This is usually done where there are many inter-personal conflicts and disagreements which may be believed to contribute to the illness. There are times when a suspected person may be forced to own up to his malice and renounce any

further harm. If the elders think that some spiritual forces are involved, the reaction is quite different from the above. If Engoro (Creator) or ancestor spirits are believed to be involved, a fowl, goat or sheep is sacrificed and this may be followed by a ritual purification for the sick person and immediate kin. Among Christians, communal prayers are offered for the patient at church or at home. Even when a person has been treated at a modern hospital, traditional or Christian ritual is usually offered, as it is believed that only Engoro (traditional) or Nyasae (Christian divine being) is responsible for complete recovery. The Mandari material is rich in examples where there is treatment of the sick by medicines, individual and group therapy at the sociological level, and purification and sacrifice to remove or appease spiritual agencies. Ngubane shows that the Zulu have the same view of treatment. She shows the link between the notions of causality and the type of treatment. For the Zulu, treatment depends on whether the illness is due to natural, moral or mystical factors. Treatment may involve empirical medicine, symbolic medicine for mystical illness and a maintaining of a 'balance' where moral factors are involved (Ngubane 1977: 131-133). I suggest that future research should explore further the link between notions of causality and the nature of treatment: the two are closely related in any medical system.

CONCLUSIONS

From the three preceding sections it is clear that concepts of health, notions of causality and the practices of treatment, all take a unified view of the physical, sociological and spiritual realms of existence. However, these three aspects of existence, though believed to converge in the sick person, are not permanently fused as some have argued (Mbiti 1969). It is arguable, therefore, that for the four societies considered here, an illness cannot exist just because the society believes in sorcery, evil eye, or spiritual agencies of causation. It is only when someone is affected by a disease that the non-biological aspects of existence become relevant in perceiving illness. On their own, the inter-personal and spiritual agencies do not constitute illness. It is the individual as a physio-psychological entity that is the focal point for an illness. This idea has been clarified by G. Lewis who has this to say: 'illness is a distinctive form of misfortune by its outstanding characteristic. Some individual is directly harmed. That individual, a self, is the subject, or for others the human object, of the harm,

having a private direct experience of it which cannot be equally or identically shared by anyone else. Thus illness is a misfortune sensed by the sick person in ways which other misfortunes, like his house burning down, are not (Lewis 1976: 101). It is true that a society may use unique concepts in explaining illness. Belief about causality may be naturalistic or personalistic (Foster and Anderson 1978) but illness is perceived by mankind as a biological condition. To some societies a germ theory of illness may suffice, while to others, unified theories of illness may be more plausible. I suggest then that though notions of causality and illness may be culturally bounded, illness is a unique misfortune, stemming from the physical condition of a human being, though capable of being extended to embrace other realms of reality, variously conceived of by different societies.

Persistence and Change: Prospects

Some comments are relevant concerning the encounter between African traditional beliefs and Western 'hospital' medicine. There is no belief system that is static. Even before the coming of Western medicine, traditional medical beliefs could and did change. Unfortunately, there is no research material available for the four societies but I wish to probe into this matter, using whatever information is available and contemplating this from personal experience. Though there are some local differences, it is possible to make some generalizations about the process of change and the accommodation of medical beliefs in Africa.

Among the Nyakyusa, Wilson noted that even during the 1940s Christian beliefs were affecting Nyakyusa notions of causality. Formal education also affected traditional beliefs. Instead of the 'breath of men' there developed among Christians the belief in mystical power emanating from God. There developed a belief in a Christian curse, within the congregation. This was supposed to result from the anger of fellow Christians if one of them committed adultery or was stingy or greedy. She also says that instead of 'sorcery' people used 'poisoning' to explain deaths believed to have been caused by medicines. Medical beliefs of the Mandari, Buxton claims, '... show a considerable flexibility and a willingness to examine it. In many ways, Mandari medicine in its theory and practice shows itself more receptive to new proof and more capable of modifying accepted dogmas than has been the case formerly with Western theory and practice' (1973: 327). Unfortunately, no recent

evidence is available to indicate how the beliefs have changed. Berglund (1976) shows how the Zulu have incorporated Western beliefs into their medical system. There are some illnesses regarded as typically 'African' and therefore treated only locally. But notions of sin and divine (Christian) punishment have been accepted at the why planes of explanation. Among the Gusii, Western ideas of medicine have been generally accepted, but still people hold the unified view of illness which is best revealed in treatment. A patient may be treated in hospital while traditional or Christian rituals like anointing and prayers may be performed on his return home.

I do not think that the unified view of illness will necessarily disappear. Some beliefs and practices related to this may be attenuated but the core of the beliefs is likely to persist. Since the beliefs have been shown to include a 'how' plane of explanation, there is no necessary incompatibility between the traditional and Western medical beliefs. What seems to be happening is that the less plausible explanations like the evil eye, the curse, sorcery etc. are being modified by concepts about stress, maladjustment, emotional instability etc. now propagated through community health programmes.

Unfortunately, the interaction between Western and traditional medical beliefs has not been smooth. Doctors, health assistants and Christian workers have discouraged traditional beliefs as 'uncivilized'. Yet, the bulk of the population is still untouched by Western medical services. It cannot be denied that some traditional medical beliefs are invalid in the face of scientific research: at the same time, there are some tenets like the belief in treating the 'whole' person that are in line with modern trends in medicine. Traditional beliefs stress social and spiritual harmony to prevent illness. The approach tends to be more 'preventive' than curative. Some of these allegedly preventive measures may not be medically helpful - but such an approach can be encouraged through community medicine. A document produced for the World Health Organization has this to say, 'modern medicine ... is ill-adapted to the provision of health care for rural populations ... African traditional medicine is one of the pillars of the cultural heritage of the region and has the potential capacity for finding a remedy to that inadequacy. An integration of the two systems, without compromise of principle, yet with full understanding on both sides, should enable the sorely under-privileged populations to benefit from one of the fundamental human rights: the right to health' (WHO, 20th Session, Kampala 8-15 Sept. 1976).

My projection then is that a dialogue is likely to develop between the two systems, in spite of initial obstacles. This trend is likely because of the interest now being developed in traditional medical beliefs by African governments and universities and research institutes. At present there is a testing process going on from the point of view of African societies. The people are being brought face-to-face with pluralistic belief systems and as Horton (1967) remarks, the experience may be painful, but the 'open' predicament will in the end be reached by the majority of the people. This is no new phenomenon in history. Topley has shown how 'naturalistic' Chinese beliefs of causality have incorporated 'moralistic' elements from Budhism (in C. Leslie (ed.) 1976). C. Leslie (1976) also shows how these beliefs have then responded to Western medical beliefs and practice.

The encounter between Western and African traditional notions of causality may even be smoother in future because there is a new trend in Western medicine towards a more 'unified' (systems approach) view of illness. In this new perspective, disease is not viewed as a discrete and discontinuous state that attaches to an organism in space and time. Fabrega says that according to this view, 'Disease is seen as a natural consequence of man's open relationship with his physical and social environment... Thus cause is multifunctional, processes are interconnected and manifestations are multifaceted' (Fabrega 1974: 141). Whether by accident or design, this view of illness is not new to any of the societies I have studied and, should I say, to many others in Africa. Even when Africans move to urban areas, this view of illness tends to persist though the factors may change in detail. Mitchell in a study among urban Africans in central Africa, gives evidence of such a persistence. He says, for example, that even in towns where different ethnic groups settle near one another, Africans interpret misfortunes, illness among them, in direct and personal terms. Such an explanation is specific to the individual concerned; it explains why the misfortune selects one particular person and not another. In urban situations, explanations at the why planes may be sought from the urban social relations and problems arising from these. At the same time, interpersonal relations with one's kin may be seen to affect a person's health, though the kin are miles away. Hospital medicine is believed to deal with the physical aspects of an illness, but traditional methods deal with the interpersonal and spiritual aspects of an illness. What needs to be stressed here is

that this is an amplification of the unified view of illness, found amongst many African societies. This view has accommodated, and continues to do so, Western ideas about illness but the reverse process has been inhibited by the attitude of Western trained medical practitioners who regard their methods as always superior to the traditional ones.

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