THE PROFESSIONALISATION OF AFRICAN MEDICINE

Edited by Murray Last and G. L. Chavunduka

AFRICAN SEMINARS: SCHOLARSHIP FROM THE INTERNATIONAL AFRICAN INSTITUTE
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Volume 5

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The following participated in the seminar but their papers could not, regretfully, be included here:

Dr Alya Baffoun, Centre d’Études et de Recherches Economiques et Sociales, Université de Tunis, 23 rue d’Espagne, 1000 Tunis RP, Tunisia. Her paper: ‘Ebranlement de la médecine traditionnelle et effets “reductionnistes” sur le rituel de la circoncision: cas de la Tunisie’.

Professor Bernardo Bernardi, Universita’ di Roma ‘La Sapienza’, Dipartimento di Studi Glottoantropologici, 00185 Roma, Piazzale Aldo Moro 5, Italy. His paper: ‘The human aspects of professionalisation: what should not be lost’.

Dr Christopher Davis-Roberts, Center for Afro-American & African Studies, Dept of Anthropology, University of Michigan, Ann Arbor, Michigan 48109, USA. Her paper: ‘Dawa ya kinchi, dawa ya kizungu: the politics of knowledge among the Tabwa of Zaire’.


Dr F. M. Mburu, Dept of Community Health, University of Nairobi, Box 30588, Nairobi, Kenya. His paper: ‘Professionalisation and differentiation of traditional medicine in Kenya’.
The International African Seminars and the seminar volumes based upon them are widely regarded as the most important contributions of the International African Institute to African studies. We are thus delighted to present the results of the seminar on ‘The Professionalisation of African Medicine’ which was held at the University of Botswana, Gaborone, in September 1983, which we hope will be the first of a new series examining topics which are both of academic and practical importance in contemporary Africa. The generally inadequate provision of ‘Western’ medical services in Africa contributes to the continuing vitality of ‘traditional’ African medical practices whose role in modern African states is a subject of lively controversy. Traditional African medical practices have thus been examined from many different points of view and not least that of the efficacy of the treatments provided. In treating this subject, therefore, we have been careful to select what we believe to be a neglected and very relevant issue: the professional structure and organisation of traditional medical practitioners and how this is affected by ‘Western’ medical institutions. The topic is treated comparatively, with contributions ranging geographically from Nigeria to Botswana, and includes extensive documentation on associations of traditional healers which is not readily available elsewhere. We hope that this volume will arouse interest and debate not only among academic Africanists but also among doctors, administrators and politicians with direct responsibility for medical care in Africa.

The Institute is indebted to all the seminar participants who assembled in Botswana and contributed to the lively discussions whose spirit is, I believe, well captured in this volume. We are particularly grateful to the editors and especially to Murray Last, without whose enthusiasm and energy the seminar could scarcely have taken place. The Institute is also deeply grateful for the warmth and skill with which Professors Michael Crowder and Leonard Ngcongco organised the seminar, for the co-operation of the University of Botswana, the Vice-Chancellor, Professor John Turner, for the staff of the two departments most involved, namely the Department of History and the National Institute of Development Research and Documentation. Their support and encouragement made the meeting – so the
participants said – almost unique in their experience, and thus greatly enhanced the success of the seminar.

Finally, I wish to thank those organisations without whose financial support the seminar would not have taken place. Through the good offices of Sir Leslie Kirkley, a grant from the Voluntary and Christian Services encouraged the Swedish Agency for Research Co-operation with Developing Countries (SAREC) to add its welcome support, and here we are particularly grateful to Dr Gerhard Hultcrantz. The World Health Organisation and the Commonwealth Foundation provided additional support. Those familiar with the Institute’s earlier seminars may recall that the previous programme of seminars was financed largely by a generous grant extending over several years from the Ford Foundation. The situation today is very different. It is proving necessary to seek support from a variety of organisations to cover the costs (moderate though they are) of a single seminar. Our thanks are therefore due to all those who value this work of the Institute and are concerned to maintain the highest standards of research co-operation in African studies inside and outside Africa by supporting us in these aims.

I. M. Lewis
Hon. Director
International African Institute
Ten years ago the Dingaka Society of Botswana was reported as having received official recognition from the Government, with a mandate to regulate the practice of traditional healing and issue licences to those whom its officers judged to be competent. This prompted Dr Priscilla Ulin, in a short study of Botswana medicine, to comment at the time: ‘structurally at least, the organisation of traditional medical practice in Botswana is moving in an increasingly rational direction’ – the implied goal then being, I suggest, the status of a profession. Yet apparently the Dingaka Society did not in the event ever perform its expected role. It thus seemed appropriate to hold a conference in Botswana to take stock of developments (and failures) in the organisation of traditional medicine during the last decade – a decade which in Africa perhaps more rapidly than elsewhere has seen the growth of a movement in support of traditional medicine.

Though the various reasons for the movement’s success do not concern us here, it is clear that it has drawn together some remarkably diverse interests into a sort of consensus or coalition: Governments (whether parties, bureaucracies or military men) who need both to cut costs and maintain popular support; WHO (or a section within it) urging these governments on with ideas and international pressure; psychiatrists puzzled by solutions to patients’ problems in other cultures and pharmacologists on the look-out for new compounds; idealists seeking to develop a truly national medicine and sceptics weary of the medical profession, its claims and its drug companies; radicals of varying persuasion, backing for example the countryside against the town or the ‘folk’ against the bourgeoisie; or realists who simply remark that ‘primary health care’ is already, de facto, the province of traditional medicine and therefore want local knowledge and skills recognised for what they are. Not surprisingly, then, at conferences no less than in policy debates, there is a danger for discussion to be at cross purposes; and the danger for anyone reading later the printed record of those debates is to be baffled by the apparent contradictions. Though a cynic might suggest that a certain confusion is essential for any coalition (or conference?), in this
brief introduction to the conference papers I wish to set out some of the ambiguities and suggest some definitions before the reader embarks on the substantive issues presented in the chapters that follow. For quite apart from any political differences, many have quite divergent assumptions underlying their use of such terms as 'traditional medicine' or 'profession'.

Essentially, such ambiguities arise out of the ambiguous position of traditional medicine itself in most states in recent years. The present position – one of more or less benign neglect – can, I think, be summarised as follows: healers have been left to practise as before, unregulated and unfunded by Government, and largely unaccountable in law for malpractice, manslaughter or fraud. Even where regulations for licensing practitioners and pharmacists have been in existence for several years, the effect nation-wide has been minimal. During this time, academic medicine has used specific healers on an ad hoc basis for referrals, for giving medical students an insight into traditional methods of medicine and for carrying out scientific studies on healers’ therapeutic techniques or, more often, on their pharmacopoeia with a view to their possible application in hospital clinics. Some would advocate that the position of traditional medicine should be kept ill-defined in this way though its use encouraged and extended piecemeal as conditions suggest. I doubt, however, whether this will prove medically, administratively or politically practicable for much longer now. Governments are being increasingly urged to go beyond merely extending the present ad hoc system; instead, they are to incorporate the traditional medical practitioner into some sort of national health service.

AMBIGUITIES

It is at this point that the ambiguities over what people really mean by 'traditional medicine' become apparent. For certain crucial choices have to be made by Government; yet to make these choices requires an unambiguous understanding of what 'traditional medicine' in any one region stands for. As regards the subject of this volume, some of the most important areas of ambiguity are, I suggest, as follows.

1 The initial decision whether:

(a) Government should use its own Ministry of Health as the sole regulating, training and managing body, and if necessary dissolve or limit such embryonic professional bodies as have already come into existence; or

(b) it should use (or if necessary establish) formal professional institutions.
If the policy is to retain professions, then the second decision a Government has to make is: what niche should practitioners of traditional medicine occupy – are practitioners to be (a) subordinate members of health teams within the existing medical profession, or (b) autonomous members of a new and independent profession of traditional medicine? If traditional practitioners are to be subordinate, perhaps functioning like extension workers for such departments as Community Medicine, Obstetrics, Orthopaedics, then inevitably they will be given some additional training, with medical and legal responsibility for management lying ultimately with the consultant. In short, the traditional practitioner will at best be ‘traditional’ only in some ‘moonlighting’ role; and it is difficult to see how ‘traditional medicine’ in this context could ever be taught to the next generation except as some ‘home remedy’.

2 Underlying the choice between a subordinate or an autonomous role for the traditional practitioner are divergent assumptions as to how or why traditional medicine works. One assumption is that

(a) traditional medicine is useful both because it has techniques and drugs that can be usefully added to the stock already in use and because it has personnel who have valuable local insight and experience. By ‘useful’ here it is usually being implied either (i) that traditional medicine works because it has pharmacologically effective drugs (and therefore these can be used outside their immediate cultural context after evaluation away in a laboratory), or (ii) that the techniques of traditional medicine work particularly well, for example, in psychiatric cases, but are largely ineffective in serious disease. Therefore the assumption here is that the traditional healer has a place locally either in primary health care or for handling specific cases under supervision.

The alternative assumption is that

(b) the biomedical model is inadequate, or at best only partially equipped for treating the whole range of illness to be found in Africa; and that what is required, alongside bio-medicine, is a more ‘holistic’, alternative system, which recognises, for example, both the importance of the mind’s control over the body and the effect of the social on the individual. In which case, only an autonomous traditional medicine can develop and sustain this second approach to health. Implied here is that traditional medicine works through a heightened placebo effect (to use a biomedical explanation!) and therefore cannot readily be divorced from its cultural context without losing its efficacy.

3 Underlying these assumptions are assessments of traditional medicine which apparently reflect experiences of widely different medical cultures. No one would seriously expect traditional medical cultures, especially
where ritual and symbolism are important aspects of therapy, to be uniform throughout a continent the size of Africa. Furthermore, it is acknowledged that these medical cultures are, and have been for decades, adapting, adding as well as dropping practices and theories – just as has medical culture elsewhere. At the very least one has to differentiate, for instance between those areas with and without:

(a) organised medical ‘guilds’, with strongly systematised theories of anatomy, illness and treatment, or in some places specialist groups (often mistakenly identified as a sort of ‘tribe’) which provide medical services over a wider region;

(b) complex herbal traditions based either (i) primarily on extensive observation and experimentation, or (ii) primarily on an extensive symbolic system;

(c) complex psychiatric traditions, often using ‘spirit possession’ as the idiom of therapy;

(d) cultures where sickness is a matter of such paramount concern that it is the idiom for articulating disaster and conflict, quite irrespective of the local epidemiology of disease;

(e) cultures where sickness is conventionally minimised (again, irrespective of local epidemiology), and illness as well as conflict is expressed in other ways.

Though within most nations there are usually a large number of medical sub-cultures, each with its own characteristics and structure, policy-makers often have in mind apparently a single, paradigmatic culture from which they generalise about ‘traditional medicine’. Inevitably such stereotypes are likely to reflect political conditions – as of course happened under colonial rule when traditional healers were categorised as ‘witches’. Yet hopes for a rational assessment, performed centrally by Government, of all the variety of medical expertise in a nation are unrealistic. If drugs alone were assessed for their safety, let alone their efficacy (and therapies were left to be reviewed later), the task would still be enormous. Even in Britain 11,000 of the 43,000 drugs on the market still require review.

As if the varieties of traditional medicine did not provide complications enough, in discussions of efficacy it is clear that the analyst tends to have a specific disease, problem or speciality in mind (favourite ones, it seems, are TB, childbirth, bone-setting & psychiatry!). Obviously a person’s assessment of traditional medicine will vary according to which paradigmatic illness he has tacitly in mind.

4 Finally, while the term ‘traditional medicine’ is full of ambiguities, meaning different things to different people, the same is true, of course, of such concepts as ‘health’. Conventionally one distinguishes between:

(a) the WHO-style concept of the whole person cured and well in all
aspects of life; or

(b) the much more limited concept of the individual ‘coping’ with various impairments and problems, adjusting as best as can to circumstances and avoiding actually ever being ‘disabled’.

But others might argue that Government priorities should lie with generating wealth (on the assumption that that leads to health) rather than promoting health per se. This in turn may reflect the analyst’s political preferences or merely a pragmatic assessment of his nation’s manpower, finances and ‘political space’. In which case ‘traditional medicine’ may be used simply as an ill-defined, rag-bag term for what people have always resorted to when left to their own devices.

Ambiguities are, alas, easier to set out than to clear up; and the reader will be quick to point out that what are here presented as stark alternatives are not in practice so clear cut. People can hold contradictory views, propose inconsistent policies – and call it compromise. But in the case of ‘traditional medicine’, the ambiguities are also, I suspect, essential to its efficacy and its survival, enabling it to adapt to new conditions yet still retain its legitimacy. Ambiguity, then, in analysis may merely reflect the essential ambiguity of the object analysed. If so, professionalisation, in the formal sense, may prove incompatible with ‘traditional medicine’ as many of us think of it now.

One ambiguity is intentional, however: by ‘African medicine’ I mean medicine of whatever kind available to the patient in Africa – including, therefore, not only all the varieties of ‘traditional medicine’ but all the varieties of non-traditional medicine, too, whether Islamic, homoeopathic or ‘Western’. For though conventionally one considers ‘Western’ medicine as a single strictly disciplined system and its practitioners as part of a single hierarchically-organised profession (with sub-divisions, however, like nursing etc.), in practice even this medicine is apt to present itself to the patient (at least in a country like Nigeria) as at best a coalition of rival practitioners of varying skill, accessibility and cost. Drugs may in fact be dispensed (albeit illegally, off the hospital premises) by a range of hospital personnel from ward cleaners upwards. Similarly, antibiotic and other drugs are available over the counter (as indeed they are in France), and traders have to learn to help diagnose and dispense imported medicines.

In this context, then, the contrast is not between professional and unprofessional medicine, but between a range of therapeutic systems which are to a varying degree ‘professional’. Professionalisation, then, is an issue not only for ‘traditional medicine’ but for hospital medicine too, where all the usual defining characteristics of a formal ‘profession’ are not necessarily equally well established. Similarly, the problem is not whether ‘traditional medicine’ is or was ‘professional’, but rather why, and in what way, are
some medically specialised groups within traditional medicine more 'professional' than others. So what is meant by 'profession'?

DEFINITIONS

As with 'traditional medicine', there are ambiguities in the way the term 'profession' is used; and these ambiguities derive from people's different assumptions about a 'profession' as an institution and their assessments of its contribution to patients' care. But there are, broadly speaking, two current definitions of 'profession', one colloquial, the other technical. The colloquial definition tends to distinguish between professional and amateur, between the profession and the lay public (as 'client' - not 'consumer') - in both cases there is implied a specialised skill and a distinct system of training which differentiates 'profession' from any other full-time occupation providing the main source of income. It is not, however, the colloquial definition I want to consider here, though the emphasis on skill and training is crucial, and common to both definitions.

The technical description of a profession lists four critical characteristics which together set a profession off from other less formally constituted occupations. The characteristics are:

(a) autonomy: the profession retains a measure of independence through its right to regulate itself; both the profession as a whole and the professional as an individual are thus able to organise and carry out their work without undue interference from the employer or the clients.

(b) monopoly: the professional also has a statutory monopoly over a defined sphere of work; the monopoly is maintained by the profession's control over licences to practise its particular kind of expertise - some of the work, however, is divided out among subordinate groups under the profession's control. (Nonetheless, in the case of medicine, there is not necessarily a general monopoly over health care - one can still set up as a healer so long as no false claims are made; similarly self-medication with defined limits is still legal, of course.)

(c) ideology of service: a code of ethics governing relations between a professional and the client and limiting competition between professionals is formally set out and can be enforced by the profession's own institutions. Central to the code is an assumption that service should replace self-interest in the performance of professional duties. In return for social recognition of its special status, the profession is accountable to the public for providing the expected level of service.

(d) body of esoteric knowledge: a profession is responsible, as 'experts', not only for applying a body of knowledge and skills in practice on behalf of the community but also for teaching and examining recruits to the profession and for promoting research so that the profession can effectively
reproduce both its membership and its claim to expert knowledge. The knowledge itself is normally structured in such a way as to be susceptible to standardised instruction and use.

Historically these are the defining characteristics of a select group of privileged occupations – the church, the law and medicine, primarily. Statutes and custom governing these professions have also been built up over time, but especially in nineteenth and twentieth century Britain and the USA, – more so than, say, in France. Developed out of ‘guilds’, the professions grew, in the case of medicine, through an amalgam of interests – the Royal Colleges and Societies, the hospitals, universities, trade-union-like groups such as the BMA. But the growing power of medicine as a profession should be seen alongside the creation of the newer professions like engineering, architecture, accountancy as part of a wider professional movement. Their history would not concern us here, being, it seems, specific to a period and place in European history, were it not that ‘secondary professionalisation’ – local professional associations developing out of, or on the lines of, metropolitan professions – is a central issue in the history of African medicine.

One consequence of the particular historical importance of professions in Britain and America is that the literature on professions outside those two countries is sparse. Recent sociological interest in the professions is usually dated back to Carr-Saunders [1933] in Britain and to Talcott Parsons [1951] and Everett Hughes [1958] in America – with the medical profession being a major focus of study. By the late 1960s, professionalisation had become synonymous with modernisation, and it was assumed that everyone would be a professional sooner or later. But just as modernisation theory fell into disrepute, so too the professions became the target of increasingly critical analysis throughout the 1970s: the ‘disabling professions’ they were called in a popular book. Today the subject of professionalism still rouses sufficient emotion and distaste to inhibit support for it as a conference topic.

Criticism of the medical profession has focused on each aspect. First, its monopolistic position has been reduced, for example by the public’s recognition of alternative systems of medicine; as a result, in Britain many ‘fringe’ therapies are now readily available, including some practised by doctors on the NHS. Second, its autonomy has been undermined by a Government concerned about the costs, whether trying to curtail doctors’ freedom to prescribe the drugs they choose, or influencing the way hospitals and services are managed. In consequence, within the profession, the hierarchy has been challenged by subordinate groups such as the nursing profession, the hospital administrators and even the hospital workers’ unions. Furthermore, malpractice suits and litigation generally suggest an erosion of confidence, too, while the code of ethics has had to be updated and circulated again. Scepticism over the ideology of service is fuelled in
the USA by criticisms of the profits made out of people's sickness. Not surprisingly academic studies are in keeping with this new attitude: concern with institutional order and ideals of service have given way to analyses of 'interests' and conflict.

Far from predicting the professionalisation of everyone, academic forecasts are now for de-professionalisation. The assumption is that video and computer systems will increasingly enable the patient to be diagnosed by machine, and in consequence the specialised skill and expertise will no longer be the province of a medical elite. In practice, certain specialities, such as surgery, are unlikely to be much affected, and the limitations of self-help are well known. But Tanzania's experience (in its Village Health Workers programme) with a non-technological version of this approach to medicine is evidence of its relevance.

The point, here, is that 'professional' is not a simple, changeless attribute—it is politically negotiable. The other important point, however, is that critics object as much to the mystification of medical expertise as to the privileges or costs of the professional system—for it is knowledge that gives medical practitioners their power over patients and patients' kin.

Knowledge as the source of power or authority is central to the notion of 'professional', whether he be a hospital specialist or a practitioner of traditional medicine. If anything, traditional practitioners are usually considered to be more jealous of their craft secrets than are scientists, whose ways of understanding the body, disease etc. are openly taught in schools and published in books (albeit in somewhat abstruse terminology!). The way this specialist knowledge has been built up, almost as a discrete entity outside the common run of learning, and how it continues to be maintained, modified and passed on, has been the other main area of academic research over the last twenty years. Michel Foucault's *Birth of the Clinic* (*Naissance de la Clinique*, 1963), like his earlier *Madness & Civilisation* (*Folie et Déraison*, 1961), pioneered the analysis of the social conditions and processes which enabled the construction of these particular kinds of medical knowledge. Similarly, it is as systems of knowledge that some of the most influential studies have analysed traditional medicine.

Just as in the literature on the professions, so in the last twenty years analyses of systems of knowledge and how they alter over time have undermined the solidity of scientific 'truth' or fact. The result is a certain convergence of the scientific with the traditional: no longer can a facile contrast be made between 'primitive' and 'scientific', at least in the sphere of thought. The privileged possession of 'knowledge' and the potential for power that it offers have been seen in all kinds of medicine as means for extracting advantages and manipulating the rest of the community.

Although much of the literature may be written in, and about, Europe and America, the issues are of course debated quite as fiercely in Africa, in
universities and elsewhere. In Nigeria, for example, television drama serials (like Hospital, scripted in Yoruba) are explicitly raising the same problems, though from the public’s perspective and with greater ambivalence than Dr Kildare. Likewise there is considerable discussion in the press, as when for example the Association of Nigerian Medical Practitioners in the USA, in a forty-page letter to the Nigerian President, demanded less ‘hard conditions of service’ as a pre-condition for any of them agreeing to return to practise in Nigeria. I have heard Nigerian doctors argue that the professional ethic of public service can no longer be taken for granted and anyway cannot really be enforced, whilst elsewhere it is the profession’s autonomy that is said to be at risk.

Given the debates within the medical profession, it was inevitable that traditional healers would become involved in these issues too. Indeed, healers’ associations, though they may have made little headway at the time, have been in existence in countries like Nigeria and Ghana since the 1930s and thus ante-date some of their hospital colleagues’ organisations; in some areas, too, practitioners have been organised, since before the colonial period, into what might be called a profession (though more often they are referred to as guilds or corporations). But when healers’ associations award their members PhDs, MAs etc., and healers start using, and are given publicly (for example on TV), the title of Doctor, – it is then that the importance of professional qualifications, the restrictions on the use of titles and the question of the public’s confidence in them become subjects of urgent debate. For titles are symbols and guarantors of expert ‘knowledge’; and it is by its ‘knowledge’ that a profession ultimately defines itself.

PROFESSIONALISATION IN AFRICA: A HYPOTHESIS

Here I would like to put forward a general hypothesis that arises out of the definitions of professional medicine discussed above. Much of my thinking, of course, is based on West Africa, and specifically on Nigeria, where I have worked intermittently since 1961.

For most of the colonial period the medical profession as a profession scarcely existed in either anglophone or francophone Africa. Doctors were appointed and worked as virtual civil servants, and though, like other technical staff, they may have been often in conflict with administrative personnel, they equally often assumed official powers (sometimes, but not always, in an ‘emergency’) as de facto members of the colonial government. In some francophone areas, and particularly in the early period, they were often under military discipline. The ambiguous position of doctors, in government service and with limited professional status, is perhaps most acutely (notoriously?) shown by the dilemma of prison doctors. Missionary doctors were anomalous in a different way – but they too have at the very
least a divided allegiance to medicine. In addition, particularly again in francophone areas, it was the colonial authorities (and not the profession) who decided whether or not a doctor’s professional qualifications, if derived from somewhere other than the metropolitan power, were acceptable in that colony. For most of the colonial period, too, doctors in African countries were too few to constitute a local autonomous professional association (only Sierra Leone stands out as a possible exception, outside the settler-dominated territories), and too cut off from colleagues in the metropolitan countries to be within the otherwise pervasive professional structure. Certainly in the eyes of the public, doctors in the colonial period were not recognised as members of some autonomous organisation called a ‘medical profession’!

By contrast the African members of the ‘learned professions’ during the colonial period relied on their professional status to overcome (with varying success, it should be said) the racial discrimination against them. For them, from a very early period, professionalisation was of paramount importance – and it did not matter whether the profession was medicine, the law or the church. In consequence, their emphasis was more on local unity among professionals than on the organisation of a particular profession itself (and in this their position was closer to that of professionals in France or Germany).

If this analysis is correct, the medical and ancillary professions, as self-conscious professions in Africa, are relatively new, dating back to the 1950s for the most part, when African doctors greatly increased in numbers, when private practice outside government or mission hospitals became increasingly common, when university medical schools and teaching hospitals were established – and indeed the whole paraphernalia of a formal profession of medicine (including often a version of the ‘British Medical Association’) were gradually instituted and won formal recognition from the government and public alike. The process of professionalisation became part of decolonisation; it coincided with the Africanisation of staff and curriculum; it was to prove, proudly, that the new independent states were not content with second best, with having only ‘sub-standard’ para-medics as their doctors. In short, it accompanied the establishment of a middle class whose legitimacy was based on educational attainments, a meritocracy to be open to all yet independent of commercial wealth or traditional power. The impetus and rationale, however, behind this new professionalisation were not just applied modernisation theory, etc., but, more importantly, that old, original professional tradition which had been maintained despite the odds, in some cases ever since the nineteenth century, by the families who pioneered higher education.

In this context traditional medicine was viewed initially with some suspicion. Whereas some of the earliest African doctors wrote their medical
theses explaining and sometimes defending traditional treatments, now in the 1950s and 1960s their descendants tended largely to ignore the traditional healers – unless the dire consequences of their ministrations directly affected out-patients’ clinics; perhaps more sharply antagonistic to traditional medicine (and much closer to the generality of patients) were the nurses and dispensary attendants. It seems too that the public began to take more eagerly to experimenting with the new, much extended facilities that were becoming available in rural as well as urban areas, not least because they cost very little and were staffed by people who understood them.

As a result, what we are now seeing, is a kind of ‘second generation’ of traditional healers who have adapted their methods to meet the competition, and organised themselves to defend their right to practise against criticism from an expanding medical profession.¹⁷ The prize is recognition from the government, and ultimately a share in the salaries, supplies and buildings provided by government. Their moves have coincided with a crisis in the medical profession, a crisis among whose symptoms are doctors’ strikes, shortages of equipment, a sharp rise in the unofficial costs to the public of obtaining treatment and a realisation on the public’s part that hospital medicine might not cure everything. For some doctors, particularly those from the older professional families, the crisis threatens all that they have stood for and, if unchecked, might result eventually in a form of de-professionalisation. On the other hand, the expansion in numbers and the rising assertiveness of the new doctors make them an even more formidable opponent for any potential rival.

It is at this juncture that the incorporation of traditional healers into a national health service has become a possibility. Obviously, to incorporate healers as subordinates within an expanding medical profession is an attractive solution for some (in Britain, the official term is a ‘profession supplementary to medicine’). But given the way healers’ associations have grown again in response to a more assertive medical profession, it was likely that these associations would become a focus of resistance to any policy of absorption, and claim instead that they might fulfil the functions of a fully independent profession. The danger, however, is that they would be called upon to be no less professional than the medical profession; and this, as we have seen, means a formal systematisation of ‘knowledge’.

If, as the price for such recognition, it was demanded that the credentials of their members should be examined to a uniform standard, that the efficacy and safety of their treatments should be tested, and practice sufficiently standardised to guarantee, at least in theory, a uniform quality of care, then of necessity colleges of traditional medicine would have to be organised, with a curriculum incorporating both the theoretical and the empirical basis of the particular traditional medical system being taught – but it would still have to be taught in a way that would satisfy the ambitions
and intellectual expectations of school-leavers who were of sufficient calibre to ensure that traditional medicine remained a viable, respected calling. Obvious models for such a college are the Indian Ayurvedic and Unani schools of medicine, some of whose problems have been examined sympathetically by Charles Leslie in a series of papers over the last fifteen years. 18

But whereas Ayurvedic and Unani (Islamic) medicine both have a large corpus of ancient literature in which their formal theories and practices have been set out, few if any systems of traditional medicine in Africa have such a corpus. Furthermore, some of the more efficacious treatments may not be part of a *system* at all. The prospect, then, of formal colleges of traditional medicine is daunting – I would say unrealistic on this scale: for no less than a fundamental construction of what will in effect be a new medical system is required. Yet unless something like that happens – so the argument goes – traditional healers will be marginal, potentially suspect as quacks and unable to attract adequate recruits. Their status in courts of law will be problematic, whether as expert witnesses or as defendants in malpractice suits, and as such always open to the risk of being legislated out of existence.

Healers’ associations, of course, need not be caught in such a trap. One alternative is not to seek national status as a profession but rather to set up local schools limited to specialising in teaching and perfecting a specific technique (of bone-setting, for example) or in a specific field (like psychiatry), much as osteopathy, acupuncture or psycho-analysis are taught elsewhere. And no doubt in some countries an alternative model for therapy, based on a radically different understanding of, say, the properties of herbs, might be developed in a systematised way and proved efficacious outside its cultural context – much as homoeopathy has proved popular in Brazil, and effective too in as unlikely, culture-free a setting as veterinary medicine.

**CONSTRAINTS**

One final area of ambiguity concerns the law. Broadly speaking, under the several Medical Practitioners Acts herbalists have not been forbidden to practise ‘native medicine’ (as it used to be called). By contrast, under the various Witchcraft Suppression Acts (many of which have been re-enacted since independence), healers are committing a criminal offence if for example, in diagnosing the cause of illness through divination or the use of ordeals and oaths, they identify a specific ‘witch’ or sorcerer as the agent responsible. 19 The legal logic for these Acts which simply made the whole matter of witchcraft potentially criminal was to avoid many of the complications of proving slander or fraud and restrict the consequences arising from debates over what was ‘reasonable belief’ or what evidence was required to prove that a ‘witch’ had indeed caused some disaster. But
knowing the statutes governing traditional medicine is one thing—it is quite another to discover the current policies of the local police, the prosecuting authorities or the different levels of courts towards cases of witchcraft.

Nonetheless, in areas where beliefs in witches and sorcerers—and not just ancestors or spirits—are an integral part of traditional diagnosis and therapy, the law is perhaps the most significant among many factors external to traditional medicine which are determining what constitutes acceptable practice (if not acceptable ‘knowledge’). As attempts to repeal the law have tended to show, the law has sufficient symbolic importance to unite the opponents of traditional medicine, whose grounds for opposition are otherwise very varied. The main grounds are:

(a) political ideology—especially for Marxisant governments such as Mozambique’s on the grounds that healers were, and potentially still are, part of the old ‘feudal’ system, unproductive, giving support to chiefs, furthering ‘superstition’ and liable to exploit the poor in their need;

(b) religious doctrine—held not only by Christians (in certain West African Aladura churches for example, as well as in missions) but also by strict Muslims who oppose particular types of traditional medicine as basically Satanic;

(c) scientific and practical reasons—most obviously by members of hospital-based professions, but also by others of a strictly rationalist persuasion (not necessarily all members of the educated elite), who object not only to the delays in effective treatment but also to the deaths or serious injuries caused by misplaced attempts at healing.

(d) opposition to the ‘underworld’ of traditional medicine. Popular culture (and not merely colonialist mythology) has a marked suspicion of medicine misused—as attendance at local law courts or regular reading of the popular press will demonstrate; similarly, an air of outrage (and anxiety) surrounds politicians who are widely assumed to make use of dubious healers in their pursuit (and exercise) of power.

While the first two sets of arguments would seek to have traditional medicine outlawed, the last two more often lead to demands for stricter control over healers. An important consequence of this opposition is that potential leaders of professional associations require more than therapeutic skills: they are functioning perforce in a political arena where the odds are weighted against them. In these circumstances, professional organisation becomes more a matter of self-defence than a claim to monopoly.

The very ambiguity of the law as it is operated in practice to-day is but one element in the wider political debate. For any profession of traditional medicine, no less than the law, has to be seen to have an interest in curbing the criminal element among healers, whether as ‘quacks’ or as ‘trouble-makers’. The difficulty, of course, lies not in the rhetoric but how (or
whether) to specify who exactly constitutes this criminal element in practice.  

‘Medicalising’ the relevant, previously religious terminology becomes thus a conscious attempt to shift the ground of this often sterile yet heated debate and make us re-think our categories. It also reflects what has long been happening already in many parts of Africa. Thus the term ‘healers’ now has to include diviners, mediums, ‘witch-doctors’ as well as herbalists; ‘therapy’, ‘treatment’ includes rituals and symbolic instruments as well as various potions, lotions, inhalants (of the sort that in earlier accounts of anointing ceremonies might have been called unguents, incense). To medicalise the vocabulary in this way is more than mere semantic piracy: it marks a serious redirection of interest away from the causes of illness and misfortune and towards the patient and his body; away from a preoccupation with ‘primitive thought’ and towards the individual quest for therapy, the problems of efficacy and coping; towards, too, what policies governments should espouse in the field of health.

Similarly, in the field of law, illness and misfortune are apt to be labelled, especially in southern Africa, as offences against a person or his property; the diviner is seen as a detective, the witch as a criminal, the patient as victim; the penalties are paid, restitution made. Indeed, given the extraordinary concern to use ‘law’ as the main means of social control in southern Africa (and as a consequence, the traditional preoccupation of social anthropologists in that region with law), one might argue that it is the language of law – and not religion – that is being replaced by medicine as the idiom of misfortune. Thus the importance given to debates over repealing Witchcraft Suppression Acts, and the significance of professionalisation as conferring on traditional medicine the whole structure of legality, may be a reflection of the pervasiveness culturally of the legal idiom in central and southern Africa – and the need there now to narrow down for people the intellectual space allowed to sources of social conflict. Thus the ambiguities in ‘traditional medicine’ may continue to play in certain states a peculiarly significant role – in politics if not in academic analysis!

IN CONCLUSION

The questions, then, that I have sought to prompt by this introduction are:
1 What, in any particular state, exactly is the ‘traditional medicine’ (or the aspect of it) that is to be organised, possibly as a ‘profession’; and what precisely are policy-makers’ assumptions about this traditional medicine?
2 What will be the consequences for the very varied expertise within traditional medicine if it is the expertise too – and not just the experts – that is to be rationally organised, as a ‘profession’ apparently requires, at least in the long term?
3 What have been the pressures – historical, political, medical; local and international – for advocating in Africa now the professional organisation of medicine (of whatever kind)?

4 What social constraints are there on the form that professional organisation (and its construction of professional knowledge) will take in any particular state? What, in short, is the particular compromise now being worked out for each kind of ‘traditional medicine’?

I have sought here only to set out the ambiguities in the use of the terms ‘traditional medicine’ and ‘profession’. I am aware that they are also used as ideology, embedded within an actual political process. The danger, it seems to me, is that the politics of professionalisation will overshadow all other issues – principal of which is the problem of how best to give patients the care that cures them. Though power undoubtedly has its place in therapy, effective traditional medicine, as I understand it, is usually more subtle and uncertain (if not more fragile) than the politicians of medicine seem to remember in the heat of debate.

That there exists at present some ‘political space’ for all the varieties of traditional medicine is clear. However, any purely political solution to how to accommodate traditional medicine may prove in the long term deceptive. For though ‘professionalisation’ is at one level all about power (and thus offers immediate scope for political solutions), at another level it is about the long-term structuring of a specific kind of knowledge, and about how to transmit what is still relevant of it to the next generation. The ultimate test of this knowledge will be not in its political successes, however – though these should not be discounted – but in its success with patients as therapy. And that is much harder to judge.

NOTES

1 Ulin, P. R., (1975) ‘The traditional healer of Botswana in a changing society’, _Botswana Notes & Records_, 7, p. 101. The article is also in _Rural Africana_, 26, 1974, pp. 123–30, and in Ademuwagun, Z. A., et al. (eds.) (1979) _African Therapeutic Systems_. Waltham: Crossroads Press, pp. 243–6. In Lesotho similarly, the Natural Therapeutic Practitioners Association was granted in 1976 powers to certify traditional healers as qualified to practise under the Natural Therapeutic Practitioners Act (no. 14, 1976, sect. 4.1.a) but nothing apparently came of it (cf. the amending Act, no. 6, 1978); homoeopaths, osteopaths, etc also came under this Act. I am grateful to Professor Michael Crowder for sending me Ulin’s article. I am also very grateful to Professors J. F. A. Ajayi and M. G. Smith and to Dr Richard Rathbone for their help in revising this chapter.

2 Stereotypes can alter subtly over time. For example, ‘witch-doctor’ means, and meant in the past, a doctor to cure witchcraft (on the analogy that an eye doctor treats eyes). The term, however, has gradually come to mean a doctor who is also a witch – that is, a ‘witchdoctor’ (cf. ‘barber-surgeon’). There is yet to be a detailed analysis of how this semantic shift came about. It is tempting to link the shift to the rise of missionary-run medicine and its allies, but there was a strong political
element too in the campaign against 'witch-doctors' (e.g. in southern Africa in the 1840s, and in East and West Africa in the early 1900s).


4 It is important to recognise that a 'profession' is itself a continuing compromise, and the 'characteristics' are but key items in that compromise.


8 General Medical Council (1983), Professional Conduct & Discipline: fitness to practise, London.


11 Cf. the studies of V. Turner on the Ndembu of Zambia (1967) Forest of
INTRODUCTION


In works of this 'school', the boundary between religion and medicine is often so slight that studies in the anthropology of religion, ritual and symbolism contain much that is relevant to traditional medical thought (e.g. Middleton, J., (1960), Lugbara Religion, London: OUP for the International African Institute, ch. III.1).


13 Adejobi Theatre Company (1982), Ile Iwosan. Ibadan: Television Service of Oyo State. I am grateful to Dr Karin Barber for discussions on this serial of 13 half-hour episodes.

14 Cf. West Africa, issue 3439, 11 July 83, p. 1609. More general moral issues in Nigeria (e.g. strikes by doctors) were discussed in 1982 at a workshop at the College of Medicine, Lagos and published as Akpata, E. S., (ed.), (1982), Medical Ethics, Lagos: Lagos University Press.


16 This is the general assessment too of T. J. Johnson in his essay (pp. 287–93) quoted in note 5 above. Before 1902, when there was formed a separate West African Medical Staff (from which African doctors were effectively barred), African and European doctors in anglophone areas had been directly employed by government agencies, with the African doctors often proving more popular – because more professional – with European patients than their European colleagues. But since 1878, African Doctors had been paid less, and usually confined permanently to the rank of Assistant Surgeon. The new Colonial Medical Service, from the mid-1930s on, may have served to make the European colonial doctor more a professional and less a local civil servant by enabling him to move from one colony to another. But this 'internationalisation' of medical practice was apparently not permitted to the African doctor: instead, medical schools were set up to give local, 'licentiate' qualifications to African medical staff (as had been done in francophone West Africa since 1918 at Dakar). Otherwise, perhaps the major issue in colonial medical politics was whether or not government doctors should be permitted also to practise privately – an issue the profession still clings to as evidence of their autonomy (and of their entrepreneurial rather than merely bureaucratic role). The distinction for the medical profession between 'government service' and 'a state service' is crucial; for this reason, fees, for example, had to continue to be charged in colonial government hospitals.


17 It is the international aspect of the healers' lobby in the 1960s and 1970s that is most visible – not least because its activities are recorded in print! See for example the First Inter-African Conference on Medicinal Plants (Dakar, 1968), the Pan-


I am grateful to Professor Leslie for a discussion of his views. The literature on the medical profession in China is also relevant, especially the work of Unschuld, P., (1971), 'Medico-cultural conflicts in Asian settings', Social Science & Medicine, 9, pp. 303–12; (1979), Medical Ethics in Imperial China, Berkeley: University of California Press). But the recent context is very different: during the cultural revolution, the All China Association of Traditional Chinese Medicine was dissolved, along with other professional bodies, only to be revived in 1978 (Hillier, C. M., and Jewell, J. A., (1983), Health Care & Traditional Medicine in China 1800–1982. London: Routledge and Kegan Paul, 326).


In southern Africa the Natal Code of Native Law (1891; cf. the draft section 137 of the Native Territories Penal Code for Transkei, 1883) – unlike Cape Colony law – had recognised traditional herbal medicine and required practitioners to be licensed. While Zimbabwe inherited the basic Cape law on this matter, East and Central African states apparently were more influenced by practice in Natal. The Acts, however, against witch finding, ordeals and witchcraft were more or less uniform. Though these Acts date back in Africa specifically to a Cape statute of 1895 (no. 2), they are drawn ultimately from English laws of 1736 and 1824. In the 1840s there was apparently a concerted drive against 'witch-hunters': the Sotho King, Moshoweshwe, himself banned independently the killing of supposed 'witches', while D'Urban's treaties of this period include specific clauses against 'witch-doctors'; this general attitude was then carried over into the new penal codes for 'native territories'. The slight but curious variations in the colonial Acts, and the ideas behind the Acts themselves, were strongly criticised in 1934 by Orde Brown, G. St J., 'Witchcraft & British colonial law', and Roberts, J. C., 'Witchcraft & colonial legislation', in Africa, VIII, 1935, pp. 481–7 & pp. 488–93. A much earlier, indigenous objection was written, necessarily pseudonymously given the law, by 'Ngxakaxa': 'On Witchcraft', Cape Law Journal, VIII, 1891, pp. 210–18. More recent discussions are: Mutungi, O. K., (1977), The Legal Aspects of Witchcraft in East Africa, Nairobi: East African Literature Bureau; Chavunduka, G. L., (1980),

20 The issue is further complicated by the argument – to be heard in both western and southern Africa – that whereas the healers of old were genuinely therapeutic, the present generation are ignorant of past skills and thus necessarily ‘charlatans’. This raises the hoary problem, of course, of what is ‘traditional’ in the context of knowledge, and calls into question from the very outset the possibility of reconstituting a ‘traditional’ profession and ensuring for it an expertise that will be widely recognised, even on its own terms, as truly ‘professional’.
Headquarters: the original ZINATHA head office in Harare (Zimbabwe).
Certificate of Registration

This is to Certify that

is a member of Zimbabwe National Traditional Healers Association and is
Authorised to practice within the terms of the Traditional Medical Practitioners
Act, No. 38 of 1981.

To Whom it May Concern

This Certificate is issued within the Traditional Medical Practitioners Act, No. 38
of 1981, (Section 18) and the holder is entitled to the rights pertaining to
privileges of that Act.

The Association's Constitution has been approved by the Minister of Health
of the Republic of Zimbabwe.

Date_________________________ Signed by ______________

President
THE ZIMBABWE NATIONAL TRADITIONAL HEALERS ASSOCIATION

2 Certificate: Zimbabwe National Traditional Healers Association. A formal
register of certified practitioners is also published (the two figures shown at the top of
the certificate were healers who led the resistance to British colonialism in 1897).
3 Certificates: Amalgamation of Nigerian Medical Herbalists (Lagos) – left: Qualified membership certificate right: Formal documentation as a limited company
MEMBERSHIP CERTIFICATE

OCHIRITSA
Reg. on 1730, 1965
Box 583, LIMBE

Name
Address

THE FOUNDER

HEADQUARTERS P.O. Box 583, Limbe

DIRECTOR

Date

HEALERS

This is to certify that

Address
Chief

is a properly registered and approved member of the TRADITIONAL MEDICINERS OF CENTRAL AFRICA by whose Authority this Certificate is granted by Headquarters at:
P.O. Box 583, Limbe.

As a member of this MEDICINARY I agree to abide by the rules of the said MEDICINARY.

Associating with £5 to become a registered member.

AIMS AND OBJECTS OF EXECUTIVE:
(a) The Medicinary shall endeavour to follow the most up to date methods in the care and treatment of patients.
(b) It shall also see that all who practice as Mediciners must be members approved by the Traditional Mediciners of Central Africa.

(c) The Executive shall seek the power to construct any person not a member of the Medicinary, as Mediciner.

(d) Any Mediciner who comes to Malawi with the intention of selling or practicing as Mediciner should contact first to the Mother Body for recognition in the Medicinary before selling or practicing, and without that the Executive will seek the way to connect the Mediciner who sells HERBS or practices as Mediciner having not reported to Mother body first.

(e) Any Mediciner must send or carry a patient who is seriously sick to the nearest Hospital, so co-operation with the Ministry of Health.

MEMBERS OF THIS MEDICINARY:
Members of Medicinary must be trusted by the MALAWI CONGRESS PARTY. Please remember to have the Black Cede and have KAMUZU LABEL BADGE, because this Medicinary is affiliated to Malawi Congress Party, National Headquarters, P.O. Box Lilongwe Malawi. We accept and recognize Dr. H. KAMUZU BANDA and MALAWI CONGRESS PARTY as our political Mouthpiece.
MUNTHU WOLOWA MU BUNGWELI

1. Munthu alyense wolowa mu Bungweli ayenera kusenda malama monga zelembedwa muliuzu.


DR. JAMES WILLARD
Chairman

17/1/19

THE AFRICAN HERBAL ASSOCIATION

MEMBERSHIP CARD
PASS BOOK IN MALAWI

This is to Certify that Dr. [Name]

Address

VH

District

is a properly Registered and Approved member of the African Herbal Association by whose authority this certificate is granted by Headquarters ZOMBA, MALAWI, as a member of this association and agree to abide by the Rules of the Association.

Joining fee is K3 to become a Registered Member.

AIMS AND OBJECTS OF EXECUTIVE

(A) The Association shall endeavour to follow most up to date methods in the care and the treatment of patients.

(B) It shall also see that all who practise as Herbalists must be members approved by the Association.

(C) The Executive shall seek the power to punish any person who is NOT a member of the Association on practicing as a Herbalist.

5 Membership card: African Herbal Association (Malawi)
ADUKE EGBA IYA ABIYE EWE DIRAN IGBEHIN ADUN

For all kinds of problem and disease such as if someone was detained by the evil doers, pregnant women who does not give birth at the normal time, someone working with ut knowing how the money goes, and all sorts of problems. We treat Small Children and Pregnant give birth in our Hospital here.

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LADY PRESIDENT PHONNM

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Tel. 062-216460

Residence
H 12 Zuntu St
Uke Kanawa Kaduna

The United African Native Doctors Society
MOTTO: United To Cure And To Protect

MR M. A. AFUAPE
(NATIVE DOCTOR)

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Is one of the above Native Doctor and he is proved as a Herbalist and Doctor. We don't use Poison, beside of Curing Diseases in Children, Women and Men.

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**Conclusion**

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