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FINAL REPORT: CONTINUITIES BETWEEN  
THE PRACTICES OF TRADITIONAL AND SCIENTIFIC  
BOTSWANA HEALTH CARE PRACTITIONERS

by

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AFRICAN-AMERICAN SCHOLARS COUNCIL, INC.

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Policy Recommendations

It is recommended that:

Organizational activities of traditional healers be facilitated and an emphasis be put upon nurturing, rather than controlling traditional healer organizational activities.

Traditional healers be registered as a separate group, and there be joint collaboration between the Ministry of Home Affairs and the Ministry of Health in this endeavor.

The health serving activities of traditional healers be recognized and continuously assessed so a more comprehensive Botswana Health Care Delivery System can be established.

Nurses be taught and encouraged to do physical examinations as basic to their outpatient practices, and the role responsibilities within hospital settings be clarified to prevent underutilization of these skilled practitioners.

Nurse training courses devote curriculum time to social and cultural factors in their practice environment.

Special consideration be given to the development of a large cadre of nurse practitioners who will serve as the primary health care providers of the Botswana Health Care Delivery System..

In recognition of their contributions to the health and welfare of their clients and community, their clients and community, the derogatory term, "witchdoctor," be abandoned and the more appropriate nomenclature, "traditional healer," be adopted.

Follow-up studies be done on patients treated in each sector to define the questions of treatment efficacy; the first of these should be carried out in the scientific sector.

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INTRODUCTION

Less than a decade and a half has elapsed since most African countries achieved independence. During colonial times and immediately after independence, most African countries were singularly committed to the development of a health care delivery system modeled after the systems developed and used in Western Europe and America. It was generally assumed that development of a scientific health care delivery system required the neglect, discouragement and even dismemberment of traditional health care practices. Those who subscribed to such practices were considered hopelessly ignorant, and traditional health care practitioners were defamed as "witchdoctors."

Today, the formerly uncritical acceptance of western health care practices is being reassessed. A central aspect of this reassessment is re-evaluation of the role of traditional health care practitioners and their potential contributions to the formulation of developing African health care delivery systems. Underlying this reassessment is greater recognition of the uniqueness of African cultures and the relationship of culture and social structure to the health seeking behavior of the African peoples.

## PURPOSE

In 1974, the African-American Scholars Council, Inc., in collaboration with U.S.A.I.D., funded a research project designed to identify continuities between the health serving behavior of traditional and scientific African health care practitioners, and characteristics of African peoples' health seeking behavior, which might suggest ways in which traditional healing practices can be included in the overall health care delivery system planning of African countries. The project was, essentially, oriented towards the development of policy for the use of traditional healers in a national health care program. The researchers were also interested in developing models of such utilization which may have relevance in other countries where traditional healing systems are vigorous. Justifiably, questions will be raised regarding the general applicability of this research to other countries. That is, of course, a problem of theory. We must live with our data a bit longer before we can make such generalizations.

Finally, in consideration of the primary mission of the African-American Scholars Council, this project was designed to facilitate collaborations between policy-oriented African and American scholars. To achieve this objective, in addition to the African and American co-principal investigators, the core research team was also comprised of two African and two American research associates.

The following report contains the major research findings and policy recommendations. It is projected that, in the near future, additional

papers, dissertations and reports based on this project will be published.

They will include:

Balintulo, Malusi. Social Stratification and Health Care Systems in Botswana.

Barbee, Evelyn. Health Action and Conflict Between Professional Health Actors. Dissertation, University of Washington.

Brown, Freida. Socialization of Children into Compliance Systems and their Attitudes about Health Care. Dissertation, Michigan State University.

Fako, Thabo. Students and Health Care Systems in Botswana.

Mbere, Nontuse. The Role of Women in the Health Care Systems in Botswana.

Osborne, Cliver. Psychosocial Aspects of Health Care in Botswana.

Osborne, Cliver and Malusi Balintulo. Health Seeking and Health Serving Behavior in an African Republic.

It is expected that continuing analysis of the data will result in additional monographs and reports.

## ACKNOWLEDGMENTS

In the course of this project, many people contributed their time, knowledge and interest to this research effort. It would be impossible to acknowledge all of these people. We do, however, wish to give special recognition to the assistance of Dr. D. B. Sebina, Permanent Secretary, Ministry of Health. His understanding of Botswana's need to develop a uniquely Botswana system of health care delivery, and his interest in the contributions traditional healers can make to the official health care delivery system, were of inestimable value to the success of this project. He was a constant source of information and advice. He facilitated the research team's entry into a number of important situations, and made available many useful facilities.

We also thank Dr. N. O. Setidisho, Pro-Vice-Chancellor, University of Botswana, Lesotho and Swaziland, and his staff, for lending the resources of the University to the research team.

Special recognition is given Professor Thomas Tlou, who, as consultant to the team, provided important information and guidance throughout the entire field project period. We also recognize the contributions of other University of Botswana, Lesotho and Swaziland faculty members who provided the research team with invaluable information about the culture, social structure and ecology of Botswana.

Finally, we acknowledge our debt to all the people, health seekers and health providers alike, whose unstinting cooperation with the research team assured the success of this project.

## ASSUMPTIONS

A number of assumptions guided the development of this research project and its policy orientation. These assumptions were:

1. The integrity of the scientific health care system will be vitiated if the existence and activities of the traditional health care system are ignored.
2. Wise use of traditional health care providers constitutes a potentially large source of health care manpower which may be incorporated into the officially recognized health care system.
3. Within the traditional health care system, there are workers who have qualities of investment, skill, knowledge and integrity which make them suitable candidates for participation with scientific health care providers in the officially recognized health care system.
4. Traditional health care practitioners represent a population of health care providers who may remain in rural and underserved areas where scientific health care practitioners are reluctant or unable to practice.
5. The organization of scientific health care systems usually reflects the culture and social structure of Western European and American societies. These may be inappropriate or may require considerable modification when applied elsewhere.
6. A variety of short and long term programs may be developed to improve the skills and utilization of traditional health care practitioners in the officially recognized health care delivery

system.

The actual research design was dictated by the need to collect comprehensive data on both the health care providing behavior of scientific and traditional health care practitioners, and the health seeking behavior of the people.

## TERMINOLOGICAL CONSIDERATIONS

Throughout the early months of the project, team members expressed concerns about the meanings of the terms scientific, traditional and faith healing, which were fundamental to the project design.

The team's discussion of this terminology revealed that each type of practice contains characteristics of the other types. For example, there are strong elements of tradition and faith in the practice of scientific medicine. Also, within the broadest usage of each term, elements of other terms could be found. An elemental definition of science is "knowledge." Thus the term has such popular usage as "the science of cooking," "the science of boxing," or "Christian Science." Such broad meanings were of little utility to the conceptualization of the project. Considerable study of the literature, dictionaries, and the usages in each sector suggested that the terms "scientific," "traditional," and "faith" were most appropriate for the practitioners of each sector.

The term "traditional" means handing down, usually orally, stories, beliefs and customs. Distinctions made between scientific knowledge and traditional knowledge cannot be absolute. For example, all knowledge must be given up or transmitted from person to person and from generation to generation. But, scientific knowledge cannot be confused with traditional knowledge, for inherent in the more restricted, rather than popular, usage of the term "science" is the scientific method. This method is, ipso facto, anti-traditional, for it prescribes continuous testing and modification of established beliefs and authority; whereas traditional knowledge depends upon maintenance of the beliefs and authority of the past, status,

wealth and age.

Nevertheless, a distinction between science and "scientific" medicine can and must be made. The application of science to healing by individual doctors, nurses or others in the scientific sector is actually an art. This art is rooted in knowledge gained from a wide array of natural and behavioral sciences, including anatomy, physiology, chemistry, botany, psychology, genetics and others. These areas of study depend upon the incremental development and systematization of knowledge. The search is for universally applicable truths. In order to achieve this universality, scientific methods are used to test knowledge. These methods are designed to insure that all scientists seeking the same truths under the same conditions will come to the same conclusions. It is for this reason that scientific medicine can be practiced throughout the world and in space; despite the individuality of each practitioner's applications, the scientific principles underlying the multiplicity of individualistic practices are the same.

There were further considerations. The term "modern," meaning recent, up-to-date, contemporary trends, ideas, beliefs and standards, could not substitute for "scientific," for, although traditional medicine emphasizes the past, it is not static. Rather, the many elements which combine to form traditional medical practices continuously change as practitioners of the art interact with healers from distant places, or as the social, economic, cultural and political context within which traditional healing is practiced changes.

However, unlike scientific medicine, traditional medical practice is

culture-specific. It requires intimate knowledge of the beliefs, mores and interaction styles of the local group. Therefore, it does not have the universal applicability characteristic of scientific medicine.

The term "western medicine" could not be considered a proper substitute for scientific medicine. It is too limiting. Although scientific medicine was developed in Western Europe and North America, the tenets of science which are the foundation upon which scientific medicine is practiced, as well as scientific medicine itself, have been adopted and used worldwide.

The term "allopathic medicine" was studied, but was found not substitutable for scientific medicine. "Allopathy," a term which gained popularity in the late 1800's, refers to an approach to healing which emphasizes stimulating body mechanisms which counter the ongoing disease: for example, the stimulation of the production of antibodies to combat antigens. In time, and through popular usage, the term came to distinguish all therapeutic methods other than homeopathy.<sup>1</sup> The specificity of the term, and the fact that it is now obsolete, rendered it of little utility for our purposes.

Acceptance of the term "faith healing" posed few problems for the team members. They agreed that such healing practices rely upon God's will rather than the knowledge and skill of the practitioner. The faith healer is an instrument of God. It is through the healer that God's intentions are achieved.

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1. Skinner, H. The Origin of Medical Terms. Baltimore: Williams & Wilkins Company, 1961, p. 18.

In most societies there is a body of commonly held knowledge about the treatment of minor illnesses and injuries. People use this knowledge to treat illnesses occurring among family members and neighbors. Within communities, some individuals may acquire a reputation for the effectiveness of their therapeutic interventions, and, in certain contexts, these people may be known as traditional doctors. The treatment activities of these people are based on family responsibilities, neighborhood relationships and their own avocational predilections. They have no formal preparation in healing, nor do they charge for their services. These people were not the focus of our study of traditional healing practices. Rather, this research is concerned with those individuals who practice traditional healing as an occupation, not as a family responsibility or avocation.

## METHODOLOGY

At the time this project was funded, the host research country had not been selected. This policy research project required the close collaboration of a Ministry of Health and a university-based social science faculty member who would assume the role of co-principal investigator/field supervisor. In late August, 1974, the search for a site began. Seven African countries were visited, numerous people were interviewed and many letters were written. A Host Country Selection Guide (Appendix A) facilitated the assessment of all potential research sites. Researchers in each of the countries visited were invited to submit proposals for participation in this study. The successful proposal of Dr. Malusi Balintulo, University of Botswana, Lesotho and Swaziland, combined with assurances of cooperation from the Botswana Ministry of Health, resulted in the selection of Botswana as the research site.

The design of this project required a multidisciplinary, as well as a multicultural, research team. At its height, the team consisted of two co-principal investigators and four research associates. The disciplines represented included sociology, anthropology, nursing and psychology. A research assistant, language instructors, interpreters and typists also contributed to the project. Members of the research team were:

Co-Principal Investigators

Malusi Balintulo, Ph.D. (Sociology), Lecturer, University of Botswana, Lesotho and Swaziland, Co-Principal Investigator/Field Supervisor

Oliver H. Osborne, R.N., Ph.D. (Anthropology), Professor, University of Washington, Co-Principal Investigator/Grantee

Research Associates

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Primary Consultant

Thomas Tlou, Ph.D., Professor (History), University of Botswana, Lesotho  
and Swaziland

On April 15, 1975, the co-principal investigators and research associates gathered together at the University of Botswana, Lesotho and Swaziland to begin their research collaborations. During the next three weeks, they participated in an orientation program and began their language training. They then began collecting data. This phase continued until mid-March, 1976. During the last four weeks of the field study phase of the project, all researchers gathered at the National Research Institutes, University of Botswana, Lesotho and Swaziland, to tabulate questionnaire

responses, interpret the data, and collaborate in developing the first draft of the final report. The field study phase terminated April 5, 1976.

#### Populations Studied

The project was designed to study the behavior of health providers and health seekers. Initially, the health provider population was subdivided into scientific practitioners and traditional practitioners. During the April, 1975, orientation program, sufficient evidence was presented to warrant inclusion of faith healers in the health provider population.

#### Research Sites

The capital city of Gaborone and the large villages of Serowe and Molepolole constituted the principal research sites. For the first three months of the project the entire research team was located in Gaborone. During the next five months, three researchers were located in Serowe. Periodically their numbers increased to five when two Gaborone-based researchers visited the Serowe site. During the last four months of data gathering, two researchers remained in Serowe, three in Gaborone, and one in Molepolole. Throughout the research project, a large number of smaller villages and cattle posts in other parts of the country were visited. It is calculated that these efforts resulted in a sampling of the health providing and health seeking behavior of nearly 70% of Botswana's people.

#### Interviews and Observations

During the early months of the field project, participant observation and structured interviews were used to gather baseline information about the people and their health providing/health seeking behavior. Most of

the interviews with traditional healers, faith healers and administrators of the health care sector were completed at that time. These interviews usually occurred in the church buildings, rondavels<sup>2</sup>, private or government clinics and hospitals which comprised the healer's usual practice environment. Interviewing in these settings enabled the researchers to study the buildings and equipment which contributed to the healer's activities. Additionally, the researchers were able to observe the health seekers, their relatives, and other individuals occupying the healing environment. Interview data and observations were usually recorded during the interviews.

Researchers also recorded observations made during field excursions, relevant data obtained from informal interactions with acquaintances and strangers, new ideas and research strategies generated during research seminars, and all other experiences which appeared to contribute to their knowledge of the health providing and health seeking behavior of the people. At least once each week, researchers transferred their data to key sort data cards. These cards were subsequently coded and punched.

### The Questionnaires

The participant observation and structured interview data provided the basis for the development of two highly structured questionnaires: the Health Providing and Health Seeking Questionnaires (Appendices B and C).

The Health Seeking Questionnaire and the Health Providing Questionnaire were constructed during December, 1975. Most questionnaires were administered at the three primary research sites; namely, Serowe, Gaborone,

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2. Rondavels are the traditional household structure of the Tswana peoples. They are circular buildings, usually composed of mud walls and thatched conical roofs, with wooden doors and wooden shutters.

and Molepolole. Convenience sampling, defined as sampling of populations accessible to researchers, was used. Scientific practitioners were visited in their hospitals and clinics. An attempt was made to interview all physicians and all available nurses practicing in the settings. In addition, nurses working in numerous health clinics were also interviewed. Both faith healers and traditional healers were discovered through referrals made by members of their groups. This method assured that the most prominent of these practitioners were interviewed during the course of the project.

Distances between the principal research sites, awareness that most Gaborone citizens have recently migrated from other parts of the country, and data gathered in smaller villages, health clinics and cattle posts provided confidence that informant responses reflected health providing and health seeking behaviors in a major portion of the populated areas of Botswana. Altogether, a total of 241 health seekers and health providers responded to questionnaires. The majority of health seeker respondents were female. This bias reflects two related characteristics of Tswana social structure. One is the crucial role of women in looking after the health needs of children within the family. The other is the long absences of men from their homes. Large numbers of Botswana men are regularly away from home, working in the mines of Botswana or South Africa, or at their own isolated cattle posts.

In constructing the tool for the health providers, the team had to decide whether to develop a questionnaire for each of the sectors or one questionnaire for all three health provider populations previously

identified. At least two possible approaches to this problem were considered. One consisted of formulating a questionnaire for each of the three health providing sectors. The chief advantage of developing separate questionnaires for each sector was the possibility of achieving tools which were sensitive to the characteristics of each group. In the analysis of the responses, it would have been reasonable to assume that all the respondents, insofar as they were answering questions peculiar to their sector, were talking about the same thing. Thus, it would have been easier to interpret the responses within the framework of each particular sector. This approach was discounted for three reasons: 1) The construction of three questionnaires would have required considerably more time than was available to the investigators; 2) within the context of the major research issues to be explored, there was no evidence that each sector was sufficiently different from the others to warrant such effort; and 3) if three questionnaires were used, the researchers would still have to confront the problems of assessing continuities in practices between the sectors.

The alternative approach, and the one that was adopted, was to devise a questionnaire which would explore issues generic to all sectors. Using this integrated approach, the same questions were asked of scientific, traditional and faith healers alike. The considerations favoring the integrated tool were based upon such initial research findings as: 1) All health providers saw themselves as having one primary goal; namely, catering to the health needs of the population; 2) all three sectors service, essentially, the same population; 3) all three sectors work within one, albeit internally diverse, social-cultural community; and 4) despite its

haphazard and ill-defined form, there are important facets of collaboration between the three sectors.

As expected, the main problem with the integrated questionnaire approach was that some of the questions were not applicable to all of the respondents. This problem had intra- as well as inter-sector aspects.

Structure. Understanding that male respondents to the Health Seeking Questionnaire would be difficult to obtain resulted in the construction of questions designed to elicit information about the health seeking behavior of the respondents' families, as well as the respondents themselves. For example, a question put to the health seeking respondents was, "Have there been any illnesses in your family in the past three years?"

Two other points should be made relating to the structure of the questionnaires.

First, besides attempting to elicit information on factors like age, sex, marital status, etc., an attempt was made to determine the socio-economic status of the respondents, principally through questions about their occupation and ownership of property. While it was fairly easy to obtain occupational information, it was extremely difficult to elicit reliable responses on ownership of property, especially cattle. Most health providers, traditional as well as scientific, claimed to have no cattle. It would be easy to accept the finding that more than 80% of the practitioners in the scientific sector do not own any cattle, simply because a large proportion of them are expatriates. However, the same assertions by traditional doctors cannot be accepted at face value. Health seekers were also reluctant to provide information about cattle ownership.

Although the question was phrased in terms of clusters (1-10, 11-20, etc.), it was frequently unanswered. Since much wealth is invested in cattle, unwillingness to provide this information was not entirely unexpected. It is analogous to the reluctance many westerners exhibit when asked to respond to questions about their income or their bank balances. In this part of the world, participation in social science research is a new experience for most people. They had many fears about providing information about their financial affairs to the researchers, not the least of which was fear of increased taxation.

Secondly, the strategy adopted for identifying patterns of health providing and health seeking practices was to pose a closed-ended question and follow it up with open-ended subsidiary questions. For example, one question of the Health Providing Questionnaire explored the problem of collaboration:

Have you ever worked with members of the spiritual sector? Yes / No

If yes: What form did/does this collaboration take?

Do you think the collaboration has been useful? Yes / No

If yes: In what way?

If no: In what way?

If no: Would you be willing to work with them? Yes / No

If yes: Why?

If no: Why not?

This strategy was intended to achieve a degree of systematization to responses, as well as to give the respondents an opportunity to provide as much information as they wished for most of the items.

Administration. The method of administration of the questionnaires

was determined by the literacy of respondents. Questionnaires were left with those respondents who were literate. Several days later, the completed questionnaires were collected. This method of administration was convenient for respondents. Unfortunately, it also provided an easy opportunity for some of them to avoid answering certain questions. Those respondents who were unable to read the questionnaire were interviewed by a researcher. When necessary, interpreters were used.

The Health Seeking and Health Providing Questionnaires were administered during January and early February, 1976. A few additional Health Providing Questionnaires were administered in March, 1976. They supplemented responses from populations which appeared under-represented in the first survey. For example, after assessment of the January-February responses, it was determined that more questionnaires should be obtained from private practice scientific health care providers. Such practitioners were identified, and their responses to the Health Providing Questionnaire solicited.

Most of the traditional and spiritual practitioners, and a few scientific practitioners, were interviewed during the first phase of the field research project, prior to the development of the Health Providing Questionnaire. An interview schedule which contained many questions subsequently incorporated in the Health Providing Questionnaire guided the collection of this health provider information. For this reason, it was decided not to ask the previously interviewed health provider population to respond to the Health Providing Questionnaire. Subsequently, it was found that nearly all of the available traditional and spiritual healers, and nearly half of the available scientific healers, had been contacted during the pre-

questionnaire phase. Consideration of the wealth of information already obtained from these healers, and limitations of time and money, resulted in the decision not to ask these people to respond to the questionnaire. Therefore, only a few traditional and spiritual practitioners were respondents to the Health Providing Questionnaire.

These differences in the manner in which data were collected from health providers created problems in the analysis of the data. In some instances, data received during the structured interview (pre-questionnaire) phase of the research project could be enumerated in the same manner as the questionnaire data. Other structured interview data did not lend themselves to such enumeration. And, because the questionnaire represented a considerable increment in our knowledge of the various health care delivery sectors, it contained some questions not asked of the pre-questionnaire respondents. For this reason, the report of the health provider responses represents the best compromise that could be achieved between the two types of data collected. Since the structured interview tools were not designed to be quantified, the most notable lacunae appear in the health provider tables, where, at times, sufficient quantitative data on all populations were not available.

## ANALYSIS AND INTERPRETATION

The analysis of the data was undertaken during March and early April, 1976. This effort involved the development of a coding frame and categories for responses to open-ended questions of the questionnaires.

For the purposes of interpretation of the data, those questions which did not yield meaningful responses were dropped at the coding stage. Examples of these were spouse's occupation, forms of marriage, and age of children. In the study of specific health providing/health seeking behaviors, several cross-validating questions were used to explore critical issues. As anticipated, some of these questions did not elicit results which warranted tabulation. They did, however, serve the purpose of validating other responses, and they were of value to the researchers' understanding of the overall patterns of health providing and health seeking behavior.

The analysis of data also entailed a review of all data contained on the key sort cards. These data were sorted and compared with the information generated by the two questionnaires. This review provided a particularly important contribution to the interpretation of activities occurring in the traditional and faith healing sectors.

The major aim of the first phase of the analysis of data was early communication of the major findings of the research in general terms. These are presented below. It is envisaged that further analysis will yield more detailed information to be communicated in subsequent papers.

## THE HEALTH PROVIDERS

Population

The health provider population was divided into the traditional healer, faith healer, and scientific healer populations. The responses of scientific practitioners were frequently broken down further into nurse, doctor, and other responses. Nurses represented the largest group of scientific practitioners. Included in the nurse category were the responses of six family welfare educators, one general duty aide, and one health assistant. Included in the other category were the responses of such contributors to scientific health care as health inspectors, dentists, health officers, medical missionaries, public health specialists, occupational therapists, physical therapists and dispensers. Respondents claimed affiliation with 15 different villages and five different districts of the 11 health districts which comprise the country.

A total of 134 health provider respondents contributed to the data upon which this report is based. Sixty-eight of these were interviewed before the questionnaire had been developed. The remainder - three traditional healers, seven faith healers, 36 nurses, nine physicians, and 11 others - responded to the questionnaire. In the following display of the data, it must be remembered that, wherever possible, structured interview data which could be quantified have been loaded into the tables.

Forty-eight per cent of the respondents were male and 52.2% were female (Table 1). Nurses were the primary contributors to the female group. The distribution of these healers across the several categories is shown in Table 2.

Table 1. Sex of Participating  
Health Providers  
N=134

Male	47.8%
Female	52.2%

Table 2. Healing Sector of Participating  
Health Providers  
N=134

Faith	21.65%
Traditional	21.65%
Scientific	56.7%
Nurse	35.1%
Physician	13.4%
Other	8.2%

#### Socialization to the Health Care Profession

Responses to inquiries about the extent of education for health providers revealed that nurses usually completed Form III, or ten years of formal schooling, before entering nursing school. The physicians, most of them foreigners, were trained in a number of different countries. They all completed high school before embarking upon their premedical college careers. All persons in the other category who responded to this question claimed to have some years of formal education.

As might be expected, primary education proved irrelevant to the practice of traditional and faith healing. Review of the data revealed that most of these respondents had either no formal education, or less than two years. Approximately seven had more than two years of schooling,

and three of these had between three and seven years of formal education. Three faith healers went to bible school but received no formal training for their faith healing activities.

Practitioners in the scientific sector were able to specify the length of their professional training in numbers of years (Table 3). There were 12.8% in the nurse category of scientific practitioners who claimed three months to two years of training. These were the family welfare educators, general duty aides and health assistants. Twenty-eight per cent of the nurses claimed to have two to four years of training, 42.5% were in training for four to seven years, and 6.4% claimed more than seven years of training. Some nurses had taken advanced training in public health or nursing education. There were also a few who had completed a program of studies in maternal-child health/family planning. Fifty-six per cent of the physicians took four to seven years of training, while 5.5% claimed more than seven years.

Table 3. Length of Training of Professional Scientific Health Providers

	Nurse N=47	Physician N=18	Other N=11	Total N=76
3 mo.-2 years	12.8%	-----	9.1%	9.2%
2-4 years	27.7%	-----	18.2%	19.7%
4-7 years	42.5%	55.6%	9.1%	40.8%
7+ years	6.4%	5.5%	9.1%	6.6%
NR*	10.6%	38.9%	54.5%	23.7%

\*No response

On the other hand, in most instances the length of professional training received by traditional and faith healers could not be assessed in numbers of years. Most faith healers were "called to healing" by God and immediately began their practice. Some received their call after experiencing a miraculous recovery from illness; others were not ill at the time of their calling. The tabulation of statements about their reasons for becoming faith healers revealed approximately equal percentages of those called with a personal illness, and those called without such illness. Only 3.5% claimed to have learned their profession from relatives.

Table 4. Reasons for Choice of Traditional and Faith Healing Professions

	Traditional N=29	Faith N=29
Called, with illness	-----	41.4%
Called, without illness	-----	37.9%
Learned from relatives	48.3%	3.5%
NR*	51.7%	17.2%

\*No response category includes those healers who were interviewed before this question was developed.

Traditional healers, however, invariably claimed to have been trained for their profession. The length of such training was difficult to assess because they provided a wide variety of interpretations of their formal and informal training experiences. A secondary review of the data revealed that 48.3% of these respondents specifically mentioned gathering herbs for

their fathers during childhood. Others spoke of having traditional healer relatives living close by. Whether they had or had not been socialized to their profession as children, many traditional practitioners spoke of having served a formal period of apprenticeship to established practitioners for terms ranging from six months to seven years. Many of these apprenticeships were served in Botswana, South Africa, and Zimbabwe. One spoke of having obtained his training in Namibia.

The question, "Was/is any relative of yours in the health care professions?" (Table 5), provided further insight, within the scientific sector, into the relationship between the health providers' family backgrounds and their recruitment to their professions. Forty-three per cent of the nurses answered "yes," and respondents in the other category were evenly divided between those who had and those who had no relatives working as health care providers. These findings may be compared with the traditional healer responses in Table 4, in which it was noted that 48.3% of traditional healers were reared in environments where relatives practice the healing arts.

Table 5. "Was/Is Any Relative of Yours in the Health Care Professions?"

	Nurse N=30	Physician N=8	Other N=4	Total N=42
Yes	43.3%	75.0%	50.0%	50.0%
No	56.7%	25.0%	50.0%	50.0%

In the European tradition, most practicing physicians come from families which contain health professionals, usually doctors. The responses

of the nurse group are interesting, since 56.7% of them said they did not have relatives in the health professions. Increasingly, in most countries of the world, professional nursing attracts people who are upwardly mobile in the social system. The ability to send a family member to nursing school represents an early step in the improvement of family fortunes. The nursing responses suggest a similar pattern for Botswana nurses, a pattern which may be expected to continue for a number of years to come. Freida Brown's preliminary analysis of the study, "Socialization of Children into Compliance Systems and their Attitudes about Health Care," appears to support this suggestion.

Continuing this theme, respondents with relatives employed in the health professions were asked their specific relationship (Table 6). Since respondents could have more than one relative so employed, all relatives mentioned were tabulated. For this analysis, the small number of responses from traditional and faith practitioners were loaded into the table.<sup>3</sup>

Table 6. Specific Relationship of Relatives Employed in the Health Professions

	Faith Healers N=6	Trad. Healers N=7	Scientific Healers			Total N=46
			Nurse N=15	Phys. N=15	Other N=3	
Nuclear family	66.7%	71.4%	20.0%	66.7%	66.7%	52.2%
Other relative	33.3%	28.6%	80.0%	33.3%	33.3%	47.8%

It was determined that a total of 52.2% of health professional

3. This series of questions was not regularly asked during structured interviews.

relatives were members of the respondents' nuclear families (father, mother, sister, brother, spouse, child, etc.), while 47.8% were other relatives, usually described as uncle, aunt or cousin.

In view of the comments already made about nurses, it is thought-provoking to note that it was this group that had a larger percentage of relatives other than nuclear family members employed in the health care professions. All other groups had more nuclear family member health care practitioners. Do these figures reflect patterns of family incentives to health careers? If the answer is yes, nurses certainly draw from a wider pool of own-family career models than do other professionals.

The next question asked was, "What specific occupation (do your health professional relatives pursue)?" (Table 7). Responses revealed that, for nurses with relatives in the health professions, 92.9% of those relatives were nurses. They reported no doctors among their relatives. This response reflects the reality that most physicians in Botswana are foreigners. It is also important to note that no respondents claimed to have faith or traditional healer relatives.

Table 7. Occupations of Scientific Sector's Health Professional Relatives

	Nurse N=14	Physician N=13	Other N=3	Total N=30
Nurse	92.9%	53.8%	66.7%	73.4%
Dentist	-----	-----	33.3%	3.3%
Physician	-----	46.2%	-----	20.0%
Pharmacist	7.1%	-----	-----	3.3%

Among physicians, who were mostly foreigners, 56.2% reported relatives who were physicians; yet a high 53.8% reported relatives who were nurses. This suggests that the "upwardly mobile" thesis continues to apply to foreign-born physicians.

In summary, the study of types of training and selected issues of recruitment into the health provider vocations revealed that traditional and scientific healers have healer role models in their families who were an important influence upon their career decisions. The same evidence was not apparent for faith healers, although it can be supposed, given socialization influences, that children of faith healers will be more disposed to become faith healers than those whose parents do not engage in such practices.

#### Cost of Training

An attempt was made to determine the training costs for providers in each sector. Exact information about these costs was impossible to obtain. Ordinarily, embarking upon a career as a faith healer requires no period of training. It has already been noted that faith healing is a "calling." Yet some faith healers reported receiving training while serving as deacons to the bishops of their churches. The amount of faith healing instruction they received in this role is yet to be determined.

The cost of becoming a traditional healer varies considerably. If the practice is in the family, the trainee collects herbs, runs errands, and generally serves as assistant to healer relatives. There can be two interpretations of the cost of this training. One is that it costs nothing. A Serowe court case illustrates this position:

Mrs. Gabwe Baikanyo<sup>4</sup> advises that she had come to the village for a court case at the Kgotla.<sup>5</sup> Mrs. Kgakgamatso Gaofiwe<sup>4</sup> is demanding payment of a cow for the traditional healer training which Mrs. Baikanyo was given by Mrs. Gaofiwe's mother, who is now dead. Mrs. Baikanyo did not pay, arguing that Mrs. Gaofiwe's mother was Mrs. Baikanyo's husband's mother too. So it was all within the family, and after all, she already knew about traditional healing from her own mother.

On the other hand, some elders adamantly maintain, "There is always a cow in the background."<sup>6</sup>

Learning to divine is another matter. Many traditional healers specifically spoke about a three to six month training course in the art of throwing bones. The cost of this training alone, or divination training combined with a prolonged apprenticeship to a traditional healer, may range from 5 Rand<sup>7</sup> to nine cows. No standardized relationship between the length of training, course content, and cost of training could be established.

Obtaining cost of training information for scientific practitioners was also problematic. Invariably, their training costs were absorbed by some government or nonprofit agency. Additionally, all of the physicians received their training in foreign countries. Since the educational preparation for practice in this sector is so radically different from education in the other two sectors, proper calculations of such costs must include all education prior to entry into professional school.

4. Pseudonyms are used to protect the informants.

5. Community council.

6. A cow is customarily paid to the trainer of a traditional healer.

7. At the time of this study, a Rand fluctuated between \$1.46 and \$1.16 (American).

### Prevention

An attempt was made to determine the role of all providers in the prevention of illness. The question, "Do you provide any services that are aimed at preventing people from becoming ill?" was not crystallized, and was not systematically asked, during the pre-questionnaire, structured interviews. Nevertheless, data obtained from these interviews suggested that the dichotomy of treatment and prevention was more germane to scientific than to traditional and faith healing practices.

In particular, the ethos and structure of traditional practice are infused with elements designed to prevent illness and fortify individuals and families against misfortune. Their repertoire of preventive activities is vast. As integral and important members of each community, they are able to advise friends and neighbors about good health practices, provide protective, preventive and fertility medicines, strengthen households, and perform rites of purification.

It appeared that faith healers are also beginning to perform some of these functions, although their primary preventive strategy remains explicit faith in God. The social structure of faith healing churches does provide a network of social support and guidance which can be considered an important bulwark against venereal disease, mental illnesses, and some physical ailments. For example, in a separate study of 20 households, the investigators were interested in determining if the households had been strengthened, and, if so, by whom. It was found that nine of the 20 households had been fortified by faith healers.

The question, "Do you provide any services that are aimed at

preventing people from becoming ill?" was asked of all scientific health care providers (Table 8). Forty-two per cent of the nurses and 55.6% of the physicians made no response to this question. Since many of the scientific health care providers in the other category do not provide direct services, their responses were not tabulated.

Table 8. "Do You Provide Any Services That Are Aimed at Preventing People from Becoming Ill?"

	Nurse N=36	Physician N=18	Total N=54
Yes	55.5%	44.4%	51.9%
No	2.8%	-----	1.8%
NR	41.7%	55.6%	46.3%

The scientific health care provider population was asked, "If yes, what kind?" Table 9 shows their responses.

Table 9. Kinds of Preventive Services Provided

	Nurse N=28	Physician N=10	Total N=38
Health education	35.7%	30.0%	34.2%
Prophylaxis	7.2%	20.0%	10.5%
Vaccination & immunization	46.4%	40.0%	44.8%
Maternal/child health care	10.7%	10.0%	10.5%

The correspondence in percentages of responses by physicians and

nurses to three of the four categories is particularly informative of role overlap between physicians and nurses. This matter will be touched upon again in later portions of this report.

#### Cost of Treatment

The question of differences in cost of health care for each sector was studied by both interview and questionnaire methods. Generally, the services of faith, traditional, and private practice scientific healers are provided on a fee-for-service basis. This contrasts with government health care, for which a fee schedule defines costs of treatment, whether the treatment is provided by a nurse, physician or dispenser.

Participant observation and initial interviews revealed two populations of faith healers. The first consists of those who consider healing an incidental, albeit important, part of their total ministry. These healers pray for sick people, and receive a donation rather than a fee in return for their services. This population of healers is important, but was not the central focus of study. The population of importance to this study consisted of those faith healers who consider healing a central aspect of their ministry, and who charge their patients for their services.

Besides praying, faith healers provide a limited range of other services. These include divination or diagnosis, water for drinking, water for vomiting, water for bathing and water for enemas. Some faith healers add ingredients, mainly ashes, to their water. Such a mixture is called sewasho. Fees for these services are charged. Annual church membership fees and special holiday tariffs are also charged members of the church, or may be solicited when the healer encourages the patient to join the

church. Usual charges for these services were found to be:

Church Costs

Church membership	R0.50 - R2.00 per year	
Good Fridays	R0.75 - R3.00	May be either fees
Easter, Thanksgiving	R0.75 - R3.00	or donations
Tithes, collections	R0.20 - R1.00	

Healing Costs

Opening bible (diagnosis or divination)	R0.10 - R0.50
Treatment of children	0 - R0.50
Treatment of adults	0 - R5.00
Treatment of elderly	0 - R1.50
Special treatments:	
Enema	R0.20 - R0.40
Bath	R0.25 - R5.00

Costs for most patients of faith healers are at the lower range of the above fee and treatment scales. However, some renowned healers charge, and receive, payments of R50.00, or even cattle, for their services. Within this sector, there appears to be no established practice regarding payment of fees for services based upon specialization, or payment of fees for services successfully performed.

In summary, faith healers provide a limited number of treatments for a wide range of complaints. Although the costs of these services are not standardized, most of them are cheap, and are, therefore, attractive, particularly when the patient is a member of the church. Successful practice as a faith healer also facilitates the expansion of church membership.

Professional traditional practitioners, as a group, treat a large number of diseases, provide a wide range of treatments, and levy a fee for their services. Their charges appear to reflect such considerations

as specialization, part-time or full-time practice, and reputation as a practitioner.

Most traditional healers rely upon divination for the diagnosis of disease. Although the casting of bones was found to be the most common method of divination, a very small number of traditional practitioners used such other methods as staring into leopard spots, water gazing, or throwing a rope. Divination costs were usually R0.50. Thereafter, fees for services performed ranged from R0.50 to R20.00. Above this point, the data suggest few cash payments. Rather, a transition occurs from payment in cash to payment in goats, sheep and cattle. Conditions which require payment in cattle are usually mental illness and witchcraft. The rationale for the high cost of treating these conditions is that much mental illness is caused by witchcraft, and that the process of curing witchcraft-related disorders may endanger the healer's own life.

Usual costs of traditional practitioners' services were found to be:

Casting bones	R0.20 - R0.50
Treatment of children	R2.00 - R3.00
Treatment of adults	R5.00 - R10.00
Treatment of venereal disease	R12.00 - R14.00
Treatment of sejeso (poisoning)	R14.00 - R20.00
Treatment of mental illness	Cattle - 1+
Treatment of witchcraft	Cattle - 1+
Increased cattle fertility	Cattle - 1
Increased farm productivity	Sorghum - 1 bag

Although the practice of traditional healing has a recognizable form, it is not institutionalized; therefore, definitive statements about payment practices are difficult to make. The evidence suggests that, as recently as two decades ago, there was no standard fee for divinations. Rather, payment for divination consisted of "giving the healer something."

Usually the fee was dictated by the type of disease and the resources of the client. If treatment were required, the healer was paid upon successful cure of the complaint. Familiarity with the healer, respect for his services, gratitude for his cure and fear of his anger were usually sufficient to insure that most patients would pay their fees.

Changes in payment practices appear to reflect the movement of increasing numbers of Batswana into the cash economy, increased movement into urban and industrialized communities and its consequent anomie, the popularity of western ideas about standardization of fees and fee schedules, and the formation of Dingaka<sup>8</sup> associations. Only trends, rather than norms, could be identified in the costs of healing services. Increasingly, traditional practitioners are establishing fee schedules. The extent to which they adhere to these schedules could not be determined. Also, a trend towards the practice of payment upon treatment appears to be replacing the older practice of payment upon cure.

A healer-client problem peculiar to recent times is practitioners' concern about the integrity of their clients. They believe that, increasingly, patients who have been cured are claiming they have not been cured, or are "staying away too long," and then returning with a new illness, insisting it is the old illness. On the other hand, patients increasingly question the sincerity and efficacy of the traditional healer, seek cures for the same illness in several sectors, and wonder whether traditional, faith or scientific healer was responsible for their cure. Considering that patients may already have paid for services performed by faith or

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8. Healers or doctors.

scientific healers, or even other traditional doctors they have seen, and considering, too, the ambiguity of the definition of "cure," their rejection of the traditional healer's request for payment upon cure, rather than payment for services, is understandable. These problems may also be related to the sense of dissatisfaction health seekers express about traditional healer services (Table 26).

Fees in the scientific sector are based upon the expectation that payments will be made for services performed, rather than for the outcomes of services. The maintenance of fee schedules is an important characteristic of this sector. Whereas among faith and traditional practitioners (and, to a lesser extent, private scientific practitioners), fees are always related to the curative needs of patients, calculations of the patient's ability to pay, and the healer's need to earn a living, other considerations enter into the construction of government fee schedules. Considerations of national policy require that such services be inexpensive and available to as many people as possible. Fee schedules must be simple in order to minimize confusion and misinformation about government health costs. There is also a concern with control of patient traffic so that the flow of patients is coordinated with the availability of scientific health care personnel. Since the largest number of patients is seen in outpatient clinics, high personnel availability is dictated during weekday working hours. Services outside these hours, including emergency services, are delivered at additional cost. At the time of the research, the fee schedule for government health services was:

0-12 years	No charge
0-12 years, private <sup>9</sup>	R1.50
12+ years:	
Outpatient visit	R0.40
Private outpatient visit	R3.00
Ward inpatient	R0.10/day
Private inpatient	R5.00/day, R25.00 deposit
Private patient check-up	R1.00

The cost of scientific healing services performed by government employees differs radically from that of services performed by private practitioners of scientific medicine. Private practitioners cater primarily to the health needs of the economically advantaged, including foreigners. Interestingly, although the financial and cultural characteristics of these patients would, seemingly, allow private practitioners to establish individual fee schedules, their schedules are quite similar. Apparently because all private practitioners draw from the same, small patient population of economically advantaged, and they all have essentially the same clinical and laboratory resources, they are constrained to charge similar fees. The usual office visit fee schedule of Gaborone private practice scientific physicians is:

Basic and/or maximum adult charge	R3.00
Children	R2.00
Treatment of venereal disease	R5.00
Injections and medicines	R5.00 for five days

In summary, faith healers have the most limited range of services to offer. Their fee schedules are, therefore, relatively simple. Traditional healers' fee schedules are individual and flexible. They are based on a variety of considerations, including family relationship or friendship,

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9. Private services are more individualized and personalized.

ability to pay, and considerations of efficacy of treatment. Scientific healers, both government employees and private practitioners, use fee schedules. Unlike traditional healers, they expect all patients to pay their fees, and fees are paid for services performed, rather than outcomes of treatment.

The traditional healers' past history of accepting payment for cure is to be contrasted with scientific and faith healers' practice of charging fees for services. Faith healers practicing in Serowe and other parts of southern Africa claimed that as recently as 15 years ago, faith healing was suppressed. Since that time, both faith healing churches and scientific healing services have expanded. The advent of these new healing sectors has put tremendous competitive pressures upon traditional medical practices.

#### Associations

There are many ways in which associations can foster the development of health professionals. Associations facilitate the gathering of people of similar vocational interests, permitting them to compare and evaluate each other's practice. Such associations usually establish a code of ethics which defines the behavioral expectations of members. Meetings, lectures, seminars and special programs sponsored by these associations constitute a primary means for members to upgrade their practice. Associations also provide a vehicle by which members can communicate their beliefs and aspirations to the community, other professional groups, and political bodies. And, ultimately, professional associations habitually attempt to control the practices of their members.

Most faith healers are leaders of churches affiliated with some national church organization. Although there is a Botswana Interfaith Council, this is primarily a coordinating group for activities of churches organized at the national level, and is not concerned with the development of faith healing practice. In fact, the nature of faith healing does not allow for professional organizations, since a faith healer's ability depends upon the grace of God, rather than the knowledge and experience of the individual healer or the collective wisdom of colleagues. As previously noted, most faith healers receive little formal education, and become healers as a result of being "called," rather than trained for their profession.

Yet, faith healers do cherish their roles as church leaders and value their associations with other church members. Of the 23 faith healers who responded to the question, "Do you belong to any professional association?" 91.3% said they did (Table 10). Since no organization was identified which could be defined as a professional faith healing association, it was concluded that faith healers thought of their churches as their professional organizations. Further interviews with faith healers did reveal a number of them who desired opportunities to associate with other faith healers for the purpose of learning more about faith healing practices, specifically the application of waters and the mixing of sewasho.

Table 10. "Do You Belong to Any Professional Association?"

	Faith Healer N=23	Trad. Healer N=19	Scientific Healer		Total N=71
			Nurse N=20	Physician N=9	
Yes	91.3%	47.4%	50.0%	88.9%	67.6%
No	8.7%	52.6%	50.0%	11.1%	32.4%

In the past, the idea prevailed that "traditional healers cannot associate with each other because they hate each other." There was also the belief that traditional doctors were, essentially, witch doctors, who were as likely to poison each other as to cooperate. These ideas have changed, if they were ever really viable. Many of the traditional healers interviewed in this study lived in Serowe, where there was no traditional healer association. For this reason, of the 19 traditional healers who responded to the question, "Do you belong to any professional association?" 52.6% responded "no." However, only one of these respondents indicated disapproval of such organizations. The majority of the traditional healers advocated the development of Dingaka associations. Many of the traditional healers living in Serowe were eager for information about the organization, leadership and location of Dingaka associations located in Gaborone, Molepolole, and Selebwe Pikwe, and the Pretoria South African Native Healers' Association.

The Botswana Nurses' Council, Botswana Nurses' Association, and Botswana Medical and Dental Society constituted the three Botswana scientific health practitioner professional organizations. When the scientific sector respondents were asked if they belonged to any professional

association, half of the nurses indicated that they did, and half said they did not. Of the physicians who responded to this question, 88.9% said "yes," while only 11.1% said "no."

### Collaborations

Inherent in this study is the critical question of the potential for collaborations among and between practitioners in each of the three healing sectors. To assess current attitudes and practices regarding such collaborations, the question, "Have you ever worked with, or would you be willing to work with, members of the faith, traditional, or scientific healing sector?" (Table 11) was asked. Responses to this question were considered positive if respondents indicated they were currently collaborating with practitioners in other sectors, or if they expressed willingness to engage in such collaborations. An "other" category was established for those responses judged not applicable, and for the frequent ambiguous responses such as, "Scientific wants traditional doctors' knowledge only," "Traditional doctors may treat only gonorrhoea successfully," "Will go to faith healer for myself only but will not send patients," "It is up to each patient to decide," etc.

Faith healers' responses indicated equivocation in their willingness to collaborate with traditional healers, for 46.7% responded "yes," and the same percentage answered "no." This equivocation disappeared when they were asked if they were willing to collaborate with scientific healers: Seventy per cent were willing, none was unwilling, while 30% of the responses fell in the "other" category.

Table 11. Willingness to Collaborate Within and Between Sectors

## A. "Are You Willing to Collaborate with Faith Healers?"

	Faith Healer N=12	Trad. Healer N=14	Scientific Healer		Total N=72
			Nurse N=35	Physician N=11	
Yes	33.3%	14.3%	20.0%	45.5%	25.0%
No	50.0%	85.7%	31.4%	9.0%	41.7%
Other	16.7%	-----	48.6%	45.5%	33.3%

## B. "Are You Willing to Collaborate with Traditional Healers?"

	Faith Healer N=15	Trad. Healer N=22	Scientific Healer		Total N=97
			Nurse N=35	Physician N=25	
Yes	46.7%	63.6%	40.0%	48.0%	48.5%
No	46.7%	27.3%	14.3%	36.0%	27.8%
Other	6.6%	9.1%	45.7%	16.0%	23.7%

## C. "Are You Willing to Collaborate with Scientific Healers?"

	Faith Healer N=20	Trad. Healer N=22	Total N=42
Yes	70.0%	68.2%	69.1%
No	-----	18.2%	9.5%
Other	30.0%	13.6%	21.4%

Considering faith healers' willingness to collaborate with other faith healers, 33.3% said "yes," while 50% said "no," indicating that faith healers were less willing to collaborate with each other than with traditional and scientific healers.

In contrast, 63.6% of traditional healers stated their willingness

to collaborate with members of their own group. Also, 68.2% of these respondents indicated willingness to collaborate with professionals in the scientific sector. The 85.7% "no" response to the question of their collaboration with faith healers was definitive. The lack of ambiguous "other" responses confirms this response.

To the question of their willingness to collaborate with faith healers, 48.6% of nurses responded in the "other" category, and 31.4% said "no." Only 20% stated their willingness to engage in such collaborations. Although nearly the same percentage of nurses who gave "other" responses to the question of collaborating with faith healers responded in the "other" category when asked about collaborating with traditional healers, twice as many (40%) were willing to collaborate with traditional healers as with faith healers. Personal acquaintance, observation and participation with the nurses support the view that, despite their largely negative or ambiguous responses to collaboration with traditional doctors and faith healers, as a group nurses were more positive to such collaborations than Table 11 indicates.

Physicians appeared more at ease with the idea of collaboration with faith healers (45.5% "yes") than nurses. Their responses in the "other" category were equal to the "other" responses of the nurses. Also, although their 48% "yes" response to collaboration with traditional healers was slightly more positive than nurses' response, their 36% "no" response was decidedly more negative than the nurses', and than their own 9% unwillingness to collaborate with faith healers. However, their combined "no" and "other" responses to collaboration with faith and traditional healers

were similar, 54% and 52%, respectively. Other evidence, collected by participant-observation and structured interview methods, indicated that physicians actually knew little about faith healing and traditional healing. Nevertheless, they believed they knew about traditional healing practices, and conveyed the impression that traditional healers were their most serious competitors in the health provider arena.

In summary, the totals of Table 11 indicate that the health provider populations were least willing to collaborate with faith healers (25% "yes" and 41.7% "no"), nearly twice as willing to collaborate with traditional healers (48.5% "yes" and 27.8% "no"), and most willing to collaborate with scientific healers (69.1% "yes" and 9.5% "no").

Inherent in the practice of scientific medicine is the collaboration of many different kinds of specialists. For this reason, nurses and doctors were not asked about their willingness to collaborate with other professionals in the scientific sector.

## THE HEALTH SEEKERS

Population Characteristics

One hundred seven people responded to the Health Seeking Questionnaire. Included in this population were 16 student nurses. These students provided the opportunity to determine if they, as a result of their aspirations and continuing socialization for service in the scientific sector, would provide different responses than the general population. The entire population represented 22 different villages and towns. Sixty-seven of the respondents lived in Serowe. These respondents claimed to belong to 15 different ethnic groups. Forty-three Ngwato, the people of Serowe, represented the largest proportion of the population. The health seeking respondents represented nine of the 11 districts of Botswana. One respondent claimed South Africa as her home.

Age. Most respondents fell into the 21-35 year old group (Table 12). This group constituted 49.5% of the respondent population. The second largest number of respondents was 36-50 years of age (24.3% of the population), followed by the Over 65 group (11.2% of the population).

Table 12. Age of Respondents to Health Seeking Questionnaire

	General Population N=91	Student Nurses N=16	Total N=107
Under 20	4.4%	6.25%	4.7%
21-35	43.9%	81.25%	49.5%
36-50	27.5%	6.25%	24.3%
51-65	6.6%	-----	5.6%
Over 65	13.2%	-----	11.2%
NR	4.4%	6.25%	4.7%

Sex. The majority of the respondents were female (Table 13). As noted in the methodology section, this bias reflects major realities of the life of the people. That is, men spend much time away from home, working in the mines of southern Africa or at their cattle posts. Women and their children constitute the largest populations in traditional and scientific healer clinics and faith healing churches. Consequently, they were the health seeking populations most readily available to the researchers. All student nurses were female.

Table 13. Sex of Respondents

	N=107
Female	77.6%
Male	14.9%
NR	7.5%

Education. Of the general population, 27.5% claimed to have had no education, while 37.3% had had at least some primary schooling (Table 14). Only three general population respondents had some post-secondary education. Thirty-nine per cent of the respondents, including all of the student nurses, had a secondary education.

Table 14. Education of Respondents

	General Population N=91	Student Nurses N=16	Total N=107
No formal	27.5%	-----	23.4%
Primary	37.3%	-----	31.8%
Secondary	28.6%	100.0%	39.2%
Post-secondary	3.3%	-----	2.8%
NR	3.3%	-----	2.8%

Occupation. In response to questions about employment (Table 15), 59.3% of the general population said they were unemployed. Most of these respondents were married females; therefore, they were categorized as unsalaried/housewife. Twelve per cent worked for the government; 12.1% were office workers; 3.3% were in business; and 3.3% were students.

Table 15. Occupation of General Population Respondents

	N=91
Unsalaried/housewife	59.3%
Government worker	12.1%
Office worker	12.1%
Business	3.3%
Student	3.3%
NR	9.9%

Marital Status. Forty-one per cent of the general population were married, 39.5% were single, and 11% were widowed (Table 16). The remainder stated they were either separated or divorced. The majority of student nurses (87.5%) were single.

Table 16. Marital Status of Respondents

	General Population N=91	Student Nurses N=16	Total N=107
Married	40.7%	12.5%	36.4%
Single	39.5%	87.5%	46.7%
Widowed	11.0%	-----	9.4%
Separated	3.3%	-----	2.8%
Divorced	2.2%	-----	1.9%
NR	3.3%	-----	2.8%

Children. Most general population respondents claimed to have one to three children (15.2%, 21.2% and 16.6%, respectively), while 22.7% of the general population had more than six children (Table 17). Of the five student nurses who had children, two had one, two had two, and one had four children.

Table 17. Children of Respondents

	General Population N=66	Student Nurses N=5	Total N=71
1 child	15.2%	40.0%	16.9%
2 children	21.2%	40.0%	22.5%
3 children	16.6%	-----	15.5%
4 children	7.6%	20.0%	8.5%
5 children	7.6%	-----	7.0%
6 children	9.1%	-----	8.5%
6+ children	22.7%	-----	21.1%

Heads of Household. The question, "What is the sex of the head of your household?" (Table 18) was asked to determine the general decision-making structure in the households of the general population informants. Also, considering the paucity of males available for interview responses, this question was designed to determine the relevance of males to health seeking decision-making. The general population respondents claimed that males headed 50.5% of their households, while 20.9% were headed by females. The most frequent response of student nurses to this question was "not

applicable." It is presumed that this response reflected the fact that the students lived in nurses' quarters.

Table 18. Sex of Head of Household  
(General Population)

Female	20.9%
Male	50.5%
NR/NA*	28.6%

\*Not applicable

Summary. Analysis of the data descriptive of the nursing students and the general population respondents to the Health Seeking Questionnaire confirmed expectations that the nursing student population was younger and more highly educated than the general population. They were more likely to be single (87.5%), and those few who were married had fewer children than did parents in the general population.

#### Health Seeking Behavior

Interviews with health seeking informants were designed to elicit information about the health seeking behavior of the informant's family as well as the individual's own behavior. Each informant was asked, "Have there been any illnesses in your family in the past three years?" Table 19 shows that 72.5% of the general population said "yes," while 18.7% said "no." Among nurses, 87.5% responded "yes" to this question. It is difficult to believe that the families of student nurses are sicker than those of the general population. It is thought that this response reflects

greater awareness of and involvement in family illness among student nurses than among the general public.

Table 19. "Have There Been Any Illnesses in Your Family in the Past Three Years?"

	General Population N=91	Student Nurses N=16	Total N=107
Yes	72.5%	87.5%	74.8%
No	18.7%	12.5%	17.7%
NR	8.8%	-----	7.5%

In response to the question, "Did you consult anyone outside the family for help?" (Table 20), 67% of the general population said "yes;" 12.1% said "no." The "no response/not applicable" category included those persons who did not respond to the question, as well as those whose family members had not suffered any illnesses during the past three years.

Table 20. "Did You Consult Anyone Outside the Family for Help?"

	General Population N=91	Student Nurses N=16	Total N=107
Yes	67.0%	68.8%	67.3%
No	12.1%	25.0%	14.0%
NR/NA	20.9%	6.2%	18.7%

Of the student nurses, 68.8% responded "yes" to this question. The similarity in percentages of student nurses and the general public who responded "yes" to this question may confirm the researchers' suspicion

that student nurses are more aware of and involved in family illness than the general public, although such illness does not require more outside consultation than is required by the general public.

A series of questions designed to track the health seeking behavior of respondents and family members was asked. These questions were: "Whom did you consult and where?" "How did you deal with the problem(s)?" "Did you get satisfactory results?" Responses to these questions were not sufficiently consistent to allow tracking of family and respondent health seeking behavior. However, these questions did provide background data for the interpretation of another series of questions designed to cross-validate the tracking responses. This series of questions focused upon health seeking behaviors in each of the three health providing sectors available to the people of Botswana.

Respondents were asked, "Have you or any member of your family ever been to a faith healer?" (Table 21). Forty-four per cent of the general population responded "yes," while 49.4% responded "no." A large proportion (75%) of the student nurses answered "yes," and 25% said "no."

Table 21. "Have You...Ever Been to a Faith Healer?"

	General Population N=91	Student Nurses N=16	Total N=107
Yes	44.0%	75.0%	48.6%
No	49.4%	25.0%	45.8%
NR	6.6%	-----	5.6%

Why student nurses or their families visited faith healers more than

the general public is perplexing. It is possible that they are more frequent churchgoers, and are thus exposed more often to faith healers than the general public is.

To the question, "Have you or any member of your family ever been to a traditional healer?" (Table 22), 42.9% of the general population responded "yes," and 48.3% said "no." Fifty-six per cent of the student nurse population responded positively to this question.

Table 22. "Have You...Ever Been to a Traditional Healer?"

	General Population N=91	Student Nurses N=16	Total N=107
Yes	42.9%	56.3%	44.9%
No	48.3%	43.7%	47.6%
NR	8.8%	-----	7.5%

The totals in Tables 21 and 22 indicate that there is little overall difference in the selection of faith healers and traditional healers for the total population.

Respondents were asked, "Have you or any member of your family ever been to a scientific doctor, hospital or clinic?" (Table 23). An overwhelming 93.4% of the general population, and 100% of the student nurses, responded that they and members of their families had been to scientific practitioners for their illnesses. Undoubtedly, the scientific sector has become the most universally subscribed to of the three sectors studied. Yet, the nursing students' responses to this series of questions raise an important issue. They are the population which has had the most exposure

to science and scientific medicine. At the same time, a higher percentage of their population utilized all three sectors than the general population. Since they are younger and more highly educated than the general population, their responses suggest that they are both more active health seekers than the general population and that they have discerned inadequacies in the scientific sector which cause them to seek health care in the faith and traditional healing sectors.

Table 23. "Have You...Ever Been to a Scientific Doctor...?"

	General Population N=91	Student Nurses N=16	Total N=107
Yes	93.4%	100.0%	94.4%
No	3.3%	-----	2.8%
NR	3.3%	-----	2.8%

Respondents were asked for what purpose they had visited practitioners in the faith, traditional and/or scientific sectors (Table 24). They mentioned a wide variety of conditions. As anticipated, this question revealed a large number of nomenclature and conceptual problems for both respondents and researchers. There were confusions of symptoms with disease categories; different names were given for the same diseases; different diseases were known and treated in different sectors, etc. The researchers attempted to categorize these many conditions. Table 24 displays the results of that effort, as well as the nominations of types of healers for each disease category.

Table 24. Purposes of Respondents' Visits to Faith, Traditional and Scientific Healers

	Visits to Faith Healers		Visits to Traditional Healers		Visits to Scientific Healers	
	General Pop. N=41	Student Nurses N=14	General Pop. N=45	Student Nurses N=10	General Pop. N=110	Student Nurses N=29
Respiratory	9.8%	7.2%	8.9%	-----	25.5%	10.4%
Infectious	2.4%	-----	-----	10.0%	5.5%	20.7%
Alimentary	19.5%	-----	6.7%	-----	13.6%	13.8%
Cardiovascular	2.4%	7.2%	4.4%	20.0%	4.5%	6.9%
Venereal	-----	-----	-----	-----	3.6%	-----
Urinary	-----	-----	-----	-----	0.9%	-----
Surgery	-----	-----	2.2%	-----	2.7%	6.9%
Nervous system	4.9%	14.2%	6.7%	30.0%	4.5%	3.4%
EENT & teeth	4.9%	21.4%	-----	10.0%	6.4%	6.9%
OB-GYN	4.9%	-----	6.7%	-----	6.4%	6.9%
General	46.4%	28.6%	42.2%	20.0%	25.5%	20.7%
Prevent/Predict	2.4%	21.4%	11.1%	10.0%	-----	-----
Destructive	-----	-----	11.1%	-----	-----	-----
Skin	2.4%	-----	-----	-----	0.9%	3.4%

Table 24 represents the best sense the researchers could make of the welter of confusing and conflicting data collected. It is included in this report to advise future researchers of these findings and to remind them of the many issues involved in such explorations. Despite these several cautions, this table is not without merit, for it does confirm data gained by participant-observation and structured interview methods. For example, traditional healers are the only practitioners of the destructive arts. The high percentage of general population respondents who visit faith healers for alimentary system problems may be associated with the large amounts of oral fluids these healers use as their primary therapeutic adjunct to prayer. Also, the large percentages of general

population and student nurse respondents who utilize faith and traditional healers for general problems (body aches, pains, malaise, etc.) cannot be ignored. It is this category which suggests the relationship between culturally embedded facets of faith and traditional healing and psychophysiological illness.

Traditional healers, and, to a lesser extent, faith healers, are respected for their ability to treat nervous system disorders. The nomination by student nurses of these healers for treatment of nervous disorders reflects an apparently increasing confidence on the part of highly educated people in the abilities of these healers. The preference for faith healers and traditional healers for prevention of disease and prediction of the future was also compatible with the participant-observation and structured interview data.

Central to the study of health seeking behavior was the determination of how individuals use family members and friends in their search for health care. Respondents were asked whose advice they followed in deciding to go to the faith, traditional, and scientific healing sectors (Table 25). As in the Health Providing Questionnaire, the definition of nuclear family was maintained as father-mother, sister-brother, wife-husband, and daughter-son. The category "other relative" defines collaterals of ascending, same, and descending generations. The category "friends" defines all non-family advisors. A "self" category was also added.

Table 25. Advisors of Visits to Faith, Traditional and Scientific Healers

	Visits to Faith Healers		Visits to Traditional Healers		Visits to Scientific Healers		Total N=193
	General Pop. N=34	Student Nurses N=12	General Pop. N=39	Student Nurses N=8	General Pop. N=79	Student Nurses N=21	
Nuclear family	41.2%	41.7%	48.7%	37.5%	49.3%	47.6%	46.6%
Other relative	14.7%	25.0%	10.3%	25.0%	5.1%	9.5%	10.4%
Self	38.2%	8.3%	33.3%	12.5%	44.3%	33.4%	36.3%
Friends	5.9%	25.0%	7.7%	25.0%	1.3%	9.5%	6.7%

As anticipated, responses for both the general population and student nurses showed that the nuclear family was most instrumental in advice given in selection of sector used. The general population chose "self" selection as the second basis for such decisions (38.2%, 33.3%, and 44.3%, respectively). Student nurses' responses demonstrated a mixed picture. "Other relatives" and "friends" were the second basis (25%) for student nurses' selection of faith healers and traditional healers, while "self" selection was the second most frequent basis for their consulting scientific healers. Of particular note is the evidence that in their use of all sectors, student nurses, the more highly educated group, were as likely to follow the advice of friends as of non-nuclear family relatives. In every instance, this group showed less inclination than the general population to use their own advice ("self") in their decisions to visit a healer. This reticence may be attributed to any number of factors, including their youth, education, close associations with a large number of health providers, socialization

factors associated with sex, etc.

The question, "Were you/they (family members) satisfied with the treatment (received in that sector)?" (Table 26), was asked to determine the extent of satisfaction of respondents and their families with the treatment obtained in each sector.

Table 26. Degree of Satisfaction with Treatment

	Faith Healing		Traditional Healing		Scientific Healing		Total
	General Pop. N=40	Student Nurses N=12	General Pop. N=37	Student Nurses N=8	General Pop. N=76	Student Nurses N=16	
Very	50.0%	58.3%	43.2%	12.5%	57.9%	62.5%	51.9%
Fairly	15.0%	16.7%	16.2%	12.5%	15.8%	37.5%	17.5%
Not	35.0%	25.0%	40.6%	75.0%	26.3%	-----	30.6%

More general respondents reported satisfaction (50%) than dissatisfaction (35%) with faith healers. Responses of the general population who had used the traditional sector were evenly divided between "very satisfied" (43.2%) and "not satisfied" (40.6%). Fifty-eight per cent of the general population respondents who had used the scientific sector claimed to be "very satisfied," while only 26.3% were unsatisfied with the services of scientific practitioners. Student nurses reported greater satisfaction with faith healers (58.3% "very satisfied," 16.7% "fairly satisfied," and 25% "not satisfied") and with scientific practitioners (62.5% "very satisfied," 37.5% "fairly satisfied," and none "not satisfied") than with the services of traditional practitioners (12.5% "very satisfied," 12.5% "fairly

satisfied," and 75% "not satisfied"). There are no specific data which would account for the traditional healers' low rating on treatment satisfaction. However, it is known that, for all respondents, traditional healers are more likely than faith healers to be invidiously compared with scientific healers. Issues of payment for services, discussed in an earlier section of this report, certainly contribute to this dissatisfaction. Cognitive dissonance in student nurses who are being socialized to scientific healing, but at the same time utilize the services of traditional healers, must also contribute to their negative sense of satisfaction with this sector.

The pre-questionnaire investigations confirmed that many respondents and family members sought help for a single ailment from more than one sector. Therefore, the question, "Have you or any member of your family ever been to more than one sector for the same disease?" was asked (Table 27). Forty-one per cent of the general population, 50% of the student nurses, and 42.1% of the total population claimed they and/or their families had used more than one sector for the same disease. A nearly equal 48.6% of the total respondents said they had not.

Table 27. "Have You or Any Member of Your Family Ever Been to More than One Sector for the Same Disease?"

	General Population N=91	Student Nurses N=16	Total N=107
Yes	40.7%	50.0%	42.1%
No	49.4%	43.8%	48.6%
NR/NA	9.9%	6.2%	9.3%

In order to assess the pattern of this health seeking behavior, the respondents who said they and their family members have used more than one sector for the same disease were asked which sector they resorted to first, second, and third. Table 28 is a synthesis of the responses to this question.

Table 28. Order of Selection of Multiple Sectors

	First N=59	Second N=53	Third N=34
Faith Healer	13.6%	34.0%	52.9%
Trad. Healer	10.1%	47.1%	14.7%
Scient. Healer	76.3%	18.9%	32.4%

The total number of respondents decreased from 59 to 34 as they indicated the first, second and third sectors used. Study of these responses suggests that the loss of the first six respondents (between first and second sectors used) can be attributed to failure to understand the requirements of the question, or to lack of interest in this section of the questionnaire. The further loss of 19 respondents between the second and third sectors used may be attributed to loss of interest in this question and/or to cessation of health seeking activity after visiting two sectors. Analysis of the responses indicates that the largest percentage of health seekers went to the scientific sector first (76.3%); on second visits, the traditional sector was favored (47.1%); while the faith healing sector was chosen most frequently (52.9%) by those who

resorted to a third sector. Future study of this behavior is particularly important. The data do not reveal how many visits a health seeker made in any one sector before trying another sector for the same complaint; health seekers' cyclical behavior between the first two sectors before a third was chosen; the percentage of those who became dissatisfied with their treatment in the third sector, and went elsewhere or re-entered the cycle; in which sector such health seekers re-entered the cycle; or why they moved from one sector to the next.

### Religion

Interaction with informants indicated the possibility of conflict between Christian religiosity and use of traditional healers, who were alleged to represent the "forces of darkness." For this reason, a series of questions was designed to determine the religious commitments of the respondents. Christianity was the only religion cited by respondents. The question, "Are you a member of any church or religious organization?" (Table 29), revealed that 58.2% of the general population and 93.8% of the student nurse population belonged to such organizations.

Table 29. "Are You a Member of Any Church or Religious Organization?"

	General Pop. N=91	Student Nurses N=16	Total N=107
Yes	58.2%	93.8%	63.6%
No	37.4%	6.2%	32.7%
NR	4.4%	-----	3.7%

Asked the specific church or religious organization they belonged to, the largest percentage (37.3%) claimed membership in the United Congregation Church of South Africa (Table 30). Most of the Serowe respondents belonged to this church, which was considered the most prestigious religious institution in that large village. The second largest percentage (22.4%) mentioned numerous churches which were reported to have a central faith healing focus. Churches in the "other" category were Lutheran, Anglican, Dutch Reformed, Trinity, Methodist and Assembly of God.

Table 30. Specific Church Membership

	General Population N=53	Student Nurses N=14	Total N=67
Faith Healing	24.5%	14.3%	22.4%
United Cong. Church of South Africa	39.6%	28.6%	37.3%
Roman Catholic	9.4%	7.1%	8.9%
Zionist Congregational	7.6%	7.1%	7.5%
Other	18.9%	42.9%	23.9%

The belief in badimo (ancestors) was considered to indicate a respondent's predilection for traditional cultural beliefs. For this reason, the question, "Do you believe in ancestors (badimo)?" was asked. Table 31 shows that 23.4% of the general population and 18.8% of the student nurse population responded "yes."

Table 31. "Do You Believe in Ancestors (Badimo)?"

	General Population N=91	Student Nurses N=16	Total N=107
Yes	49.5%	12.5%	43.9%
No	48.3%	87.5%	54.2%
NR	2.2%	-----	1.9%

The researchers wanted to know what percentages of the total population believed in both God and badimo. Secondary analysis of the data related to this question (Table 32) revealed that the large majority of respondents (95.3%) believe in God. Yet an impressive 45.1% of those who believe in God continue to believe in badimo, as well. This findings suggests that there is no necessary conflict between Christian religiosity and traditional cultural beliefs.

Table 32. Expressed Belief in God and Badimo

	<u>N</u>	<u>%</u>
God only	56	52.3%
God and <u>badimo</u>	46	43.0%
<u>Badimo</u> only	1	0.9%
Neither	2	1.9%
NR	2	1.9%
Total	107	

### Summary

In many ways the student nurses' use of traditional and faith healing sectors proved to be different from that of the general population. It was not surprising that they saw more illness in their environment (Table 19) and used scientific healers more (Table 23) than the general public. As budding health professionals they were expected to exhibit these behaviors. What was surprising was their greater utilization of faith and traditional healers (Tables 21 and 22) than the general public. The low percentage of student nurse satisfaction with traditional healer services (Table 26) must be compared with the health provider nurses' willingness to collaborate with traditional healers (Table 11). These differences suggest that with further socialization to their profession and actual experience in the working world, their opinions about traditional healers will be modified.

Despite their aggressive health seeking behavior, an interesting difference between student nurses and the general population appeared in health seekers' use of advice in their choices of health providers. Table 25 reveals that, in their use of every sector, student nurses were less inclined to rely upon their own judgment than was the general public. Also, with the exception of their use of the scientific sector, student nurses relied very heavily upon the advice of nuclear family, other relatives, and friends to visit health providers. Their greater reliance upon family and friends for health seeking advice may be attributed to their isolation from their home communities and to their greater involvement in health care institutions than the general public. Their mobility and

their greater involvement in the money economy, urbanization, and bureaucratization suggest that their responses may be indicators of that portion of the Botswana population who are involved in similar processes.

## SUMMARY AND RECOMMENDATIONS

Populations are not static. People move from place to place, absorb new ideas, interact with strangers and create new tools. All of these experiences result in new patterns of social interaction and behavioral possibilities. New nations, such as Botswana, are particularly susceptible to rapid social and cultural change. Under such conditions, social science research can only be suggestive. Much intensive work and many years must pass before an adequate social science research environment is achieved, and findings from a number of research projects can be used to cross-validate each other. It is with this understanding that this report is forwarded.

Throughout this research, it was apparent that profound differences exist between the views scientific, faith, and traditional healers have of the world. For example, there was an attempt to gather health seeking data from Europeans. This was not useful. They are not part of the culture. The questions would not have made sense to them. At the same time, most of the scientific physicians are also not members of the culture. They do not speak Setswana, and are minimally informed about the activities of faith and traditional healers. They do not own farms and cattle, nor are they members of an extended family, the essential Tswana family form. They lack the cultural fit which is the peculiar strength of both traditional and faith healers.

For these reasons, participant observation data, structured interview data, and data gathered from a number of special surveys were of inestimable value in the interpretation and cross-validation of the responses to the

Health Providing and Health Seeking Questionnaires.

Policy research findings can clarify, but seldom determine policy. Most often, as in this instance, research projects are focused upon specific organizational issues. In each organizational setting, there are always economic, technical, social and political considerations which contend with the data supplied by the researcher. It is with this understanding that this policy project was undertaken.

Issues of theory supported the selection of Serowe, a large Botswana village and capital of the Ngwato people, as one of the primary research sites. For a number of decades, the leaders of the Ngwato have fostered Christianity as a major means of developing their community during the earlier period of colonization and this most recent period of national development. This necessitated the suppression of certain traditions which were believed to be in conflict with the contemporary aspirations of the people. Traditional healing and faith healing were among these traditions. However, during the last 15 years, faith healing, with its roots in Christianity, has flourished there. Thus, Serowe provided a fitting test for the twin problems of utilization and theory: That is, in what sense are traditional and faith healing utilized in Christian settings? Theoretically, the study of institutional conflict can provide more insight into problems of collaboration than the study of institutions which have established a collaborative modus operandi. Because of Serowe's history, traditional healing practices which occur there have taken a most muted form. Therefore, since the Serowe population contributed so heavily to the data, the findings and the resulting policy views must be considered

to be conservative evaluations of the expression of traditional healing practices which exist in Botswana.

### Collaborations

Faith Healing. The data do not allow recommendations for collaborations between the scientific and faith healing sectors, or between traditional and faith healing sectors. The evidence demonstrates that faith healers and traditional healers do not desire to collaborate with each other; rather, they both wish to collaborate with scientific healers.

Yet, fundamental characteristics of faith healing limit the potential of faith healer collaborations with scientific practitioners. The faith healer is called by God to the profession. Considerations of training or education for practice do exist, but are minimal. Further, since faith healing is a calling, it tends to emphasize the healer's special relationship with God and the healing skills of the individual healer. Therefore, it lends itself to individualism, and, ultimately, cultism. The result is continuous fragmentation of faith healing churches as individual members "receive the call" to begin their own ministries. For this reason, faith healers are often reluctant to collaborate with each other.

Another consideration is that faith healers are not primarily health workers. Rather, they are basically religious workers. The fact that they cure is incidental, not central, to their promulgating the faith. Nevertheless, it is recognized that many healers will, after applying their ministrations, refer patients to the scientific sector. Methods of facilitating such referrals deserve further investigation.

Finally, the vigor of faith healing appears to depend upon the history

and sociology of local communities. Compared with scientific or traditional healing, it is not yet a general or national phenomenon.

In summary, with the exception of facilitating referrals from faith healers to the scientific sector, there are few continuities between the faith and scientific healing sectors which can lead to institutionalized collaborations.

Traditional Healing. The traditional healer's potential for collaboration with scientific healers requires more positive consideration than that given the faith healer. Traditional practitioners are health workers, although the diseases they treat and their manner of treatment differ from those of scientific practitioners.

Unlike faith healers, traditional healers do take responsibility for their activities. That is, they do not invest their successes and failures upon higher authorities. Yet, in contrast to most scientific practitioners, they believe it is legitimate for their patients to seek treatment freely in either of the other two sectors, before, during, and after receiving traditional treatments.

Traditional medical practice is learned through informal and formal apprenticeships. Therefore, the basis for further informal and formal training exists. Most traditional healers interviewed also expressed strong interest in such training. Traditional healers seek to develop their knowledge through association with each other and with scientific practitioners. Many of them have concluded, however, that scientific healers do not desire collaborations as equals with traditional healers.

There is evidence that this evaluation is correct. A good proportion

of scientific healers who were positive about collaboration with traditional healers appeared to be scientific imperialists. Such statements as, "Collaboration with traditional doctors is OK if traditional healers' methods are subjected to scientific analysis," or "Traditional healers should be put under government control and their medicines monitored," reflect this orientation.

The evidence also suggests that traditional practitioners are prepared to form associations among themselves and with scientific practitioners. They have already developed Dingaka associations in such places as Gaborone, Selebwe-Pikwe, Francistown, Molepolole, and Kanye. Frequently these organizational efforts founder for lack of organizational talent. If the aspirations traditional healers have for their own local and national associations are facilitated, both they and their patients will be better served. Study of the activities of the established Dingaka associations suggests how traditional healers perceive the objectives of their associations. These associations are characterized by standards of behavior and codes of ethics. They have served as forums for discussion of traditional medical practices. It is interesting in this regard that these discussions, and the generally open responses of most traditional healers to the inquiries of members of the research team, refute the often expressed opinion that traditional healers are secretive about their practices.

It is recommended that the organizational activities of traditional healers be facilitated, and that there be an emphasis upon nurturing, rather than controlling, traditional healer organizational activities.

It is also recommended that traditional healers be registered as a separate group, and that there be joint collaboration between the Ministry of Home Affairs and the Ministry of Health in this endeavor.

The Ministry of Home Affairs currently registers healers. The investigators discussed the specific issue of national registration of traditional healers, as a separate category, and are biased towards accepting this principle. They suggest cooperation between the Ministry of Home Affairs and the Ministry of Health in its implementation. Registration does imply official sanction, but it does not sanction all aspects of traditional practice. Rather, it provides a tool for enumerating and defining those persons who are professional traditional health care practitioners. Such information will facilitate programs designed to enrich the quality of traditional practice, and cull charlatans, as defined by the healers themselves, from the ranks of traditional practitioners.

The data suggest that, with sensitive programming, scientific health care practitioners can train selected traditional practitioners in the rudiments of scientific health care practices (such as the training Family Welfare Educators receive). All researchers agreed that sanitation and physiology are subjects traditional healers should learn. Also, under equally sensitive circumstances, traditional healers can contribute to the training of scientific health care practitioners. However, initial efforts towards this kind of collaboration must be considered experimental until the right combination of curriculum elements, participating personnel, and educational setting can be identified.

This effort touches on the most fundamental problem this research has unearthed. Although scientific, and even traditional healers practice in the same community, treat many of the same conditions, and often treat the same patients, they remain uninformed about each other's practices. This lack of knowledge inhibits the development of collaborations between practitioners in each sector, fosters confusion in patients and confound the development of an effective health care delivery system. For this reason:

It is recommended that the health serving activities of traditional healers be recognized and continuously assessed so that a more comprehensive Botswana Health Care Delivery System may be established.

For a variety of reasons official recognition of the existence of the practices of traditional medicine may prove difficult. There is, of course, the alternative of official oversight. The attraction of this alternative is understandable. However, important social changes are occurring in Botswana, and the pace of these changes will increase. A usual result of such changes is greater psychophysiological, psychological and social illness. As a consequence, the people will place increased reliance upon all health care systems available, and if the available systems are not sufficient, old institutions will be elaborated (as in the instance of traditional healing) or new ones will be created. Twumasi of Ghana has recently observed that, in developing countries, whenever the scientific health care sector is improved, the practice of traditional healing will be invigorated.<sup>10</sup> China actively trains and employs thousands of traditional healers in its health care .

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10. Twumasi, P.A. Medical Systems in Ghana: A Study in Medical Sociology Accra-Tema: The Ghana Publishing Co., 1975

program. Recently in the United States, the National Institute of Mental Health has financed programs to use the contributions of traditional healers more effectively. For Botswana, anticipation of future consequences of social change, and the evidence presented in this report, would advise against a policy of official oversight.

Scientific Healing. Beyond the collaborations between traditional and scientific healers already mentioned, a few words about collaborations within the scientific sector are warranted. The problem of training adequate numbers of local scientific physicians is recognized. Great reliance is placed upon the training of nurses to meet the health care needs of the people. The team has remarked upon their effectiveness, but has noted critical inconsistencies in their beliefs about their practices and their actual practices.<sup>11</sup>

Briefly, nurses diagnose and treat, yet they are reluctant to admit to themselves and to others that they diagnose and treat. A common disclaimer offered was that nurses take patient histories but do not do physical examinations. Nevertheless, in actual practice, the nurses do diagnose and give medicines. Another inconsistency appears when nurses who have functioned successfully as diagnosticians and healers in rural health clinics find themselves reduced to the role of "handmaidens" when assigned to hospitals. These inconsistencies create role dilemmas for nurses which erode the effectiveness of their services. In view of these dilemmas:

11. This issue is highlighted in Nomtuse Mhere's Preliminary Report: The Role of Women in the Health Care Systems in Botswana, 1976.

It is recommended that nurses be taught and encouraged to do physical examinations as basic to their outpatient practices. It is also recommended that role responsibilities within hospital settings be clarified to prevent underutilization of these skilled practitioners.

It has been noted that traditional healers are responsive to the social-cultural needs of the populations they serve. In contrast, scientific health care practices focus almost exclusively upon the physical needs of individuals. It is recognized that nurses trained at the Public Health Institute already receive some opportunity to study the social-cultural needs of their patients, and some nurses posted to rural areas are responding to these needs in a very thoughtful and sensitive manner. In support of these trends, and in recognition of the special characteristics of all facets of the Botswana health care delivery system:

It is recommended that nurse training courses devote considerably more curriculum time to social and cultural factors in their practice environment. It is believed that such studies will facilitate nurses' understanding of the health seeking behavior of their clients and the role of traditional medical practitioners in the health care system.

In view of their proven capability to serve and the already established capability to train nurses within Botswana:

It is also recommended that special consideration be given to the development of a large cadre of nurse practitioners who will serve as the primary health care providers of the Botswana health care delivery system.

### Treatment Efficacy

Faith Healing. The data indicate that, for certain historical and social reasons, faith healing now flourishes in some sections of the country. The fundamental basis of faith healing is faith in a creator or god, and an appeal to that god for mercy and relief from affliction. The incorporation of such additional elements as medicinal waters to drink, medicinal baths and medicinal enemas, are affectations apparently taken from the traditional and scientific sectors. In many instances, they have psychological value. There may also be physiological value in the large amounts of water drunk, particularly for people who are dehydrated. But induced vomiting and enemas can be dangerous, and are, therefore, suspect. They represent more aggressive intrusions into the body than can be attributed to the usual practices of traditional healers.

The churches in which faith healing is usually practiced deserve comment. These churches provide emotional support to people, particularly women, who are lonely or who have other unmet psychological needs. Nevertheless, there is a popular social concern that the intensity of some interpersonal associations which develop in these churches may be disruptive to family relationships. Whether these churches are, on the whole, supportive or disruptive to family relationships requires further study.

Traditional Healing. The evidence also shows that within Botswana there is an active traditional healing sector which is highly utilized by people from all strata of society. Traditional healers treat a wide variety of diseases. As with scientific practitioners, the data do not reveal rates of cure for traditional practitioners.

Traditional medicine is rooted in the traditional culture of the people. Unlike scientific medicine, its practice does not require a huge bureaucracy, high specialization and technology, vast amounts of materials or large capital investments. It is a very personalized service which caters to the physical and psychological needs of patients, as well as the well-being of the patients' relatives. It is, in fact, a much more general social institution than scientific medicine, for its practitioners are concerned not only with the health of their patients and patients' relatives, but also with the social and economic fortunes of members of the community. In this regard, the matter of witchcraft must be considered. The practice of witchcraft does not require the talents of a traditional healer. Traditional healers may have some knowledge about witchcraft, but visiting misfortune upon some hapless victim, or mixing poisons for malicious clients, does not appear to be a significant aspect of their practice. Beliefs in witchcraft result in a number of social and psychological maladies. Some traditional healers will diagnose and treat such conditions.

In recognition of their contributions to the health and welfare of their clients and community, the abandonment of the derogatory term, "witchdoctor," and the adoption of the more appropriate nomenclature, "traditional healer," is recommended.

Scientific Healing. The evidence demonstrates that the scientific sector is highly utilized by the vast majority of the respondents. Many claim it is the only sector they and their families will use. It is also the sector considered most capable of treating the widest variety

of diseases. Putting aside the question of communicable disease control, the research cannot define whether illness in discrete individuals is more successfully treated by scientific, faith, or traditional healers. The evidence only states that more people go to the scientific sector for more diseases, and that they claim greater satisfaction there than from the other sectors.<sup>12</sup> But the sine qua non of efficacy for scientific medicine has always been rates of cure, rather than numbers of people treated, numbers of diseases treated, and satisfaction of clients.

The question of treatment efficacy is confounded by numerous issues. Many diseases treated in all sectors will, as a result of natural factors, be self-limiting. Some of the treatments applied by faith healers and traditional healers contain elements (such as large doses of water) which facilitate the normal curative actions of the body. There is also the question of over- and under-treatment; that is, once treatment has begun, for a variety of reasons, healers and/or patients may not diligently pursue the "prescribed" course of treatment, or they may pursue a more aggressive treatment strategy than the complaint would normally require. Because the scientific sector engages in surgery and utilizes highly potent drugs, this issue may be a more serious consideration for that sector than for the other sectors. Finally, there is that large population who will seek treatment, care and satisfaction in all sectors, either at the same time or serially.

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12. It is possible that these high positive ratings stem from the respondents regarding the researchers as representatives of the scientific health provider group.

The vehicle for delivery of scientific medicine must also be considered. The scientific health care delivery system tends to be monolithic, bureaucratic, highly specialized and technical, materialistic, impersonal and expensive. Efficiency and efficacy are important values of this system. The system is designed to diagnose and cure or prevent disease, as it is defined by scientific health care practitioners. These health system imperatives justify, in part, the three- to five-minute average of healer/health seeker outpatient interactions recorded during investigator observations in the scientific sector. However, this limited time cannot meet the emotional needs of patients.

Follow-up studies of patients treated in each sector are recommended to define the question of treatment efficacy. It is further recommended that the first of these studies be carried out in the scientific sector.

The opinion may prevail that studies of treatment efficacy must first be done in the traditional healing sector for the purpose of verifying or refuting the legitimacy of traditional medical practice. Those who hold such opinions must consider that the fundamental problem researchers confront in assessing the three sectors is to view them, and understand them, as much as possible in their own terms, and to judge them from the western perspective with great caution. When the values of each sector are considered, it becomes apparent that testable criteria of efficacy reflect scientific medical values. Application of such criteria therefore suggests that follow-up studies be carried out first in the scientific sector.

These recommendations are based upon a pioneering study of the health seeking and health providing behavior of the people of Botswana. As such, all the issues raised in this report deserve further study. The investigators hope that, very shortly, the findings of the special projects mentioned earlier in this report will be available.

APPENDIX A  
HOST COUNTRY SELECTION GUIDE

This guide provided the basis for selection of the prospective host countries visited in September, 1974, and, ultimately, of the host country.

	<u>Criterion Measure</u>
I. A. Response to initial letter of inquiry	Date of response
B. Character of response to initial inquiry	Tone (friendly, querulous, indifferent, hostile)
C. Content of response to initial inquiry	Data (information given, no information given) Invitation (offered, not offered)
II. A. Availability of potential host country health care system information within United States	Much, fair, little, none
1. Libraries and archives	Available, not available
2. Informants	
III. A. Status of health care educational system	Professional training, paraprofessional training, no training
B. Status of health care delivery system	Organized, not organized Elaborate, simple Emphasis (health and/or treatment)
IV. A. Status of traditional health care system	Organized, not organized Elaborate, simple Emphasis (natural, supernatural, interpersonal, etc.)

APPENDIX A  
 HOST COUNTRY SELECTION GUIDE, page 2

<u>Indicators</u>	<u>Criterion Measure</u>
V. Potential urban research site identified	Yes, no
A. Characteristics of site	Population characteristics (size, ethnicity, economics, religion, etc.) Community characteristics (government, business, academic, health, etc.)
B. Characteristics of health care personnel training center	University health sciences and hospital structure Freestanding hospital structure
VI. Primary contact persons	Identified, not identified
VII. A. Potential Principal Investigator A <sub>2</sub>	Identified (credentials needed), not identified Level of interest (high, moderate, low) Amount of time available for study (sufficient, insufficient) Prior interest in traditional healing (yes, no)
B. Research Associates B <sub>2</sub> and C <sub>2</sub>	Identified, not identified Discipline (professional, academic)
VIII. Institutional support for Principal Investigator	Space, staff, assistants, size of department, stature in educational system, stature in health care system
IX. Institutional willingness to finance portion of project	Allocation of 1) actual monetary support, 2) institutional space, 3) equipment (chairs, desks, typewriters, filing cabinets, duplicating equipment), 4) supplemental transportation, 5) ancillary support personnel (interviewers, nurses, doctors, behavioral scientists, etc.), and 6) housing
X. Ease of entry into country	Availability of visas Hospitality of customs and other government officials, etc.

APPENDIX A  
 HOST COUNTRY SELECTION GUIDE, page 3

<u>Indicators</u>	<u>Criterion Measure</u>
XI. Political stability	Stable, unstable
XII. A. Rural research site identified	Yes, no
B. Characteristics of site	Population characteristics (size, economics, religion, etc.) Community characteristics (government, business, academic, health, etc.) Housing potential for research team (good, poor)

APPENDIX B  
HEALTH PROVIDING QUESTIONNAIRE

1. Name:
2. Village:
3. Ward:
4. District:
5. Sex:
6. Age: 20-35 years / 36-50 years / 51-65 years / Over 65
7. Ethnic group:
8. Education:
9. Occupation:
10. Marital status: Married / Single / Widowed / Separated / Divorced / Other
11. If married, number of spouses:  
Spouse(s) occupation:  
Form of marriage: Customary law / Christian rites / Civil marriage
12. Sex of household head:
13. Number of children:
14. Age of first born:  
Age of last born:
15. Children's occupation:
16. Number of cattle: None / 1-10 / 11-30 / 31-50 / 51-100 / 101-200 / Over 200
17. Do you have any goats, sheep or chickens? Yes / No
18. If yes, estimate number of goats; sheep; chickens.
19. Do you own any business? Yes / No  
If yes: What kind?
20. Where were you trained?  
When were you trained?  
How long did the training take?  
How much did your training cost?  
Who paid for your training?  
Did you have any specialized training? Yes / No  
If yes: What kind?
21. Was/is any relative of yours in the health care professions? Yes / No  
If yes: Which relative?  
What specific occupation?
22. Why did you decide to follow the specific profession you are in?
23. How long have you been practicing?  
Part-time or full-time?

APPENDIX B

HEALTH PROVIDING QUESTIONNAIRE, page 2

24. How many patients do you see per week? month?
25. Would you say you see mainly young or old, male or female, rich or poor patients?
26. Where do your patients come from?
27. What diseases do you treat?  
Which ones do you treat most often?  
Which ones do you think you can treat best?  
What would you say is the most common disease in Botswana among adults?  
among children?
28. Do your patients return for other illnesses? All / Most / Some / Few /  
None / Don't know
29. How much do you charge for examinations (consultation)?
30. How much do you charge for treatment?
31. Do patients pay you regardless of whether they are cured or not?
32. What are the symptoms of: Pelo? V.D.? T.B.? Others (specify)?
33. What do you use for diagnosing illnesses? Bones / Birds / Water / Bible /  
Other (specify)
34. Are there any diseases you do not treat? Yes / No  
If yes: Which ones?  
What do you recommend for patients who come for these?
35. Who (which sector) do you feel deals with the following better:  
Infertility? Fractures? Snake bites? Misfortune? Drought? T.B.?  
Sunken fontanelle? Umbilical hernia? Pelo? Mental illness?
36. Do you provide any services that are aimed at preventing people from becoming  
ill? Yes / No  
If yes: What kind?
37. Do you see any patients who are not ill? Yes / No  
If yes: Roughly how often?  
How do you treat them?

APPENDIX B

HEALTH PROVIDING QUESTIONNAIRE, page 4

43. Do you see any patients who have been to other sectors? Yes / No  
If yes: Mostly which sector?  
Often? very often?
44. Are you registered? Yes / No  
If yes: With whom?  
How much do you pay a year?  
If no: Why not?
45. What do you think causes sickness/ill health?
46. What, in your opinion, are the causes of the following diseases: Infertility?  
T.B.? V.D.? Pelo? Mental illness?
47. Do you belong to any church or religious organization? Yes / No  
If yes: Which one?  
How often do you attend services?
48. Do you believe in ancestors (badimo)? Yes / No
49. What do you think happens to people after they have died and been buried?
50. What improvements would you like to see made in the health care delivery system in Botswana?

APPENDIX C  
HEALTH SEEKING QUESTIONNAIRE

1. Name:
2. Village:
3. Ward:
4. District:
5. Sex:
6. Age: Under 20 years / 20-35 years / 36-50 years / 51-65 years / Over 65 years
7. Ethnic group:
8. Education: Primary / Secondary / Post-secondary / None
9. Occupation:
10. Marital status: Married / Single / Widowed / Separated / Divorced / Other
11. If married, number of spouses:  
Spouse(s) occupation:  
Form of marriage: Customary law / Christian rites / Civil marriage
12. What is the sex of the household head?
13. Number of children:
14. Age of first born:  
Age of last born:
15. Children's occupation:
16. Number of cattle: None / 1-10 / 11-30 / 31-50 / 51-100 / 101-200 / Over 200
17. Do you have any goats, sheep or chickens? Yes / No
18. If yes, estimate number of goats; sheep; chickens.
19. Have there been any illnesses in your family in the past 3 years? Yes / No
20. If yes, who was affected by what illness?
21. Did you consult anyone outside the family for help? Yes / No
22. If yes, whom did you consult and where?
23. If no, how did you deal with the problem(s)?
24. Did you get satisfactory results? Yes / No
25. What was the result of each case?
26. Have you or any member of your family ever been to a traditional doctor?  
Yes / No

APPENDIX C

HEALTH SEEKING QUESTIONNAIRE, page 2

27. If yes, who and where?  
For what purpose?  
When?  
On whose advice?  
How much did you/they pay?  
Were you satisfied with the treatment? Very satisfied / Fairly satisfied /  
Not satisfied  
Explain the reason for your answer:
28. Have you or any member of your family ever been to a scientific doctor,  
hospital or clinic? Yes / No
29. If yes, who and where?  
For what purpose?  
On whose advice?  
How much did you/they pay?  
Were you satisfied with the treatment? Very satisfied / Fairly satisfied /  
Not satisfied  
Explain the reason for your answer:
30. Have you or any member of your family ever been to a spiritual healer?  
Yes / No
31. If yes, who and where?  
For what purpose?  
On whose advice?  
How much did you/they pay?  
Were you satisfied with the treatment? Very satisfied / Fairly satisfied /  
Not satisfied  
Explain the reason for your answer:
32. Have you or any member of your family ever been to more than one sector for  
the same disease? Yes / No
33. If yes, for what disease(s)?
34. For each disease, state which sector you went to first; second; third.  
Explain clearly the reason for your choice:
35. In your family, who would you say makes decisions as to where to go for  
treatment in cases of illness?
36. On what basis do you think these decisions are made? Friends' advice /  
Influence of elders / Religious beliefs / Family traditions /  
Influence of neighbors / Other
37. Who (which type of healer) would you say deals with the following ailments  
best (a) in your own personal assessment (b) according to society's evaluation:  
Infertility? Fractures? Snake bites? Misfortunes? Draught? T.B.? V.D.?  
Sunken fontanelle? Umbilical hernia? Poisoning (sepsis)? Pelio? Mental  
illness? Witchcraft?

APPENDIX C

HEALTH SEEKING QUESTIONNAIRE, page 3

38. Have you/has your wife (in the case of males) ever been to an ante-natal clinic? Yes / No  
If yes: During which month of pregnancy?  
On whose advice?  
If no: Why not?
39. Have you/has your wife (in the case of males) ever been to a post-natal clinic? Yes / No  
If yes: Which one?  
If no: Why not?
40. Have you (or your spouse) been to a child welfare clinic? Yes / No  
If yes: Which one?  
If no: Why not?
41. Are you a member of any organization which deals with health care? Yes / No  
If yes: Which one?
42. Are you a member of any church or religious organization? Yes / No  
If yes: Which one?  
How often do you attend services?
43. Do you believe in God? Yes / No  
Do you believe in ancestors (badimo)? Yes / No
44. What would you say happens to people after they have died and been buried?
45. Some people believe that there are evil spirits that are sometimes connected with witchcraft and that these can be combated by "strengthening" one's household. Do you think the same? Yes / No  
If yes: How often have you had your household strengthened?  
What was the fee?  
Who or what sector is, in your mind, best for performing this task? Traditional / Spiritual / Scientific
46. What improvements would you like to see made in the health care delivery system in your area?
47. Is there any other information that you feel is relevant to this research that you would like to volunteer?