Professionalisation of African Healers: Apparent problems and constraints

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INTRODUCTION

There is much talk afoot about the professionalization of African healers (or African medicine) but there is little evidence of any attempt to deconstruct the notions involved. I will examine the terminology and the assumptions embodied in a question which is commonly posed: What constraints are encountered in attempts at professionalization of African medicine? I then present three different positions from which to view African medicine, postulating that unless the different positions are acknowledged it remains impossible to address the question. Finding difficulty too with the notion of professionalization, I describe various ways in which the concept is viewed. Only after this 'deconstruction' do I attempt to directly discuss some of the problematics raised by the question. By this stage it will have become obvious to the reader that there is no single answer. Instead there are possible answers from each of the positions I outline. I point to a possible view that members of the 'western' medical profession perceive African medicine as 'matter out of place' and briefly outline this perspective. I suggest that, from this position, the solution to the 'problem' is found in the idea of professionalization - i.e. in cleansing and purifying the polluted. My final thesis is that the process of professionalization is a rite of passage. This paper highlights that attempts at professionalization of African medicine involve not only a range of positions but also some hidden agendas.

From a particular position, the question I examine can be seen as encompassing unselfconscious dogma. Anyone occupying the position from which it originates conveys that they know, and know that the reader knows

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what they are referring to; 'African medicine' is something clearly identifiable and the people who practice it are not professionals. This concept is generally used unselfconsciously. As a consequence, anyone who asks about constraints encountered in attempts at professionalization presumes that there is no doubt in anyone's mind that there exists a concrete, discrete and clearly bounded system of practices which comprise African medicine. The implication is that anyone to whom the question is addressed will know exactly what is meant by African medicine and that as such it is something only 'Africans' can experience and perform. Such a position might also imply that the system could be extended to apply also to 'traditional','tribal', 'non-western', 'irrational' groups of people found outside Africa. What I am drawing attention to is the argument that asking such a question is suggestive of an ethnocentric bias. It tells us more about the position from whence it comes than it does about African medicine. The wording of the proposal to professionalize is suggestive of stereotypic and dualist thinking - of the kind suggested by Sharp and West (1982).

The meaning of professionalization is assumed to be quite clear and the move is assumed to be an obvious and natural route for progress. There is an insinuation that the people who practice African medicine are resisting (ignorantly?) this obvious and desirable path to 'advancement'. Implicit in the idea is Durkheim's extremely problematic stage theory of human development - of the childish, irrational and superstitious belief in magic (primitive science), followed by the priestly and politically fraudulent belief in religion and finally the mature, rational belief in science (Douglas, 1966).

Suggestions for the professionalization of African healers come from not only a belief in this last so called mature and rational phase, but also with the belief that it is quite natural to be firmly rooted in such a system. The notion of 'professionalization' is a construction; the word describes the process whereby legal sanction is given to people assumed to have 'specialist knowledge' which entitles (forces?) them to membership of the society (profession). The end result is one in which the profession is able to monopolize members' 'services' (Helman, 1984). It seems to me that professionalization is a method by which boundaries are set up with the result that certain people are defined in or out. This also has significant implications for later discussion.

The issues to be discussed must be seen from at least two perspectives - though there are possibly other positions from which to view this "landscape" (Sless, 1986). One outlook would seem to subscribe to the ethnocentric thinking I have suggested. A second would not. My choice here is to move between these two positions and attempt to comment on the range of views expressed. My chosen stance means that much of what I posit will reflect my own interpretation of what has been said by the various authors from whom I have drawn. It is mostly informed by two seemingly distinct positions, neither

of which I am happy to discard.

My position is influenced by the literature available and by the positions taken by the anthropologists I have encountered. Much of the literature originates (not surprisingly) from within institutional frameworks. This is not unproblematic because much of it subscribes to unquestioning notions of "norms" based on samples of white middle-class college students, scientific thinking, professionalization, and progress.

One of the positions referred to above attempts to be value free. It is relativist and stems from within institutional walls and is informed by "mainstream" theories. It respects the various methods of healing and sees them as relatively separate, different and discrete (e.g. Last and Chavunduka, 1986). I shall refer to this position under the heading of "differences". The second perspective also originates from within institutional walls but its focus is different. It looks for similarities rather than differences. It argues that Western medicine is not devoid of ritual nor is it scientific. It argues that medicine is tied into the social system and reflects and perpetuates the 'norms' of the social system. It is skeptical of the idea that there are two separate systems arguing that non-scientific explanations of misfortune are found outside Africa and African medicine. Examples would draw from Comaroff's (n/d) study of the explanations given by the parents of children with leukemia. The "similarities" position postulates pluralistic medical systems and in viewing them, takes serious account of the actions of those who use the services offered to the patient (Janzen, 1978). It is noteworthy that much of the literature ignores this detail. We cannot assume that patients see discrete systems of medical services, something for which there is little (if any) evidence (Boonzaier, 1985).

Thus far I have attempted to illustrate that there are two ways in which the question could be viewed. Each in isolation appears logical but to attempt to take account of both becomes hugely problematic. This is a significant point in the field of the social sciences S.A. today, where these polar opposites are continually meeting physically but not intellectually. The issue is important for psychology and some resolution must be worked out. Without access to this kind of debate, researchers and students will have to tap dance between the two positions. I now focus on the next problematic concept: what is African medicine and what are African healers?

To answer such a question depends on the position from which one speaks. It therefore depends on who you ask. There are a range of perspectives from which to view this kind of medicine, but because Western medicine seems to be viewed as the dominant 'system', attempts to define African medicine immediately sets up distinctions - 'theirs' and 'ours'. In spite of what is suggested by much of the literature, African medicine is not something which

can be easily systematised. The term has been used to describe a range of healing practices. Most often the differences between such practices and western medicine have been described at the expense of the similarities, hence a distorted picture has been presented. Furthermore, as a result of interaction with different systems there have been modifications to African medicine but such changes have often been ignored in the literature. Looking at some examples elsewhere it is noteworthy that Janzen (1978) describes how whenever he returns to Zaire he is impressed by the apparent transformations but that a few "conversations with old acquaintances usually suffices to persuade (him) that little has changed at all" (p.xvii). Also, transitions do not necessarily move in the direction of Western medicine. Ngubane (1986) points to dramatic changes in the social structure which have resulted in increased ritual killings in Swaziland, a practice which is by no means similar to that of Western medicine. Such information has persuaded me to resist over-emphasising similarities at the expense of differences.

THE "DIFFERENCES" POSITION

Descriptions of African medicine can be broken into at least three main postulates. The first suggests that it is wholly different to Western medicine (seen as 'professional' medicine). It would probably classify African medicine as that which falls within Kleinman's (1980) folk sector. This covers all those practitioners who are not given full legal status or sanction in any given society. It is suggested that in this sector the practitioner and client share the same views, beliefs, values and explanatory models (Helman, 1984). Patients generally speak the same language as the practitioner who is generally known to them and works in familiar settings with whole families involved, i.e. therapy management groups (Janzen, 1978). This view is not uncommon but is problematic. It can lead to either a romanticized view of African medicine (e.g. Buhrmann, 1980) or one in which it is seen as inferior, ignorant and based on a belief in the supernatural (in Wilson, 1980). Discounting evidence of this in their own society (in e.g. Comaroff, n/d), supporters of this essentially Western position would argue that within African medicine (and only African medicine) explanations are given in terms which are magical, primitive and irrational. Such a dichotomy is a product of Western thought. This is clearly demonstrated in a recorded conversation between an Mbundu rainmaker and Dr. Livingstone (Janzen, 1978, p.38-40).

The terminology (I refer only to English texts) used by proponents of this position includes notions of for example, 'witchdoctor' - generally value-laden and used incorrectly (Ngubane, 1988a). It is thus unacceptable from any of the positions I describe later. An alternative word is a 'diviner' - again problematic because of the wide range of such healers. Ethnographies have attempted to distinguish between the 'diviner' and the 'herbalist' suggesting that there are two kinds of categories. One is either psychic or natural, the other good or evil. The diviner is both psychic and good; the herbalist is

natural and good; the witch is evil and psychic and the sorcerer is natural and evil. Clearly this view is problematic - something which is pointed out by those subscribing to the second view which I portray later.

I have sketched a perspective which focuses on the differences and on the disasters, failing to acknowledge that others systems share similar practices and also disappoint. The view I have described however, persists in asking questions of the efficacy of African medicine. For example: do any of the techniques work? Is there any formal training? What do practitioners charge? How much time do they spend with patients? Can practitioners recognise obvious diseases and do they refer patients to practitioners of Western medicine if they are unable to help? Why is it that African women consult with Western doctors only when they have advanced states of cancer? Many of the questions are biased in favour of Western medicine; the answers will locate it in good light. Evaluation is difficult and answers to each of these questions will vary, depending on the position held (Sless, 1986). There is a difference between for example, the efficacy of the contraceptive pill as against its lack of effectiveness in a country such as S.A. (Cochrane, 1984). Further, Western medicine has been known to appropriate and synthesize herbal remedies used elsewhere, e.g. quinine. There is no recognition of problems of availability of practitioners, transport costs and services (Westcott, 1979) or the notoriously bad treatment given to African women in the hospitals (van Selm, 1984). Neither is recognition given to the perception that many Africans who have been treated by practitioners of Western medicine have died (Ngubane, 1988b). But, such answers can be misleading in that they could be interpreted to suggest that African perception is different - a dangerous notion for the servants of apartheid who can use the idea to support the commonly held belief that ignorance is related to 'race' (Colman, 1987). What is overlooked is that there are many non-Africans who fail to keep appointments or who choose not to undergo chemotherapy and radiation treatment because they believe it will substantially reduce the quality of their life.

There is a need to look not only at the patient's perspective, position and prior experiences but also to ask how the various 'systems' distinguish between empirical ills and social ills (Ngubane, 1988a). The following scenario might help to illustrate my point. Practitioners of African medicine do recognise obvious diseases, for example tuberculosis. But, which of Western or African medicine can treat it more successfully? Western medicine can treat it in the short term by dispensing appropriate medication and giving sufferers the rest and food they need. However, in the long term the condition will recur. The symptom has been cured but not the cause. What might African healers do? It has been suggested that a practitioner might claim that the disease is a punishment for the misdemeanors of the father (who is unemployed and drinks heavily). Since families are involved in treatment (Janzen, 1978) it is

plausible that the father will stop drinking. As a result he might obtain employment which means that the family might have more money and consequently more food etc. This then suggests that African medical practices might provide a better long-term solution or cure (Frankenberg and Leeson, 1976). In this way, contrary to Western practices, African medicine is not taking lifes problems and medicalising them (Kennedy, 1980).

What I have been arguing for is the obvious need to ask different kinds of questions. For example, why is there a range of healers available and why do people consult them as they do? Such questions are asked by those who subscribe to the "similarities" view and bear significant relation to the question of professionalization or integration.

THE "SIMILARITIES" POSITION

This position would suggest that rather than look at the differences, the strengths and weaknesses of the particular systems should be considered (Boonzaier, 1988). Explanatory models, i.e. how people interpret illness and to what extent the healers explanation differs from that of the individual patient should also be studied (Helman, 1984).

In this second position African medical practices would probably also be classified within Kleinman's folk sector. The healers are not seen as homogeneous nor as professionalized to the same extent as they are in viewing Western medicine. There is a vast range to be identified and the kind of terminology mentioned earlier is again a problem for similar, but also for additional reasons. The terminology does not allow for the recognition of continua of types of healers. Practices are not seen as discrete. Further, as well as being value laden the terminology tells us more about the user than that which is observed; divisions are seen as attempts to divide according to problematic notions of for example, 'western', 'rational' and 'scientific'. As a consequence it is argued that there is a whole range of exaggerated and misleading images of African medical practices.

This position argues that the practices of African medicine are not static. It points to the many changes which have been observed, for example those found within the practices of the Prophets and healers within African Independent Churches (West, 1975). It also points to the danger of focusing narrowly on the healer and then generalising from this to the whole, e.g. Buhrmann (1984) who studied only "the Tiso school". This is an extremely small group of indigenous Xhosa healers (amagqira, translated as "indigenous healers") from which Buhrmann generalizes to such an extent that she draws comparisons with Senghor in West Africa. Such a position does not take account of the possibility that individual practitioners could differ in the way they practice. It also fails to consider the importance of looking at what patients do (i.e. consult different kinds of healers).

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As one of the few authors who does acknowledge patients' roles in this landscape, Last (1986) describes African medicine as "medicine of whatever kind available to the patient in Africa" (p.5). By definition it includes "not only all the varieties of 'traditional medicine' but all the varieties of non-traditional medicine, too, whether Islamic, homeopathic or 'Western' ... (which is not a) .. strictly disciplined system (nor are) its practitioners ..part of a single hierarchically-organised profession ..." (p.5). Clearly there is no doubt in Last's mind that medical pluralism exists. As such, there are in all societies differently designed and conceived medical systems (Janzen, 1978, p. xviii). Boonzaier (1985) and Last (1981) have suggested that patients will have consulted with each at some point, distinction between 'systems' is clearly made mainly by healers and scholars; boundaries are easily transcended by patients. Surely then, whether or not the 'system' is professionalized is not of major concern to the patient, most of whom I suggest are generally not even aware of the implications of professionalization. Few are aware of their rights or of the ethical codes and duties of members of the profession.

This second position also warns that there might be negative consequences as a result of the professionalization of African medicine. An example of such dangers is given by Boonzaier (1988) who argues that Western medicine might react by re-structuring their field in such a way as to choose their domain more specifically. This could involve a failure to take responsibility for firstly, the whole patient, suggesting that certain aspects would be better handled by the practitioners of African medicine. This is already true of Western medicine relative to e.g. social workers, physiotherapists etc. (Comaroff and Maguire, 1981). Secondly, Western medicine might attempt to deny responsibility for African patients, justifying this by arguing that African patients should seek medical advise from practitioners of African medicine.

A THIRD POSITION

Displaying commonalties with both positions discussed so far, there is a third position which does not derogate African medicine, nor is it romanticized. The position acknowledges similarities between African and Western medical practices but points to the differences, presenting the practices in a manner which suggests that they are relatively static and clearly bounded systems. In this sense then this position is similar to the first but in opposition to the second. This view does not seem to attempt to classify African medical practices in terms of Kleinman's (1980) three health sectors. Instead it sets out distinctively different kinds of healers. Chavunduka (1986) lists eight main categories of traditional healers in Zimbabwe. Ngubane (1988a) refers to five in Southern Africa (as compared with Buhrmann's (1984) suggestion that they are all the same - igqira, meaning "indigenous healer"). They are as follows: there is first the diviner (also known in the literature as a sangoma). The diviner is "pure" and does not use "death medicines". She is always a

woman, is a custodian of morality and might be compared with a western priest. She deals with spirits and, to the extent that she understands "medicine" in an empirical sense, she is a doctor. She is also a psychologist, in that she talks with the patient at great length. Ngubane (1988a) describes her as a theologian (or philosopher, sage, or wise woman); she "interprets the world". She is innovative in terms of the interpretive nature of her skills which adjust to the changing times and social practices of the people with whom she works.

A second kind of healer is known as an Inyanga who is trained only in "medicine". The training does not incorporate any rites of passage as is found in that of the diviner (Ngubane, 1977). Inyangas work in a competitive way as individuals. They do not share their knowledge and therefore would, according to this position, be difficult to professionalize (Ngubane, 1988a).

A third type of healer is that which is referred to as the specialist Inyanga, e.g. *inyanga yomhlabelo*, the *inyanga* who deals with fractured bones (Ngubane, 1986, p.191). The required knowledge is passed on to "chosen" family members through generations and is based on straightforward "scientific" information. Professionalization will involve a need to patent these skills if such healers are to continue to play the same kind of role in the medical system as a whole (Ngubane, 1988a).

A fourth practice is that of Faith Healing. Connected with religion, such healers work with the social practices of the people who consult them. They therefore deal with problems encountered in the social lives of the patients. They do not give up their religion to become for example, Christian. They use mostly white medicines, wear a lot of white but they also use and wear other colours, for example, red, green and blue. Each colour signifies something depending on their strength or intensity, a notion dealt with by Ngubane (1977). For example, red softens black and leads towards white. If too much white is used it points to abnormality because there is a suggestion of too much purity. Green and blue (in Zulu the same word) are used therefore to soften white (Ngubane, 1977). These aspects are clearly distinguishable to those who know what to look for.

There are clearly so many differences and similarities that to professionalize would surely change the very nature of the whole set of practices (Fyfe, 1987, pp.5-17). These issues are discussed in the sections which follow. First, there is another concept to be looked at closely.

WHAT IS "PROFESSIONALIZATION"?

Members of a profession are given legal sanction within the society in which the profession is formed. In India and China traditional medicine has been given legal sanction; it is therefore professionalized (Helman, 1984). In

Southern Africa, Western medicine is professionalized and like the medical profession everywhere it is in fact the epitome of a profession (Foster and Anderson, 1978). This is a significant point because professionalization is controlled and has certain implications for the society in which it occurs (Freidson, 1970b). There are therefore different ways of viewing the concept 'professionalization', each of which depends again on the theoretical notions to which the viewer subscribes.

A first descriptive position might highlight that to gain membership involves particular skills and prolonged training in which a specialised body of abstract knowledge is imparted (Helman, 1984). This suggests that the profession itself guarantees certain minimum fees and salaries to its members. Professions also form associations or governing / controlling bodies and establish for themselves codes of ethics. There is an orientation towards service; members provide skilled services or advice but no products. Finally, most members are of the opinion that their work is a "fulltime, lifelong undertaking" (Foster and Anderson, 1978).

What the descriptive position fails to consider are the various characteristics associated with professions in general. Firstly, the profession decides its own standards of education and training (Helman, 1984). Student professionals go through a very extensive socialisation process over and above the professional training (Helman, 1984). For example, medical students learn how to conduct themselves as medical students, how to dress appropriately etc. Lectures are given to them on these subjects. Medics can only practice if they are registered with the controlling body - in S.A., with the S.A. Medical and Dental Council. This body also controls a range of other professional bodies (Louw, 1986). This fact is one which Boonzaier would presumably insist on being considered in discussions relative to professionalization of African medicine. This is because he argues that professionalization of African medicine might only occur on terms dictated by Western medicine who will therefore take control (1988). The notion of control is significant also to the fourth characteristic which suggests that most of the legislation affecting the profession is shaped by the members of that profession and which is, in S.A. given Statutory powers (Louw, 1986). As a consequence it is logical to argue that the occupation gains in income, power and prestige (Freidson, 1970a).

A vicious circle ensues. The profession attracts a 'higher calibre' student (in effect a member of the privileged few who have been appropriately schooled for such professions), only the best of whom meet the required standards (set by the profession). This justifies the argument that the training requires a 'better' student - a powerful mechanism to exclude certain people from the profession. These facts have significant implications for the 'professionalization of African medicine'.

A functionalist view of professionalization might argue that the profession is located within a wider social system and that it provides vital functions within the society as a whole. Proponents to the position would argue that the profession evolved because it is the natural and only way. Expert knowledge is essential and is used in the interest of society to prevent exploitation. The control of such a profession is necessary for its commitment to the maintenance of health and it is in the interests of patients. It is because the services of the profession play such a vital role that the status and the financial rewards are high; members are fulfilling their natural role in society and because the responsibility is great so too should the income be high.

Arguing strongly against this is a more radical position which disputes first that professionalization is a natural or rational outcome of knowledge. There is no natural evolution; the medical profession is the outcome of a historically specific process in which there was conflict of power among a number of different interest groups, for example the developed versus the underdeveloped and the urban versus the rural. Since the interests of the dominant group are served by the medical profession, this is the one which is given legal sanction (Doyal and Pennell, 1979). Historically, there have been other perhaps less obvious sources of conflict involved, for example groups of psychologists, nurses, physiotherapists, naturopaths (Louw, 1986). I suggest that the practitioners of African medicine could be added to this list. The postulation is that in the light of the existence of these 'alternative' practices, medicine itself becomes an interest group struggling for status and wealth. From this position, the dominant elite and the State are seen to have given autonomy to Western medical practices. The profession then, is a way of organizing in a manner which reflects the dominant values and power structures in society. The training is necessary to limit the numbers of practitioners. The kind of knowledge imparted creates a distance between the practitioner / producer and the patient / consumer (Doyal, 1979). Language is mystified unnecessarily (Klein, 1979). As a consequence the doctor is seen to occupy a relatively more powerful position. Further, because the organised profession acts as one body, individual patients are powerless when it comes to complaints against practitioners. The medical profession is free from the control of the lay person (Doyal, 1979). Malpractice suits require evidence from another practitioner but in terms of the codes of conduct it is unethical to criticize another member (Kennedy, 1980). A member of the public therefore stands little chance of succeeding in such a suit. The profession then serves to re-enforce the positions of power, wealth and status of its members, not necessarily the health of the society at large (Doyal and Pennell, 1979). It is with these thoughts in mind that Boonzaier (1988) argues for special consideration when discussing the professionalization of African medicine. There is surely no benefit to be had for anyone but the members of the profession if these negative characteristics are taken on board uncritically.

A materialist approach to the concept of professionalization might suggest that the power of the profession is intimately tied up with the requirements of the economic system. To be successful it is dependant upon clientele and operates then on the principles of supply and demand. But it also has the ability to perform functions of social control (Doyal and Pennell, 1979). It can validate a person's subjective feelings by issuing a sick note (Klein, 1979). In S.A. this aspect is important because Western medicine translates collective political and social problems into biological, individual ones. This is illustrated in the distribution of disease in the country (Goldblatt and London, 1981). Many of its less enlightened members persist in arguing that disease is caused by germs which act independently of any socio- political factors. The implication of this kind of thinking is that the rampant ill health of many in the 'townships' (WIP, 1982) is caused by ignorance and dirt. Since all the inhabitants of the 'townships' are African, the next insinuation is that all Africans are ignorant and dirty. This is what gives rise to the common belief that disease in S.A. does not strike at random, but along certain colour lines. This opinion is clearly absurd and dangerous.

WHAT CONSTRAINTS ARE ENCOUNTERED IN ATTEMPTS AT PROFESSIONALIZATION OF AFRICAN MEDICINE

I have touched on this question in various ways. I have indicated that the question posed forces a position from which to view the landscape - from the perspective of someone who subscribes to a belief in the justifiable dominance of Western medicine, to the notion that African medicine should be professionalized and which believes that for some inexplicable reason, its practitioners are resisting it. This is a paradoxical situation because professionalization is argued to offer its members more advantages than disadvantages. It is therefore logical to expect that decisions to professionalize would come from within the ranks of those entitled and not from without - the literature highlights the struggle many professions have had to gain recognition (e.g. Napoli, 1981). But, what has been overlooked in this view is that the proposal for professionalization has come from the dominant elite. Why should this be so? I suggest that it might be because control is slipping away - their boundaries seem to have been transcended by other healers and it has become evident that patients do use other systems. In S.A. the professionalization of psychologists illustrates a similar history (Louw, 1986).

The discussion around professionalization of African medicine is also curious because in much of the literature on Africa there is evidence of organizations of groups of practitioners of African medicine which are similar to those of a profession. I do not want to make the mistake of over-generalising but point to evidence in Africa of associations, companies and / or co-operatives of African medicine (Semali, 1986; Chavunduka, 1986). In parts of S.A.

professional conferences are held to discipline and supervise what might be referred to as 'professional activity' (Ngubane, 1986, p.199). And, according to some discussion at the Medical Conference (1988) there is a register of 'traditional healers' kept by the Department of Labour in Pretoria. Whilst I acknowledge that this does not on its own, denote professionalization per se, I am still not clear as to the meaning of this term and there remain unanswered questions. Who wants to professionalize who and what exactly do they mean by this? Chavunduka suggests that professionalization is probably necessary for traditional healers not, as is expected, to improve their status, training etc., but for tactical reasons. He suggests that such a move would help prevent a situation in which traditional healers "remain politically powerless within or alongside a much more powerful system, and accept direction from planners, government and other 'full' professionals" (1986, p.267).

By now it should be obvious to the reader that constraints to professionalization (if there are any) depend very much on the position from which the landscape is viewed. I propose a particular argument which views the question from the position in which I probably feel most comfortable. I have also chosen to take a leaf out of Ngubane's (1986) book and present an argument which illustrates an extreme point.

My explanations thus far have indicated that there may well be resistance on the part of 'African' healers to be incorporated into the professional hierarchy of Western medicine and used to perform the more menial tasks at lower levels of status, pay etc. (Feierman, 1986). There is another way of looking at this situation which makes use of the literature on the subject of pollution and the notion of "dirt" put forward by Douglas (1966).

Applying Douglas' ideas I have suggested elsewhere (Kottler, 1988) that practitioners of Western medicine see African medicine as ambiguous and anomalous. In Douglas' terms Western medicine sees it as "dirt" in that it is "matter out of place". As such, African medicine makes practitioners of Western medical anxious. Since it cannot be ignored (because patients use it, because of the population explosion and because of the lack of resources) I suggest that there is a concerted effort on the part of Western medicine to change African medicine. An extreme way of doing so is to force on practitioners a particular process of professionalization - that of undergoing Western medical training. In terms of my argument, this will move African medicine out of its polluted state. I suggest that this will involve three phases: separation, margininalisation and incorporation. Those familiar with the ideas of van Gennep will recognise that I am referring to a process involving a rite de passage. Looking at medical training in this way has revealed striking similarities between this and the process of initiation described by Turner (1967).

This notion offers a somewhat unorthodox analysis of motivations to professionalize African medicine. An obvious consequence of this argument is to suggest that there are no constraints to professionalization of African medicine. Whilst there is an innocent suggestion that its professionalization is an appropriate move forward, one which is for the benefit of the practitioners, the people, and the country as a whole, this is not the whole truth; there is something else at play. My paper attempts to highlight that each of the concepts involved can be seen differently and that the arguments proffered by proponents of these positions can be used for different purposes. I have advocated that the issues which arise as a result of discussions about therapeutic services in a country should be looked at with less bias. Questions about professionalization of African medicine hide assumptions which have to be addressed.

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