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*Religious Beliefs, Health Seeking and Health Provision  
Behaviours in Botswana*

Guest Editors

Lovemore Togarasei and Rebecca Kubanji

Editor-In-Chief

Afe Adogame

 **AASR**  
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## Editor's Note

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I am very delighted to introduce and welcome readers to the Special Issue No. 6.1 (November 2023) of the *AASR E-Journal for the Study of the Religions of Africa and the African Diaspora*, a peer reviewed, open-access journal of the African Association for the Study of Religions (AASR). We are thankful to the guest editors, Lovemore Togarasei and Rebecca Kubanji, for putting together interesting articles based on an ethnographic research study “The impact of religious beliefs on health seeking and health provision behavior: lessons for theological education review at the University of Botswana” carried out under the Nagel Institute’s African Theological Advance project, funded by the Templeton Religion Trust (TRT). This research conducted between July 2018 and September 2019 in Botswana sought to establish how religious and cultural beliefs and practices influence health seeking and health provision behaviors among Batswana and how this knowledge can help in reviewing theological education at the University of Botswana. The primary questions addressed by the study are: How do religious beliefs influence one’s health seeking and health provision behavior? Based on their reading and interpretation of the Bible, how do African Christians view traditional and modern medicine? Does the un/availability of good medical facilities in one’s society influence people’s views of the different health systems? What about the health and medical training programs, do they have courses or content on spirituality and health? How do they view the relevance of religion in their medical training? How do the answers to these questions influence the direction of theological education in Botswana and other African countries?

The study utilized theoretical formulations from literature review on the subject of religion, culture and health together with empirical data collected from Botswana. Empirical data was collected through survey questionnaires, in-depth interviews and focus group discussions. Specific communities that represent the diversity of religion, ethnic groups, geography and access to health care were purposively selected. Respondents were health seekers, traditional, medical and faith healing practitioners, academics in the areas of health and medical sciences and theology and religion and government and non-government health policy makers. Health seekers and health providers were selected from those who claim to be Christians and/or traditional religious adherents in selected geographical areas. Data was analyzed using basic statistical and qualitative analysis tools and techniques.

Generally, the findings of this research, as demonstrated through the Introduction and eight chapters in this special issue, indicate that the majority of Batswana are influenced by their religious and traditional cultural beliefs and practices in their health seeking behaviors. Despite the need to stick to professional health ethics, health practitioners - medical, faith and traditional including health policy makers, are influenced by their religious and traditional cultural beliefs and convictions in their provision of health services. Findings also show that the relationship between religion, health and healing beliefs and practices are not satisfactorily addressed in theological and medical health

curricula in Botswana. Thus, drawing from the research findings, the contributors propose a review of theological, medical and health education for the purposes of promoting holistic health through the integration of medical, traditional and faith healing. It is hoped that the findings of this study will be used to review theological education at the University of Botswana, but broadly speaking, impact on interdisciplinary curriculum review and change across universities and theological institutions in Africa.

Dear friends and colleagues, I wish you happy reading!

Afe Adogame  
Editor-In-Chief  
November 2023

# Introduction

**Lovemore Togarasei and Rebecca Kubanji, Guest Editors**

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This volume contains articles that were developed from a study conducted in Botswana to establish how religious beliefs impact health seeking and health provision behaviours among Batswana and, from the findings, to propose review of theological, medical and health education for the purposes of promoting holistic health through the integration of medical, traditional and faith healing. The study was conducted between July 2018 and 30 September 2019. The editors and the whole team of researchers are grateful to the Templeton Religion Trust for funding the project and to the Nagel Institute of Calvin University, Michigan, United States of America for administering the funds and the general running of the project.

From the time of the Enlightenment, the relationship between religion and science became very complex. As a result, to date, people hold different opinions concerning the relationship between the two. This is particularly so when it comes to the role of religion and religious beliefs to health seeking and health provision behaviours. Whereas there are those who see a close relationship between the two and therefore call for their integration for the good of humanity (e.g. Lucchetti, Lucchetti, Espinha, Oliveira, Leite and Koenig 2012:1), there are others (e.g. Sloan, Bagiella and Powell 1999: 664) who find religion and religious beliefs to be a hindrance to health seeking and health provision in the modern scientific world. The side-by-side existence of both religiously based health care systems and the medical care health systems in Africa and other parts of the world do make the debate even more complex and heated tearing the health seeker and health provider apart. This is because, despite the promotion of medical health care, alternative health systems remain very popular. Thus in 2002, the World Health Organisation (WHO) called for the integration of alternative health systems into national health policies. Despite this call, Botswana remains one of the countries that have not developed guidelines for engaging traditional and faith healers in health provision. The Botswana Public Health Act does not recognize the role of faith healers, traditional medicine or other alternative treatment and healing modalities. Does this mean that Batswana do not use alternative health systems? From 2011 to 2016, Togarasei, Mmolai and Kealotswe (2016) undertook a research project funded by the University of Botswana Office of Research and Development to investigate Batswana health seeking practices. The objective was to establish how Batswana make use of the three available health systems in the country: traditional healing, faith healing and medical healing. The study established that Batswana make use of all the three although priority is given to modern health facilities. What the study did not establish, however, is how one's religious affiliation influences their health seeking practices. On the other hand, no studies have focused on how religion and religious practices influence health seeking

and health provision behaviours and how this knowledge can help inform medical, health and theological education.

In light of the above position established from literature, this study sought to establish the relationship between faith and science by considering Batswana's use of traditional healing, faith healing and allopathic (medical) healing. How do believers who belong to churches that emphasise faith for healing view bio-medicine? At the height of the HIV pandemic, because of some churches' teaching that with faith nothing is impossible, we learnt of people who gave up medication for faith healing (Togarasei 2010). We learnt of pastors who discouraged the faithful from seeking medical assistance. Was this teaching and the resultant health seeking practice limited to HIV and AIDS? What prevails in the contemporary times of non-communicable diseases that we have learnt are as devastating as HIV? Cases of people who give up their high BP, diabetes, mental health medication because of faith for miraculous healing have been reported but no study had been conducted in Botswana to establish empirically how one's religion influences this behaviour. What exactly do theological training institutions in Botswana teach concerning faith and science, in this case specifically on Christianity and health and healing? What do pastors teach their members and what goes on in counselling sessions? What theologies inform such teachings and practices? What about traditional beliefs and modern medicine? Broadly speaking, healing amongst most Africans should involve diagnosis of both the nature of the ailment and its cause, curative method and a preventive measure by protection and strengthening against witchcraft (Gluckman 1965). What then are the national policies concerning collaboration between traditional medicine and modern medicine? Are there specific ailments that Batswana believe are best treated by traditional doctors and is this influenced by their religious beliefs? Additionally, no study has established how the religious affiliation and/or beliefs of the health providers affects their health provision practices. Do medical practitioners who belong to churches that emphasize faith healing encourage their patients to seek faith healing? What about those medical practitioners that uphold traditional beliefs?

The above questions seek answers for a holistic health system in Botswana. This study therefore sought to establish the impact of religion, in this case African traditional religion and Christianity, to one's health seeking or health provision behaviour. The articles in this volume present findings to some of the questions investigated during the study.

While each of the articles describes the methodology in brief, they do so focusing on data relevant for the particular chapter. In this introduction we therefore give a full picture of the methodology to contextualise the articles in this volume. The study adopted a mixed methods approach. Beginning with detailed review of existing literature, it collected quantitative data using questionnaires and qualitative data through focus group discussions and individual in-depth interviews. The study was conducted among villages, towns and cities drawn from the northern, southern, eastern and western parts of Botswana. They included Gaborone, Tutume, Mahalapye, Maun, Bobonong, Molepolole, Hukuntsi and Tsabong with participants also drawn from the smaller villages surrounding the town centres to include both urban and rural perspectives.

To ensure validity and reliability of the data collection tools, tools were pretested before the main survey. This was done in Ramotswa which was not part of the selected survey sites. The site was chosen because of its proximity to Gaborone, where the research team was stationed. This made the pretesting less costly. Further, being a peri-urban area, it provided the characteristics of both a city and a village, characteristics that are

representative of the sampled sites and indeed the country of Botswana. The pretesting of tools also served as an opportunity to train research assistants.

To ensure respect of the rights and autonomy of participating individuals and institutions, the study underwent ethical review and throughout the study, ethical standards were held in high regard. Ethical clearance of the study was done by the IRBs of the University of Botswana and the Ministry of Health and Wellness. The Ministry granted us the research permit. The study proposal was also reviewed by the IRBs of the District Health Teams (DHTs) in the different districts where the research was undertaken. All respondents completed a standard consent form. Questionnaires did not request for self-identifying information. Rather, each respondent (even for individual interviews) was given a code only understood by members of the research team. It is these codes that are used in the presentation of the results.

All data in form of completed questionnaires, audio records of interviews and researcher notes were kept under key and lock in the office of the project leader at the University of Botswana. Electronic data was kept in password protected computers.

The volume comprises eight articles. Amon Marwiro and Lovemore Togarasei open the volume with a review of the policies and guidelines that govern medical practice in Botswana with the aim of establishing implications for holistic health services provision in the country. The article established that although many Batswana make use of alternative health systems, there are no policies to regulate the practice of alternative medicine and, especially, to allow collaboration of both medical and alternative health practitioners. The article recommends that Botswana should establish policies and guidelines to govern the practice of alternative health systems guided by World Health Organisation recommendations.

The next article is by Sana Mmolai. This article explores major determinants of health-seeking behaviour, with the view to establish how health-seekers' religious beliefs, spirituality and faith influence their health-related decision making. It argues that since religious beliefs have a significant influence upon health-seekers, health providers should be fully aware of this issue. The article then challenges health providers to integrate health seekers' religious beliefs, faith and spirituality within their profession. It concludes by appealing to both medical and theological institutions to infuse the interdependence of religion and health into their curricular.

Whilst studies abound on the impact of religion on patients' health seeking behaviours as stated above, studies on how religion affects medical practitioners' (especially doctors and nurses) medical practice are limited. In view of this, Rebecca Kubanji's article addresses this subject. The article explores the role of religious and traditional beliefs on medical practitioners' health provision behaviours. It establishes that religious beliefs of the medical practitioner play an important role in the provision of patient care. The article therefore recommends that the healing power of science needs to be linked to the dynamics of curing and caring that is derived from religious and traditional contexts.

Noting the lack of collaboration of different health care practitioners in Botswana, the two articles look at this subject of collaboration. Abel Tabalaka's article looks at ethics of health collaboration using perspectives from Batswana health seekers. Tabalaka observes that the increasing number of studies on the importance of the collaboration between medical healthcare professionals with other players from alternative healthcare. He notes

that, notwithstanding the amount of research that underscores the significance of this collaboration, on the ground the nature of this collaboration continues to be riddled with challenges and there are pockets of uncharted areas that still need to be explored. The article then explores perspectives of health seekers in Botswana on the collaboration of medical and religious healthcare systems. He concludes that health seekers support the view that the collaboration between modern medical system, represented by medical practitioners and religious healthcare systems should be complementary in nature.

The second article on collaboration is by Tshenolo J. Madigele and Abel B. Tabalaka who note that despite the availability of Western medicine across the country, many of Batswana continue to utilize either of the three or all available health systems: traditional, Western and pastoral systems of healing and care. They argue that the three need to collaborate for effective and holistic health care provision. They then argue for the development models of collaboration that promote a workable relationship amongst these three health systems. The article advocates for holistic care as it acknowledges the need to give attention to all dimensions of human existence and ultimate healing. It also calls for the implementation of interprofessional health policy in Botswana, collaborative patient centred practice, changes in attitude towards interprofessional collaboration and for the development of interprofessional curriculum in educational institutions.

Beginning with the time when scientific medical institutions were solely run by Christian churches, pastoral care has been associated with health care provision in Botswana. Tshenolo J. Madigele's article visits this subject by assess the contribution that local churches in Botswana make to health and wellbeing. The article is built on the hypothesis that religion contributes immensely to better health and wellbeing. It therefore argues that biomedicine by itself has limited capacity in fulfilling the human quest for meaning. Thus, employing a holistic pastoral theological methodology, the article argues that it is necessary to include pastoral care as a valuable and necessary human resource and partnership for healthcare and development.

With the need for taking religious beliefs and practices seriously in patient care established, the last two articles of this volume zero in on the need for curriculum review in both medical/health and religious/theological education. Tinoonga Shanduka's article discusses Batswana medical practitioners' views on the impact of religion and spirituality on health and medical education. Noting that religion and spirituality are essential aspects of patients' life which ought to be addressed by medical practitioners during healthcare provision, the article concludes that spirituality and religion should therefore be part of medical/health education. Lastly, Lovemore Togarasei's article joins the call for theological education review by focusing on the need to incorporate health and healing in this review. The article argues for incorporating health and healing in the revised African theological education curriculum, among other reasons, on the pursuit for healing in African churches. While Africans seek healing from the church, theological institutions are not producing graduates trained in this area.

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## REFERENCES

Gluckman, M. 1965. *Politics, Law and Ritual in Tribal Society*, Oxford: Basil Blackwell.

Lucchetti, G., Lucchetti, A. L.G., Espinha, D.C.M, De Oliveira, L.R., Leite, J.R., Koenig, H.G. 2012. Spirituality and health in the Curricula of Medical Schools in Brazil. *BCM Medical Education* 12, article 78 doi: 10. 1186/1472-6920-12-78.

Sloan, R. P., Bagiella, E. and Powell, T. 1999. Religion, Spirituality and Medicine, *The Lancet*, 359:9153, 664-667.

Togarasei, L. 2010. Christian theology of life, death and healing in an era of antiretroviral therapy: reflections on the responses of some Botswana churches, *African Journal of AIDS Research* 9:4, 429-435.

Togarasei, L., Mmolai, S.K. and Kealotswe, O.N. 2016. “Quinine”, “Ditaola” and the “Bible”: Investigating Batswana health practices. *Journal for the Study of Religion* 29 (2): 97-117.

# Botswana Health Policies and Alternative Health Services: Implications for Holistic Health Services Provision

Amon Marwiro and Lovemore Togarasei

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## Abstract

This article reviews the policies and guidelines that govern medical practice in Botswana with the aim of establishing implications for holistic health services provision in the country. Based on both review of literature and fieldwork findings from health experts, the article established that although many Batswana make use of alternative health systems, there are no policies to regulate the practice of alternative medicine and, especially, to allow collaboration of both medical and alternative health practitioners. The article recommends that Botswana should establish policies and guidelines to govern the practice of alternative health systems guided by World Health Organisation recommendations.

**KEY WORDS:** Botswana, Health, Policies, Regulations, Traditional Healers, Alternative Health Practitioners

## Introduction

In an environment where several options for health and healing services are available, like in Botswana, health care seeking or health provision are visible behaviours which reflect deep rooted cultural, social and religious beliefs. As much as behaviour is moulded by religious, social and cultural beliefs among many other factors (Latunji and Akimenyi 2018),<sup>1</sup> it is imperative to understand the regulatory framework within which health care is sought and provided, the scope that was provided to the board providing oversight to the provision of health care and the resources that are available as these invariably influence health care seeking and provision. Togarasei, Mmolai and Kealotswe (2016) observed that despite widespread usage of alternative health systems in Botswana, the health regulatory framework did not accommodate alternative health systems. It is on this basis that the regulations, policies and guidelines providing health care in Botswana were reviewed as part of the study on the impact of religious beliefs on health seeking and health provision behaviours among Batswana. It is anticipated that the provisions of the regulatory

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<sup>1</sup> Latunji, O.O. and Akimenyi, O.O. (2018), "Factors influencing health-seeking behaviour among civil servants in Ibadan, Nigeria," *Annals of Ibadan Postgraduate Medicine* 16(1): pp.52-60.

framework, when analysed together with health care seeking and provision behaviours, recommendations on improvement of health through changes in theological and medical education can foster synergistic collaboration among faith, traditional and biomedical health care providers.

In 1948, WHO defined health as, “a state of complete physical, mental and social well-being and not just the absence of disease or infirmity” (WHO, 1948). This definition has continued to guide nations in wholistic health provision. Globally, the World Health Organization (WHO) offers guidance to member countries on how health is provided. Member countries in turn adapt the guidance to suit their local contexts. WHO advocates for health to be treated as a human right, which gives governments the responsibility to create an environment where culturally acceptable health care is available, safe, effective and affordable. Botswana is one of the WHO member countries that follow the guidance of WHO in the provision of health care.

In Botswana, the constitution is the highest law of the land and govern the development of all the other regulatory guiding instruments. In addition to guiding the selection of the head of state, establishment of the cabinet and all the other governing bodies such as the parliament and judiciary and their responsibilities, the constitution stipulates the rights of the citizens inclusive of health. The government department charged with the responsibility of providing overall oversight and delivery of health services for Botswana is called the Ministry of Health and Wellness. It is charged with the formulation of regulations, policies, standards, norms and guidelines for health provision. In addition, the Ministry of Health and Wellness also provides health services through a network of health facilities and management structures (Botswana National Health Policy, 2011). In this article, we therefore review some of the acts, regulations, guidelines and policies that guide the provision of health care in Botswana. Besides making a review of the policies, this article also presents findings on what the effects of these policies are to holistic health care in Botswana. Data for the article was collected through desk review and fieldwork as detailed in the next section that outlines the methodology that was used for the study from which data for this article is drawn.

## **Methodology**

This article is drawn from a larger study that was conducted between 2018 and 2020 in Botswana. The aim of this study was to establish how religious beliefs impact health seeking and health provision behaviours among Botswana and, from the findings, to propose review of theological, medical and health education for the purposes of promoting holistic health through the integration of medical, traditional and faith healing. The study adopted a mixed methods approach. Beginning with detailed review of existing literature, it collected quantitative data using questionnaires and qualitative data through focus group discussions and individual in-depth interviews. The quantitative and qualitative tools sought to collect information from four different groups of people (medical health practitioners, traditional healers, faith healers and health seekers) on their views on causes of illness, medication, collaboration of alternative health systems, organ and blood donation and curriculum issues in religion and health. Data for this article is, however, limited to views on health policies and health policies formulation as supplied by participants. Participants who provided data on this aspect of the study included government ministers, hospital superintendents, directors in different departments of the Ministry of Health and Wellness and other members of the District Health Management

Teams. The participants were drawn from 8 different geographical areas representing the north - south and the rural - urban divides of Botswana. All necessary steps were taken to protect the identities of the participants. Thus, for example, in presentation of data, we do not identify the respondents by name but by codes (e.g., MAP001) that each of the respondents was given during data collection.

## **Botswana Regulations, Policies and Guidelines on Health Care**

### ***The Public Health Act (1981)***

Promulgated by the parliament according to the provisions of the Botswana Constitution, the Public Health Act guides the Ministry of Health and Wellness on actions that need to be taken to prevent the spread of infectious diseases. The act gives the Ministry the power to institute control measures. Armed with the Public Health Act, the Ministry of Health and Wellness can enforce treatment, immunization, inspections, destruction of potential sources of infection even in private properties and even against one's cultural, religious or health and healing beliefs. According to the Public Health Act, the health of the population supersedes the rights of individuals. This standpoint is well aligned to the WHO's International Health Regulations of 2005.

The Public Health Act also stipulates the role of the Ministry of Health and Wellness as to educate, communicate and create awareness on diseases that have the potential for spread, the control measures and the treatments that are available. The interventions stipulated in the Public Health Act are proven biomedical interventions with effectiveness that has been proven scientifically. The Act does not recognize the role of faith healers, traditional medicine or other alternative treatment and healing modalities in the prevention and control of infectious diseases. The basis for the interventions is mainly motivated by the biomedical evidence of disease causation and prevention principles.

### ***The Medical, Dental and Pharmacy Act (2001)***

The Act stipulates the establishment of the Health Professions Council and guides its operations. The mandate of the Council is to license and monitor the practice of doctors, dental, pharmacy and allied health practitioners. The Act also guides the registration and licensing of practice. The prerequisite for licensing is based on the recognized training that is based on biomedical training. There is no provision for registration of practitioners of alternative health care.

### ***The Nurses and Midwives Act (1986)***

The Nurses and Midwives Act guides the practice and ethical conduct of nurses and midwives as providers of health in Botswana. It stipulates the formation of the Nurses and Midwives Council and gives the council the mandate of licensing, maintaining registration and set the code of conduct and ethical and nursing practice standards including the disciplinary procedures and deregistration in case of misconduct. It also defines the scope of nursing practice. The act does not cover traditional midwives.

### ***The National Health Policy (2011)***

The National Health Policy, which affirms health as a right, acknowledges the broader definition of the determinants of health which include the environment where people grow, live, work and age as key influencers of the health of the population. The Policy stipulates that a number of providers, not just the Ministry of Health and Wellness, are responsible for providing health care and contribute to keeping the nation healthy. Other non-Ministry of Health and Wellness providers include private for profit, private not for profit and other government departments such as the Botswana Defence Force, Botswana Prison Service and Botswana Police Service. Traditional health providers are currently not regulated, nonetheless they were consulted during the revision of the National Health Policy of 2010.

Using the modified WHO Health System Framework, the National Health Policy stipulates the goal, objective and policy initiatives of each of the building blocks of a health system namely i) leadership and governance, ii) health service delivery, iii) lifestyle/behavior determinants of health, iv) health resources (human resources for health, medicines, vaccines and medical equipment, health infrastructure and health financing) and iv) health management information system. The policy also outlines the implementation framework, highlighting the responsibility of government departments, including the role of the parliament and the Office of the President. The policy also stipulates the need for monitoring and evaluating the implementation of the policy.

### ***The Essential Health Services Package (EHSP) (2010)***

As part of its mandate of providing health care to Botswana, the Ministry of Health and Wellness developed and defined a list of essentials also called minimum services. The document defined the minimum package of service that can be provided at different levels. The levels were defined as community/home, health post, primary health centre, primary hospital, district hospital and referral hospital. The EHSP also sets the norms and standards of providing service such as the minimum number of providers and facilities per population. The choice of service was mainly based on i) technically effective and can be delivered successfully; ii) services that target high burden diseases looking at effect at individual, social impact and economic effects; iii) sustainability of services and iv) equity. This means that rigorous review of research materials, previous service delivery reports and intensive consultations preceded the development of the EHSP.

Although the EHSP was comprehensive in including promotive, preventive, curative and rehabilitative service, it still needs to be used with other guiding documents. The EHSP document was very explicit that it only provides the 'what' of services and not 'how' the services would be provided. The District Health Management Teams (DHMTs) had the responsibility and autonomy to determine how they would provide the services. Alternative health systems are neither explicitly nor implicitly catered for in this package.

### ***Other Guidelines***

The Ministry of Health and Wellness also provides department or medical condition specific guidelines or strategies which help the health workers to provide services at standards that are acceptable, evidence based and up to date with best practices. Such examples include guidelines for management of HIV/AIDS, Cervical Cancer and hypertension. These guidelines continue to be reviewed as new evidence becomes

available. The guideline are mainly focused on mainstream medical practice not alternative health practices.

### Study Findings

As stated above, apart from desk review, we consulted health policy makers and government officials on policies governing health provision in Botswana. Respondents who included government ministers, hospital superintendents, directors in different departments of the Ministry of Health and Wellness were agreed that the government does not have a specific policy on alternative health systems. In fact, MAPM003 said, strictly speaking the government had no policy, “policy is a big word, but we have a code of practice, guiding practices that are currently in place.” He said this code is called a “collaborative partnership between us (medical practitioners) and the alternative medicine practitioners.” The practice calls for patients to be given information to make informed choices. The policy calls for respecting an individual’s religious beliefs in the provision of healthcare services.

Respondents said there is, however, an ongoing demand by some social players that the government should acknowledge alternative health systems, in particular traditional medicine. In the past, especially during the peak period of the HIV and AIDS scourge and during the period of diarrhoea outbreaks, efforts were made to educate and even collaborate with traditional healers to fight the problems (GAPM). K. E. Jensen and L. Katirayi (2011:158-179) give a detailed analysis of the collaboration of traditional healers to HIV response. They concluded that Botswana traditional healers willingly collaborated with medical doctors although the same was not true of the attitude of medical doctors towards traditional doctors.

Respondents also referred to the Revised National Health Policy (2011) saying it did not directly mention traditional and faith healers but uses the term ‘private practitioners’. This means that they are not necessarily excluded because the policy also states that all efforts by all stakeholders will be incorporated in implementing the policy (TSPM). One respondent stated,

“Now what is happening right now is to encourage all efforts for the well-being of the patients, because at the end of the day, the patient here is a client to all of them and the main point is to restore and maintain the health of the patient ... the government is not stopping anybody from seeking treatment where he/she wants but it’s not in black and white to consult traditional doctors, for instance” (TSPM).

### Implications for Holistic Health Care

Writing on indigenous theories of contagious diseases, E. Green (1999:217-218) made a strong observation that, “Public health programs in developing countries..... would be more effective if those who design and implement programs possessed an empirically based understanding of existing ethnomedical beliefs and practices...” This is, however, not the case when one analyses Botswana health policies. Although a number of people in Botswana seek healing and health care services from faith and traditional healers (Togarasei, et al 2016), these healers are not recognized officially as health providers as seen in the policies and guidelines reviewed above. The Botswana health policies and

guidelines discussed above definitely have implications for the provision of holistic health in the country. Faith and traditional healers are not regulated, their practice is not standardized, and there is no recognized training. Guided by the above policies, respondents noted that the policies have implications for collaborations of the different health services providers in the country: biomedical practitioners, traditional and faith healers. They noted that although government has always worked closely with faith healers allowing them to pray for patients in hospitals and providing counselling services, this was not the case with traditional doctors. Traditional healers are not allowed to come and administer their medication in hospitals. They said there were now new efforts for collaboration with traditional healers but no clear policies have been developed. MAPM001 said the attention on traditional healers was out of the realization that many Batswana make use of the services of the traditional healers while questions remain on their medication: safety of the medication, the doses, property rights, etc. Like other respondents, GAPM001 noted that collaboration with traditional healers intensified during the height of the HIV pandemic. K. E. Jensen and L. Katirayi (2011) give an elaborate outline of the traditional healers during the height of the HIV pandemic. Policy makers acknowledged that this collaboration remains predominantly one way, with medical practitioners educating traditional healers on hygiene and the need for referring patients to hospitals and clinics. Policy makers said there was a strong government effort to engage alternative health providers, especially traditional healers as shown in government celebration of World Traditional Medicine Day annually. At the dissemination workshop for the results of our larger study mentioned above, the Minister of Health and Wellness also highlighted the Ministry's observation of World Traditional Medicine Day as an indication of government's willingness to closely work with traditional healer. Health policy makers also said they have different forums where the different health providers meet to share ideas. However, because of the lack of clear policies on alternative health practices, there was no defined collaboration among the different health providers. Medical doctors, for example, cannot openly refer patients to traditional doctors even if they feel that patients may find help there. Respondents said medical practitioners are not supposed to refer patients to traditional healers. For example, according to MOPM001, "In the hospitals we do not refer people to *dingaka* (traditional doctors), rather they are the ones who refer people to us." The reasons for not referring to traditional doctors were captured by MOPM001 who said, "here in the hospital when we treat we are able to diagnose and tell what a person is sick of. If its pneumonia, we can be able to tell and we will focus on treating that condition. If its diarrhoea I will deal with diarrhoea, but when they (traditional doctors) treat they'd not have diagnosis."

Respondents noted the importance of policies that encourage collaboration of all health systems for holistic health. They noted that use of alternative health systems promotes and takes advantage of indigenous knowledge reducing the medical imports bill drastically. One respondent pointed out that,

It can be good economically, it can really boost economy because we are buying medicine from the West at great cost. Botswana is spending 3-4 billion Pula (US\$300 million) each year on medication only, so we are spending a lot on that whereas we could save a lot on that or even export if we made use of our traditional medicine. Because indigenous knowledge has been looked down upon then it's the white people who came and told us some of our indigenous plants are good but we have always known that (GBPM).

They also noted that people have always had faith in faith and traditional healers. Promulgating policies that promote these alternative health practitioners would therefore promote holistic health. They noted that collaboration with organizations which engage people's faith helps in a quick promotion of health programs as people's response to modern medicine is influenced in many ways by their traditional, cultural and religious beliefs. One of the policy makers stated that,

The ministry is trying to encourage collaboration, for example, via the health education meetings through DMSAC (District Multi-Sectoral AIDS Committee). Pastors' Fraternity and the fire people are engaged in the campaigns against diarrhoea, where they are given ORS to distribute to the patients who visit them. Most of the time, it is more effective when ORS is coming from the traditional or faith healers than when it is given by the nurse because of the faith people have in these people (TSPM).

### **Conclusion**

There is limited documented official collaboration between the biomedical health care providers and faith/traditional health providers in Botswana. This is despite the fact that, according to the World Health Organization, there is a strong relationship between cultures, religion and alternative medicine – traditional, faith healing. As a result, there is so much secrecy on the interventions/treatments that are available in some countries. There is also limited data on evaluation of the effectiveness, safety and cost of the services and interventions which, when combined with absence of standardized training, poses a challenge in regulation of services and providers. All these have implications for holistic health services provision in Botswana.

The World Health Organization views the absence of regulation or other form of guidelines for the practice of alternative health care providers as a major gap in health care provision. It is estimated that alternate health providers care for a significant population in different countries. For instance: traditional medicine accounts for about 40% of all health care in China; 71% in Chile; 40% in Columbia and 65% of the rural population in India (WHO, 2003). In Ghana, Mali, Nigeria and Zambia, traditional medicine is the first line treatment option for more than 60% of children with high fever (WHO, 2003).

Given the population that is served by traditional medicine, it is imperative for governments, as the protectors of the citizens, to put a structure that would enable the regulation of alternate health providers which in turn will allow evaluation of safety and effectiveness of traditional health services and if possible foster collaboration and inter-referrals between alternative and biomedical health care. The problem of lack of policies means that the government does not know what is going on in the area of traditional medical practice.

In 2000, WHO noted that some countries had made some advances in recognizing alternative health care; for instance, it was estimated that 70 counties had regulation or registration procedures for herbal procedures while 25 counties reported to have a national policy for traditional medicine. Traditional Asian procedures such as Acupuncture have been demonstrated to be effective for certain conditions such as headache and chronic back pain and have been regulated in China and the US. Its safety has also been assessed and in some areas, there is collaboration and referrals between biomedical and

Acupuncture practitioners. This strengthens the argument that there is potential benefit to regulation and building of collaboration between alternative health care and biomedical care.

Having recognized the role of traditional medicine in countries where it is accepted and deemed valuable, the World Health Organization developed a strategy to assist member states. The strategy identifies the role of WHO (2003) as "...to broaden the recognition of traditional medicine, to support its integration into the nation's health system, to provide technical guidance and inform the safe and ethical use..." According to WHO, this would be achieved through developing policies, implementing programs and promoting safety, efficiency and quality by providing regulatory and quality assurance standards.

We therefore conclude this article by recommending that the Ministry of Health and Wellness consults with stakeholders and develop a policy framework for alternative health care. This will help in guiding the provision of alternative health, evaluation of safety, effectiveness of intervention and development of products and interventions. Botswana may learn from other countries like Nigeria that followed the WHO recommendations and developed Traditional Medicine Policy of 2007. The policy aims to develop and facilitate the use of Traditional Medicine in Nigeria in the official health care system, harness the potential and economic benefits of traditional medicine practice to accomplish the provisions of the National Economic Empowerment and Development Strategy (NEEDS) and establish a country-specific institutional framework for traditional medicine (Traditional Medicine Policy for Nigeria, 2007).

In cases where alternative health care was recognized, it grows and develops with regulation, registration and training of health care providers and significantly contributes to the population's health needs. For instance, in Australia, visits to complementary health professionals such as acupuncturists, chiropractors and naturopaths have been growing rapidly with an increase of over 30% between 1995 and 2005 while increasing recognition of alternative health care is recognized in China, Lao People's Republic and Saudi Arabia (WHO, 2013). Botswana have continued to use traditional healing services and the practice needs to be officially recognised and mainstreamed within the national health system.

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**Amon Marwiro** is a public health practitioner who actively promotes health and wellness and support efforts in improving access and uptake of modern health care services. He has more than 19 years of clinical and public health experience in Botswana and Zimbabwe. His passions include strengthening health systems, improving the quality and efficiency of public health interventions and continuous community engagement in scaling up interventions that have a demonstrable public health impact. Dr Marwiro has intensive experience in community engagement during design, planning, implementation and monitoring of health interventions and programs. He is currently a Country Representative of an international non-governmental organization that supports the Botswana Ministry of Health and Wellness in improving health care and fostering community to facilitate interface with special attention to HIV/AIDS, other communicable and non-communicable diseases. He is a member of various Botswana Ministry of Health and Wellness technical working groups (TWGs). He is a holder of MBChB (Zim, 2003), Dip. HIV Management (SA, 2008), MPH (Zim, 2010) and MBA (UK, 2017).

**Lovemore Togarasei** (PhD) is Professor of Religious Studies at the Zimbabwe Open University where he teaches courses in biblical studies. He has also taught at the universities of Zimbabwe and Botswana. He was the Principal Investigator in the project in which the articles in this volume are derived. He has published widely and undertaken consultancy work in the areas of religion and health, gender, politics, prosperity gospel, leadership and popular culture. His latest edited book is *Lobola in Southern Africa* (Palgrave Macmillan, 2020). E-mail: ltogarasei@gmail.com

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## REFERENCES

- Government of Botswana (1981). Public Health Act, Gaborone.
- Government of Botswana (1986). The Nurses and Midwives Act, Gaborone.
- Government of Botswana (2001). Medical, Dental and Pharmacy Act, Gaborone.
- Government of Botswana (2011). National Health Policy 'Towards a Healthier Botswana', Gaborone.
- Government of Nigeria (2007). *Traditional Medicine Policy for Nigeria*, <https://www.health.gov.ng/doc/TraditionalMedicine.pdf> accessed 01/08/2012.
- Green, E. (1999). *Indigenous Theories of Contagious Diseases*, California: Alta Mira Press.
- Jensen, K. E. and Katirayi, L. (2011). The Faith of Our Fathers: Collaborating with traditional leaders in HIV and AIDS response, in Togarasei, L. Mmolai, S. K. and Nkomazana, F. (eds), *The Faith Sector and HIV/AIDS in Botswana: Responses and Challenges*, Newcastle upon Tyne: Cambridge Scholars Press, 158-179.
- Latunji, O.O. and Akimenyi, O.O. (2018). Factors influencing health-seeking behaviour among civil servants in Ibadan, Nigeria. *Annals of Ibadan Postgraduate Medicine* 16(1), 52-60.
- Togarasei, L. Mmolai, S. K. and Kealotswe, O. N. 2016. 'Quinine,' 'ditaola' and the 'Bible': investigating Botswana health seeking practices, *Journal for the Study of Religion* 29:2, 97-117.
- World Health Organization (1948). WHO Constitution.
- World Health Organization (2003). *Fifty-Six World Health Assembly Traditional Health*, Report by Secretariat.
- World Health Organization (2005). *National policy on traditional medicine and regulation of herbal medicines*.
- World Health Organization (2013). WHO Traditional Medicine Strategy 2014-2023.

# Major Determinants of Health Seeking Behaviour

Sana Koketso Mmolai

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## Abstract

This paper uses document review to explore major determinants of health-seeking behaviour, with the view to establish how health-seekers' religious beliefs, spirituality and faith influence their health-related decision making. It argues that since religious beliefs have a significant influence upon health-seekers, health providers should be fully aware of this issue. This paper therefore challenges health providers to integrate health seekers' religious beliefs, faith and spirituality within their profession. In conclusion, this paper appeals to both medical and theological institutions to infuse the interdependence of religion and health into their curricular. Such a provision is capable of creating rapport between health providers and health seekers. This paper is therefore a valuable contribution to the growing literature geared towards the promotion of a holistic health provision, catering for the physical and spiritual needs of health seekers.

**KEY WORDS:** Health, Healing, Health-Seeking Behaviour, Religion, Spirituality, Botswana

## Introduction

The influence of religious and spiritual factors in health reflects a larger issue; the role of meaning in life. Without positive meaning, human life withers and health fails (Levin, 2001, p. x).

While many Africans seek help from modern practitioners, they at the same time seek such help from both traditional and faith healers. However, apparently there exist preferences to some health providers in comparison to others. For instance, in the majority of cases, while most Christians seek help from biomedical practitioners and spiritual healers, the majority of non-Christians seek health from biomedical practitioners and traditional healers. Considering this norm, one wonders if religious beliefs, spirituality and faith somehow influence patients' health seeking behaviours. It is against this background that this paper explores and establishes major determinants of health-seeking behaviour and the possible contribution of such determinants in encouraging or impeding patients' health-seeking behaviour. This discussion would, hopefully, offer the reader some useful knowledge pertaining to the significant role played by patients' spirituality, religious beliefs and faith in the search for health and healing. We will commence our discussion with the determinants of health seeking behaviour, before exploring the nature of the relationship

between religious beliefs and health-seeking behaviour. The paper will conclude with an appeal to both medical and theological institutions to incorporate religious beliefs into the curricula of their institutions.

### **Determinants of Health-Seekers Choice of Health**

It has to be pointed out at this preliminary stage of our discussion that among most Africans, there are three types of health providers; biomedical practitioners, traditional and faith healers (Magezi and Magezi, 2017). First and foremost, it should be noted that determinants of health-seeking behaviour are complex due to patients' religious beliefs, spirituality, values and attitudes on the one hand and patients' information related to health providers, on the other hand (Victoor, Delnoij, Friele and Rademakers, 2012). In other words, patients have to choose suitable health providers, based on both internal and external influence, hence the complexity of the choice. This argument is further developed in a study conducted on 'Use of traditional healers and modern medicine in Ghana' by Tabi, Powell and Hodnicki (2006). The most important finding of their study is that patients' health-seeking behaviours are influenced by pressure from the family, relatives, friends, employers, education and religion.

Still on this topic, Uchendu, Llesanmi and Olumide (2013) and Muriithi (2013) added that in general, health-seekers' choice of health is based on quality of health care, trust, waiting time, available information about the service provider, gender, distance, out-of-pocket costs, health provider's communication skills, courtesy and administration burden, amongst others. We realise from such an observation that one's decision to seek health provision is based on various influential factors. It has to be emphasised while still at this point that an analysis of relevant literature on determinants of health-seeking behaviour reveals that patients' trust on the ability and quality of health providers is the most influential aspect in health-seeking behaviour. This issue is confirmed by Victoor, et. al. (2012) who point out that in some North West European countries, health-seekers' choices are mostly based on the quality of the service provided, and experiences with the provider. It therefore follows that if quality of service provided is the most influential determinant of health seeking behaviour, it is precisely for this reason that health providers should aim for high quality services, which are capable of attracting health-seekers. It is this issue that we now briefly explore.

Let us commence our discussion by exploring how trust and ability influence health-seekers behaviour. As will emerge, health seekers prefer certain health providers due to their ability in healing. However, as we shall also realise as the argument of this paper unfolds, in some instances, some health providers are specifically preferred for their consultation techniques, as in the case of traditional and faith healers. In this connection, when referring to the outcome of a 2005 baseline survey done by UN HABIT and Republic of Kenya in Kibera slum, Muriithi (2013) observes that whilst there were government health facilities which were nearer to respondents and less expensive, the majority of the them did not use them. Several questions arise from such an observation; one wonders what could be the driving force behind this peculiar norm. It also becomes interesting to find out if these findings can be generalized to other countries, particularly Botswana. It therefore becomes imperative to turn to Botswana in order to compare Muriithi's findings with our experience.

To begin with, as is the case in many African countries, in Botswana biomedical healing takes place in both private and government clinics and hospitals. While still at this point, it is worth stating that in general, high charges and distance have no direct influence to health-seeking behaviours among Batswana. The general observation is that whilst Batswana believe in biomedical, traditional and faith healing, they somehow give priority to biomedical healing. Apparently, many patients believe that biomedical practitioners are knowledgeable in diagnosing and treating various diseases and infections. For instance, the findings of a study conducted by Togarasei and his colleagues (2011 to 2016) on Batswana health seeking practices confirmed that when in need of health services, Batswana first consult biomedical practitioners, before turning to either traditional or faith healers. Among various reasons cited for this tendency is that, “....clinics and hospitals can properly diagnose and offer proper medication which has been scientifically proven and is administered in right dosages” (Togarasei, Mmolai and Kealotswe, 2016:100).

What emerges from the above findings is that trust is the major factor which attracts patients to biomedical facilities in comparison to traditional and faith healing. However, as observed by Uchendu et al. (2013), besides trust, the high charges by both traditional and faith healers has in some instances been cited as another impediment. This finding, however, differs from the Botswana situation, as revealed by the findings of the aforementioned study conducted on Batswana health seeking practices:

...Botswana health facilities provide free services and are generally well stocked with medication. But despite these facts, the study has shown that Batswana still seek the services of *dingaka* and faith healers whose services are more expensive than those of modern health facilities (Togarasei, Mmolai and Kealotswe, 2016:113).

On the basis of this finding, it becomes important therefore to explore and establish reasons why Batswana prefer these healers, despite their high charges. Hopefully, such an exploration would assist in any further investigation on possible collaboration between these three types of healing among Africans. In other words, one wonders if the major attraction emanates from trust, relevance to culture, faith or quality of service. Another issue of interest relates to the common tendency of making biomedical healers the first port of call. If Batswana trust traditional healers, why do they first have to visit biomedical practitioners?

A more interesting issue to highlight at this point of our discussion is that relevant experience in healing among Batswana confirms that in most cases, Batswana visit biomedical practitioners for remedial purposes rather than consultation. In other words, they first go to clinics and hospitals for medication, which they are sure of getting straight away, thereafter they consult traditional healers, faith healers or both. In most cases, patients use modern medicine concurrently with traditional healers' herbs or faith healers' *dimacho* (placebos). However, in rare cases, due to desperation or other personal reasons, the patient uses the three prescriptions concurrently.

Another important observation which emerged in our previous discussion of biomedical healing is that trust and ability are some of the major determinants of health seeking behaviour. This is also prevalent among Batswana concerning their consultation of traditional healers; in the majority of cases, people who visit traditional healers believe that ancestors have more healing powers than both modern practitioners and Christianity. Further still, available literature related to healing among Batswana confirms that during

the consultation these healers diagnose the illness and its cause, before any treatment. This argument was further developed in the above-mentioned study conducted by Togarasei, Mmolai and Kealotswe (2016) who posit that in many cases, Batswana are of the view that biomedical practitioners ask patients the illness and its cause. It is this aspect of the consultation process, which, as pointed out, challenges the patient who hopes to get such information from the practitioner. It is arguable that this aspect has the potential of discouraging some patients to solely seek health from biomedical practitioners, hence their attraction to traditional and faith healers.

It is from this understanding that it becomes arguable that patients consult traditional healers because they trust their efficacy and effectiveness for healing Setswana ailments in comparison to biomedical practitioners. For instance, it is evident from the findings of the study on Batswana health seeking behaviour that there are specific diseases such as widowhood, food poisoning as well as ‘sexually transmitted diseases (STDs), general body pains, bad luck, headaches, overdue pregnancies, snake bites, bone fractures, *phogwana* (children’s diseases) etc.’, which can only be addressed by traditional healers (Togarasei, Mmolai and Kealotswe, 2016:103).

As can be gathered from the above cited examples, certain diseases related to Setswana culture and belief system are preferably considered to be well attended by traditional healers. The general feeling being that the cited diseases are unknown and complex to biomedical practitioners. The findings of this study further confirm that trust and ability greatly influence Batswana to seek health from traditional healers. One other interesting issue emerging from relevant literature on determinants of health-seeking behaviour is that religion is one of the influential factors. In the light of this observation, it becomes imperative to explore the impact of religious beliefs, spirituality and faith on health-seeking behaviours.

### **Impact of Religious Beliefs on Health Seeking Behaviours**

In this section, we will borrow Levin’s (2001) understanding of the word religion. According to him, “To talk of practicing religion or being religious refers to behaviors, attitudes, beliefs, experiences, and so on that involve the domain of life” (Levin 2001: 9). As we can realise, the above definition is very broad, as it incorporates both established religious institutions and one’s inner life or spirituality. Based on our preceding discussion of major determinants of health seeking behaviours, we now turn our focus to how religious beliefs can specifically influence health seeking behaviours. Such an exploration is capable of creating relevant knowledge geared towards holistic healing among Batswana and other Africans based on patients’ needs and interests. Let us commence our discussion with Gooden (2008) who urges faith healing practitioners to combine healing of the body and that of the soul. We realise from Gooden’s argument that healing should not be confined to the patients’ physical well-being without incorporating their spiritual being. This being the case, it is noteworthy for health practitioners to explore and establish patients’ religious beliefs and spiritual being prior to and during the healing process. Such an approach is capable of creating a favourable working relationship between health seekers and providers.

This is, however, an issue which has been undermined by almost all health providers. For instance, health providers seldom, if ever explore and establish their patients’ choice of health providers. Even though this exploration is undermined, it has the potential of

revealing determinants of health seeking behaviour to health providers. The point to emphasise here is that such a revelation has far reaching positive consequences on health provision. In other words, health providers' awareness of such determinants has a positive impact on their health provision. Arguably, if health providers become aware that patients prefer healers who acknowledge patients' religious beliefs; it is possible for such healers to incorporate patients' religious beliefs and spirituality, during their healing process. In this respect, one must hasten to argue that such an approach could in turn promote collaboration amongst health providers, since they could possibly become interested in knowing more about other health providers. For instance, if medical practitioners gather adequate information related to religious beliefs associated with either traditional or faith healers, it is possible that they could be motivated to research on such information. Arguably, this has the potential of encouraging health providers to contact one another on issues of concern.

The findings of the above mentioned study by Togarasei and his colleagues, reveal that traditional and faith healers are willing to collaborate with modern medical practitioners. Still on this issue of health and beliefs, it appears that Africans link health and wellness to religion (Onunwa, 1986; Magezi et. al. 2017). For instance, the findings of a study by Onunwa (1986) confirm the relationship between the physical and spiritual being of patients, by stating that:

Healing either in the traditional African society or in the ministry of the Lord Jesus Christ is therefore an elaborate enterprise in which the practitioner does not seek only the person's physical wellbeing but also his spiritual and psychological fulfilment (Onunwa, 1986: 58).

What emerges from the above argument is that though philosophically, conceptually and academically distinct entities, in practice religion and health are closely related. In general, such an observation lays a strong foundation in understanding sickness and healing amongst most Africans. It is on the basis of this observation that we now turn our focus to how religious beliefs can determine patients' health-seeking behaviour.

An important point to mention here is that religion has the potential of either encouraging or discouraging patients from seeking help from some health providers. In the first place, some patients may involuntarily seek health service from certain health providers mainly because their religion expects them to do so. A relevant example of such a scenario would be whereby followers visit either biomedical or faith healers, while shunning traditional healers, in order for one to be perceived as being loyal to their faith. There are also rare and extreme instances, whereby some religions forbid followers to seek health from any providers, including biomedical practitioners. The case of the Zezuru tribe in Botswana illustrates such a case, by restricting followers to use modern medicine. Secondly, some religions particularly some forms of Christianity, specifically criticise traditional healers and discourage followers to visit them, hence followers visit these healers during the night, as observed by many researchers on this topic in Botswana, including the writer.

We will commence our discussion with how religion or faith are capable of determining health seekers' preference for biomedical healing, before turning our attention to traditional and spiritual healing. Tabi et. al's (2006:55) observation on this issue is that:

Some patients, especially those of Christian or Muslim faith, associated demonic influence with traditional medicine and thus preferred to use modern medicine.

What emerges from the above argument is that in such circumstances, followers' health-seeking behaviours are directly influenced by their religion, which preaches against traditional healers. As earlier pointed out, patients' loyalty has to be sustained; hence they ultimately shun traditional healers in favour of modern medicine.

As already highlighted, while religious beliefs have the potential of encouraging patients to consult modern medicine practitioners, they are at the same time capable of discouraging patients to visit such healers. In this connection, the findings of the study from Uganda by Nwaka, Okello and Orach (2015) on the treatment of cervical cancer in northern Uganda becomes relevant due to its finding that:

Barriers to biomedical care and community beliefs in the effectiveness of traditional medicines encourage use of traditional medicines for treatment of cervical cancer but might hinder help-seeking at biomedical facilities (Nwaka, Okello and Orach 2015:503).

This example illustrates how beliefs are capable of encouraging patients to seek help from traditional healers on the one hand, and discouraging them to seek help from modern practitioners, on the other hand. What emerges from the above studies is that while the study by Tabi et, al. (2006) illustrates the positive effect of religious beliefs on health-seeking behaviours, the one by Nwaka, Okello and Orach (2015) illustrates both the positive and negative effects of religion on health-seeking behaviours. It is this second study which clearly demonstrates the complexity faced by health seekers with regards their decisions and choices pertaining to health provision.

Turning our focus to traditional healing, available literature on this topic reveals that traditional healing is practised by most Africans. For instance, Patel and colleagues (2015:13) confirm that in Tanzania, traditional medicine is highly used by people from all walks of life for 'daily symptomatic ailments and chronic diseases'. According to this study, strong cultural identity is a factor which influences people to visit traditional healers.

In Botswana, similar findings have been reported by other investigators assessing the use of traditional healing amongst Batswana. For instance, Marobela (2013) confirmed that traditional healing remains popular amongst Batswana. Further still, the findings of the above cited study by Togarasei and his colleagues confirm that even though Batswana do not use traditional healers as their first port of call for health assistance, a significant percentage (39.2%) has consulted traditional healers when they were not well, with 24% being treated and healed.

The findings of this study pointed out numerous reasons given for visiting traditional healers. For instance, it emerged that the majority of respondents' decision to consult traditional healers emanates from the fact that traditional healing is part of their religious belief, tradition and culture, as illustrated by the following extracts, amongst others:

MAS 033 said, 'It is my culture and religious belief', while SE 28 said, 'I am a pure traditionalist who works with ancestors so I first consult traditional doctors to guide me where to seek help' (Togarasei, Mmolai and Kealotswe, 2016:102).

What emerges from the above verbatim quotes from the study conducted on Batswana health seeking behaviour concurs with the observation made by Stanifer et. al (2015) that strong cultural identity is one of the major determinants of health-seeking behaviour among patients in northern Tanzania.

Of more relevance to the central argument of this paper is the observation made by Mwaka and colleagues that some of the issues capable of influencing patients to prefer traditional medicine are 'socio-cultural beliefs about the superiority of traditional medicine and privacy in accessing traditional healers' (Nwaka, et al. 2015:503). The point to emphasise here is that culture and religion are closely related; they both encompass sets of beliefs, values, attitudes, interpersonal relationships, amongst others. It is on this ground that we realise that in Tanzania religion is one of the major determinants of health seeking behaviours, with specific reference to traditional healing. In other words, in such a scenario, one cannot argue that culture, and not religion, influences Tanzanians to seek health from traditional healers. Hence it becomes appropriate in our current discussion to argue that religious beliefs are determinants of health-seeking behaviour among Tanzanians and Batswana.

With this in mind, let us now explore and establish how religion impacts health-seeking behaviors by restricting patients from seeking help from traditional healers. To begin with, in Botswana, as Kealotswe (undated) observed, traditional healers were despised by both Christian missionaries and western culture. According to Kealotswe (undated:115), even though the 1972 Societies Act necessitated the registration and recognition of these healers, their "influence in the community was taken over by the prophets who paraded under the Christian umbrella." He further points out that in many cases, Christians prefer faith healers to traditional healers because visiting the latter is likely to be alleged to be sinful.

What emerges from Kealotswe's observation is that the negative role played by religious beliefs towards traditional healing has a substantial potential to restrict patients from visiting traditional healers. This observation which concurs with Tabi et al. (2006) is further confirmed by Onunwa (1986: 62), who argues that, "A strong faith in God enables a man to decipher the basis of any sort of ritual involved in any form of traditional healing." However, as already argued, some patients involuntarily or pretend to undermine the role of traditional healing in their lives, hence they visit these healers in secret. Still on this issue, another relevant research study conducted among the indigenous tribes along the Okavango Delta in Botswana by Bolten (1998) reveals that the locals who converted to Christianity ceased using traditional medicines. He concludes by lamenting that:

The pattern of people converting to the church and using either faith healing solely or both the church and the hospital is not one that will be slowed or altered unless the people can be given a pragmatic reason to believe in the power of their traditions (Bolten (1998).

This conclusion creates awareness that traditional healers are part of the African culture and religion. This being the case, perhaps restricting African patients from seeking health from these healers creates both personal and social conflict. In the first place, personal conflict is created by their guilty conscience of leading a double life; pretending loyalty to their religion by appearing not to be seeking health from such healers, whilst the reality is that they do so in secret. If ever discovered, fellow Christians and the community at large would accuse them of living double standards. Further still, both church leaders

and other followers would despise them for breaking their loyalty to the teachings of the religion, hence a social conflict.

With regard to faith healing, available literature on health reveals that besides biomedical and traditional healing, faith healing is also common among many Africans. In general, Christian patients prefer such health providers for both diagnosis and healing, instead of biomedical and traditional healers. It emerged from studies on this topic that reasons for consulting faith healers emanate from Christian beliefs and teachings. For instance, belief in God, belief in prayer and trust in some faith healers are among the common reasons for preferring these healers. It is against this background that we realise that religious beliefs encourage patients to seek help from faith healers, on the one hand and restrict them from visiting traditional healers, on the other hand. It is therefore possible to argue that religious beliefs greatly influence health seekers' behaviour.

### Conclusion

The paper explored major determinants of health-seeking behaviours, with the view to establish the role of religious beliefs and faith in this respect. It was argued that due to the numerous and diverse determinants, health-seeking behaviours are very complex. One major conclusion of this paper is that while patients' health-seeking behaviours seem to be influenced by various factors, faith, spirituality and religious beliefs greatly encourage or discourage patients to seek help from specific health providers. Based on this observation, this paper argues that in order to provide holistic health among patients, health providers need to be fully aware of this role. This paper therefore challenges both medical and theological training institutions to specifically construct curriculum materials geared towards the promotion of attitudes of tolerance and respect among existing health providers among Botswana. It urges medical practitioners to be aware of patients' religious beliefs and faith in order to appreciate and integrate them in their healing. This being the case, religious beliefs should form part of the curricular for training institutions for medical doctors.

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**Sana K. Mmolai** (PhD) recently retired from the University of Botswana where she served as a Senior Lecturer in the Department of Languages and Social Science Education. She has published widely in the areas of religion and religious education. Her research interests lie in the areas of religion and health and religious education. Email: [skmmolai@gmail.com](mailto:skmmolai@gmail.com).

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### REFERENCES

- Bolten, C. 1998. *Healing Knowledge and Cultural Practices in a Modern Tswana Village*, A Thesis submitted to Williams College, Williamstown, Massachusetts.
- Gooden, R. 2008. Seeking Help for the Body for the Well-being of the Soul, in Mitchen, S. and Townes, M., (eds). *Faith, Health and Healing in African American Life*, London: Prager, 147-159.

Kealotswe, O. undated. Acceptance or Rejection: The Traditional-Healer Prophet and his integration of his Healing Methods.

Levin, J. 2001. *God, Faith and Health: Exploring the Spirituality-Healing Connection*, John Canada: Wiley and Sons.

Magezi, V. and Magezi, C. 2017. A Pastoral Evaluation and Responses to the Challenges of Spiritual Insecurity in African Pastoral Ministry and Christianity, *Verbum et Ecclesia* 38 (1) 91734.<https://doi.org/10.4102/ve.v38i/.1734> x.

Marobela, K. 2013. Lack of law on indigenous medicine hampers research, cited in Sunday Standard, 18<sup>th</sup> September.

Muriithi, M.S. 2013. The Determinants of Health-seeking Behaviour in a Nairobi Slum, Kenya, *European Scientific Journal*, 9 (8), 151-163.

Nwaka, A.D., Okello, E.S., Orach, C.G. 2015. Barriers to biomedical care and use traditional medicines for treatment of cervical cancer: an exploratory qualitative study in northern Uganda, *European Journal of Cancer Care* (24), 503-513.

Onunwa, U. 1986. The Biblical Basis for Some Healing Methods in African Traditional Society, *Africa Theological Journal* 15(3):188–195.

Stanifer, J. W. Patel, U.D., Karia, F. Thielman, N. Maro, V. and Shimbi, D. 2015. The Determinants of Traditional Medicine Use in Northern Tanzania: A Mixed-Methods Study, *PLoS One* 10 (4): e0122638.[doi:10.1371/journal.pone.0122638](https://doi.org/10.1371/journal.pone.0122638).

Tabi, M.M. Powell, M. and Hodnicki, D. 2006. Use of Traditional Healers and Modern Medicine in Ghana, *International Nursing Review*, 53, 52-58.

Togarasei, L., Mmolai S. and Kealotswe, O. 2016. 'Quinine' 'Ditaola' and the 'Bible': Investigating Batswana Health Seeking Practices, *Journal for the Study of Religion*, 29 (2) 95-117.

Uchendu, O.C. Illesanmi, O.S and Olumide, A.E. 2013. Factors Influencing the Choice of Health Care providing Facility among Workers in a Local Government Secretariat in South Western Nigeria, *Annals of Ibadan Postgraduate Medicine*, 11 (2), 87-95.

Victoor, A., Delnoij, D. Friele, D. and Rademakers, J. 2012. Determinants of Patient Choice of Healthcare Providers: *A scoping Review*, <http://doi.org/10.1186/1472-6963-12-272e>.

# **The Role of Religious and Traditional Beliefs on Botswana Medical Practitioners' Health Provision Behaviours: Some Highlights from a Recent Study**

**Rebecca Kubanji**

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## **Abstract**

Religious and traditional belief systems have a bearing on health care provision and vice versa. Faith healing is a crucial component of health care provision. Holistic care should be intertwined within both medical practice and religious and traditional belief systems in order to attain optimal patient care. Using qualitative methodology, this study explores the role of religious and traditional beliefs on medical practitioners' health provision behaviours. Medical professionals who informed the health provision behaviour were purposively sampled from medical facilities. The results from the study emphasize that a peoples' religious belief system is a crucial component of delivery of health care. The religious beliefs of the medical practitioner play an important role in optimising patient care. The healing power of science needs to be linked to the dynamics of curing and caring that is derived from religious and traditional contexts. Further research related to religion-medicine interrelationships is recommended.

**KEY WORDS:** Religious Beliefs, Health Care Practitioners' Beliefs, Health Provision Behaviours, Health, Impact

## **Background**

Religious belief is a belief in the reality of the mythological, supernatural, or spiritual aspects of a religion. Health provision runs across different types of health care provisions and religious beliefs. For example, one's religious beliefs may somehow influence their health care provision. Health is said to include responsible medical practices as well as the utilisation of spiritual, cultural, psychological and social resources. In that regard, the deliberations on holistic, people centred approach to health should encompass practical theological approach (Louw 2008: 426). Furthermore, health also has a religious- ethical component which recognises a person's source of faith that enables them to live meaningfully as the starting point (Louw 2008: 426).

In 2002, the World Health Organisation (WHO) called for the integration of alternative health systems into national health policies. However, Botswana is one of the countries that have not heeded this call. Although the Botswana Public Health Act of 1981 does not recognize the role of faith healers, traditional medicine or other alternative treatment and healing, Botswana utilizes these alternative health systems. From 2011 to 2016, Togarasei, Mmolai and Kealotswe (2016) undertook a research project that sought to establish how Botswana makes use of the three available health systems in the country: traditional healing, faith healing and medical healing. The study established that Botswana makes use of all the three although priority is given to modern health facilities. What the study did not establish, however, is how one's religious affiliation influences their health seeking practices. On the other hand, no studies have focused on how religion and religious practices influence health seeking and health provision behaviours and how this knowledge can help inform medical, health and theological education. The project, from which this paper derives, aimed to establish how religious beliefs impact health seeking and health provision behaviours among Botswana and, from the findings, to propose a review of theological, medical and health education for the purposes of promoting holistic health through the integration of medical, traditional and faith healing. Additionally, no study has established how the religious affiliation of the health providers affects their health provision practices. Do medical practitioners who belong to churches that emphasize faith healing encourage their patients to seek faith healing? What about those medical practitioners that uphold traditional beliefs?

In the light of this background, this paper assesses the role of religious and cultural beliefs on health provision behaviours in Botswana. Specifically, the paper seeks to establish how medical practitioners, traditional and faith healers exercise their religious beliefs in providing care to their clients.

### **Brief overview of Literature**

#### ***The Role of Religion in Health Provision***

In order to realise the health targets of the post 2015 agenda for sustainable development, Olivier et al. 2015 (1765) stress the important role played by faith-based healthcare providers. In order to achieve better partnerships and strengthening of health systems, the authors further underscore the need to align faith-based health care providers with national systems and priorities, and also improve information at all levels. This is because evidence has shown that faith-based health care providers continue to play a crucial role in health provision, especially in fragile health systems, hence the need for collaborative effort with public sectors.

Religion and spirituality also play a crucial role for the healthcare worker. This is so because in most cases religion and spirituality are connected to a sense of calling or a personal philosophy about care (De la Porte 2016: 7). These two also play an important role in resilience, coping with a stressful environment and preventing burnout. In support of this view, Williams and Sternthal (2007: S47) also assert that religion tends to refer to aspects of belief and behaviour, including spirituality, which are related to the sacred or supernatural and are grounded in a religious community or tradition. In this regard, holistic and people centred care is recommended by the authors, as a meaningful approach in health care. This can only be realised if the health care system is alive to the religious and traditional beliefs of medical practitioners. Corroborating findings from a study,

Baldacchino (2015: 594) also emphasizes the active role of health care providers in meeting the spiritual needs of patients in collaboration with the family and the chaplain. In a study on belief and causes of ill-health, Kahissay, Fenta, and Boon (2017: 124) also support Williams and Sternthal's assertions that the supernatural forces were the most important cause of ill health. They further articulate the role played by natural causes and social relationships in maintaining good health. The authors also caution that when Western biomedical practitioners scorn the supernatural convictions held by the individuals or group, they risk distancing the very individual they provide health care to. In this regard, they recommend the need for engagement of extension workers who have knowledge of both worlds, in order to bridge the gap between the indigenous beliefs in supernatural causes of illness and health education based on modern science. Agreeing with Olivier et al. (2015: 1764), Kahissay, Fenta, and Boon (2017: 124) also advocate for a closer collaboration between indigenous and biomedical health frameworks, with a further eventual integration, as recommended by the World Health Organisation. The authors, like others, recommend that health care providers should be privy to patient needs in relation to their beliefs that ill-health is caused by the supernatural, natural and social elements.

Being vigilant in relation to the spiritual/religious beliefs and practices can be advantageous and it can lead to early patient release dates, fewer medical errors and stronger communication between patients and health care providers (HCPs). Furthermore, Rumun (2014b, 37) reiterates the need for HCPs to understand the religious beliefs of their patients in order to meet their health care needs. This calls for a skills training, so that HCPs may be able to deliver person-centred care. With such skills, they can meaningfully contribute to patient holistic care that takes on board the psychological, social and physical health of their patients, the authors further argue.

### ***Religion and the Practice of Medicine***

Religion is perceived to provide a set of explanations for the existence and meaning of illness and curing. This is because it distinguishes as to whether sickness is naturally or unnaturally intrusive; an uncontrolled evil or partial good; a result of impartial or personal causes; an enemy to be actively eradicated or an entity to be passively accepted (Vanderpool 1977: 258-259). It therefore follows that the relationship between religion and medicine undertakes that notions about disease, health and therapy are continuously informed by the world view of every particular human cultural group. The author elucidates that the interface between religion and medicine involves caring much more than curing. In addition to promoting ethical concern, it contributes to the caring of human beings and gives valued, curative emotional and psychological support to those who have religious inclinations. The author further recommends that attention be given to religiously centred cures, both past and present. He further underscores the need for research to emphasise on the need for medical practice to be more intertwined with neighbourhoods, churches, and local schools. That way, the healing power of science would be linked to the dynamics of curing and caring based on traditional, social and religious contexts. In this context, the role of religion and traditional beliefs of medical practitioners can shape the course of health care provision, which this study seeks to investigate.

Corroborating Vanderpool (1977: 258-259), Vanderpool and Levin (1990: 16) further postulate that religious beliefs sustain and shape the practices of medicine, irrespective of whether they are recognised or practiced within medical institutions. Furthermore, both religion and medicine define the ethical wrongs and rights like healthcare provider-patient

relationships; organisation of health care delivery; controversial procedures like organ transplantation, surrogate motherhood, and passive euthanasia, among others. The authors conclude that religion and medicine are widely used as ethical gatekeepers for the daily decisions of the ordinary citizens. Additionally, human beings rely on religion and medicine to establish institutions, roles and training programs for medical practitioners. The role of medical professionals in this regard is therefore to enhance their understanding of religion so as to utilise its complementary contributions, and to effectively diffuse its influence when it appears to be harmful. These findings are in agreement with those by Williams and Sternthal (2007: 864), who also documented negative aspects of religion on health for some aspects of religious beliefs and behaviour under certain conditions. Reciprocally, religious leaders can contribute meaningfully to religious patients' decision making by equipping themselves with historical legacies of providing healing and medical care, and also educating themselves with regard to the modern developments within medicine (Vanderpool and Levin 1990: 16). By implication therefore, medical practitioners should endorse religion critically, and also need to have a better understanding of the attitudes, beliefs and practices of their patients in order to deliver effective health care. Corroborating these findings, Hirono and Blake (2017: 13) underscore the need for collaborative effort between mental health professionals and religious leaders to reduce pain, bring comfort and hope, and pray for those who lost their loved ones to natural disasters.

### ***The Role of Religion in the Medical Curriculum***

There is also need for collaboration between religious and medical institutions in order to enhance training of professionals within each area. For example, with the rise of church based clinical and community medicine, offering continuing education for interested physicians and pastors could enhance cooperation and ease tensions, alleviate feelings of intrusion experienced by both groups. Joseph (2016: 493) emphasises the need for health care and religious belief systems to be complementary rather than competing with one another for optimisation of patient care. It thus calls for the importance of having medical personnel that are religiously and culturally literate in order to bridge gaps in patient care. Medical personnel are therefore urged to be sensitive to patient beliefs when performing examinations or recommending a course of care. This type of collaboration has further implications for the incorporation of content on the traditional systems in both the pastoral and medical education and curricula.

## **Methodology**

### ***Research Design***

This study followed qualitative methodology employing techniques that were crucial in understanding the context within which decisions, actions and events relating to health provision behaviours occur. Under the qualitative paradigm, the study explored the meanings, experiences and processes of health provision behaviours in the context of the individual's religion and traditional culture. The qualitative study was based on semi-structured interviews with individuals who provide modern health services. In-depth interviews provided deeper meaning of the topic under investigation. These were key persons involved in health and healing matters.

### ***Study Population***

The study population comprised of medical professionals who provide modern health services. These were recruited from hospitals and clinics.

### ***Study Areas***

The study was conducted among villages, towns and cities drawn from the northern, southern, eastern and western parts of Botswana. They included Gaborone, Tutume, Mahalapye, Maun, Bobonong, Molepolole, Hukuntsi and Tsabong with participants also drawn from the smaller villages surrounding the town centres to include both urban and rural perspectives.

### ***Samples and Sample Sizes***

As stated above, data was collected through in-depth interviews. Participants for in-depth interviews were key persons involved in health and healing matters including government policy makers. Purposive sampling method was utilized and as many participants as possible were interviewed until a saturation point was reached in each geographical area.

### ***Data Analysis and Synthesis***

In-depth interviews were subjected to thematic content analysis to gain insight into factors influencing health provision behaviour in the context of religious and traditional beliefs. Data analysis involved review of transcripts, initially using open coding to allow for emergence of recurrent themes. Concepts which are closely linked in meaning were grouped into categories. Audio taped data was transcribed verbatim, coded word by word, sentence by sentence and paragraph by paragraph to generate themes. These themes were grouped further to form broader themes that are in line with the study objectives.

## **Findings**

### ***Beliefs on Traditional Medicine***

Asked what their beliefs are concerning traditional healing, many medical practitioners were sceptical about encouraging patients to use traditional medicine on the basis of lack of scientific basis, unknown toxicity and lack of government policy governing the use of such. Most of them did not believe in the use of traditional medicine; neither did they recommend it for patient use. However, those who acknowledged use of traditional medicine that have been tested accepted its use within a regulatory framework. The following participant cited lack of scientific testing:

“But I wouldn’t encourage anyone to use those because they are not really tested...”  
(MHMP 001).

Those who advanced reasons relating to lack of scientific dosages had the following to say;

“I have seen traditional medicine kill people, so I have a very bad view towards it. I have seen a 7 day old baby who was given traditional medicine and had liver failure so it was a very bad experience for me to see such an innocent baby die” (GAMP 001).

“How safe is it? I have grown to believe that every medication should have a dosage, but the traditional medications do not. A higher and stronger dose of healing medication can be lethal to the patient” (MAMP 001).

“Some of these traditional medicines, if you do not know their concentration, they can be harmful.... So if it is something you are going to have to take into the body, we now are talking chemistry, two objects reacting can cause a bad side or a good side” (TSMP 001).

“I also take traditional medicine but I take those that have been tested before, like *moringa*, *sengaparile* (*devil's claw*) you see, those kinds of things” (MHMP 001).

Those who cited lack of government policy on traditional medicine as a contributing factor to discouraging its use had this to say:

“I do what is approved by the government. Maybe I can try it on my own but to a patient no! because I have to be professional considering that I don't have proof on traditional healing” (TSMP 001).

However, there were a few who acknowledged the importance of traditional medicine especially for those diseases caused by witchcraft and other culture related ones such as *bosnagadi* (*widowhood*), amongst others. But they acknowledged them with conditions:

“I do not categorically refuse traditional medicine... these things have to be monitored. That's why we have to include the department called Botswana Food Control to check and monitor these things. Organic chemists also need to come on board. That way, I wouldn't have problems with traditional medicine” (TSMP 001).

### ***Beliefs in Faith Healing***

While the majority of medical practitioners approved faith healing due to its effects on good mental health for the patient, some disapproved of the use of faith healing by patients, especially where chemicals are used in the process of healing. Most practitioners believed in God, hence recommended prayer for healing. Medical practitioners were more appreciative and accommodative of faith healing than traditional healing. They expressed the views that faith healers treat most diseases which are related to emotions, feelings and spirituality:

“Faith is psychological so I can encourage this one...we are talking about its psychological impact, if the patient believes in prayer its ok because there is no harm. I disapprove when it involves use of chemicals” (TSMP 001).

“I accept the ones who practice healing by word/praying because personally I know the Word of God heals, but we cannot base on that alone we have to consult the hospital” (GAMP 002).

They were more comfortable with faith healing that does not use other forms of media as stated by one respondent:

“It just depends on one’s belief, someone can lay a hand and pray for the patient, and for me it is harmless. I am not comfortable with the ones that are drunk or eaten” (MHMP 002).

Based on their beliefs, we asked the medical practitioners whether they encouraged their patients to consult faith healers. Though they were accommodative of faith healing, they did not officially refer patients to faith healers:

“I do not encourage it but cannot force them to stop....” (GAMP 002).

Many said they allowed faith healers to pray for patients but did not necessarily invite the faith healers or refer patients to them;

“I cannot call them but I have seen in Marina (the largest referral hospital in Botswana) pastors coming in to pray for patients” (MHMP 001).

Only one participant said they sometimes advised (not formally refer) patients to faith healers,

“An example I can give is when a patient has emotional problems. You can advise them to go talk to their pastors, that is, when faith pitches in. Faith has a role in my work because I always encourage my patients, especially those with chronic diseases like BP, TB to believe that God can heal them, .....if you are still alive today you should have hope” (MHFGD MP).

### ***On establishing if patients are on alternative medication***

As part of the care process, medical practitioners agreed that they establish whether patients were on alternative medicine or not. This was mainly to take into account the issue of drug interactions, that is, modern medicine and alternative medicine. There were varied opinions, with some educating patients on the use of alternative medicine; some discouraging patients to use such; while others adopted a holistic approach to patient care by allowing them to use whatever they believed would help their ailment. Respondents said they asked whether patients are on medication although establishing use of alternative medication (especially non-drug) was not required by policy:

“Yes, it is to check if the drugs given won’t contradict with the ones he/she is having whether it is traditional or modern medicine. If you don’t you may think a person is sick where as it is just the side effects of the medicine he is taking....” (MHMP 002).

“Eh! We do not routinely ask them if they have been to a traditional healer, but we ask them if they are having any other treatment. Yah! So, that way, they open up and say, Okay, I have been that side and have been given this and that. Even some of these churches, they also give some stuff” (MAMP 002).

In doing so, many said they establish that patients have been to alternative health providers. Their reactions to patients taking alternative medication differed. Some were positive:

“It is not a problem if the patient is on alternative medicine, all she/he has to do is to tell us the medicine she/he is taking so that we can establish if it is ok on their health because we have different beliefs and we cannot stop them to use those” (GAMP 002).

I have had a patient recently with that issue; we had a very long discussion about it. She believed she had demons which were making her do things. Everybody who goes to seek help be it from a traditional, faith healer or medical doctor comes with an expectation ..... We referred her to the psychologists and social workers but she still said she was not well. She told me that when she talked to her prophet, things would get better. As a doctor I did holistic approach. I considered the physical, psychological and spiritual aspects and then advised her to go and consult the prophet. For me what you believe in would work for you, ...if they come here expecting me to help with the headache, do so, or if they believe if *moruti* (pastor) prays for them it gets better, it's actually better than giving medication. I would say look at the patient as a whole than medication only because at times medication won't help (GAMP 001).

“Yes, I do come across patients who are on alternative medicine. One thing is, I give them my opinion about alternative medicine. A lot of them are just herbs, fruit extracts, and food supplements. I do not discourage them. Most of them do not really counteract modern medicine, so I just allow them to continue!” (MAMP 001).

Other respondents had a negative attitude towards faith healing:

“We ask them to stop using the alternative drugs. The thing is to educate the patient” (MHMP 002).

“I usually tell them we do not know what it has and what it affects. For example, people on HIV treatment who would take *monepenepe* (a traditional concoction used to treat many ailments), we do not know how it will affect your pill, the body or the system because most of the time traditional medicine affects the liver. I make sure I tell you what I know about the medication I give you and what will happen if you mix it with that other medication” (GAMP 001).

“...if herbs I would advise the patient to stop for the time being because I do not know their composition” (TSMP 001).

### ***Medical practitioners and prayer***

The study also sought to establish medical practitioners' views on prayer and medication. Responses differed depending on personal religiosities, availability of time/ nature of medical requirement and institutional expectations. For those who are Christians, responses were like:

“I'm not really a good prayer person, but here in Botswana for everything you pray” (TSMP 001).

Those who are non-Christians responded thus,

“Yah (laughing) I have seen that in movies. In real life I haven't. But if a patient or the relatives ask to pray, I do not have a problem with that” (GAMP 001).

Some participants indicated that availability of time and nature of medical requirement also influenced the place of prayer:

“If time allows we can start with a prayer and we do not prevent churches from coming in at lunch hours and on weekends” (GAMP 002).

“It depends on the nature of the emergency. So one day there was an emergency and I didn’t wait for a prayer. I had to go straight on operation believing that whatever I’m doing God is there. They went to report me to the authorities. I wondered if they knew what an emergency is” (TSMP 001).

Institutional expectations also influenced medical practitioners’ use of prayer:

“At a Catholic hospital, if you are doing an operation, you have to pray...” (TSMP 001).

### ***Professional and religious influence***

The study wanted to establish whether medical practitioners’ religious beliefs influenced their professional practices, especially in counselling sessions and outside their professional practice. Do they, for example, encourage patients to seek alternative medication in their private life? Although many said their profession influenced their practice even in private counselling or in their private life, there were a few who accepted that there are certain professional practices that they do not do because of their religious beliefs.

“To a certain extent, I think so. Because there are certain things which you feel you are a Christian and you cannot do. For example, termination of pregnancy, you know such controversial issues” (TSMP 002).

“You can say so, because you find that maybe, a woman is stressed, crying, -I need to abort-, but you refuse. She goes to someone who is not a Christian and it is done” (MAMP 002).

Others said their profession, not religion or personal practice, comes first:

“No, because I carry the name doctor anywhere I go, what I do/say to a patient has a very high impact. There is nothing private, government or personal” (TSMP 001).

## **Discussion**

Findings from this study reflect that non-belief in the use of traditional medicine has a huge bearing on the provision of health care to patients who believe or practice such, as medical practitioners had a negative attitude to the use of such, citing lack of scientific basis. However, religious beliefs are interwoven within health care provision. As such, studies underscore the need for HCPs to be cautious of their religious beliefs as these can be an impediment to health care provision. It calls for them to accept alternatives to the biomedical care models in relation to illness, health and healing. Supporting such findings is Rumun (2014a: 46-47) who urges health care providers to engage with and listen to patients and their families in relation to their religious beliefs and practices. The author reiterates that there is need for the medical team to document and understand the spiritual and religious needs so that they may be integrated into treatment planning and care. Given

the negative attitude towards traditional medicine portrayed by the medical practitioners interviewed, this lack of acceptance may be fuelled by the medical practitioners' own religious and traditional belief systems. These findings corroborate Dillard et al.'s (2021: 16) who unveiled lower levels in incorporating diverse religious and cultural beliefs into clinical practice, and call for the need for hospital settings to create conducive environments that embrace different religious and non-religious medical personnel and patients. Furthermore, the authors advocate for improved and sustained cultural competency education across all levels of medical training. It is eminent from the findings of this study that the organisational framework within which medical practitioners operate may not be conducive for them to practice their traditional and religious beliefs, even if it is to the advantage of the patient.

The study underscores the need for health care provision to take cognisance of the religious and cultural beliefs of patients. Additionally, Malik et al. (2019: e019954) also emphasise on the need for the health policy to be sensitive to health care providers' religious beliefs. This will have the added benefits of diversifying the health care personnel base by allowing for inclusivity, non-discriminatory and acknowledging religious rights of HCPs from minority groups like the Muslims. If medical practitioners are allowed to practice their religious beliefs, it may have added benefits to optimisation of mental health care, which may not necessarily need modern medical drug intervention but rather religious or traditional ones. However, it should be emphasised that such belief systems should be practised within the confines of medical code of conduct. Health care providers also need to apply a case by case strategy in mitigating stereotypes directed to their religious beliefs, as a way of making their services relevant to the communities they serve (Lindholm 2017: 289-290). In that regard, their health care provision will address the specific contexts of health care needs within varied backgrounds and environments. The medical practitioners in the study were biased towards faith healing than traditional healing. This bias was because most of them ascribed to religious beliefs like believing in God. The implication from this is that patients who ascribe to religious beliefs of the practitioner were more likely to receive mental health intervention than those of traditional belief systems. Such bias is likely to discriminate patients with traditional belief systems because they may not be congruent with that of the medical practitioners.

Furthermore, Basharat and Shaikh (2017: 1) similarly reiterate the need for HCPs to understand the context of religious beliefs, practices and cultural norms that can impede the success of health care provision and public health priorities like the eradication of polio in Pakistan. Findings from this study show positive attitudes of medical practitioners towards praying before doing patient consultations. However, in emergency situations there may be no time for physical, but internal prayer performed by the medical practitioner, for example, before a surgeon operates on a patient. Corroborating these findings, Atanga et al. (2017: 161) also identified HIV status denial and stigma, and religious beliefs as the main contributing factors to stopping lifelong antiretroviral therapy (ART) in Cameroon. Additionally, Plunkett et al. (2014: 1721), reiterate that religious places need to be viewed as health promoting and socially inclusive places for rural women. The study recommends the need for partnerships (irrespective of religious affiliation), as a way of improving the experiences of health and healing, and health provision. These research findings resonate with findings from the current study as it highlights that among contextual matters, religious, cultural and environmental factors can impede optimal health care seeking and provision behaviours. Thus, the role of the medical practitioners' religious and traditional beliefs cannot be ignored for long, if the health care system is to reap the bonus that comes along with medical health care provision.

Supporting these findings, Chadwick and Lown (2016: 583) call for a framework that can guide doctors to contribute to compassionate medical care. Such a framework should take into account the working conditions which can lead to exhaustion and burnout among medical personnel. The authors argue that for compassionate medical care to be sustained, it should include awareness, self-care, attentive listening to patients, collaboration and support for colleagues. Ironically, findings from this study reveal that such compassionate care by medical practitioners can be frustrated by organisational systems that bar medical professionals to practice their traditional and religious beliefs in their care provision, as and when needed. Such bottlenecks may need an overhaul of the medical professional code of conduct, which can accommodate such flexibilities.

According to Arousell and Carlborn (2016: 77,84), negative stereotypes about Muslims, for example, can lead to religion-blind health care delivery, leading to inadequate provision of health care. In areas with limited resources like during Sierra Leone's Ebola epidemic, religion was identified as a motivating factor for providing care among HCPs. Further to this, Freeman and Coast (2019: 106), also advocate for the need to eliminate HCPs' right to conscientious objection, in order to increase access to health care services like safe abortion. In the UK, Ally and Brennan (2015: 45) advocate for incorporating religious beliefs and non-western alternatives in providing care for the mentally distressed. Findings from this study reflect limitations within the health care system, as it shuns the religious and traditional beliefs of health care professionals. Such can allow inconsistency in the provision of health care as some may apply their belief systems on patient care behind closed doors. Consequently, the health care system may be marred with inequitable health care provision to the general clientele of patients.

It therefore calls for infusion of religious belief system within the curriculum. There is need to stress on the need of increasing awareness of the impact of diverse health and belief system on the interaction of HCPs and patients of diverse backgrounds (Berlin and Fowkes Jr 1983: 934).

## **Conclusion**

It is evident that a peoples' religious belief system has a crucial bearing on the delivery of health care. Faith based care of the patient takes the centre piece for delivery of holistic care, while the religious belief of the health care provider also plays a role in optimising patient care. Medical professionals were more accommodating and appreciative of faith healing, citing that it is good for the mental health of patients. Traditional medicine, which is used in the traditional healing process, was mostly criticised for its lack of scientific basis, unknown toxicity and lack of government policy regulation. Although medical professionals claimed to adhere to the professional code of conduct, some admitted that they could not perform certain medical procedures due to their religious beliefs. It is thus evident that the interrelationship between religion and the meaning of illness and curing need to encompass the dynamics of curing and caring within the traditional, social and religious contexts. Further research is recommended in the areas of religion- medicine interrelationships; influence of religious beliefs of health care providers on clinical decision making and care; impact of religious beliefs and practices of medical professionals, among others.

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**Rebecca Kubanji** holds an MSc in Medical Demography from the London School of Hygiene and Tropical Medicine, awarded in 1998, and is currently pursuing her PhD with the University of Botswana, where she is also a lecturer in the Department of Population Studies. Her research engagement covers nuptiality, alcohol use among HIV positive men and women, HIV positive adolescents' experiences, and fertility and sexual health practices of HIV+ individuals. Ms Kubanji has been a member of the University of Botswana Socio-Behavioural Institutional Review Board from 2016 to date. She has collaborated and is still collaborating with US researchers on several NIH-funded behavioural HIV research studies. Her Orcid Id- 0000-0003-1934-0067.

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## REFERENCES

- Ally, Farida, and Toni Brennan. 2015. Schizophrenia, psychiatry and East African Muslim families in the United Kingdom: a pilot study. *Mental Health and Social Inclusion* 19 (1):45-51.
- Arousell, Jonna, and Aje Carlbom. 2016. Culture and religious beliefs in relation to reproductive health. *Best Practice & Research Clinical Obstetrics & Gynaecology* 32:77-87.
- Atanga, Pascal N, Harrison T Ndetan, Eric A Achidi, Henry D Meriki, Michael Hoelscher, and Arne Kroidl. 2017. Retention in care and reasons for discontinuation of lifelong antiretroviral therapy in a cohort of Cameroonian pregnant and breastfeeding HIV-positive women initiating 'Option B+' in the South West Region. *Tropical Medicine & International Health* 22 (2):161-170.
- Baldacchino, Donia. 2015. Spiritual care education of health care professionals. *Religions* 6 (2):594-613.
- Basharat, Sarah, and Babar Tasneem Shaikh. 2017. Polio immunization in Pakistan: ethical issues and challenges. *Public health reviews* 38 (1):6.
- Berlin, Elois Ann, and William C Fowkes Jr. 1983. A teaching framework for cross-cultural health care—application in family practice. *Western Journal of Medicine* 139 (6):934.
- Chadwick, R.J, and BA Lown. 2016. What do we need to do to sustain compassionate medical care? *Medicine* 44 (10):583-585.  
doi: <https://doi.org/10.1016/j.mpmed.2016.07.003>.
- De la Porte, Andre. 2016. Spirituality and healthcare: Towards holistic peoplecentred healthcare in South Africa. *HTS Teologiese Studies/Theological Studies* 72 (4):1-9.
- Dillard, V, J Moss, N Padgett, and A.B Kennedy. 2021. Attitudes, Beliefs and Behaviours of Religiosity, Spirituality and Cultural Competence in the medical profession: A Cross-Sectional Survey Study. *PLOS ONE* 16 (6).  
doi: <https://doi.org/10.1371/journal.pone.0252750>.

Freeman, Emily, and Ernestina Coast. 2019. Conscientious objection to abortion: Zambian healthcare practitioners' beliefs and practices. *Social Science & Medicine* 221:106-114.

Hirono, Tatsushi, and Michelle Emery Blake. 2017. The role of religious leaders in the restoration of hope following natural disasters. *Sage open* 7 (2):2158244017707003.

Joseph, Osafo. 2016. Seeking Paths for Collaboration between Religious Leaders and Mental Health Professionals in Ghana. *Pastoral Psychology* 65. doi: 10.1007/s11089-016-0703-7.

Kahissay, Mesfin H, Teferi G Fenta, and Heather Boon. 2017. Beliefs and perception of ill-health causation: a socio-cultural qualitative study in rural North-Eastern Ethiopia. *BMC public health* 17 (1):124.

Lindholm, Kristin. 2017. Handling Stereotypes of Religious Professionals: Strategies Hospice Chaplains Use When Interacting with Patients and Families. *Journal of Pastoral Care & Counseling* 71 (4):284-290.

Louw, Daniel J. 2008. Space and place in the healing of life: towards a theology of affirmation in pastoral care and counselling. *Verbum et Ecclesia* 29 (2):426-445.

Malik, Abida, Hafsa Qureshi, Humayra Abdul-Razakq, Zahra Yaqoob, Fatima Zahra Javaid, Faatima Esmail, Emma Wiley, and Asam Latif. 2019. 'I decided not to go into surgery due to dress code': a cross-sectional study within the UK investigating experiences of female Muslim medical health professionals on bare below the elbows (BBE) policy and wearing headscarves (hijabs) in theatre. *BMJ open* 9 (3):e019954.

Olivier, J., C. Tsimpo, R. Gemignani, M. Shojo, H. Coulombe, F. Dimmock, M. C. Nguyen, H. Hines, E. J. Mills, J. L. Dieleman, A. Haakenstad, and Q. Wodon. 2015. Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *Lancet* 386 (10005):1765-75. doi: 10.1016/S0140-6736(15)60251-3.

Plunkett, Robyn, Beverly Leipert, Joanne K Olson, and Susan L Ray. 2014. Understanding women's health promotion and the rural church. *Qualitative health research* 24 (12):1721-1731.

Rumun, Akpenpuun Joyce. 2014a. Influence of Religious Beliefs on Health Care Practice *International Journal of Education and Research* 2 (4):46-47.

Rumun, Akpenpuun Joyce. 2014b. Influence of religious beliefs on healthcare practice. *International Journal of Education and Research* 2 (4):37-47.

Togarasei, Mmolai & Kealotswe. 2016. 'Quinine', 'Ditaola' and the 'bible': Investigating Batswana Health Seeking Practices. *Journal for the Study of Religion* 29 (2):95 - 117.

Vanderpool, Harold Y. 1977. Is religion therapeutically significant? *Journal of Religion and Health* 16 (4):255-259.

Vanderpool, Harold Y, and Jeffrey S Levin. 1990. Religion and medicine: how are they related? *Journal of Religion and Health* 29 (1):9-20.

Williams, David R, and Michelle J Sternthal. 2007. Spirituality, religion and health: evidence and research directions.

# The Ethics of Collaboration: Perspectives of Batswana Health Seekers on Health Systems Collaboration

Abel Tabalaka

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## Abstract

Studies on the importance of the collaboration between medical healthcare professionals with other players from alternative healthcare systems are on the increase across the world. Most of the studies place the patients at the benefiting end of this collaboration. Notwithstanding the amount of research that underscores the significance of this collaboration, on the ground the nature of this collaboration continues to be riddled with challenges and there are pockets of uncharted areas that still need to be explored. For example, research on collaboration of healthcare systems in young and developing countries like Botswana is still far from being adequate. Further, this collaboration still needs to be investigated from perspectives of other players like the health seekers, religious leaders and community leaders. This paper specifically explores perspectives of health seekers in Botswana on the collaboration of medical and religious healthcare systems. The findings from the study carried out among the Batswana health seekers seem to support the view that the collaboration between modern medical system, represented by medical practitioners and religious healthcare systems should be complementary in nature.

**KEY WORDS:** Health, Healing, Collaboration, Religion, Health-seekers, Beliefs

## Introduction

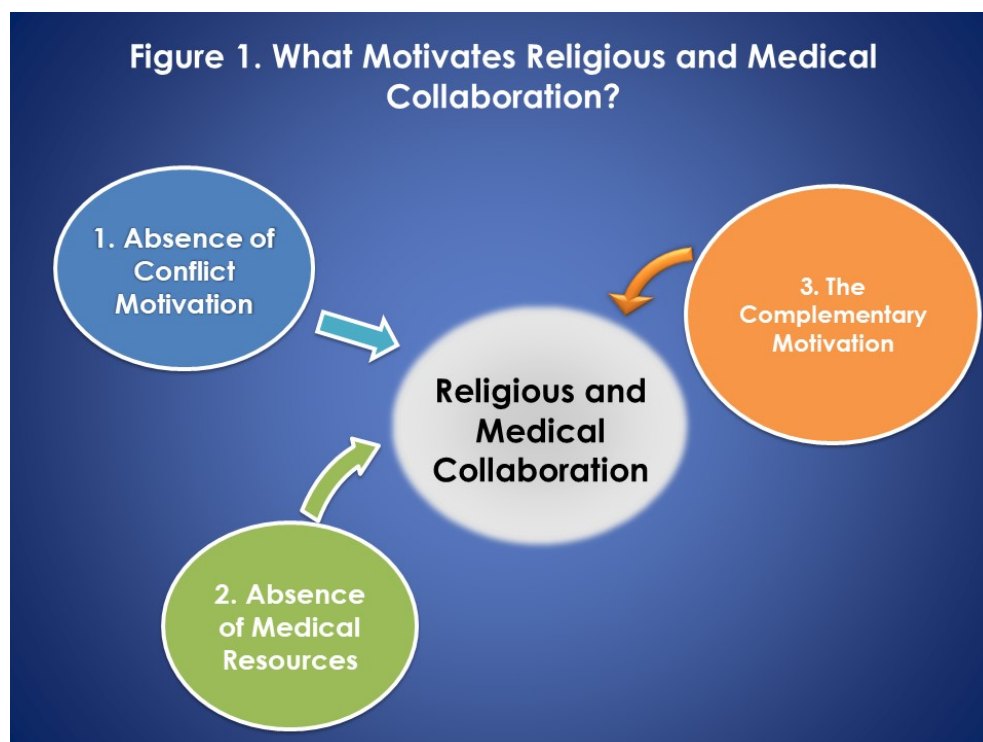
Discussions on spirituality and/or religion are increasingly taking the center stage in both academic dialogues on healthcare, at the same time as a number of medical schools are introducing spirituality programs, courses or topics as part of their curriculum (Puchalski 2009, Post 2009). This increase stems from the fact that spirituality and religious beliefs play a very important role in how people cope with different sicknesses and problems that they face. Further, patients want their medical doctors not only to discuss their spiritual needs with them but also to integrate these spiritual needs in their treatment plans (Puchalski 2009). At the same time, religious beliefs are continuing to prevail across the populations of the world. A study conducted in the US in 2014 showed that more than 70% of adults identified themselves as Christians, while 6.7% identified themselves with other religions like Islam and Hinduism (Zaidi 2018). These figures do not seem to have

changed much in the 2020 census of American religion, where 70% of adults identify themselves as Christian and 5% as followers of other religions (PRRI 2020). In Africa, surveys on religious affiliation show that more than 9 in 10 Africans (95%) identify themselves with a religion (Brian 2020). This means that the greater percentage of the population, and thus the greater percentage of patients identify with one form of religion or another. In dealing with these patients, medical doctors may not ignore the extant religious health systems in the community, because the religious beliefs of the patients are more likely to influence their perceptions towards health and ill-health.

This paper explores the views of different Batswana health-seekers on the collaboration of various health systems in Botswana. The paper begins by exploring debates on collaboration between the medical and religious health systems in extant literature. It particularly develops a three-fold perspective model that explains the motivation behind the collaboration of these two healthcare systems. The paper then ends with a presentation and discussion of the views of health seekers on this collaboration as presented in the study carried out in Botswana.

### Literature Review on Collaboration of Health Systems

Literature reveals that collaboration between medical doctors, the clergy and other health systems in any given community is of paramount importance (Koenig, McCullough and Larson 2001). However, the rationale for the collaboration is presented differently in literature. Below, a model which presents three motivations behind the collaboration of healthcare systems has been developed from the review of extant literature. These are distinguished as ‘the absence of conflict’ motivation, ‘the absence of medical resources’ motivation, and lastly, ‘the complementary’ motivation perspective (see figure 1). These motivations for collaboration are critically discussed below. Later, the same motivations will be utilized in discussing the data from the field.



### ***‘The Absence of Conflict’ Motivation***

‘The absence of conflict’ motivation for collaboration holds that the medical and religious health systems should collaborate especially where there is no conflict between the two. This type of motivation is represented by Koenig et al. (2001) who are of the view that as long as there is no conflict between the religious beliefs of patients and their medical treatment, it is important to support these beliefs in one way or another, as this proves to be good for clinical care. Due to their commitment to protecting patients from harm, physicians find it difficult to accept religious decisions that may subject the patients to adverse health conditions (Curlin et. al. 2005).

However, at the same time, it seems reasonable to say that the patient-clinician relationship demands that the medical practitioner should go beyond ‘the absence of conflict’ motivation. Even when there seems to be conflict between the patient’s religious beliefs and their medical treatment, the clinician needs to collaborate with religious practitioners, helping the patient to find their way through the maze of these seemingly conflicting values. The clinicians should move beyond their comfort zone to empathize with their patients. Collaboration by definition does not imply absence of dissonance. It means recognizing first of all, that there is disagreement, but then, choosing to work together towards a greater goal, in this case, the health of the patient. As Puchalski (2009:804) argues, the “clinician’s ability to form a compassionate relationship with the patient is as important as that clinician’s ability to diagnose and treat the patient scientifically”.

### ***‘The Absence of Medical Resources’ Motivation***

While the preceding argument for supporting a patient’s beliefs seems to be limited to instances where there is no conflict between the patient’s religious beliefs and medical treatment, others ground the need to take the religious health system into consideration on the socioeconomic position of a given locality. This is the position that religious health systems are important because in some places, these are the only readily available health systems. In this instance, what creates the importance of the other (religious health system) is not the absence of conflict between the two systems, rather the absence of the other system (that is, modern medicine). In this paper, this is called ‘the absence of medical resources’ motivation for collaboration. Oshodi et al. (2018) argue that in some low- and middle-income countries, there is acute shortage of both human and physical medical resources and infrastructures to properly deal with certain ill-health. This shortage thus necessitates the need for alternative health systems to assist people to attain their health goals. The lack of medical resources in some developing countries and the predominance of faith-based remedies in these countries may not be denied (Samuels, Geibel and Perry 2010). However, basing the medico-religious collaboration on the lack of resources or shortage of medical manpower seems to indirectly water down the significance of the collaboration. This is because one may wonder whether the need for collaboration between the medical and the religious institutions in the healthcare of patients ceases when medical resources become available. Does the importance of religious belief fade away when one is faced with health challenges in places with adequate medical resources? Furthermore, thinking of religious healthcare system in this way seems to imply that consideration of religious beliefs of patients is only important in the absence of modern medicine. Thinking of collaboration from this point of view seems problematic and rather condescending to religious health care systems.

***'The Complementary' Motivation***

Besides the above perspectives, others argue that what necessitates the collaboration between medical health and other alternative health systems is the fact that different health systems have their own strengths that may be lacking in the other systems. For example, there are limitations in scientific medicine that needs to be complemented by the strengths available in other health systems. It is argued, for example that religious beliefs, as a complementary health system provides patients with the needed resilience and ability to cope with illnesses (Lion et al 2019). Of course, the downside of religious beliefs may be that due to the influence of their religious beliefs some patients may refuse to be assisted through the standard medical processes. However, even in this case the collaboration between the medical practitioners and religious leaders may go a long way in closing the gap.

Emebo (2006) maintains the perspective that there is need for other health systems to complement scientific medicine. He argues that a holistic approach to health care insists that while scientific medicine has made a lot of undeniable successes in the health care, it is not without limitations. Emebo argues that one of the major limitations of Western medicine is that it has been overly 'mechanistic' in its approach to healthcare, that is, treating a human body as if it was a machine, thus leaving out other aspects of a human person, that is, the emotional, the mental and the spiritual aspects. Similarly, Jonas and Jonas note that the common role taken by physicians is that, "The physician makes rounds, looking at the physical components of a patient's illness and body, and ordering tests – but rarely inquiring about their mental and spiritual needs" (Jonas and Jonas 2019:1). Hence, there is need for religious specialists to come alongside the medical practitioners in addressing the aspects that are often left out by the medical practitioner. In this more attractive perspective to collaboration, other health systems like the spiritual domain are not just seen as 'holding the fort' in the absence of Western medicine, but instead the collaboration becomes complementary and timeless in nature. Furthermore, instead of seeing the conflicting perspectives between the medical and the religious healthcare systems as a problem, these differences become the very reason that necessitates the collaboration between the two systems. At this level of collaboration, the practitioners from both ends say to each other, 'We are aware of our different approaches to health, but we share the client, and we also share the goal and the desire of seeing this client being healthy'.

Later on, when discussing the perspectives of health seekers towards the collaboration of healthcare systems in Botswana, it may be interesting to find out how those perspectives are related or unrelated to the motivations identified above. However, regardless of the motivation behind the partnership of the medical institutions and religious or spiritual health systems, it is argued that the collaboration may add value to the present and future health situations of the patients. Koenig et al (2001:445) argue that the partnership may add value, "in terms of ensuring patient compliance, increasing continuity of care and facilitating future referrals."

Collaboration between medical and faith practitioners is important because these two complement each other in addressing the questions that the patient may have regarding their ill-health. The two practitioners do not necessarily provide the same answer to the patient's situation. But it is interesting to note that these different answers are usually complementary rather than contradictory to each other. Jonas and Jonas (2019) note that when a patient makes an inquiry on their condition by asking the 'why' question, the

medical practitioner is more likely to provide physiological answers to the questions. The physician may, for example, answer in terms of the biochemical conditions of the patient, their genealogical circumstances or the risk factors involved in the condition of the patient. Contrastingly, to the same 'why' question, the faith practitioner may provide some existential answers to the condition of the patient.

Failure to collaborate between the various health professionals and spiritual/religious leaders can lead to detrimental consequences on the side of the patients. For example, research shows that many of the inpatients who visit the hospitals have several religious needs during their hospitalization. These religious needs are usually ignored if there is no proper collaboration between medical professionals and religious leaders. Koenig et al. (2001:445), for example observe,

...more than three quarters of medical inpatients had three or more religious needs during hospitalization. Many of those needs go unaddressed because patients do not volunteer them and health professionals do not ask; unfortunately, this "don't ask, don't tell" policy may be contributing to unnecessary emotional distress and physical morbidity.

### ***Challenges in the Collaboration and how to Promote Collaboration***

Having discussed the importance of collaboration between medical and faith practitioners, it is perhaps necessary to also acknowledge some challenges that may persist in realizing this collaboration and also discuss some suggestions that have been made in dealing with some of these challenges. One of the glitches that arise in the medical and faith partnership is the problem of language and communication (Jonas and Jonas 2019). For proper collaboration between medical and faith practitioners, there ought to be a common language of communication between them. For example, it seems that there is no shared understanding on the concepts around the constituents of a human person that need to be addressed, that is, whether practitioners are dealing with the dualist perspective of mind and body or the tripartite notion of spirit, soul and body. These are of course age-long issues that still continue in philosophical debates today, which perhaps demand understanding of different perceptions rather than trying to achieve common answers to them.

It seems that one effective way to promote collaboration between medical and faith practitioners is to instill this partnership earlier on in the life of both medical practitioner trainees and the pastors to-be, where both parties are introduced to the basics of each other's world. Koenig et al. (2001) argue that for collaboration to take place for example between health professionals, and in particular the future physicians and the future pastoral leaders (church leaders), there has to be an earlier interaction when they are undergoing training as students. They should take some courses together and even do some clinical duties together.

Perhaps the above discussion addresses the problems which were cited by others, that physicians do not have the time nor the training to deal with patients' religious beliefs (Sloan 2009). As noted earlier, many medical universities have introduced courses on spirituality to provide future physicians with foundational understanding on these issues. Collaboration is meant to also address the view that physicians do not have the time to deal with patients' religious beliefs. Instead of the physician trying to singlehandedly deal with spiritual matters that the patients have, the community faith leaders could be brought

on board. Hospitals may allow for visitation of community clergy, permit access to religious and spiritual resources such as religious inspirational literature, radio and television based religious programs, permit time for the offering of prayer by religious leaders, and even providing interaction time with patients to discuss their religious or spiritual concerns. One way to establish interaction between healthcare providers and the religious professionals is by establishing a “parish nurse program” (Koenig et al 2001:447). A parish nurse is a professional nurse who is also part of the religious institution(s) in the community. Given her/his ambidextrous position, she/he is able to contextualize and promote healthy lifestyles that take into cognizance both the medical and the religious contexts.

Another important way to promote collaboration is by considering the patients religious history, that is, besides their medical history (Koenig et al. 2001). When a medical practitioner is aware of the religious history of a patient, they are able to support and encourage those religious beliefs and behaviors that may assist the patient in dealing with their ill-health.

Having discussed the significance of the collaboration between medical and religious practitioners as presented in extant literature, the next section discusses perspectives and experiences of the members of the community (health seekers) regarding collaboration between health systems, as presented in a study carried out recently in Botswana. However, this is preceded by a brief discussion on the methodology that guided the study.

### Methodology

The discussions of this paper are based on a study carried out in Botswana between July 2018 and September 2019, entitled, “The Impact of Religious Beliefs on Health Seeking and Health Provision Behaviors in Botswana”. The study covered perspectives of key players of various health systems, such as medical doctors and nurses, traditional healers and faith healers (church pastors), together with the views of health seekers, on the collaboration of these various health systems. The main aim of the study was to investigate how religious beliefs impact health seeking and health provision behaviors among Batswana and, from the findings, to propose review of theological, medical and health education for the purposes of promoting holistic health through the integration of medical, traditional and faith healing. However, the present paper concentrates on the responses of health seekers towards the collaboration of medical practitioners on one hand and traditional healers and faith healers (church pastors) on the other.

Qualitative data (through individual and focus group interviews) and quantitative data (through structured questionnaires) were collected from 826 respondents across the country, covering places like Hukuntsi, Tsabong, Molepolole, Letlhakeng, Gaborone, Mahalapye, Maun, Tutume, Bobonong, and surrounding areas of these major places. Respondents were randomly selected from the general population that affiliates to Christian and traditional beliefs. The data covered the views of health seekers on the relationships of medical practitioners (physicians and nurses), traditional healers (*Dingaka tsa setso*) and faith healers (church pastors and prophets); and also, how these relationships affect them as health seekers. The data was transcribed and coded. It was analyzed through thematic analysis where emerging themes and patterns were recorded.

## Findings and Discussion

The findings of the study as presented below show the situation of the collaboration of different health systems from the views of the health-seekers (the general community). The views of the health seekers are based on their interaction with the different health-providers like traditional healers, faith healers (pastors of different churches) and modern medical doctors. The data shows that there are some persisting problems in the collaboration between these various health systems.

### *Collaboration with Traditional Healers*

From the study, it appears that the nature of collaboration between medical healers and traditional healers affects the way the members of the community perceive and respond to these various health systems. For example, it was noted that due to the negative perception medical practitioners have towards traditional healers, many members of the community are embarrassed to show that they seek assistance from traditional healers. They instead secretly seek for the services of traditional healers. Table 1 below shows the views of health seekers towards traditional healers. The responses presented in the table constitute part of the quantitative data, which was presented in a Likert scale of 1 to 5, where 1 represents strongly agree, while 5 denoted strongly disagree.

*Table 1: Health seekers' views on why people secretly consult traditional healers*

	1. Many people think it is embarrassing to confess that one seeks health service from traditional healers.	2. Many people seek the services of traditional doctors in secret.	3. Medical doctors/nurses should discuss their patients' beliefs and use of traditional medicine.	4. A medical doctor/nurse has discussed with you your beliefs and use of traditional medicine	5. Do you feel free to discuss your beliefs and use of traditional medicine with your doctor/nurse	6. Your faith allows you to visit traditional healers whenever you are ill.	7. Your faith encourages the use of traditional herbs.	8. Your faith encourages you to seek health from only traditional healers.
Total	2.18	1.78	2.61	3.78	2.90	3.65	3.66	4.31

The first two questions deal with whether health seekers are free to consult with alternative health systems, in this case, with traditional healers. The table above shows that many health seekers agreed that people find seeking health services from traditional healers as embarrassing, thus, they sought the services in secret. Similarly, in the qualitative data collected via interviews, health seekers elaborated that some people are embarrassed to confess that they make use of traditional healers' services and thus they consult them in secret because traditional healers are usually associated with witchcraft; they are labelled as witches and witchdoctors (HUHS001<sup>1</sup>). The negative perception towards traditional healers is confirmed in the different statements made by the respondents. For example, traditional healers are accused of doing "unspeakable things" (FRHS001), which include the view that they are used to bewitch others and that people use them to execute "revenge" on others (MAHS001). There is generally a stigma attached to traditional health

<sup>1</sup> HUHS001: These are anonymous codes used throughout the study to represent the different respondents.

practice (BOHS002). The respondents noted that given that many of the traditional healers are not officially recognized, they may not be liable to account in case some complications arise out of their practice. Hence, they are stigmatized (FRHS003). Further, some churches are said to be preaching against traditional healers, thus exacerbating the stigma towards them in the community (HUHS001).

From the above data there seems to be some looming problems with the collaboration between medical practice and traditional healing practice. While there is a stigma associated with traditional healing practice, people continue to consult them, mostly in secret as demonstrated by the Median=1.78 (agree to strongly agree) in Table 1 above. One wonders whether this secrecy in the consultation of traditional doctors is good for the general health of the patients. Earlier, I identified three motivations behind the collaboration of healthcare systems, which I distinguished as 'the absence of conflict' motivation, 'the absence of medical resources' motivation, and lastly, 'the complementary' motivation perspectives. It appears that the first two motivations towards collaboration may not help to address the problem of embarrassment noted here by the health seekers. Instead, these two types of motivation may perpetuate the embarrassment and secrecy in the patients' consultations with alternative health care. For example, where patients sense some possible conflict between their religious beliefs and modern medicine, they may continue to secretly use such traditional 'reliefs' (like traditional *muti*/medicine). But if they are aware that there is a close complementary collaboration between medical doctors and traditional healers in the community, this may help to arrest the problem of embarrassment towards the use of traditional health systems, and perhaps even help them to speak openly and avoid unnecessary secrecy.

In fact, from the responses of the health seekers on the next question, one may deduce the problems of this secrecy. The next question (question 3) was on the views of health seekers on open discussion of their use of traditional medicine and services. While a few respondents actually affirmed that their medical doctors or nurses asked them about their beliefs and use of traditional medicines, most respondents stated that they are never asked about these (M=3.78, disagree). However, most of the respondents felt that it is important for medical doctors and nurses to ask for this information (M=2.61). From the data obtained through interviews, health seekers gave the following as what they perceive as the reasons why medical practitioners should inquire of the history of the patients' consultations with traditional healers. The respondents argued that if medical practitioners were to inquire on the history of the patients' consultations (including their prior consultations with traditional healers), they will know how best to treat these patients having understood their medical background (FRHS001, BOHS002, and FRHS001). Further, the medical practitioners will be able to appreciate the faith of their patients (BOHS001). Due to their understanding of the entire medical history of the patient, they may be able to avoid administering medication which will be contrary to, or which may react with the traditional medicine that the patients may still be taking (TSHS001).

The reasons forwarded by the health seekers then seem to suggest that it is necessary for medical practitioners to collaborate with traditional healers, if anything, for the sake of the good health of the patients. If there is lack of collaboration, then there may be some gaps in the information which health seekers perceive necessary for their health. Going back to the motivations for the collaboration as discussed in the first sections of this paper, it appears that health seekers are aware of the fact that from time to time, the medical practitioners may have to deal with extant contradictions between the medical plan recommended by the physicians and the religious background of the patients. Hence, we

see responses that suggest that when there is collaboration, “The medical practitioners may be able to avoid administering medication which will be contrary to, or which may react with the traditional medicine that the patients are still taking” (TSHS001). Such a response suggests the importance of the ‘complementary’ motivation to the collaboration above the other motivations discussed.

This complementary perspective to the collaboration of different healthcare systems is in fact buttressed by the view of the health seekers where they argued that there are certain diseases and health problems that are better dealt with by medical practitioners and those which are better attended by religious specialists like traditional doctors or pastors. They argued for example that there are certain diseases like *phogwana* (sunken fontanelle in babies), traditional poison (*sejeso*), epilepsy (*mototwane*), stroke (*go swa mbama*), syphilis (*rasephiphi*), some sexually transmitted infections (*Go lomina*), migraine headache (*tlhogo e tona*), which are better attended by the traditional healers. The table below shows some of these responses. Just as Table 1 above, the results are taken from the quantitative data, which was presented in a Likert scale of 1 to 5, 1 representing strongly agree, while 5 denoted strongly disagree.

Table 2: Health Seekers' Views on Medication

View	Mean
When you are ill you always seek help from the hospital/clinic first.	1.55
When you are ill you always seek help from the traditional healer first.	4.11
When you are ill you always seek help from the faith healer ( <i>moruti</i> ) first.	3.02
When you are ill, the type of illness determines where I first seek help.	2.62
Your religion encourages the use of modern medicine	1.72
Your faith encourages the use of healing water, oil or powers from faith healers	2.42
Your religion encourages the use of traditional herbs	3.67
Use of any medicine shows lack of faith in God's healing power.	3.88
A doctor/nurse can treat BP, diabetes and cancer.	2.34
A doctor/nurse can treat mental illness	2.61
A doctor/nurse can treat <i>thibamo</i> (when a baby is in a breech position at childbirth)	3.24
A doctors/nurse can treat <i>boloi</i> (witchcraft)	4.54
A doctor/nurse can treat <i>phogwana</i> (sunken fontanelle in babies)	3.67
A doctor/nurse can treat <i>boswagadi</i> (widowhood-related disease)	4.35
A faith healer can treat BP, diabetes and cancer.	3.23
A traditional healer can treat BP, diabetes and cancer.	3.82
A faith healer can treat mental illness.	2.98

The results reveal that health seekers agreed that modern medical services can treat such health problems like BP, diabetes and cancer (M=2.34) and mental illness (M=2.61). They were neutral when it comes to medical doctors' ability to treat *thibamo* (when an unborn baby is in a breech position) (M=3.24) and out rightly disagreed that they can treat *boloi* (witchcraft) (M=4.54), *phogwana* (sunken fontanelle in babies) (M=3.67) and *boswagadi* (widowhood-related disease) (M=4.35). It can be gathered from these results that whilst respondents confirm medical practitioners' capability in treating BP, diabetes, cancer and mental illness, they however, doubt these practitioners' ability in healing Setswana (traditionally) related diseases. These views seem to underscore the need for collaboration of different health practitioners in order for them to complement each other in the promotion of the health of the communities.

In the next section, the collaboration of different health systems is discussed from the experiences of health seekers with faith healers.

### ***Consultation with Faith Healers/Church Pastors***

Most respondents said that their churches practiced faith healing through use of mediums such as water (either from the rivers or just tap water) (HUHS001, and FTHS003), oil (GAHS001), *divacho* (holy ash) (MAHS002), and tea (BOHS001). While a few respondents stated that they only seek health services from their church (TSBHS001, and FTHS003), many of the health seekers stated that they actually seek for health services from other churches as well (HUHS001, GAHS001, and FTHS002).

On the question whether health seekers secretly consult faith healers, it may be interesting to note that unlike in the case of traditional healers, those who consult with faith healers pointed out they are never embarrassed to confess that they seek help from faith healers. Therefore, they do not consult faith healers in secret. This will imply that within the communities under investigation, the stigma attached to consulting traditional healers is not found with consulting church pastors. Besides the view that traditional healers are usually associated with witchcraft as stated above, it is worth noting too that some respondents mentioned that the churches themselves preach against the consultation of traditional healers.

Notwithstanding the above, some respondents pointed out that those who secretly consult faith healers do so because some of the prophets that are consulted are uncertified or their churches are not legally registered (TSHS001). Others secretly consult faith healers because they fear that they may be criticized by their pastors and fellow members for asking for spiritual help from other churches (BOHS001, and BOHS002). For example, one respondent said that the reason for secretly visiting other churches for help is that, "...sometimes members are afraid to disclose that they got assisted from other churches because it will show that the other church is more powerful than theirs" (BOHS001). While the study focused on collaboration between the three health systems, the modern medicine, traditional healing, and faith-healing, this latter comment presents an interesting challenge in the collaboration among churches themselves. Collaborations at this level may be challenged due to denominational competition, the 'more powerful than thou' mentality, which seems to present an obstruction for health seekers to seek for help in the different extant churches.

The health seekers were asked whether they are open to discuss with their medical doctors concerning the use of faith healing remedies. The interviews revealed both affirming responses, (that is, cases where doctors and nurses actually asked their patients of their beliefs and use of faith healing) and denying responses. All the respondents, however, affirmed that they would want their doctors or nurses to ask about their beliefs and use of faith healing. They provided the same reasons given under the consultation of traditional doctors. For instance, they noted that by asking the patients of their history with other health systems, this may avoid a situation where the medication prescribed works contrary to substances that the faith healers have recommended previously. Further, they pointed out that if doctors converse with patients regarding their faith, this may create confidence in the patients, rather than embarrassment when they consult their faith healers.

It is important to note that among those who seek health service from churches, there was a more holistic approach towards health seeking, that is, the respondents would go to the hospital or clinics and then go to the churches if the problem persists (MAHS002, and FRHS001). This is depicted in responses like, “First, I consult modern medical practitioners then I go to church” (FTHS001 and FTHS001). Another related response was that “I first go to the clinic for a diagnosis. If it’s possible, then I go to the church then traditional healers, checking where I can get better and be healed” (MAHS002). The same respondent argued that it is important to seek modern medical attention in order to obtain some diagnostic facts on the sickness one is suffering from rather than just assuming spiritual causes, such as witchcraft. Quantitative data too, confirmed the predominance of a holistic approach to health among health seekers, in that most health seekers agreed (M=2.62) that when they are ill, the type of illness determines where they first seek help. These comments too seem to emphasize that according to the health seekers, the best model to the collaboration of different health systems in the community is one based on a ‘complementary’ motivation discussed in this paper.

### Conclusion

From the findings of both traditional medicine and faith healing, health seekers are of the view that there has to be collaboration between medical practitioners and alternative health systems, that is, traditional doctors and faith healers. The stigma attached to consultation of alternative health systems especially traditional healers does not seem to be helping the delivery of health for the patients. The findings suggest that when openness is encouraged, such that health seekers are free to discuss with their medical doctors about the kind of assistance they obtained from other health systems, this will be a step ahead in the right direction. Collaboration between medical doctors and other alternative health providers will help all parties involved to contribute positively to the health plans of the patients. The findings from the study seem to support the ‘complementary’ motivation model to the collaboration of medical practitioners and religious specialists in the community. This is a collaboration where the significance of alternative health systems is not dependent on nor justified by the absence of modern healthcare. Instead, alternative health systems are seen as timeless partners to modern medicine for as long as religious beliefs are part of human existence.

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**Abel Tabalaka** (PhD) is Lecturer in African Philosophy and Business Ethics at the University of Botswana, Gaborone, Botswana.

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### REFERENCES

Emebo, Blaise. 2006. *Healing and Wholeness in African Traditional Religion, African Islam and Christianity*. Aachen, Germany: Shaker Verlag.

Curlin, Farr A., C.J. Roach, R. Gorawara-Bhat, J.D. Lantos, M.H. Chin. 2005. Patients Choose Faith Over Medicine: Physician Perspectives on Religiously Related Conflict in the Medical Encounter. *Arch Intern Med.* 165:1, 88–91. doi:10.1001/archinte.165.1.88.

Howard, Brian. “Religion in Africa: Tolerance and Trust in Leaders are High, But Many Would Allow Regulation of Religious Speech” *Afrobarometer*, 339, Last modified 28<sup>th</sup> January 2020.

[https://afrobarometer.org/sites/default/files/publications/Policy%20papers/ab\\_r7\\_dispatchno339\\_pap12\\_religion\\_in\\_africa.pdf](https://afrobarometer.org/sites/default/files/publications/Policy%20papers/ab_r7_dispatchno339_pap12_religion_in_africa.pdf)

Jonas, Wayne B. and M. Jonas. 2019. Faith-Health Collaboration to Improve Community and Population Health’ National Academy of Medicine, *NAM Perspectives*. Commentary, National Academy of Medicine, Washington, DC.

Koenig, Harold G., M.E. McCullough and D.B. Larson. 2001. *Handbook of Religion and Health*. Oxford, Oxford University Press.

Lion, Alex H., J.L. Skiles, B.N. Watson, J.D. Young, A.M. Torke. 2019. Chaplain Care in Pediatric Oncology: Insight for Interprofessional Collaboration. *Pediatr Blood Cancer*;66:e27971. <https://doi.org/10.1002/pbc.27971>.

Oshodi, Yewande O., E.R. Ogbolu, P.N. Oluseun, A.T. Onajole, G. Thornicroft and J.D. Adeyemi. 2018. Medico-Religious Collaboration: A Model for Mental Healthcare in a Resource Poor Country, *Nigerian Journal of Medicine*, 26, 4.

Post, Stephen G. 2009. ‘The Perennial Collaboration of Medicine and Religion”, *American Medical Association Journal of Ethics*, 11, 10, 807-811.

PRRI, “The American Religious Landscape in 2020”. PRRI. Last updated 08<sup>th</sup> July 2021. <https://www.prri.org/research/2020-census-of-american-religion/>.

Puchalski, Christina M. 2009. Ethical Concern and Boundaries in Spirituality and Health, *American Medical Association Journal of Ethics*, 11, 10, 804-807.

Samuels, Fiona, R. Geibel and F. Perry, 2010. Collaboration between Faith-based Communities and Humanitarian Actors When Responding to HIV in Emergencies, *Project Briefing*, 41, May.

Sloan, Richard P. 2009. Why Patients’ Religion is not their Doctor’s Business, *American Medical Association Journal of Ethics*, 11, 10, 811-815.

Zaidi, Danish. 2018. Influences of Religion and Spirituality in Medicine, *American Medical Association Journal of Ethics*, 20, 7. 609-612.

# Interprofessional Collaboration of Health Care Providers in Botswana: A Holistic Approach to Health Care

Tshenolo Jennifer Madigele and Abel B. Tabalaka

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## Abstract

Notwithstanding the availability of Western medicine across the country, many of Batswana continue to utilize either of the three or all available health systems; namely traditional, Western and pastoral systems of healing and care. There is therefore a need to develop models of collaboration that promote a workable relationship between these three health systems. This paper seeks to establish the possibility of the interprofessional collaboration by medical professionals, African traditional healers and pastoral care givers in Botswana health care system. It is based on both primary and secondary data collected for a period of two years in Botswana. Although it used mixed methods, the study was primarily qualitative in nature. The paper advocates for holistic care as it acknowledges attention to all dimensions of human existence and ultimate healing. It also calls for the implementation of interprofessional health policy in Botswana, collaborative patient centred practice, changes in attitude towards interprofessional collaboration and for the development of interprofessional curriculum in our local educational institutions.

**KEY WORDS:** Health, Collaboration, Health Care Professionals, Holistic Care, Interprofessional, Patient-Based Care

## Introduction

Studies on health and healing in the African region and specifically in Botswana show that in spite of the widespread use of Western medicine and consultation for modern health practitioners, Batswana continue to utilize alternative health systems, particularly traditional and faith healing systems (Togarasei, Mmolai and Kealotswe 2016). Earlier studies on the status of traditional medicine and complementary or alternative medicine: revealed that there are about 3100 traditional health practitioners in Botswana, of which approximately 95% of them reside in rural areas (WHO, 2001). Further, the National Development Plan of 1976–1981 had acknowledged that “Although not part of the modern health care system, the traditional healer (*ngaka*) performs a significant role in Botswana, especially in the rural areas” (NDP 1981). A more recent study that investigated the prevalence in the use of traditional, complementary and alternative medicine in

Botswana shows that 48.9% of the population under study utilized traditional, alternative and complementary medicine (Ntsetselele 2017).

Moreover, the former Minister of Nationality, Immigration and Gender Affairs, Mr Edwin Batshu noted that the Societies Act had registered 2 238 religious organizations in Botswana as at 30 June 2017. He added that Hindu had registered four, Muslims seven, Rastafarian five while Sikh had registered two. Christian churches on the other hand have registered 2 218 (Danani 2017).

Looking at the statistics provided by the Societies Act, Christian Churches registered constitutes about more than ten percent of the population of Botswana. It could therefore be concluded that most of Batswana are members of Christian churches. Scholars maintain that religious faith and practices have a central role in the lives of many people, especially during illness (Hirsto and Tirri 2009). This means that the impact of Christian religion on people's health should not be undermined. The existence of traditional practitioners and their impact on human health can neither be denied.

This paper is therefore an attempt to engage the health and hospital care delivery system in Botswana made up of medical, traditional healers and pastors on the need to appreciate interprofessional collaboration in patients' caregiving to promote holistic care of the sick. The paper argues that even though the National Development Plan of 1979–1984 promised to improve mutual understanding between the Ministry of Health and traditional practitioners, health system in Botswana is highly fragmented and linkages between different levels are weak. Little is captured about the relationship between traditional healers, medical doctors and pastoral care givers or chaplains in Botswana.

This paper is based on the view that pastoral care and traditional healing resources and practices should be of recognizable value to the health care system in Botswana, and as such the inclusion of pastoral care, medical care and traditional healing in hospital care could contribute to holistic and quality hospital care for patients' satisfaction. In order to bring across this position, we begin below by attempting to conceptualize health from various perspectives.

### **Conceptualising Health**

Scholars approach the definition of health from different perspectives, such as the religious/theological, medical and cultural dimensions. However, it appears that what often influence the definition that the different scholars hold are their metaphysical notions of what human reality consists of. Most sources acknowledge the multifaceted nature of human reality. For example, the World Health Organization holds that health is not simply the absence of disease. It covers holistic well-being in the physical, mental and social aspects of human-beings (WHO 2008). This definition is dualistic in nature as it appreciates the two entities, the body –“Physical” and the mind—“mental” as aspects that may be affected by ill-health. The inclusion of the “social” sphere in this definition does not seem to add any other distinct aspect to human reality. It seems to simply appreciate how an individual's health may be affected by their relationship with other “mind[s]” and “body[-ies]”. This definition thus overlooks the third dimension of human life, which other sources include. For example, health has been defined as “optimal functioning of the human organism to meet biological, psychological, social and spiritual needs” (Ashley and O'Rourke 1997). From this triad definition of health, we don't only see an appreciation of

the mind and the body as entities that make up a human person, but also the third aspect, the spirit. Like the previous, this definition also brings in the relatedness of a human being to others, (the “social needs”) as important to health.

From the preceding, it would seem that defining health should include not only how the metaphysical notions of body, mind, and/or spirit may be affected, but also how these realities of an individual person interact with other humans. In fact, others in their definition of health expound the relatedness of humanity to other beings and realities, that is, other than humans. Cook for example defines health in terms of relationships with God, self, others and the environment (Cook 1990).

The table below actually demonstrates how the different dimensions of human existence can contribute to ill health:

*Table 1: Dimensions of Human Existence*

	Physical	Social	Psychological	Spiritual
<b>Deals with</b> <b>I AM ...</b>	Body Material world Nature	Place in society Relations	Identity character traits Thinking and feeling	Soul Meaning Self-transcending ideals
<b>Values</b> <b>ENERGY,</b> <b>time, money</b>	Health Safety Comfort	Esteem, succes Connection	Autonomy Freedom Knowledge Authenticity	A better world, Consciousness of unity 'Being values'
<b>Threats</b> <b>WORRIES</b>	Pain, sickness Death Poverty	Rejection Loneliness Guilt, shame	Confusion Doubt Imperfection	Meaninglessness Futility Evil
<b>JOY</b> Perennial philosophy	BEAUTY	GOODNESS	TRUTH	LOVE

*(Leijssen, 2014; van Deurzen, 2009)*

From this table, one may appreciate how one type of health system, for example, allopathic health system, may not singlehandedly address health needs of humanity. At least it seems logical to hold that allopathic medicine may easily deal with certain threats like physical pain and sickness than they can with a feeling of meaninglessness or loneliness. Someone's ill health may have emanated from societal rejection or lack of understanding of the meaning of life. Therefore, remedies like forgiveness of oneself and the people we live with may guarantee good health. For example, it is argued that the physical and mental health benefits of forgiveness can be amazing, regardless of age, gender or even the most unimaginable hurts (Worthington 2006, Witvleit and McCullough 2007). Reconnecting with God and understanding the meaning of life during stressful situations may therefore yield positive outcomes in health.

Thinking of health from these various realms demonstrates the need for a multifaceted health care, which addresses all these aspects of humanity. This understanding of the multidimensional notion of health and healing is underscored in the literature (Van Deurzen 2008, 2009) and indeed buttresses the understanding of health care that is crucial to this paper. This paper aims at contributing something further to the mainstream or conventional understanding of health care in Botswana. It could be maintained that health

care professionals are challenged to acknowledge the complexity of the human beings that they treat. Based on the discussed understanding of health and care, this paper asserts that health care should address a multi-dimensional being, should be holistic, culture sensitive and patient based. The multifaceted nature of illness makes it impossible to address healing from one perspective only. In fact, according to the World Health Organization, “the medical model which seeks to treat patients by focusing on medicine and surgery and gives less importance to belief and to faith in healing ... is no longer satisfactory” (WHO 1998). Therefore the medical model, which may be effective in treating illnesses, should be holistic in nature.

Holistic care is understood in this paper to refer to caring for the whole person. This caring model should focus on the therapeutic interventions that are directed to meet the needs of the whole person. This paper also argues that healthcare professionals need to learn to recognize their own cultural beliefs and attitudes as well as the cultural beliefs and attitudes of the different people they serve; understanding and respect develop through this recognition. Health care is vital to people in general and leaving it exclusively to medical professionals may not be a very helpful approach.

Having explored the meaning of health and implications of this meaning, the next section looks at the concept of collaboration among different health providers. Actually, one may argue that the concept of collaboration is implied in the very meaning of health. If the aspects of a human being that need health attention are diverse, and each of the available health systems address specific aspects of this health, from this logic, it follows then that collaboration of the various systems is required for the restoration and maintenance of the patient's wholeness.

### **Collaboration of Health Care Providers**

If collaboration is to be properly realized, it ought to be properly understood. Collaboration is understood as a process through which members of different disciplines contribute to a common goal that cannot be reached when individual professionals act alone (Bronstein 2003). This means that a collaborative process demands that one should appreciate that their contribution or their expertise is important but not adequate, by itself. The last part of this statement is probably the most difficult for professionals to deal with, and thus warrants some emphasis. Collaboration demands that a professional should deliberately step out of one's professional pride to appreciate the other. The 'other' here is used to distinguish between the practitioner and other practitioners that may be outside one's professional purview. Further, the 'other' is used here to distinguish between the practitioner and the patient. In both cases, the practitioner is cautioned to deliberately confront any overt or covert professional bigotry. Collaboration demands that the practitioner should not let their individual or professional prejudice to blind them from genuinely seeing the significance of other alternative health practitioners and from failing to put the interest of the patient at the forefront.

Clinebell argues that “in a society that fragments persons and relationships, it is imperative that healers get together. Otherwise, they will continue to contribute to the splintering of contemporary man” (Balch 1991:47). These words are very relevant to our health care system in Botswana. If the aim of care giving is directed to improving ones' health, and if healing is patient centred, interprofessional collaboration should not be a problem. Campbell *et al.* (2005:31) remark that:

... the most dangerous practitioner is the 'loner' who attempts to work in isolation from colleagues in the field, and without reference to those who have different expertise either within the medical disciplines or other professional field. In order to work in the best interest of patients, every practitioner must learn to share the decision-making process with others, to consider alternative diagnoses and treatment, and to find correction or support when the decisions are especially difficult and uncertain.

The danger lies with the fact that one who fails to collaborate with others is somewhat tempted to ignore what we discussed in the previous section as the multifaceted nature of human reality. Such an individual goes ahead to attend to 'an aspect' of human reality as if it were the whole person. Collaboration is therefore an ethical and moral responsibility that medical professionals, pastoral care givers and traditional healers should have towards the sick despite the challenges. In cases where health care providers see that there is need for other systems of care which contradicts theirs, it is imperative to do transfers. This view entails that it is imperative to serve the interests of those that seek help rather than serving one's personal interests.

Collaboration also demands that a practitioner should step out of their 'world' into the realities of the world of those they are serving, that is, the world of the patients. A practitioner, for example, may come from a background that recognizes allopathic remedies as the only solution to human ailing. But in their medical practice, they now need to appreciate the worldview of their patient, which may be different to the worldview of the practitioner. For instance, in health seeking, most Africans simultaneously combine the efforts of traditional healers, health practitioners and pastoral care. This health seeking behavioral pattern is particularly informed by the African understanding of a holistic approach to life and its importance to health. A holistic approach and readiness for different remedies in African thought was demonstrated through a study according to which traditional healers expressed a lack of appreciation from Western medicine. However, they were open to training in Western biomedical approaches and in establishing a collaborative relationship in the interests of improving patient care. On the other hand, Western biomedically trained practitioners were less interested in such an arrangement (Campbell-Hall et. al. 2010). If we are to go by these findings, one may then say that a holistic approach to healing, which demands a collaborative relationship between different practitioners seems to be analogous to African world view. In this world view, it is the other that is given preeminence. Collaboration therefore involves working towards measurable goals for utilitarian reasons or for the greater good.

### **Approaches to Health**

Having explored the meaning of health and collaboration, at this point the paper explores the common approaches to health in Botswana. If collaboration of health systems is to be a success, it seems necessary to have some clarity on how each system approaches health and healing. In this way then not only the differences will be appreciated, but also the points that necessitates the synergies between the systems. In every society, there are various systems that have been developed in order to maintain and restore health and general well-being (Figueras and McKee 2012). These systems will usually consist of the allopathic or professional health systems and the alternative medical system (McCleod and Chung 2012).

Besides allopathic health system, in Botswana the most common approaches of health are traditional African health and pastoral health systems. The systems are influenced by differences between cultures and their understanding of health and disease. It is also undeniable that philosophical approaches to life may determine access and utilization of different health services in a given locality.

Basically, the modern system of medicine and the alternative health systems have diverging perspectives towards what causes ill-health, and thus how to ameliorate situations of ill-health. The traditional and pastoral health systems, whilst administering healing, look into the world of the spirit to know the origins of a sickness. For example, for traditional healing, ancestors are consulted for direction and instruction. On the other hand, the allopathic system looks at material causations in treating illnesses. Whereas in Western biomedicine ill-health is approached from the perspective of 'what' caused it and 'how', traditional healing deals with 'who' caused it and 'why' (Juma 2011). The type of knowledge applied in these systems also differs. The allopathic is characterized by the application of scientific medical knowledge and technology to health and the healing process (Kreitzer, Kligler and Meeker). On the other hand, the traditional and pastoral health systems rely exclusively on observation and practical experience, handed down from generation to generation verbally or in writing (WHO 2002). Cultural experience plays a very significant role in the traditional health system. In this health system, culture becomes, "the bridge to the past as well as a guide to the future" (Carpenter 1960). Tapping into the peculiarities of how people in a given place think and what they value, provides materials for the maintenance and restoration of their health.

From the preceding, it seems that the wealth of knowledge within which each health system develops is distinct and may be of some significance to the patient. While the allopathic constitutes knowledge gathered from a general study of human ailments, the traditional health system is informed by the wealth of knowledge developed over the years from the local experiences on sicknesses and diseases. Having discussed the peculiarities that each health system brings into the collaboration, perhaps one would want to understand the challenges that arise in the collaboration of the various health systems. These are derived from a recent study that was carried out in Botswana.

### **Complexities of Collaboration – A Botswana Study**

A fifteen-month mixed-methods study that revealed the complexities of collaboration between different health systems in the country was carried out between July 2018 and September 2019 in Botswana. Through the use of both interviews and questionnaires, the study collected data on the views of health seekers and the different health providers, like the medical health practitioner, traditional healers and faith healers in Botswana on causes of illnesses, medication and collaboration of different health systems. Both focus-group discussions and in-depth individual interviews were used to collect data from 826 respondents. This paper, however, focuses on the views of different health providers in the study. Through purposive and snowball sampling methods, participants were identified and interviewed from eight different geographical areas, representing the north-south and rural-urban areas of Botswana. The three types of health systems in Botswana were represented in the study, namely, modern medicine, traditional healing and faith healing (churches). The modern medical system was represented by medical doctors, nurses and other health practitioners from different hospitals and clinics in the country, while a pull of pastors and church leaders were drawn from the three Christian umbrella organizations

in the country, namely, the Botswana Christian Council, the Evangelical Fellowship of Botswana and the Organization of African Independent Churches.

From the study several challenges and obstacles towards collaboration of different health systems were identified, which are discussed below. In discussing these challenges, it will be observed that some suggestions were made from the field as possible ways of dealing with some of the challenges.

### ***Prevalence of One-sided Referral***

The study showed that while faith healers and traditional healers were willing to collaborate with medical health practitioners, the latter were not equally keen about the collaboration. One faith healer, for example, expressed his willingness to collaborate with medical practitioners by saying,

... my wish is that the hospital practitioners should send patients to us, that is, when they meet some hitches in the treatment, so that we try our best in treating the patients and then give feedback to the medical doctors. My desire is to have direct communication with hospital practitioners; A situation where I can say to them, "I have this patient, may you check him/her for me? So far I have administered such-and-such treatment; I began here and ended there. That is my desire" (MAFH003)<sup>1</sup>.

Traditional healers too, confirmed that they collaborate with modern medical personnel by referring patients to them. They pointed out that there are a number of instances in which they would refer their patients to medical practitioners, such as when there is need for different scientific tests, for example blood tests and/or blood transfusion, when a person requires hydration, and when a patient is too weak. One of the traditional healers acknowledged their limitations saying,

Yes, I do (refer patients to medical practitioners) because like I said, some illnesses are a result of the nature of a human body ... I have not learned how the body works which means it is not easy for me to treat the body like those who have been trained on how it works (GATH001).

As argued earlier when defining collaboration, this bold acknowledgement of one's own limitation while at the same time appreciating the contribution that others may bring to the table is a very important ingredient towards healthy collaboration of different health systems. However, it is important to note that while other practitioners referred patients to medical practitioners, the medical practitioners rarely referred patients to them. When asked whether medical doctors referred patients to them, one of the faith healers noted with disappointment, "No, it has never happened. It is rather us who refer patients to them" (TSFH001). The prevalence of this one-sided referral was also confirmed by the medical practitioners themselves who responded overwhelmingly that they usually do not refer patients to faith healers nor to traditional healers. In the few instances where patients were referred to alternative health providers, it was for them to receive pastoral counselling

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<sup>1</sup> MAFH003: These are anonymous codes used throughout the study to represent the different respondents. To maintain the anonymity of the respondents, respondents from different study sites were assigned codes.

and prayers. Faith healers also acknowledged that medical practitioners allow them to visit patients in hospitals to pray for their healing.

It may be interesting to note that notwithstanding this predominantly one-sided referral, the faith and traditional healers strongly felt that they have a greater influence on decisions that patients make, that is, more than medical practitioners. In this way they argued that ignoring them is futile. Hence, they argued for necessity of collaboration. To demonstrate their influence over the patients' decisions, one faith healer said, "if I tell 100 people in the community to stop taking modern medication, and the medical doctor tells the same 100 people to continue taking the drugs, I will win!" (MAFGDHP). Thus the alternative health providers felt that their influence over the daily decisions that patients make regarding their health necessitates that they should be taken as important collaboration partners in health matters.

### ***Lack of Formalised Records for Referrals***

Having pointed out that other health providers are willing to collaborate with medical professionals in the hospitals and clinics, and that they actually make referrals to the hospitals and clinics, they however regretted the fact that the referral system is not formalized and that there are no records for the referrals. One of the faith healers for example said,

The problem is lack of some sort of evidence to show that a patient is referred to the medical doctor from a faith healer. There must be a sort of booklet or a card that shows that a patient was assisted by a faith healer and now is transferred to a medical doctor (HUFH001).

The faith healers expressed their wish that a common medical card should be developed, such that whenever they sense a need for an intervention of a medical professional in the healing process of the patient, they would simply write down their observation and the medical history of the patient (MAFH003).

### ***Late Referrals of Patients from Traditional Healers***

Another challenge to collaboration cited by allopathic doctors against traditional healers was delays in referrals. They complained that traditional health practitioners tend to refer the patients to hospitals as a last resort. In fact, these findings are confirmed in the extant literature. For example, there are claims that it is common for traditional healers to refer patients when they are in the final stages of illness. This sometimes leads to death because chances of successful treatment interventions are normally slim (Summerton 2006). Another study conducted by Sorsdahl, Stein and Flisher (2010) also brought to light the fact that in some places, traditional healers' referral to Western care comes as the last resort.

However, the view that traditional healers only refer patients to modern medicine as the last resort needs to be properly assessed from different perspectives, so that there is a balanced understanding and a lasting solution on the matter. It may be argued that as long as collaboration between different health systems is not in place, other alternative health providers will only receive patients as the last resort, when it may be too late to help the patient. This is because when there is no collaboration, one of the health systems, whether allopathic or one of the alternative health systems will view themselves as 'the' only health provider, at least until they fail. For example, it is common knowledge that when the

allopathic system fails, they normally ask the family to find alternative home-based means to help the patient, which may include consultation of alternative health providers. This is indirectly a last resort referral, which does not in any way differ from a situation when the traditional system refers patients to medical hospitals in the last stages of their illness. Thus, late referral of patients to other health practitioners should not by any means be regarded as a failure by the traditional system alone. It is fundamentally the failure in collaboration in general. Collaboration is more likely to solve this problem because communication barriers will be brought down. It will be through communication that traditional healers will know when to refer and when not to dispense their drugs.

### ***Mistrust of Traditional Healers***

One of the challenges that appeared to recur in the study is that of mistrust of traditional healers by other health providers, that is, both the modern medical professionals and some faith healers. The majority of the faith healers in the study stated that they do not seek help from nor refer their patients to traditional healers. Most of the faith healers who held this position were pastors from Pentecostal and charismatic backgrounds together with leaders from mainline churches.

Traditional healers also confirmed that they suffer from this prevailing mistrust from medical practitioners. One of the traditional healers said they never receive patients referred to them from medical practitioners. He said, “No, I haven’t received patients from modern medical doctors. They say that we are witches, they rather refer them to *baruti* (faith healers)” (HUTH002). While the traditional healers receive this negative treatment from those in the modern medicine, they pointed out that different families continue to bring in their patients to them for traditional healing. Further, some traditional healers revealed that, under the concealment of the family, they are often invited to secretly administer traditional medicine to the patients who are already admitted in the hospitals (BOTH002).

From the above, it seems that sidelining of traditional healers and failing to bring them into the collaboration network is not helping any of the stakeholders in health provision. Instead of helping, it appears rather detrimental to the health of the patients, because without any communication between health providers, two remedies are administered concurrently, that is ‘the apparent’, modern medical treatment and ‘the concealed’, traditional medical treatment.

### ***Doubt on the Efficacy of Traditional Healing and its Possible Interference with the Efficacy of Hospital Treatment***

Almost all modern medical practitioners were negative on the question whether they refer patients to traditional healers. They categorically argued that they do not encourage their patients to consult traditional healers or to take traditional healers’ medicine. One of the reasons given for not referring patients to traditional healers was that the medication is not tested, that is in terms of the active ingredients in the traditional medicine. For example, one respondent said,

I don’t encourage people to use them, most patients who use traditional medication come here with kidney problems because contents are not measured, their safety or side effects are not documented. So, usually I discourage the patients

from going there because their medicine will interfere with the medicines we give (TSMP002).

Medical practitioners argued for the possible interference of traditional healers' concoctions with the modern medication. For example, one respondent stated,

For me it is a requirement because the medication that I give may be based on the patient's condition, for example, it might be related the functionality of their kidneys and/or liver. So, if the patient is taking other medication out there especially those which I am not sure of, their safety and side effects will interfere with the ones given. For example, patients on traditional medicine will come here with acute kidney injuries and if they are in severe pain you can't give them medication like brufen because they will injure their kidneys even the more. That's how they interfere with what we give here and yes it is a requirement to know if the patient is on alternative medicine (TSMP002).

Although they did not refer patients to traditional healers, medical practitioners said they received patients referred to them by traditional and faith healers. Medical practitioners said these are referred for different reasons: to confirm the faith/ traditional healer's suspicion or to confirm if the traditional or faith healer's treatment has worked. "Actually, sometimes, I get two forms of referrals, before contact with the faith healers and afterwards" (MAGP002).

From the preceding observations from the study, a number of challenges continue to prevail in the quest for collaboration between different health systems in Botswana. While traditional healers are the ones who often receive a negative review from both scholars and health practitioners, it seems that the real problem goes beyond them. Failure for collaboration of the various health systems is bound to create more problems than solutions in the health of patients. Below, some useful strategies for collaboration are suggested.

### **Useful Strategies to Foster Collaboration**

Positive attitudes and personal relationships are imperative for collaboration. There is too much stigma towards traditional medicine. All health care professionals should be firstly committed to collaboration, be patient focused, acknowledge holistic care, take interprofessional education into cognizance, and open doors of communication. Building social networks is important because together, different health care providers could come with strategies of dealing with problems they encounter in collaborative healing.

#### ***Commitment to Collaboration***

Governments have come to the realization that as healthcare evolves, it is important to investigate possibilities of collaboration. New understanding of the traditional system brings about the need to make plans so as to benefit from traditional healing systems. It is not only a matter of benefits of the traditional health system; problems rooting from lack of collaboration are also real motivators. There is need for cultivating positive attitudes within the health care fraternity. Committing to working together in overcoming barriers of health should be encouraged. Maintaining equal relationships among health care

providers is important. There is no way people can work together coherently under unequal circumstances.

The World Health Organization advocates for the establishment of structures that would facilitate collaboration. Pretorius who, in his work, dealing with analogical model of the Biomedical and Traditional Medical Relationship, advocates for an inclusive parallel system that recognizes all faculties (Pretorius 1991). It has been argued earlier in the paper that healing by definition has to be holistic, taking into cognizance various aspects of human reality.

### ***Being Patient-focused***

The approach that is suggested is reaching out to the wellbeing of individual persons. In other words, it emphasises the patient-centred approach. This approach aims for the best possible outcomes and takes the plight of the patient into cognizance. Its focus is on the outcomes, rather than on the practitioner's health care system preference. Different health care providers can therefore work together for the sake of the welfare and the interest of their patients.

### ***Inter-professional Education***

Although interprofessional education could be a strategy to foster collaboration, it is not adequately introduced in higher institutions of learning which have health departments, especially in countries like Botswana. Curriculum resources that emphasize on teamwork should therefore be introduced for student doctors and nurses so that they can be in a position to provide better care and collaboration after graduating.

### ***Acknowledging Holistic Care***

A holistic approach includes all dimensions of life. Therefore, for health care to be holistic, there is need to meet people at their multiple points of need. Studies reveal that illness is multidimensional therefore it is important to address the needs of patients holistically.

### ***Communication***

Information technologies and telecommunication could lead to telemedicine and easy collaborative practice. It can also improve health outcomes. Other social media platforms such as Facebook and WhatsApp can create easier and faster communication channels. Through these platforms, health care practitioners from various health systems could share patients' issues. This is even possible nowadays in Botswana, where cellular phones are used practically in most regions and by all health providers.

### ***Building Social Networks***

It is necessary for healthcare providers to have a good relationship for the sake of quality healthcare services. Through communication they can know who is best in certain areas and to share ideas and learn from each other. Some of the strategies used to build interprofessional relationships include referring challenging cases to the most experienced health care provider, discussing with other health care professionals in order to provide the best treatment to the patient and teaching student doctors and nurses on collaboration of healthcare professionals.

## Conclusion

This paper reviewed different scholarly works on the importance of collaboration of health care professionals. It also presented findings on the challenges of collaboration of the various health systems from a study that was held in Botswana. It was argued that our understanding of both healing and collaboration may go a long way in making collaboration of different health providers a reality. Approaches discussed are the allopathic medicine, traditional African approach and pastoral care approach. Through the literature and the data from the field, it may be concluded that collaboration is possible if it is built on mutual understanding, respect of uniqueness and understanding of systems. From the literature that was reviewed as well as field research, it came to light that capacity building is essential for collaboration to be effective. The importance of education for effective collaboration has been underscored. Education will assist traditional healers in understanding health issues, correct clinical procedures and the health system. The allopathic doctors will also understand the traditional healing systems, including culture and traditional healing through the inclusion of these in the nursing and allopathic curricula.

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**Tshenolo Jennifer Madigele** (PhD) is a Theology Lecturer at the University of Botswana. Her teaching areas include Pastoral Care and Counselling and Systematic Theology. Her research interest includes Human Sexuality, Pastoral Care and Counselling to The LGBTIQ (Lesbians, gays, bisexuals, transgendered, intersexed, and queer) community, Pastoral Care and Counselling to the Ageing community, Botho Pastoral Care and Counselling as well as Health, Spirituality and Healing.

**Abel Tabalaka** (PhD) is lecturer in African Philosophy and Business Ethics at the University of Botswana, Gaborone, Botswana.

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## REFERENCES

- Ashley, B.M. & O'Rourke, K.D., 1997. *Healthcare ethics: A theological analysis*, 3rd edn., St Louis: The Catholic Health Association of the United States.
- Balch, F. 1991. Strengthening chaplain-physician relationships in long-term care settings, in L. VandeCreek and L. Burton (eds.), *The Chaplain-Physician Relationship*, 47–57, New York: The Haworth Press, Bronstein, L.R. 2003. A model for interdisciplinary collaboration, *Social Work* 48:3, 297–306. <http://dx.doi.org/10.1093/sw/48.3.297>.
- Campbell, A., Gillet, G. and Jones, G., 2005. *Medical ethics*, 4th edn., South Melbourne: Oxford University Press.
- Campbell-Hall, V., Petersen I., Bhana A., Mjadu S, Hosegood V., Flisher A.J. 2010. MHaPP Research Programme Consortium, *Transcult Psychiatry*. 47:4, 610-628. doi: 10.1177/1363461510383459. PMID:20940271.

- Carpenter, G.W. 1960. *The Way in Africa*, Great Britain: Friendship Press.
- Danani, D. 2017. Religious organizations in Botswana, *Botswana Daily News*, 20 Jul.
- Figueras, J. and McKee, M. 2012. *Health Systems, Health, Wealth and Societal Wellbeing*, Berkshire: Open University Press.
- Cook, A. 1990. *Theological Health*, South Melbourne: Oxford University Press.
- Hirsto, L. and Tirri, K. 2009. Motivational Approaches to the Study of Theology in Relation to Spirituality, *Journal of Empirical Theology*, 22:1, 88–102. <http://dx.doi.org/10.1163/157092509X437233>.
- Juma, J.O., 2011. African Worldviews – Their Impact on Psychopathology and Psychological Counseling, Master Thesis, University of South Africa, Pretoria. <http://uir.unisa.ac.za/>.
- Kubukeli, P. 1997. A ‘Traditional’ Traditional Healer, *South African Medical Journal*, 87:7, 917.
- Kreitzer, M.J., Kligler, B. and Meeker, W.C. 2009. Health Professions Education and Integrative Healthcare, *Explore (NY)*, 5:4, 212–227. <http://www.iom.edu/~media/Files/Activity%20Files/Quality/IntegrativeMed/Health%20Professions%20Education%20and%20Integrative%20HealthCare.pdf>.
- Leijssen, M. 2007. The validation of the body in psychotherapy. *Journal of Humanistic Psychology*, 46, 126–146.
- McCleod, H. and Chung, V.C.H. 2012. The Integration of Traditional and Complementary Medicine in Health Systems, Joint IACA, IAAHS and PBSS Colloquium, Hong Kong, 6-9 May, <http://www.actuaries>.
- NDP, *National Development Plan of 1976–1981*, Section 14.86.
- Ntsetselele, K. 2017. *Traditional, complementary and alternative medicine in Botswana: Patients Attitudes, Knowledge and Use*. Masters Dissertation, University of the Western Cape.
- Pretorius, E. 1991. Traditional and Modern Medicine Working in Tandem, *Curationis* 14:4, 10–13.
- Sorsdahl, K., Stein, D.J. and Flisher, A.J. 2010. Traditional Healer Attitudes and Beliefs Regarding Referral of the Mentally Ill to Western Doctors in South Africa, *Transcultural Psychiatry*, 47:4, 591–609.
- Summerton, J.V. 2006. Western Health Practitioners’ View About African Traditional Health Practitioners’ Treatment and Care of People Living with HIV/AIDS, *Curationis*, 29:3, 15–29.
- Togarasei, Lovemore, Mmolai S. and Kealotswe O. 2016. ‘Quinine’, ‘Ditaola’ and the ‘Bible’ *Journal for the Study of Religion*, 29:2. 95–117.

- Van Deurzen, E. 2008. *Psychotherapy and the Quest for Happiness*, Los Angeles: SAGE.
- Van Deurzen, E. 2009. *Everyday Mysteries: Existential Dimensions of Psychotherapy*, Los Angeles: SAGE.
- Witvliet, C.V.O., and McCullough M.E. 2007. Forgiveness and health: A review and theoretical exploration of emotion pathways, in Post S.G. (ed.), *Altruism and Health: Perspectives from Empirical Research*, New York: Oxford University Press, 259-276.
- World Health Organization, 1998. Department of Mental Health, Social Change Cluster, *WHOQOL and Spirituality, Religiousness and Personal Beliefs*, last reviewed 15 January 2013, [http://whqlibdoc.who.int/hq/1998/who\\_MSA\\_MHP\\_98.2\\_eng.pdf](http://whqlibdoc.who.int/hq/1998/who_MSA_MHP_98.2_eng.pdf).
- World Health Organization, 2002. African Forum on the Role of Traditional Medicine in Health Systems - Final report. Harare: World Health Organization, Regional Office for Africa.
- World Health Organization. 2001. Programme on Traditional Medicine. "Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review, World Health Organization.
- World Health Organization. "Integrated Health Services - What and Why", *Technical Brief*, 1. 2008. Accessed 2018, April 16, [http://www.who.int/healthsystems/topic/delivery/technical\\_brief\\_ehp.pdf](http://www.who.int/healthsystems/topic/delivery/technical_brief_ehp.pdf).
- Worthington, E.L. Jr. 2006. *Forgiveness and Reconciliation: Theory and Application*. New York: Routledge/Taylor & Francis Group.

# Pastoral Caregivers in Botswana Government Hospitals: A Holistic Pastoral Theological Approach

Tshenolo Jennifer Madigele

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## Abstract

This paper seeks to assess the contribution that local churches in Botswana make to health and wellbeing. It is part of an ongoing study on the impact of religious beliefs on health seeking and health provision behaviors in Botswana. The hypothesis of the study is that religion contributes immensely to better health and wellbeing. This paper seeks to contribute to the hypothesis by asking the question on what local churches in Botswana do in order to contribute to health and wellbeing. It argues that wholeness and health are some of the most important concerns of Botswana and the global community. Illness is complex in that it often defies remedy even when people seek remedy in hospitals. The study shows that biomedicine by itself has limited capacity in fulfilling the human quest for meaning. The paper argues that it is necessary to include pastoral care as a valuable and a necessary human resource and partnership for healthcare and development. Religion and spirituality have been suggested as vital in many people's quest for meaning. This study has employed a holistic pastoral theological methodology.

**KEY WORDS:** Pastoral Care, Health, Illness, Spirituality, Wholeness, An Integrated Theological Methodology

## Introduction and Background

This article simply suggests that pastoral caregivers should work hand in hand with other health care practitioners in order to provide a significant holistic caregiving to health seekers. Since its inception, the Christian Church has always been engaged with matters of health in Botswana. From around 1847, the London Missionary Society (LMS) practiced medicine in their mission station at Kolobeng among the Bakwena of Sechele. We learn of David Livingstone being a medical missionary. It was through medicine that it was possible to introduce the gospel with more ease among the local tribes of the Botswana (Macaulay 1889:40). In one of the letters to his countrymen, Livingstone wrote,

Here I have an immense practice. I have patients now under treatment who have walked 130 miles for my advice; and when these go home, others will come for the

same purpose. This is the country for a medical man if he wants a large practice; but he must leave fees out of the question (Macaulay 1889:40).

The above extract shows that people were attracted to Livingstone because of medicine and his acts of compassion. Health and religion thus remain inseparable entities. The Livingstone medical mission model had more to offer in the context of Botswana as it reached out to the spiritual, social, physical (medical), and welfare needs of the people. The model aimed at addressing all dimensions of human existence hence holistic. It was also communal since he engaged local people in continuing propagating the Gospel during his absence. Engaging locals in God's mission shows that David Livingstone made cultural considerations. However, Mudimbe (1964) highlights that the formal education system that was introduced by missionaries was designed to alienate them from their cultures and people.

Notwithstanding, holistic, communal, contextual and intercultural pastoral theological approaches that are proposed in this article are therefore not new; they were used by David Livingstone during his missionary work among Batswana. History teaches that Western medicine in the form of hospitals, was introduced in Botswana around 1922 by Christian missionaries led by the Seventh-day Adventists (SDA) in Kanye (Molefe 1996). Around the same time, we hear of dispensaries in the Kalahari Desert where missionaries came in hundreds to hear the Word of God as Western medicine was used in their bodies. Five years later the Dutch Reformed Church (DRC) opened its medical mission hospital institution in Mochudi, while in 1934 a mission hospital was opened by the LMS in Molepolole. In 1933 the Lutherans and the Catholics began with clinics at Ramotswa and Kgale, respectively. The second hospital of the Adventist Church was opened in Maun in 1938 (Molefe 1996).

As years passed by, medical missions encountered challenges such as capital needs, plurality in the use of various medical systems available i.e. biomedicine, spiritual or faith healing and traditional healing (McGilvray 1981). The overwhelming prevalence of HIV and AIDS in Botswana drained the finances of the hospitals and human resources.

This study maintains that there is an interchange and exchange among African traditional healing, modern medicine, and Christian healing. The paper aims at helping parallel medical systems, especially the spiritual or faith healers and biomedical healers to work together for the health and wellbeing of the people. Missionaries such as David Livingstone used medical work in missions because they believed it to be complementary to the gospel message.

In African countries such as Botswana, faith healing and modern medicine have an old historical connection. As mentioned above, the church started building hospitals, clinics and health centres in order to provide healing to African people. Their concentration was not on spiritual needs only; it was also on physical needs. Their mission was holistic in approach.

The above background suggests that health and Christianity were initially inseparable entities. The approach that was used was holistic. Initially, healing was used to attract people to Christianity. Today, the Church neither does have the means nor the capacity to attend to health and wellbeing of the people holistically. Both Christian medical missions and the government provide primary Western health-care. The faith healing and modern medicine are entities working in parallels. The public sector dominates the health system,

operating 98% of the health facilities (WHO 2013). Bamalete Lutheran and Kanye Seventh-day Adventist hospitals respectively are medical mission hospitals that apply the scientific model along with Christian principles.

This article is focused on the official government hospitals or health care centres which exclusively use Western medicine. At these health facilities, medicine is used to address the physical impact of illness upon the sufferer while the Church addresses causes of suffering upon the sufferer through spiritual comfort. The connection between faith and health, and the multifaceted nature of illness i.e. spiritual, physical and social dimensions of health and healing make it inadequate to address healing from one perspective only. “The medical model which seeks to treat patients by focusing on medicine and surgery and gives less importance to belief and to faith in healing is no longer satisfactory” (WHO 1998). Therefore, for the medical model to be effective in treating certain diseases, it should integrate all dimensions of sickness, including the spiritual (Hill and Smith 2010). Religious and spiritual aspects should be integrated in healing because cultural values, norms, principles and beliefs which are often embedded in religion and spirituality influence people’s perception of illness and their decisions for or against medical treatment.

Which diseases can only be healed through integration of modern medicine and faith healing? How do cultural values and beliefs influence people’s perception of illness and how can the integration of faith healers and medical practitioners facilitate health and wellbeing of individuals? This paper answers these questions by presenting and discussing findings on the views of faith healers and medical practitioners in Botswana. Our discussion will start with the methodology, followed by the presentation and discussion of the findings and the conclusion.

## **Methodology**

The data that is used in this paper is from a study that was conducted in 2018 and 2019. The study adopted a mixed methods approach. The quantitative data was collected through questionnaire while qualitative data was through interviews and focus group discussions. The first methodology for data collection that the research employed was literature review. The literature reviewed included studies in the field of Pastoral Care and its relationship, relevance and contribution to hospital care. Literature such as journals, books, conference proceedings and internet sources were utilized in order to have the grounds for the theoretical analysis and to connect the outcomes to broader discussions about the role and importance of the pastoral care in hospital care. It should also assist in showing the importance of integrative approach to health care and authentic pastoral care approach that can address the needs of people within hospitals in Botswana. The second method was conducting specific oral and written interviews with the medical health practitioners, traditional healers, faith healers, health seekers and policy makers. The third method of data collection was questionnaires with medical health practitioners, traditional healers, faith healers, and health seekers. Data was also collected through focus group discussions with health seekers and health providers. Data was collected from eighteen research sites across the country.

### ***Holistic Pastoral Theological Methodology***

Holistic care is understood to refer to caring for the whole person. This caring model should focus on the therapeutic interventions that are directed to meet the needs of the whole person. Pastoral Care must cover a person's whole being; holistic health care. It has been argued that any care delivery endeavor that does not attend to the needs of the whole person is inadequate. Peter Hampson (2010), for example, argues that a true and broader meaning of pastoral care is that which acknowledges the complexity of human beings and attends to human beings holistically. Therefore, pastoral caregivers are advised to make use of the holistic approach in order to address mind, body and soul. Existentialists appreciate that human beings have complex dimensions of existence which are physical, social, emotional/psychological, spiritual to name the least (Van Deurzen 2009). Within the Tswana worldview, ideal care incorporates physical, social, mental, and spiritual dimensions and emphasises that the care and wellbeing of the community and the individual are interdependent and equally important (Tshalana 1991). Msomi (2008) argues that pastoral care and counselling should take the cultural, social, religious and political factors seriously in the context of its operation.

In light of the issues raised above, the holistic pastoral theological approach embodies an intercultural perspective of Pastoral Care practice for the effective implementation of pastoral care in any context. This model takes seriously the message of Scripture, the person of the care seeker and the context in which the care seeker is embedded. Appropriate care responds in a balanced way to people's needs and expectations by improving the life situation of individuals, families and communities. This approach goes beyond mere preaching or prayer or administering sacraments; it takes on issues of advocacy, justice, development and empowerment as well as moral and bioethical issues. Pastoral Care should be concerned with the whole person (Rattray 2002). The pastoral needs are varied, depending on the coping resources available to a care seeker, which require pastoral assessment (Driscoll-Lamberg 2001).

### **Findings and Discussions**

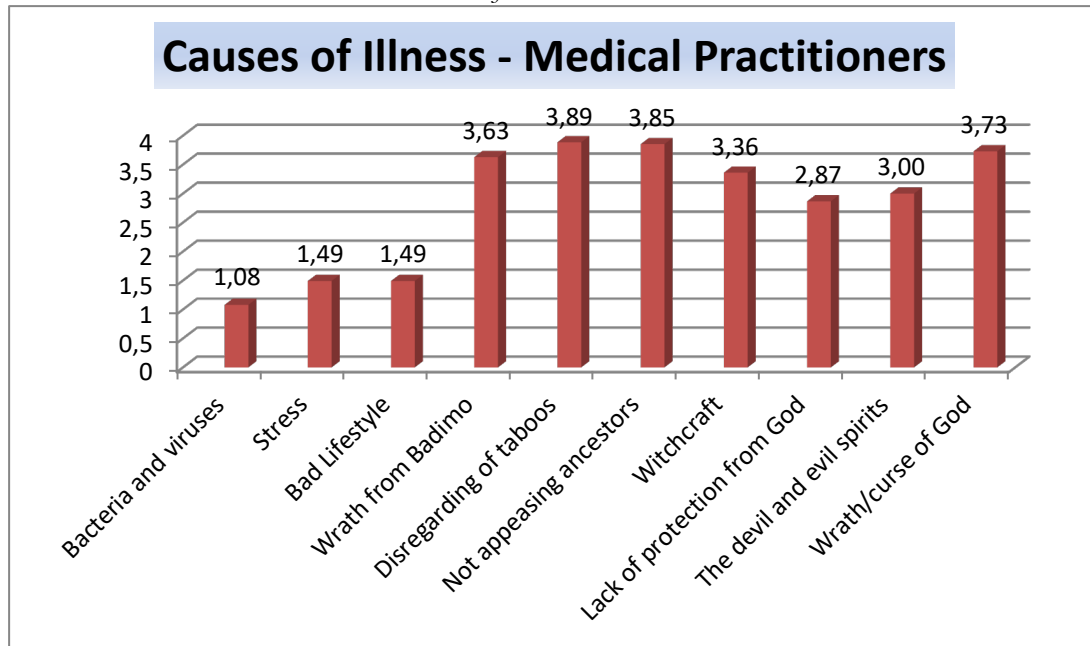
Both the quantitative and qualitative tools had questions to establish the faith healers' views on which illnesses and diseases can only be healed through integration of modern medicine and faith healing. The tools also assisted in establishing cultural values and beliefs that influence people's perception of illness and how the integration of faith healers and medical practitioners facilitate health and wellbeing of individuals. Researchers started preparing for data analysis in the first quarter of 2019 with statistical analysis through using SPSS. Statistical data was analyzed and presented in tables, pie charts and graphs. In the case of interview data, the interviews were transcribed and stored electronically and on paper. The researchers analyzed the data and identified themes that emerged from it. The next section deals with data analysis and discussions of themes that emerged from the data.

#### ***Views on Illnesses and Diseases that can only be Healed through Integration of Modern Medicine and Faith Healing***

##### ***Causes of Illness – Medical practitioners***

Data presented here was collected from medical practitioners. The table below summarizes medical practitioner's views on causes of illness:

Table 1: Causes of Illness- Medical Practitioners



When asked about causes of illness, they stated physical factors, stress and behavioural factors as main causes of illness. Other causes to choose from include wrath from God, disregarding taboos, not appeasing ancestors, witchcraft, and lack of protection from God, the devil and evil spirits and the curse of God. Based on the findings, according to health practitioners, causes of illnesses are predominantly physical, psychosocial and psycho emotionally inclined. This suggests that for health to be achieved, the whole person should be addressed. Bircher (2005) argues that health should include bio-psycho-social dimensions. He contends that, “[h]ealth is a dynamic state of wellbeing characterised by a physical, mental and social potential, which satisfies the demands of a life commensurate with age, culture, and personal responsibility.”

It is important to note that the model that had been introduced by Bircher lacks the spiritual or religious dimension. The model that could be efficient is bio-psychosocial-spiritual. This dimension has to be included in medical and theological conception of health.

### *Integration of Religion and Health*

As the table above shows, medical practitioners affirm that there is a connection between religion and health. The general view of medical practitioners is that faith motivates medication adherence; spiritually helps with the healing process; influences good behaviour and health. This is represented in the following verbatim responses,

‘I place God above in the sense that I will encourage patients to take treatment fully while also praying to God for healing’ (Interview, FRMP008).

‘Psychologically, someone has to have faith that a medical drug can cure, therefore that can motivate the person to take drugs’ (Interview, TSMP001).

Most of the medical practitioners acknowledged the power of God in health and healing even though they stick to medical diagnoses and treatment. Based on the findings

of the study, medical practitioners were adamant that they only address physical illnesses. This disregards the connection between faith, religion and illness. The World Health Organisation also recognizes religious and spiritual dimensions of care by medical professionals and organisations. It is found in the report published in 1998:

Until recently the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery and gives less importance to beliefs and to faith-in healing, in the physician and in the doctor patient relationship. This reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realize the value of elements such as faith, hope and compassion in the healing process. The value of such 'spiritual' elements in health and quality of life has led to research in this field in an attempt to move towards a more holistic view of health that includes a non-material dimension (WHO: 1998).

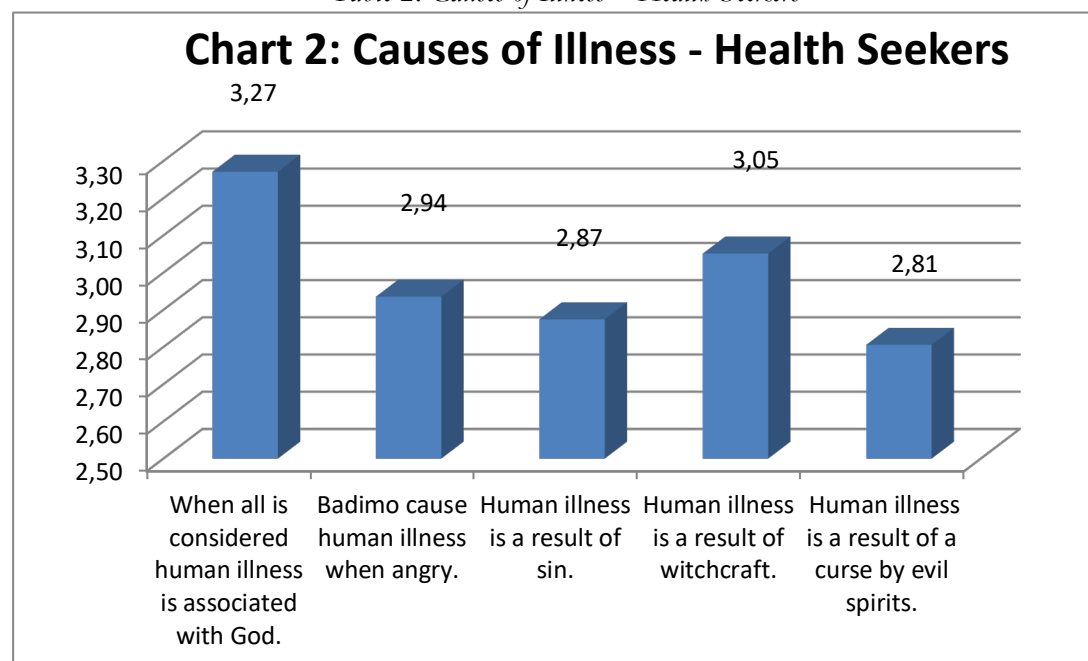
Data collected from medical practitioners' shows that there is an increasing recognition and sensitivity to religious and spiritual caregivers to minister to the needs of patients. This is represented in the following verbatim extract:

'I do respect their spiritual beliefs, but I deal with the physical aspects using whatever medical approach that I have. I can counsel them depending on what I think the condition is' (Interview, MAMP009).

Meanwhile, the findings from health seekers too emphasize the importance of the pastoral care to the healing process among patients in Botswana and suggest the need for medical staff to work with pastoral care givers in hospital care.

Table 2 below shows the responses of care seekers on causes of illness:

*Table 2: Causes of Illness – Health Seekers*



Based on the above chart, health is understood in terms of the relationships which appear to be an important component of human identity. Firstly, there is a relationship

with God, ancestors or supernatural entities. It would seem from the foregoing graph that there should be that harmonious relationship between an individual with a transcendental entity for them to enjoy health and wellness. Further, the graph suggests that the harmony might be destroyed by sin and be restored differently by different people.

From the in-depth interviews, health seekers, like faith healers identified behavioural factors as common causes of illness. This is represented in the following verbatim response,

“.....Illness can be caused by different things such as lifestyle, the kind of food, and reckless lifestyles” (Interview, TSHS002).

Within this view, there should be functional relationship among the individual, God, others and the environment. The quality of life and peace is assured in the context of good relationships with the self, God, others and nature. Failure to have a good life means that one has failed to keep harmonious relationships.

Health seekers also expressed their views on the African cultural conception of health. Their reflections show that spiritual realities play a significant role in the issues of sickness and restoration to health. Lack of spiritual observance as a cause of illness was popular among health seekers. The following was stated:

My belief teaches that instructions should be followed. There is a problem with new generation who wants to know the gender of the baby before the baby is born; immediately the baby is born at the hospital, they will take pictures and put them in Facebook. But there are illnesses such as *thibamo*, which come because of seeing an un-cleansed baby (FTHS007).

Speaking from African perspective, Louw (2008:44) maintains that health should not be separated from existing cultural contexts. The majority of health seekers indicated that religion and spirituality are essential factors, especially when they are sick. Basically, for them the quality of life is characterised by religious and spiritual support. Unfortunately, the religious and spiritual needs of care seekers are often neglected at a clinical setting. Studies reveal that within a hospital setting, religious and spiritual needs assessed for less than 10% of sick, elderly persons (Balboni, Sullivan et. al 2013).

According to the findings of this study, pastoral care with its tools of religious and spiritual engagement could be a feasible vehicle for providing spiritual care within the hospital environment in Botswana. Moreover, religio-cultural assumptions and personal experiences are significant and could contribute towards wholeness, healing and a better coping process. Medical practitioners are becoming aware that the biomedical model is not sufficient for holistic hospital care. This calls for the accommodation of complementary and alternative approaches.

### **Pastors and Health**

During interviews with medical personnel, some physicians reported that some patients visit religious leaders when they are ill. They also reported that some health seekers in hospitals sometimes demand the services of pastors. When hospitalized, some raise spiritual concerns which medical practitioners find difficult to deal with. This is when they

require the assistance of pastors with the belief that they would get to understand what is going on with the patients. Sometimes pastors encourage them to go to hospital. Demanding the services of pastors while at the hospital shows that some health seekers want their pastoral needs to be addressed. "Patients turn to what they hold sacred because they want help with their spiritual struggles during illness. These struggles, however, can contribute to spiritual deterioration or become chronic if they are not resolved" (VandeCreek 2010:5).

Medical professionals in Botswana are not trained to address all dimensions of human existence. Neither are they trained in pastoral care in hospital care nor in recognising the importance of including pastoral care in hospital care. They cannot even handle all the needs of patients (Hill and Smith 2010:175). Medicine is unable to mediate spiritual healing and wholeness. This is where it becomes apparent for the medical practitioners to consult with pastoral caregivers who have competence to provide authentic and appropriate spiritual intervention.

### **Holistic Pastoral Theological Approach and Collaboration in Hospital Care**

The history of modern medical practice in Botswana reveals that there was collaboration between medical care and religion during the missionary era. Responsibilities for pastoral care rested on the same individual who was both a priest and physician. Some hospitals and clinics in Botswana owe their existence to the mission work. Therefore, the health sector is called to rebuild the fallen foundation now with a stronger structure of care. This article realizes that the fragmentation of health systems in Botswana makes it possible for the failure to attend to the health needs of patients and proposes a holistic framework. This framework takes into consideration the physical as well as the non-physical and spiritual components. The complex reality of illness therefore necessitates a collaboration of medical care professionals with Pastoral Care professionals within a team approach. Therefore it could be argued that the pastoral caregivers and the medical personnel need to collaborate for holistic healing.

Intercultural perspective of pastoral care could be of greater use for the effective implementation of Pastoral Care in the hospital context. This perspective emphasizes on the person of care, the message of Scripture and the context in which the person is embedded. Lartey (2003) uses the term intercultural, to describe an approach to care and counselling that responds to a dynamic complexity of cultural pluralism around the world. Intercultural care also seeks to correct the problematic consequences of Eurocentric cultural and political hegemony. It values the rich, dynamic, interpretive complexity of interactive cultures and rejects typologies that reduce such complexities.

Lartey's (2003) intercultural approach draws attention to African worldview, culture, customs, beliefs and views of the people it serves. According to Lartey, authentic pastoral counselling takes the culture of the people and African psychology seriously. This means that pastoral caregivers need to take it into account the underlying factors, including the in-depth knowledge of the individual. Transformation in this context should be dual; it should have an individual therapeutic effect and socio-political transformation. This approach to Pastoral Care takes on issues of advocacy, justice, development and empowerment as well as moral and bioethical issues rather than focusing on prayers, physical healing and being present. It is in this sense holistic.

## Conclusion and Recommendations

In conclusion, the paper argues that the inclusion of pastoral care and the appropriate holistic approach to the care of health seekers in a hospital context could contribute towards quality care of the people in Botswana. Given the limitations of medical care and pastoral care working independently, the paper revealed that care requires the combined efforts, skills and expertise. This paper, therefore, recommends:

- The need to assess the religious and spiritual needs of care seekers in a hospital or clinical setting. There should be guidelines that address spiritual issues.
- An approach that acknowledges that there are needs that are specific to health seekers. Improved understanding of religious and spiritual care provision can positively lead to interventions aimed at improving the psychosocial wellbeing of care seekers.
- An educational programme for both health practitioners and pastoral caregivers that aim at equipping them to help people deal with meaning questions in the context of suffering.
- A need of policy making that gives dignity to the patient through considering unique identities of patients in Botswana.

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**Tshenolo Jennifer Madigele** (PhD) is a Theology Lecturer at the University of Botswana. Her teaching areas include Pastoral Care and Counselling and Systematic Theology. Her research interest includes Human Sexuality, Pastoral Care and Counselling to The LGBTIQ (Lesbians, gays, bisexuals, transgendered, intersexed, and queer) community, Pastoral Care and Counselling to the Ageing community, Botho Pastoral Care and Counselling as well as Health, Spirituality and Healing.

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## REFERENCES

- Balboni Michael, Adam Sullivan, et al. 2013. Why is spiritual care infrequent at the end of life?: Spiritual care perceptions among patients, nurses, and physicians and the role of training. *Journal of Clinical Oncology*. 31: 461- 467.
- Bircher, Johannes. 2005. Towards a dynamic Definition of Health and Disease. *Medicine, Healthcare and Philosophy*, 8:335-341.
- Driscoll-Lamberg. 2001. Integrating Spirituality in counselling with Older Adults, in Moberg, D. O. *Aging and Spirituality: Spiritual Dimensions of Aging Theory, Research, Practice, and Policy*. New York: The Haworth Pastoral Press, 125-132.
- Hampson Peter, 2010. Grace and Truth, *a Journal of Catholic Reflection for Southern Africa*. August, 27 (2), 2- 19.

Hill Peter, Smith, Gary. 2010, Coming to Terms with Spirituality and Religion in the Workplace in Giacalone, R.A. & Jurkiewicz, C.L. (eds.) *Handbook of Workplace Spirituality and Organizational Performance (Second Edition)*. New York: M. E. Sharpe. 171-184.

Lartey Emmanuel. 2003. *In Living Color. An Intercultural Approach to pastoral Care and Counselling*, London: UK Cassell.

Louw, Daniel. 2008. *Cura Vitae: Illness and the Healing of Life*. Wellington: Lux Verbi. BM.  
Macaulay James, 1889. *Livingstone Anecdotes: A Sketch of the Career and Illustrations of the Character of David Livingstone, Missionary, Traveller, Philanthropist*, London: The Religious Tract Society, 40.

McGilvray, James. 1981. *The Quest for Health and Wholeness*. German Institute for Medical Missions: Tubingen.

Molefi, Rodgers Keteng. 1996. *Medical History of Botswana: 1885-1996*. Gaborone, Botswana: The Botswana Society,

Msomi, Vivian. 2008. *Ubuntu Contextual African Pastoral Care and Counselling*, Pretoria: CB Powell Bible Centre.

Mudumbe, Valentin Yves. 1964. *The Idea of Africa*, London: James Currey.

Tshalana, Charles. 1991. *Communalism in Africa*, Maryknoll, NY: Orbis.

VandeCreek, Larry. 2010. Defining and advocating for Spiritual care in the Hospital in *Journal of Pastoral Care and Counselling*, 64(2):1-10.

van Deurzen, Emmy. 2009. *New School of Psychotherapy and Counselling*, London: SAGE Publications.

World Health Organization, "Botswana: The Health System,"  
[http://www.who.int/profiles\\_information/index.php/Botswana:The\\_Health\\_System](http://www.who.int/profiles_information/index.php/Botswana:The_Health_System) (accessed December 11, 2013).

WHO. 1998. WHOQOL and Spirituality, Religiousness and Personal Beliefs. Department of Mental health, Social change Cluster.  
Available: [http://whqlibdoc.who.int/hq/1998/who\\_MSA\\_MHP\\_98.2\\_eng.pdf](http://whqlibdoc.who.int/hq/1998/who_MSA_MHP_98.2_eng.pdf) (accessed 2020, January).

Rattray, Lorna. 2002. Significance of the Chaplain within the Mental Health Care Available: *Psychiatric Bulletin*,  
<http://pb.rcpsych.org/cgi/content/full/26/5/190> (Accessed August 28, 2020).

WHO. 1998. WHOQOL and Spirituality, Religiousness and Personal Beliefs. Department of Mental health, Social Change Cluster.  
Available: [http://whqlibdoc.who.int/hq/1998/who\\_MSA\\_MHP\\_98.2\\_eng.pdf](http://whqlibdoc.who.int/hq/1998/who_MSA_MHP_98.2_eng.pdf) (accessed January 15, 2020).

# Religion and Spirituality in Health and Medical Education: Batswana Medical Practitioners' Views

Tinoonga Shanduka

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## Abstract

This paper discusses Batswana medical practitioners' views on the impact of religion and spirituality on health and medical education. The paper relies on the fieldwork research findings on the impact of beliefs on health seeking and health provision behaviors in Botswana. Additionally, the paper is a product of internationally published literature sources on the importance of religion and spirituality in healthcare provision. In terms of methodology, the paper used a variety of data sources. Primary data was collected through fieldwork using questionnaire and interview guides as instruments for collecting data. Secondly, a desktop approach was used for collecting secondary data. Documentary analysis and review of varied literature sources also produced data for this paper. The paper established that religion and spirituality are essential aspects of patients' life which ought to be addressed by medical practitioners during healthcare provision in Botswana. These are part of alternative medicine important for holistic healing of illness. The study found out that spirituality and religion should be part of medical education in Botswana.

**KEY WORDS:** Bible, Health, Medical Education, Religion, Spirituality, Theosomatic Medicine

## Introduction

Nothing in life is more wonderful than faith — the one great moving force which we can neither weigh in the balance nor test in the crucible . . . Faith has always been an essential factor in the practice of medicine . . . Not a psychologist but an ordinary clinical physician concerned in making strong the weak in mind and body, the whole subject is of interest to me (William Osler. In R. D'Souza, 2007).

The relationship between humanities and sciences has always been a challenge among scholars. Humanities and natural scientific disciplines are viewed as two sides in opposition. Humanities are less scientific but warm hearted while natural sciences are considered as cold and without feelings. Though faith or religion, a discipline within humanities is different from natural sciences such as modern medicine, D'Souza (2007) cited above observes that there is a link between them. This paper assesses the link between

humanities (religion and spirituality) and hard science (health and medicine) by examining Botswana medical doctors and nurses' views on the role of religion and spirituality in human health. Levin (2001) holds that despite some arguments which seek to prove that there is no link between spirituality and religion on one side and medicine on the other side; there is research evidence which indicates that these two different fields have a point of intersection.

This paper examines the impact of beliefs on health seeking and health provision behaviours in Botswana. The paper starts by presenting findings on the impact of religion and spirituality on health according to Botswana medical practitioners. This is followed by a general discussion on Botswana medical practitioners' views on the importance of religion and spirituality on human health. It then outlines the benefits of integrating religion and spirituality in healthcare systems. Moreover, the challenges that hinder the incorporation of religious and spiritual aspects in healthcare provision systems are discussed. The paper then addresses issues of religion and spirituality in medical schools. Finally, the paper provides a conclusion.

### **Impact of Religion and Spirituality on Health- Botswana Medical Practitioners' Views**

This section presents the findings of a fieldwork study on the impact of beliefs on health seeking and health provision behaviors in Botswana. Data was obtainable from modern medical practitioners (nurses and doctors) who were recruited from hospitals and clinics, in different parts of Botswana. Regarding the relationship between faith and health, medical practitioners were of the view that faith motivates medication adherence; spiritually helps with the healing process; influences good behavior and health. Botswana medical practitioners believed that faith and healing are connected to some spiritual forces. Moreover, they were of the view that psychologically, patients should have faith so that medical drugs can cure their sickness. Additionally, they said patients with faith were motivated to take the drugs.

During the study, medical practitioners were asked about where they placed God in human illness. In response, they acknowledged the power of God in health and healing. Moreover, they recognised patients' religious beliefs yet sticking to medical diagnosis and treatment. Furthermore, Botswana medical practitioners described the Bible as a blueprint for healthy living. One medical practitioner responded as follows, "I believe God is above everything, even when I am personally experiencing some social problems in my life, when I come to the hospital I ask for his strength and wisdom to help his people with diligence. I place God above, but I encourage patients to take treatment fully while also praying to God for healing" (Interview, GAMP002).

Regarding the cause of illness, medical practitioners adopted a neutral position in relation to wrath from God, lack of protection from God, the devil and evil spirits and curse of God as possible factors that can cause illness. Nonetheless, they cited physical factors (bacteria and viruses), stress and behavioural factors (bad life-style) as the main causes of illness.

One of the areas that required medical practitioners' answers was on training on religion and health in medical schools. The majority stated that it was important for medical schools in Botswana to offer courses on health and religion/spirituality. Nearly all the

medical practitioners stated that their training included very little to nothing on religion and health. Medical doctors' responses in questionnaires showed that their training had reasonable content (ranging between limited and comprehensive) on the effects of religion and belief systems on health care and respectable patient care. They stated that the curriculum at medical schools where they received training had limited content on traditional health, faith healing and spirituality.

Nurses who were interviewed stated that they learnt something on religion and health from sociology courses while medical doctors learnt a little from courses on Community Health/Medicine. Be that as it may, medical practitioners were taught to accept patients with their beliefs, treating all of them equally knowing that they have different beliefs. It was important for medical practitioners to be taught about people's belief systems if they are to help patients better. Responding to a questionnaire, the majority of medical practitioners (69%) believed that all of them should have training in using alternative medicine in health provision. This means they supported the inclusion of religion and spirituality in medical practice. Some further argued that it is important for medical practitioners to have a working knowledge of other religions besides Christianity because other health seekers in Botswana believe in religions such as Islam, Hinduism and so on. Having basic knowledge of these religions would help medical practitioners to address their health effectively. However, there were some few practitioners who were not certain regarding the relevance of religion in health.

## **Discussion**

The review of literature on the impact on religion and spirituality on health and medical education is also informed by the findings of the fieldwork research in Botswana titled "The impact of religious beliefs on health seeking and health provision behaviors: Lessons for theological education review at the University of Botswana." The fieldwork research established that in health seeking, faith motivates adherence to medication while spirituality plays several positive roles to the life of a health seeking person. The findings drawn from a sample of medical practitioners, faith healers, traditional doctors and health seekers indicated that spirituality helps with the healing process. Moreover, research evidence has confirmed that spirituality influences good behavior and health. Additionally, the results of the fieldwork research publication revealed that faith and healing are connected to spiritual aspects (Togarasei, Gabaitiri, Kubanji, Madigele, Mmolai, Shanduka, Tabalaka and Marwiro, 2020).

The fieldwork research also established that Botswana and other nations in Africa may need to re-examine the idea of collaboration between the modern western medical theory and practice, biblically informed faith healing which involves the presence of Christian spirituality and also indigenous medical knowledge provided by African traditional healers. Collaboration of these three in terms of healthcare provision can enhance public health in Botswana and other African states in general. Collaboration of modern medicine, spiritual-faith healing provided by church pastors and healing done by traditional doctors have the potential to improve healthcare provision system especially if the three types of practices refer patients to each other. Referrals can help patients to achieve holistic healing since Africans in general believe that healing can be provided by the three identified systems of healthcare provision. Considering this view, medical education can also borrow from biblical and pastoral faith healing as discussed in the previous passages and African

spirituality emanating from the rich indigenous knowledge on healing and health derived from the continent of Africa.

Overall, the fieldwork research established that religion and spirituality have positive effects on health and medical education. Therefore, in light of these findings, it is necessary that theological and medical education personnel at the University of Botswana and elsewhere in Africa may need to consider reviewing their curricular so as to include courses on the impact of religion and spirituality on human health. Curriculum development in medical schools should also include modules on holistic human health. Such modules may include the importance of Christian faith to the Bible believing patients in hospitals or at home. Other modules may also include the importance of prayer in its abilities to aid healing and the benefits of attending to church for patients who affiliate to different Christian churches.

In addition to the fieldwork research findings, medical education in Botswana can benefit from the work of Levin (2001: 13-14). Concerning the impact of religion and spirituality on human health and medical education, Levin states that, it is necessary for medical education to take into cognizance the seven scientific grounded principles of theosomatic medicine.<sup>1</sup> The first principle shows that affiliation to a religion such as Christianity promotes healthy lifestyles and behavior. The second principle states that fellowshiping with others in a religion has benefits for health. Religious fellowship provides support responsible for buffering the effects of isolation and stress. The third principle shows that prayer and participation in worship have benefits for health through their 'physiological effects of positive emotions.' Fourth principle explains that Christian beliefs benefit health by their similarity to personality styles and health-promoting beliefs. The fifth principle states that simple faith benefits human health as it leads to thoughts of positive expectation, hope and optimism. The sixth principle provided by Levin (2001:14) reveals that mystical experiences have benefits for health since they activate a human life force or healing bioenergy. Moreover, they can also alter the state of consciousness. Finally, the seventh principle states that there is scientific evidence that distant spiritual intercession or absent prayer heals the sick through divine interventions or para-normal means.

While the respondents underlined the importance of religion and spirituality in medical care, literature shows both benefits and challenges. The next sections will discuss these benefits and challenges before proposing a way forward.

### **Benefits of Integrating Religion and Spirituality in Health Care Systems and Lessons for Medical Education**

Spirituality and religion are aspects of human health which a health care system must attend to in its endeavor to address patients' needs. A study conducted by Memaryan, Rassouli, Nahardani and Amiri (2015) revealed that traditional medicine physicians considered spirituality<sup>2</sup> and religion as effective factors in health care provision systems.

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<sup>1</sup> Theosomatic medicine, according to Levin (2001:207) is an approach that perceives human health determinants based on the connections between faith in God or God or spirit and the wellness of the body. The theosomatic medical model challenges the psychosomatic approach (body-mind) as insufficient in providing holistic healing of patients. Levin (2001) coined the concept theosomatic medicine after realizing the credible and scientific evidence of the link between body, mind and spirit.

<sup>2</sup> The definition of spirituality is contested. There is no consensus among scholars regarding an agreeable definition of spirituality (Memaryan, et al, 2015). The same also applies to religion as stated in the previous discussion. The definition for spirituality is contested. It is a challenge to differentiate between spirituality and religion. However, the two concepts, spirituality and religion are not synonyms, though they

Although modern medicine physicians have not reached a consensus regarding the impact of religion and spirituality to health and medicine, there are some of the physicians who subscribe to the view that spirituality and religion have a role to play in individual patient's health (Levin, 2001).

The significance of spirituality and religion in people's health and treatment is also raised by D'Souza (2007) who posits that incorporation of the spiritual and religious dimension of patients into their treatment and health management is a need. D'Souza (2007) further reinforces this view by stating that recent surveys on the link between religion and health indicated that separating patients' beliefs and spiritual/religious needs from their care deprives them an important element that is likely to be at the core of their coping and support systems. According to Bolhari, Alivand and Mirzaee (2012), religious and spiritual aspects may be integral to patients' well-being as well as their recovery. Barnett and Fortin (2006) also subscribe to the view that spirituality and religion are significant aspects of human health; however, though these elements of faith are important in medicine and treatment of patients, clinicians must not prescribe religious beliefs or impose their beliefs on patients. If medical practitioners are not trained on how to handle patients' faith needs, it is the trained clergy who can provide in-depth religious counseling to the sick.

Yousefi and Abedi (2011) are also among the researchers who have established the link between religion and health<sup>3</sup>. They state that the doctor who considers the patient's spiritual dimension sends a significant message that he or she is concerned with the person holistically. Moreover, by so doing, the clinician enhances the patient-physician relationship and this may increase the impact of medical therapy and intervention. Lucchetti and Lucchetti (2014) also posit that it is a need for mental health clinicians and other health care professionals to learn about the ways in which spirituality, religion and culture impact on the patients' needs and recovery.

There is need for spiritual and religious care among hospitalized patients (D'Souza, 2007; Lecchetti & Lucchetti, 2014). Similarly, Yousefi and Abedi (2011) state that spiritual needs are part of individual people's essential needs everywhere and at all times. This is so because humans have both physical and spiritual dimensions. These are intrinsic needs of a person throughout life; as such, they are a major element which holistic nursing care system should address. According to D' Souza (2007), satisfying patients' spiritual needs is one of the greatest challenges which nurses face. In their study which utilized a hermeneutic-phenomenological approach, Yousefi and Abedi (2011) arrived at the deductions that spiritual needs are needs which when satisfied cause an individual to grow spiritually thereby making a person social and hopeful individual who thanks God all the times in life. When people grow spiritually, they develop a desire or need to communicate with God as they become hopeful. In this regard, Yousefi and Abedi (2011) concluded

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overlap. Like religion, spirituality encompasses belief in a deity such as god, God or any other supreme being. The discussion of spirituality is centered on the fact that there are ways by which people fulfill what they perceive as their purpose in life according to the divine's provision. Though people adhere to different religions, the concept of spirituality is similar to most of them (D'Souza, 2007). Spirituality according to McCormick (2014) is "a search for that which is sacred in life, one's deepest values; a relationship with God or a higher power transcending the self. People may have powerful spiritual beliefs and may or may not be active in any institutional religion."

<sup>3</sup> The term health according to World Health Organization (WHO, 1949) is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Ai (2008) offers some insights on health by linking it to human well-being; that is being free from injuries experienced during accidents, sickness caused by various factors and also death.

that it is possible to satisfy spiritual needs in the nursing system and when a patient's spiritual aspects are considered, his or her treatment accelerates.

The medical world today, unlike the previous years, has accepted the role of spirituality and religion during interventions and therapies to treat and cure patients. A similar view is postulated by Puchalski (2001) who posits that sometime ago, discussions concerning religion and spirituality were considered inappropriate in the study and practice of medicine. However, this bias is beginning to change as clinicians begin to appreciate the significance of spiritual and religious aspects to health and well-being of patients and the role of faith in the lives of both patients and doctors.

The impact of spirituality and religion in the health of Americans was also revealed by Eisenhut (2016) who posited that faith is a major factor in the lives of the people of America. Eisenhut further states that, despite the fact that individual Americans have diverse cultures, religion and spirituality remain vital to their lives. He cites the Pew Research Center which shows that 65 percent of Americans in 2016 identified themselves as religious while 18 percent described themselves as spiritual. However, regardless of the impact of spirituality and religion in the lives of the people, Eisenhut states that not all medical institutions in the USA take into account patients' religious and spiritual matters as they treat them.

The medical fields in some parts of the USA are disconnected to faith aspects due to the fact that many healthcare providers have been trained during their medical education and practice to look at health and medicine from the mindset of a natural scientist. Having this worldview regarding health, healthcare professionals leave out religion and spirituality outside their health provision and care plans. In consideration of this view, Yousefi and Abedi (2011) state that this is a modern way of looking at medicine which is totally different from the historical times when health care was connected to religion. Eisenhut (2016) concurs with Yousefi and Abedi's (2011) view that in the previous centuries, physicians and spiritual-religious leaders were one and the same. In those years, individuals who were sick and in need of medical assistance looked for a religious guider. However, with the progression of time, there came a period when society decided to separate medicine from the church.

Owing to the importance of spirituality and religion to human lives and health, Eisenhut (2016) urges healthcare providers to be respectful, empathetic and to remain mindful of the patients' spiritual and cultural needs. He stated that there is a proof that a number of Americans are comforted and calmed when they resort to their faith during healthcare trials. Then, finally, Eisenhut (2016) suggested that it is of paramount importance that healthcare providers give patients an opportunity to discuss their religious beliefs with physicians in order to adjust treatments if need be. D'Souza (2007) shares similar sentiments by suggesting that healthcare institutions must educate their staff on how to address different world religions which diverse patients subscribe to. The reason behind the suggestion is that, educating health providers on how to address religious matters helps them gain a sense of awareness thereby doing away with misconceptions on patients' faith issues. Moreover, Barnetti and Fortin (2006) established that exposing healthcare providers to training on matters of religion enhances their ability to engage in valuable conversations with individual patients on their religions as they seek treatment. In addition to this finding, Eisenhut (2016) states that when healthcare providers open communication channels with their patients, it becomes easier to incorporate religion and spirituality in a healthcare system. More so, being vigilant concerning religious and spiritual

practices can speed up patients' recovery, reduction of medical errors and also enhancement of effective communication between patients and healthcare providers.

Aspects of religion and spirituality have positive effects to health and longevity. Amongst scholars who subscribe to this view is Levin (2001) who states that the positive effects of faith to health has prompted some physicians to learn about the extent of the impact of faith in order to use the findings for the benefit of patients. In their endeavor to gather more information on the subject, their research produced evidence that people who attend to religious services on regular basis have recorded lower rates of illness and death compared to those that do not attend regularly or those that do not attend at all.

In the USA, studies on the top three causes of death namely heart disease, cancer and hypertension revealed that people who affiliate to religion have lower rates of the diseases. Another study also established that old people who participate in religious activities have lower rates of depression, dementia, chronic anxiety and less disability (Hall, Koenig & Meador, 2004; Puchalski, 2001). Moreover, the study by Levin (2001) concluded that religious people live longer on average due to the fact that their behaviors and characters are determined by the moral teachings of their religions. The study revealed that most people who are religious avoid behaviors such as smoking and drinking too much which increase the risk of illness and death. Religion and spirituality play a major role in healthcare provision systems.

The above view on the significance of religion and spirituality is maintained by several researchers of which Puchalski (2001:4) is one. Puchalski argues that technological advancement witnessed in the previous decades tended to alter the "focus of medicine, a caring service-oriented model to a technological, cure-oriented model." Puchalski further states that the current physicians particularly those in the USA are attempting to balance the care as they reclaim medicine's spiritual roots. By so doing, they link religion and spirituality with health and medicine. The result of the linkage of these is known as spiritual or compassionate care. Thus Puchalski (2001) views compassionate care as the kind of healthcare which seeks to attend to the person's health holistically. Compassionate care addresses the spiritual, physical, emotional/psychological and social aspects of each individual patient. Therefore, understood this way, compassionate care used in treating patients can be effectively achieved through the combination of bio-medical model added to the practice of addressing a patient's spirituality, psychological and social aspects. This combination altogether produces the bio-psychosocial model of health and medicine. Such a model attempts to address the entire patient's needs effectively.

Holistic intervention strategies to health and diseases are also a requirement in Africa (Byaruhanga-Akiki, 1995). The study conducted in Botswana by Togarasei, Mmolai and Kealotswe (2016) established that health seekers can benefit a lot from a healthcare system that collaborates modern medical practices with those of the traditional and spiritual healing systems. The study also revealed that besides seeking bio-medicine or allopathic health provision alone when they are sick, in addition, Batswana consult traditional and spiritual healers. The reason for combining bio-medicine with traditional and spiritual healing systems by Batswana and other African health seekers elsewhere is that, they believe in holistic healing as Byaruhanga-Akiki and Kealotswe (1995) concluded.

Generally, the African belief is that bio-medicine alone cures the physical ailments of the body, but it cannot address social and spiritual challenges faced by patients. Therefore, Africans believe that spiritual and social challenges can be dealt with effectively by the

traditional and spiritual healing systems whose values are grounded in African religious belief systems, traditional medicine and the Christian-Bible believing church. Overall, the implication is, in an African context, a healthcare system can be more relevant if it combines bio-medicine, religion, be it Christianity and/or African indigenous religions (AIRs) among others. Thus, in an African set-up, medical education can be compliant and relevant if it incorporates the teaching of bio-medicine, traditional-indigenous medical knowledge drawn from African traditional healers and also spiritual-faith knowledge obtainable from the Bible. All churches in their various forms namely mainline, African independent and Pentecostal churches have a role to play in the health of believers. Churches can therefore work in collaboration with healthcare provision systems to enhance health (McCormick, et al, 2012).

Regarding the need for a holistic approach to human health, Ross (2009) perceives that a holistic approach to medicine is the only viable model suitable for addressing human illness effectively. Moreover, Ross (2009) proposes that there is need for integral healthcare whereby complementary and alternative medicine is integrated with conventional healthcare practices. Integral medicine according to Ross (2009) recognizes the fact that people have emotional, mental as well as spiritual dimensions that are very important in the diagnosis and treatment of illness as well as the cultivation of wellness. Similar views are also maintained by Schlitz, Amorok and Micozzi (2005:1) who state that it is integral medicine's concern that a patient should be helped as a whole person, physically, mentally and spiritually. To elaborate this view, Schlitz et al (2005:1) stated that, "Body, mind, and spirit are operating in self; culture and nature, and this health and healing sickness and wholeness are all bound up in a multi-dimensional tapestry that cannot be cut into without loss."

Overall, health and modern medicine should embrace a paradigm shift which calls for integral medical practices. In this case, medicine elaborates the basic model of "body, mind and spirit" into a more inclusive manner that embraces political, economic, social, ecological, metaphysical and worldwide dimension or aspect of healthcare (Ross, 2009:2). Although physicians cannot heal every challenge experienced by human body and life in general, they at least should be cognizant of cultural, spiritual, social and psychological problems in their patients. Moreover, they should also be aware of the implications of failure to consider these aspects of health and healing. Therefore, integral medicine incorporates all dimensions of complimentary, alternative and conventional medicine and healing- from physical, to psychological; cultural to spiritual (Schlitz, Amorok & Micozzi, 2005; Ross, 2009).

It has been, however, noted that, spirituality and religion are vital to patients' lives; as such, incorporating them into a healthcare system yields positive outcomes. Be that as it may, not all public healthcare centers and medical systems address patients' faith needs due to a variety of obstacles. According to Memaryan, et al (2015) there are several challenges which cause certain health providers fail to address patients' spiritual needs. The section that follows examines some of the challenges that act as barriers to incorporation of religious and spiritual needs into healthcare provision systems.

### **Exploring Challenges that Hinder the Incorporation of Religious and Spiritual Aspects in Healthcare Provision Systems**

One of the challenges that seek to hinder the incorporation of religion and spirituality in medicine is lack of consensus on the definition of the concept's religion and spirituality. Considering the relationship between medicine, spirituality and religion, scholars have brought forward two different approaches. Some emphasized the idea of "spirituality and medicine", while others considered the concept of "religion and medicine" (Balboni & Peteet, 2017:3). Those that propose religion and medicine resist spirituality because they are worried about its individualistic connotations and lack of connection to theology. Therefore, if the concept of religion is de-emphasized, then certain beliefs and practices of some religions will be reduced. Proponents of spirituality see religion as only one of the several broad expressions and categories. There are diverse religious practices and cultural beliefs internationally. Therefore, those that propose spirituality approach are of the view that the concept "spirituality and medicine" enables dialogue among varied "religious groups by emphasizing the common starting point of a shared humanity..." Moreover, if spirituality is emphasized over religion, as proponents of spirituality argue, groups which do not fit easily into definitions or religious categories, for instance, those that describe themselves as spiritual but not religious can be easily included. Thus, this view calls for an inclusive approach to facilitate spiritual care to a pluralistic set up made up of religious and those that claim to be non-religious but spiritual (Hall, Koenig, & Meador, 2004; Balboni and Peteet, 2017:3).

Furthermore, another reason why spiritual and religious aspects are not addressed in some health and care provision institutions is that, clinicians lack training in the area of patients' faith (Bolhari, Alivand and Mirzaee, 2012). It is therefore essential that during training in medical schools, doctors and nurses be equipped with skills to incorporate spirituality and religion when providing health care services. The study by Puchalski (2001) reveals that inclusion and integration of spirituality and religion in public health and medicine curricula has long been suggested as an important requirement. Thus, Barnett and Fortin (2006) suggest that modern medical education syllabi should have spirituality and religion as part of the package.

Despite the impact that spiritual and religious aspects seem to have on health, these values are still ignored in practice of medicine particularly in the developing world. For instance, in Iran, Memaryan, et al (2015) established that there is no trace of spiritual and religious related education observed in the country's medical schools. This is quite puzzling considering the fact that Iran is Islamic. Islam is the most dominant religion in the Arab World in which Iran is located. That being said, the situation in Iran is, however, different from that of the USA, a developed country where a number of medical schools have started promoting the inclusion of spirituality and religion in medical education (Barnett & Fortin, 2006). By comparisons, statistics in the USA medical institutions show that, only 3 medical schools addressed the aspects of spirituality and religion in 1993 increasing to 100 in 2011 (Memaryan, et al, 2015). This is not the case with Iran and other countries in the developing world where factors related to religion are sidelined or ignored in medicine.

Despite the fact that there is evidence showing the relevance of including the components of spirituality and religion in medical education curriculum, there are challenges threatening the inclusion of these aspects of faith. D'Souza (2007) cited challenges in academic planning. Memaryan et al (2015) elaborated this view by pointing out that there is lack of necessary content for inclusion in medical education. This challenge

relates to the abstract nature of spiritual-religious aspects and experimental and material nature of bio-medicine. Therefore, these differences between aspects of religion and spirituality and that of health and medicine make it difficult to combine the two. Moreover, Memaryan et al (2015) contend that, so far there is no consensus reached on the definition of spiritual-health. Thus, in several developing countries among them Iran, there is no standard intervention and care model put in place in accordance with the country's context.

Another challenge that acts as a barrier to incorporation of religion and spirituality in public health systems is that, medical education curricula in some contexts is saturated. Therefore, there is no space for inclusion of new components such as spirituality and religion (D'Souza, 2007). Moreover, this problem is coupled with the need for skilled manpower to train medical specialists in religious-spiritual therapy. Therefore, though spirituality and religion have proved to have certain positive effects to health and medicine, their integration in medical training courses is a challenge.

Several other challenges hinder the incorporation of the aspects of religion and spirituality in public health and medicine. For instance, the study by Memaryan et al (2015) shows that in some communities in Australia, religious beliefs and culture can either act as facilitators or inhibitors in the integration of spiritual-religious programs in medical curricula in the university. According to D'Souza (2007), in some parts of Australia, inclusion of spiritual-religious aspects into medical education is not considered a noble idea in the sense that the aspects of faith are of very little value to these communities.

Case studies show that there is diversity in the type of challenges faced by communities, which hinder incorporating spirituality and religion into health and medical practices. In Brazil, according to the study by Jafari, Loghmani and Puchalski (2014), there was lack of time for inclusion of aspects of faith into healthcare system. Moreover, in some cases, people were not aware of the relevance of including spiritual-religious components in medical education. In addition, lack of training in spiritual-religious matters coupled with fear that some patients may not subscribe to spirituality and religion in their lives are some of the barriers to implementation of aspects of faith in the modern public health education system. Most of these challenges according to Memaryan et al (2015) are attributed to the failure of medical schools to provide appropriate development and training in the aspects of religion and faith. Therefore, the non-inclusion of religious-spiritual aspects in medical education's academic curricula is the major barrier hindering modern medicine- health care providers to provide such care.

Several stakeholders in the field of health and medicine particularly in the developed world acknowledge the need for addressing aspects of religion and spirituality in formal public-health-medical education. Nonetheless, Yousefi and Abedi (2011) state that the implementation of these programs requires a study that explains possible strategies used to overcome challenges in designing and integrating religion and spirituality in medical education.

Professional ethics to some extent acts as an obstacle to the inclusion of religious and spiritual aspects into healthcare systems. In light of this view, McCormick (2014) posits that professional-medical ethics do not require physicians to impinge their beliefs on patients who in most cases are in a vulnerable position as they seek treatment. Moreover, the situation is further complicated by religious and cultural pluralism. There is a wide range of belief systems and varied religious and spiritual practices. There is therefore no physician who can understand all these different religions and faith communities.

So far, the paper has discussed the benefits and prospects as well as challenges of incorporating spirituality and religion in healthcare systems. The section that follows examines how issues concerning spirituality and religion can be addressed in medical schools.

### **Addressing Religion and Spirituality in Medical Schools**

Having realized the significance of religion and spirituality in health and medicine, some providers of public health suggested that the concepts of faith be included in medical education. Research has revealed that in the recent past years, interest concerning religion and spirituality among academic physicians has grown rapidly. Evidence has shown that in the USA, there was a single medical school offering a formal elective course in religion, spirituality and medicine in 1992. However, by 2001, there were above 70 medical schools offering courses on religion, spirituality and medicine (Puchalski, 2001). In some of the medical schools in the USA, courses in religion and spirituality are compulsory. Moreover, these courses are integrated with the rest of other courses in the medical school curriculum. McCormick (2014) posits that integration of religion and spirituality into medicine in the USA was made possible through working together of several healthcare associations. Among these associations according to Puchalski (2001) are the Association of American Medical Colleges (AAMC) and the National Institute for Healthcare Research. These two associations are said to have sponsored conferences on the development of spirituality, religion and medicine curriculum. Koenig (2004) states that the main reason for including spiritual and religious issues into medical school curricula is to enhance holistic treatment and to make medicine more human.

Regarding addressing issues of faith in the USA medical schools, students who take courses on religion, spirituality and medicine have to work with several facets of faith. Moreover, they focus on the clinical integration of the themes of spirituality and religion courses into chronic pain, pregnancy and childbearing; addiction and dependency disorders; psychiatric illness, disability as well as caring for the dying patients. Sessions on religion, spirituality and faith of caregivers are also included. These sessions on religion and spirituality help medical students recognize the religious-spiritual dimension of their own lives and how this can impact their practices at work (Puchalski, 2001). In teaching these sessions, several pedagogical styles are employed. According to Koenig (2004), some sessions provide students with the opportunity to explain or describe their understanding of spirituality and how religion and faith help them cope with the stress of medicine as well as emotions that arise from caring terminally ill patients. Furthermore, Puchalski (2001) states that other courses provide opportunities to practicing doctors to share how they perceive their personal spirituality and how this affects their practice of medicine.

Courses in religion and medicine emphasize the compassionate and spiritual aspect of the bio-medical profession. Compassion is the common most significant theme that student doctors and those already practicing medicine need to realize as servers of people. Providing service to others is considered the root cause of medicine and it is the highest spiritual value (Koenig, 2004; Puchalski, 2017). Therefore, the concept of compassion and palliative holistic care drive several medical education programs which combine diverse methods to teach religion, spirituality and medicine in medical schools. Regarding the teaching methods, Puchalski (2001) posits that there are didactic sessions that cover topics such as the role of religion in healthcare, the part played by spirituality in chronic illness and also in end-of-life care; the use of religion in addressing patients' suffering; how

religion helps patients in seeking meaning and purpose of life in the context of suffering; how to compile a spiritual history and also the roles of pastors/clergy and chaplains in healthcare provision.

In teaching religion, spirituality and medicine courses, Puchalski (2017) emphasizes the need for interdisciplinary sessions delivered by different professionals and providers such as medical doctors, nurses, chaplains, pastors, pastoral counselors and social workers among others. Moreover, in teaching multi-disciplinary courses in medical schools, methods such as storytelling, group discussions, case presentations and discussions; reflective writing; panels where patients, physicians and chaplains among others discuss; as well as the use of literature and poetry to communicate spiritual themes can be used (Puchalski, 2001; Bolhari, Alivand & Mirzaee, 2012).

Curriculum development is one of the most important issues when addressing religion and spirituality in medical education. Though curriculum development has been highlighted elsewhere in the current paper, it has not received a wide coverage. Regarding curriculum development, Mitchell et al (2016) state that though several studies have addressed the integration of spirituality and/or religion curriculum into medical school training, few studies describe curriculum development process that is based on qualitative data gleaned from the faculty and students of medicine. Therefore, in their study, Mitchell and collaborators propose that those who develop the curriculum on religion/spirituality and medicine may explore the perceptions of medical students and pastoral/chaplaincy trainees to facilitate reflection on religious and moral dimensions of caring for critically ill patients and also to train students in self-care practices in order to promote professionalism.

## **Conclusion**

To sum up, the paper has shown that religious and spiritual beliefs play a vital role in the lives of several patients according to Botswana medical practitioners' views. Research has shown that, during a life-threatening illness, several patients seek both physical and spiritual treatment and healing. In other words, patients would be looking for holistic healing that healthcare providers can only achieve if they put into practice or implement bio-psychosocial approach to health in addressing disease. Therefore, through the channels of religion, spirituality and medicine, patients will wrestle with issues of suffering, despair and death while they search for hope and meaning in the crisis of disease and sickness. Furthermore, research has also revealed that religion and spirituality promote good health and longevity to those who take part in faith services at church and others. Finally, though religion and spirituality are different fields of study from medicine, they have a vital role to play in human health and medical education. Inclusion and infusion of the elements of religious and spiritual aspects on health into medical school curricular can be of great benefit to students and those already practicing medicine according to medical practitioners in Botswana. Religion and spirituality are important elements which can enhance public health delivery systems in Botswana.

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**Tinoonga Shanduka** is a trained theologian and a PhD candidate at the University of Botswana. He holds BTh and MA degrees. Shanduka worked for ten years as church

leader in Zimbabwe, two years as World Vision Project facilitator; eight years as a teacher and lecturer in Zimbabwe, plus six years as teaching assistant at University of Botswana. Furthermore, he spent one year as a lecturer at Gaborone University College of Law and Professional Studies.

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## REFERENCES

Ai, A. 2008. Spiritual and Religious Involvement Related to End-of-Life Decision-Making in Patients Undergoing Coronary By Pass Graft Surgery. *International Journal of Psychiatry in Medicine*, 38 (1): 111-130.

Balboni, M.J. & Peteet, J.R. 2017. *Spirituality and Religion within the Culture of Medicine: From Evidence to Practice*, Oxford: Oxford University Press.

Barnett, K.G., Fortin, A.H. 2006 Spirituality and Medicine: A workshop for medical students and residents. *Journal of General Internal Medicine*. 21 (5): 481-485. Doi: 10.1111/:1525-1497.2006.00431.x.

Byaruhanga-Akiki, B.T. and Kealotswe, O.N. 1995. *African Theology Healing*, Gaborone: Print World.

Bolhari, J.M., Alivand, H.D., & Mirzaee, M. 2012. Spiritual approach in medical education and humanities. *Medical Ethics* 1 (20): 103-128.

D'Souza, R. 2007. The importance of spirituality in medicine and its application to clinical practice. *The Medical Journal of Australia* 186 (10 Supplements): 557-559.

Eisenhut, A. 2016. Cultural Link Connecting Culture, Improving healthcare. *The Impact Religion can play in Healthcare*. <https://theculturalink.com/2016/10/17>.

Jafari, N., Loghmani, A., Puchalski, C.M. 2014. Spirituality and health care in Iran: Time to reconsider. *Journal of Religion in Health* 53(6), 1918-1922.

Hall, D.E., Koenig, H.G. and Meador, K.G. 2004. Conceptualizing “religion”: How language shapes and constrains knowledge in the study of religion and health. *Perspect Biol Med*, 47 (3), 386-401.

Koenig, H.G. 2004. Spiritual Care: Whose Job is it Anywhere? *Southern Medical Association*.  
Levin, J. 2001. *God, Faith and Health-Exploring the spirituality healing connection*, New York: John Wiley & Sons.

Lucchetti, G. and Lucchetti, A.L. 2014. Spirituality, religion, and health: over the last 15 years of field research (1999-2013). *The International Journal of Psychiatry in Medicine*. 48 (3): 199-215. Doi:10. 2190/pm. 48. 3.e.

McCormick, T.R., Hopp, F, Nelson-Becker, H, Ai, A, Schlueter, J.O, Camp, J.K. 2012. Ethical and Spiritual Concerns Near the End of Life. *Journal of Religion, Spirituality and Aging, September*, 301-313.

Memaryan, N. Rassouli, M, Nahardani, S.Z and Amiri, P. 2015. Integration of Spirituality in Medical Education in Iran: A Qualitative Exploration of Requirements. *Evidence- Based Complementary and Alternative Medicine Journal*. Doi:10.1155/2015/793085. Accessed 14/03/18.

Mitchell, C.M., Epstein-Peterson, Z.D., Bandini, J., Amobi, A., Cahill, J., Enzinger, A., Noveroske, S., Peteet, J., Balboni, T., & Balboni, M.J. 2016. Developing Medical School Curriculum for Psychological, Moral and Spiritual Wellness: Student and Faculty Perspectives. *Journal of Pain and Symptom Management*. Vol. 52. No. 5. November.

Puchalski, C.M. 2001. Spirituality and Health: The art of Compassionate Medicine, *Hospital Physician*, March, 30-36.

Puchalski, C.M. 2017. *Integrating Spiritual Care into Palliative Care: A Whole Person Approach*, Washington DC: George Washington Institute for Spirituality and Health (G Wash) & George Washington University School of Medicine and Health Sciences.

Ross, C.L. 2009. Integral Healthcare: The Benefits and Challenges of Integrating Complementary and Alternative Medicine with a Conventional Healthcare Practice. *Inter Med Insights* 4: 13-20.

Schlitz, M, Amorok, T. and Micozzi, M.S. 2005. *Consciousness and Healing: Integral Approaches to Mind-Body Healing*. St Louis, MO: Elsevier/Churchill Livingstone.

Togarasei, L., Mmolai, S.K. and Kealotswe, O.N. 2016. “Quinine”, “Ditaola” and the “Bible”: Investigating Batswana health practices. *Journal for the Study of Religion* 29 (2): 97-117.

Togarasei, L, Gabaitiri, L, Kubanji, R, Madigele, TJ, Mmolai, SK, Shanduka, T Tabalaka, A and, Marwiro, A. 2020. Christian Medical Mission from the Perspective of Batswana Faith Healers- *International Bulletin of Mission Research* 45 (2): 145-156.

Yousefi, H., Abedi., H.A. 2011. Spiritual care in hospitalized patients. *Iranian Journal of Nursing and Midwifery Research* 16 (1): 125-132.

# The Need for Incorporating Health and Healing in Theological Education in Africa

Lovemore Togarasei

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## Abstract

Observing that theological education in Africa needs a review in light of its history of association with Western missionaries, this article joins that call by focusing on the need to incorporate health and healing in this review. The article is based on findings from a field study as well as from literature. It argues for incorporating health and healing in the revised African theological education curriculum, among other reasons, on the pursuit for healing in African churches. Opening with a discussion of theological education in Africa in terms of its offering, its meaning and goals, the article then makes a presentation of findings on Botswana's views of health and healing in theological education. It then discusses the need for incorporating health and healing in theological education as reflected by respondents and in literature.

**KEY WORDS:** Health and Healing, Theological Education, Africa, Botswana, Curriculum

## Introduction

This paper makes an argument for the need for incorporating health and healing in theological education based on recent findings from a study conducted in Botswana as well as from evidence from literature that has been produced on the subject of health and healing in theological education (TE). Although I take a global perspective, I am mainly interested in African theological education. The overall objective is to justify the need for incorporating health and healing in theological education in view of current calls to make African theological education speak the African Union's Agenda 2063,<sup>1</sup> the United Nations' Sustainable Development Goals<sup>2</sup> and the Botswana Government's outcomes-based education (Adedoyin and Shangodoyin 2010). The need to review African theological education actually has a longer history and continues to be made. Abraham Folayan (2017) cites such scholars as D. Kesley (1992), G. Cheeseman (1993) and Robert Banks (1999) who have noted that Third World TE in particular requires review in light of

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<sup>1</sup> See: All Africa Conference of Churches 2019-2023 Strategy (AACC, 2019).

<sup>2</sup> The United Nations 2030 Agenda for Sustainable Development has 17 goals that all aim to, "...improve health and education, reduce inequality and spur economic growth..." (<https://sdgs.un.org/goals>), accessed 7 March 2022).

the fact that it was brought by the missionaries and that the role it played then might not be relevant today. W. P. Wahl (2013:266-285) notes that since Christianity's centre of gravity has shifted to the global South, there is need to strengthen leadership. This need for competent church leaders, especially in Africa, is also emphasised by Chitando (2009), Gatwa (2009), Naidoo (2008:128), Walls (2002:220-221), and Werner (2008:86-87). These scholars argue that a new and alternative framework for theological education in Africa is needed; something that will produce church leaders that are competent to meet the contextual challenges of this continent. In the same vein, Gerloff (2009:17) also identifies that "fresh educational tools" are needed to equip church leadership in Africa. Health and healing is one aspect of African life that calls for a review of TE in Africa. As already stated, based on recent field findings in Botswana and review of literature, this paper therefore makes an argument for incorporating health and healing in the revised African theological education. This is urgent considering the pursuit for healing in African churches. Though many African theologians have given attention to issues of healing and health as shall be demonstrated below, works reviewing how TE is tackling health and healing are scarce. The paper opens with a discussion of theological education in Africa in terms of its offering, its meaning and goals. This will be followed by a presentation of findings on Botswana's views of health and healing in TE. The next section will then discuss the need for incorporating health and healing in TE as reflected by respondents and in literature. A concluding section then wraps up the paper.

### **Theological Education in Africa: An Overview**

In Africa, TE is offered in Seminaries or Bible Schools often run by specific churches or church bodies. It is also offered in public universities in Faculties/Departments of Theology and/or Religious Studies or some related names. Theological education is also offered through distance education as in Theological Education by Extension (TEE). Where it is offered in universities, often, such Faculties or Departments also include courses or programmes in Philosophy or Classical Studies.<sup>3</sup> Generally, TE in Africa follows the Western structure of running under four major theological disciplines: biblical studies, church history, systematic theology and practical theology. In the past few decades, African theological institutions have added to these disciplines the study of other religious traditions such as African Traditional Religion (s) (ATR), Islam, Hinduism and other world religions. But despite the 'formalised' TE we discussed above, we must hasten to mention that a great deal of 'informal' theological education takes place in in-house training 'schools' within different churches. Here, the church leaders/founders train their fellow leaders informally, a kind of on-the-job training. Institutionalized theological institutions, especially non-denominational ones and state institutions, need to develop ties with these churches to provide short term theological courses, for example.

### **The Meaning and Goals of TE**

Since TE is offered at different levels in Africa, the understanding of its meaning and goals slightly differs depending on the level and context at which one discusses the subject. For those scholars who look at TE as it is provided in churches and seminaries, "...theological education consists in the formation of the people of God in the truth and wisdom of God for the purpose of personal renewal and meaningful participation in the fulfilment of the

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<sup>3</sup> For example, at the University of Zimbabwe and University of KwaZulu Natal in South Africa.

purpose of God in the Church and the world” (Noelliste 1995:299). Noelliste sees theological education as the process of formation that leads to the transformation of the world through the individual and the collective participation of God’s people in God’s mission. Using the example of education in pre- Christian Africa, he says education in general should aim at character formation and learning of specific skills. Noelliste (1995) also makes a very important observation that the relevance of education arises from societal need, the sharing and transmission of collective spiritual and moral values, and the close relation of education to work. He concludes that education should aim at bringing quality and fulfilment to human life.

Peter Nyende (2013:600-610), discusses the subject matter of theological education, its aims, its current state in Africa and proposes the infusion of ethnic studies in it. He says since TE is about God (his words, actions, agency, character, etc) and God’s world (human beings, nature, environment, societies, etc), it ought to infuse life with morals and values. For Nyende, the purpose of TE is to infuse life with morals and values. Thus, he says, “(TE)...offers inquiry, instruction, knowledge and practice which in relation to humans’ perceptions and experiences of the transcendent, draw from both the moral and value-oriented domains.” For him, TE therefore influences most other human endeavors, be they scientific, artistic, social or political, for *good* or *ill*.

Nyende (2013:601) also discusses the aims of TE in formal higher education in Africa. He says 21<sup>st</sup> century higher education ideally strives to provide knowledge and skills necessary for public service and other vocations. Higher education therefore exists to benefit a nation’s economy. So should be TE especially when it is offered in departments and faculties of theology and religious studies in African universities. In these cases, TE should provide knowledge and skills for services in the church and in the wider society where the church lives: these include addressing all of Africa’s pressing problems, finding the purpose and meaning of the gospel in different social and ecclesiastical contexts. He (Nyende 2013:602) cites Tinyiko Maluleke who makes a very important observation on the place of theological education in Africa saying, “If official statistics are to be trusted, Africa is a very religious continent with Christianity, however nominal it might be, occupying a place of pride in this. This means that TE in Africa has public consequences beyond the narrow confines of seminaries and church congregations. In many countries therefore, African theological and religions education is public education- quite apart from whether governments recognize this or not.”

In short, Nyende says TE aims to infuse life with morals and values to mould a just, moral and peaceful society and to provide knowledge and skills to serve the church and the wider society.

After making a quick survey of the content of TE in Africa, he notes that there have been attempts to make TE answer to Africa’s needs. Thus, apart from teaching the traditional disciplines of TE such as biblical studies, systematic theology and church history, there has not only been attempts to contextualize these but also introduction of such courses as Peace and Conflict Resolution, Christianity, Justice and peace in order for TE to grapple with Africa’s political and social contexts. Be that as it may, he concludes that there is still room for revising and improving the TE curriculum in Africa. He suggests adding ethnic issues as one area that requires to be addressed by TE. Nyende’s proposal for including ethnicity to TE in Africa serves as a good model to follow when suggesting the need to add health and healing issues to TE. He suggests that one can introduce the subject as a discipline, as an interdisciplinary subject, as offered across the curriculum or

as a general or core course in TE in Africa. His proposal is important for reviewing theological education to also infuse health and healing.

W.P. Wahl (2013:266-285) also provides a review of the meaning and purpose of TE in Africa centering it on leadership. In doing so, he underlines what other scholars like Chitando (2009), Gatwa (2009), Naidoo (2008:128), Walls (2002:220-221), and Werner (2008:86-87) have long called for this. These scholars argue that theological education in Africa should produce church leaders that are competent to meet the contextual challenges of this continent. For Wahl (2013:269), theological education in Africa is currently facing a number of challenges and those tasked to develop its curricula, programmes, institutions and methodologies are compelled to critically reflect on the relevance of the models used. He identifies the following as challenges for theological education in African: access; the lack of resources; sociopolitical and social-economic illness; and an Africanised scholarship and curricula. Noting that African theological curricula is often Western in its content and mode of delivery, he follows many African scholars in making a case for accredited and accessible competence-based curricula relevant to the African context. Other scholars who emphasise the need for relevance in African TE include Gatwa (2009) who argues that theological education must resource the life of the people. In the same vein Swanepoel (cited by Wahl 2013) identifies a gap between the needs of the people in the church and the content taught in theological institutions; curricula need to become relevant. Chitando (2009) also makes a case for accredited theological curricula in Africa and identifies the following relevant themes to be addressed: HIV and AIDS; political literacy; and masculinity.” With these views and suggestions, we approached Batswana to get their views on theological education and health and healing in a bid to review TE in Botswana and the rest of the African continent.

### **Batswana Views on Health and Healing in Theological Education**

In view of what literature says about the need to review theological education in Africa, our team conducted a field research study, among whose objectives was to establish Batswana’s views on health and healing in theological education. The study was conducted between 2018 and 2019 in Botswana. The aim of this study was to establish how religious beliefs impact health seeking and health provision behaviours among Batswana and, from the findings, to propose review of theological, medical and health education for the purposes of promoting holistic health through the integration of medical, traditional and faith healing. The study adopted a mixed methods approach. Beginning with detailed review of existing literature, it collected quantitative data using questionnaires and qualitative data through focus group discussions and individual in-depth interviews. The quantitative and qualitative tools sought to collect information from four different groups of people (medical health practitioners, traditional healers, faith healers and health seekers) on their views on causes of illness, medication, collaboration of alternative health systems, organ and blood donation and curriculum issues in religion and health. Data for this article is, however, limited to views on health and healing in theological education curriculum. Participants who provided data on this aspect of the study included faith healers and academics in theological education institutions. The faith healers were drawn from all the Christian traditions found in Botswana, that is, mainline, African initiated, evangelical, Pentecostal and charismatic churches. The participants were drawn from 8 different geographical areas representing the north - south and the rural - urban divides of Botswana. Both purposive and snowball sampling methods were utilized and as many participants as possible were interviewed until we reached a saturation point in each geographical area. All

necessary steps were taken to protect the identities of the participants. Thus, for example, in presentation of data, we do not identify the respondents by name but by codes (e.g. MAP001) that each of the respondents was given during data collection.

Data gathered reflected that faith healers (church ministers/pastors) always deal with issues of health and healing. From prayers for healing to burial of the dead, health and healing issues are at the centre of their work. All faith healers said they practiced some form of faith healing. Common forms mentioned were prayer, prayer with laying on of hands, use of water, use of oil, use of sacraments like the Eucharist and use of other healing objects such as stones, leaves, etc. The Bible provided the most influence in the practice of faith healing,

“Eh, eh, we believe that the great physician is God, that is why we base on God. Yes, in the Bible some people were healed after prayers. But we encourage people to go back to the hospital for check-up, to prove that they are healed” (MAFH 001).

Considering their role in health and healing, the study then sought to establish if their training included issues of health and healing. While all the ministers from mainline churches had undergone pastoral training, many in African independent churches had not. Those faith healers who received training said their training included some courses on health. One respondent said, “Even though I was trained way back, I remember being taught that our bodies have their own healing mechanisms. I also remember being told to seek help from medical doctors and avoid diseases prone to certain regions/environments like yellow fever. We learnt about missionaries who ignored medication and died over there because of those diseases and that those who took medication survived the conditions” (TSFH002). Other respondents like HUFH001 were specific about the courses on religion and health they studied, “We were trained in what is known as clinical psychology, also we did practicals by visiting hospitals.”

The majority of the faith healers, however, said they had no pastoral training or their trainings did not have courses on religion and health. This was confirmed by the curricula of different theological institutions we studied. There were no specific courses discussing religion, health and healing. Heads of theological institutions interviewed confirmed also that such a gap existed in their curricula with some pointing at attempts to close them by offering courses on religion and HIV and AIDS. Both faith healers who had received pastoral training and those who did not were agreed that pastoral/theological training should include courses on health and healing. They argued that since pastors deal with people on a day-to-day basis, they need knowledge on health and healing, “We are in charge of the people of God, a pastor is someone who the people listen to very much and whatever he says, people usually follow so it’s important that we are taught” (GAFH001). They even suggested the course content to include, Psychology, Clinical Pastoral counselling, Healing rituals in specific religions, Health and prosperity, Satan and Illness (Demonology), Causes of Human Illness, God and medicine, Holistic healing and Collaboration with other health providers. Underlining the urgency of these courses, they suggested that while these courses are prepared for those undergoing training, there was also need for short term courses for those already in service.

### Discussion: the Need for Incorporating Health and Healing in TE

The call for incorporating health and healing in TE is growing confirming the views of Batswana pastors and faith healers. Peter Bartmann, Beate Jakob, Ulrich Laepple, Dietrich Werner (2008) paid attention to health and healing in TE in a position paper developed out of the observation of the growing desire for healing and health in Germany. The authors also noted the growing discourse on health, healing and spirituality, not only in Germany but worldwide. That this discourse is growing is also attested by several returns that one finds if they were to do an internet search of health, healing and religion or spirituality. Peter Bartmann, Beate Jakob, Ulrich Laepple, Dietrich Werner (2008) began with an attempt to define health, went on to discuss health in the global context, health in Germany and the challenges it throws to the church and church ministry. They also discuss Christianity as a therapeutic religion, the church as a healing community and suggest ways by which the church can become a healing community. Their suggestions for the way forward are very important for this study. Although they do not address the implications for theological education, there are many lessons for theological education review to be drawn from their position paper. In fact, their recommendation number 7 says, “More attention needs to be paid to health, healing and spirituality in the training, and further training, of pastors and deacons, as well as of doctors and nursing staff. Existing course models for the relevant training courses should be revised and made accessible” (Bartmann, Jakob, Laepple and Werner 2008:86). They elaborate this suggestion by saying, “In many places, we need a decentralized system of training courses on health, healing and spirituality to teach these subjects to current staff and, vice-versa, to introduce new experiences gained in this field into the teaching material. An important step might be to regularly offer the Diaconal Academy and the Association for Missionary Services regular further training and qualification courses in this field.” (Bartmann, Jakob, Laepple and Werner 2008:86).

The outbreak of HIV and AIDS called many theologians to wake up to the call to contextualize theological education. It is no surprise then that the area of HIV and AIDS has several publications on the subject of health and healing in TE. In 2007, Nothando Hadebe published *A Theology of Healing in the HIV&AIDS Era*. Hadebe looks at Christianity, ATR and Islam and outlines their theologies that can be used to respond to HIV and AIDS. She works with an understanding of theology as, “... the study of God and God’s activity as revealed in the faith traditions of all religions. One of the aims of theology is to connect beliefs about God to current social contexts and life experiences. Each religion has resources that they use to develop their theology” (Hadebe 2007:23). Hadebe’s work already addresses the place of religion in health and healing and response to Batswana call for strengthening this in the review of theological education.

Ezra Chitando and Charles Klagba (2013) edited a book comprising 10 chapters that address healing in the context of HIV. Written by a team of theologians, historians, pastors and other professionals, the book addresses different perspectives from African Traditional Religion and Christianity for understanding healing in the context of HIV and AIDS. For example, the first chapter by Tabona Shoko examines the interpretation of sickness and health in African Traditional Religion reminding readers of the importance of indigenous approaches to health and healing. Togarasei’s chapter 2 provides an overview of the Bible’s approach to sickness while proposing harmonising biomedical and spiritual approaches to healing. Other chapters address different aspects of healing in the Bible and Christian history. Of much interest to TE is chapter 9 by Marcellin S. Dossou. After analyzing the sending-in-mission texts by Jesus (Luke 1:1-2 and Mark 16:17-18),

Dossou notes that the contemporary church in Africa has the tendency to emphasise medical works when it comes to healing and health. She thinks this has both advantages and disadvantages that need to be addressed by TE, “Our institutional churches have emphasized intellectualization in the training of their pastors, which is an excellent thing. Unfortunately, such intellectualization is done to the detriment of the spiritual aspect” (Dossou 2013:181). Dossou goes further to note that this intellectualization results in the absence of healing prayers in TE curriculum. She therefore urged theological training institutions to include healing prayers in their curriculum, a call in line with the responses of Batswana.

The Bible is central in TE in Africa. As a result, the Bible is often consulted in discussing healing and health, for good or for worse. We saw above from Batswana respondents that their practice of healing is influenced by the teaching of the Bible. It is therefore important to pay attention to works that address the Bible, health and healing. Although not focusing on Africa, John J. Pilch (2000), looks at healing practices in the gospels and other books of the New Testament. The book is important for understanding healing and curing and especially as it provides models to be learnt from the Bible to address healing today. Concluding the book, Pilch (2000:143) underlines the relevance of the book saying, “The definitions and models presented in this book and applied..... can contribute to a richer and more precise understanding of these questions in antiquity. Armed with these insights, modern readers will be in a better position to draw truly respectful and relevant conclusions for their situations.”

Unlike Pilch who discusses the Bible, health and healing in general, Judith L. Hill (2007), specifically uses the New Testament to discuss health, illness and healing in Africa. She begins by making a very important observation that, “In the search for better health for Africans, a variety of solutions have been attempted” (Hill 2007: 151). She identifies the three health systems consulted by the Africans as she states, “The traditional healers as well as the sorcerers are ever-present and frequently consulted. Sometimes, well-wishers from other parts of the world offer African states the wonders of Western medicine..... Still others take a different approach. (and) tend to downplay this present life and simply emphasize eschatological joys and glorious, heavenly bodies... (while)....the supporters of the Health and Wealth Gospel fervently proclaim healing in the atonement and a theology that announces prosperity and good health in this life for all those who believe in Jesus.” Having observed the problems associated with health and health care in Africa, Hill suggests the need to study closely what the Bible says about health and healing. Hill’s suggestions show the need for TE in Africa to focus attention on health and healing as many people flock to churches for this service. The Bible is central in providing a theology that guides attitudes to health and health care. In her article, Hill provides a theology of health, healing and the Bible that can be used in TE in Africa. For example, having analysed different texts on health and healing from both the Old and the New Testaments, she draws a number of implications some of which are, “it is permissible to seek healing-through prayer, through the ministry of someone with the spiritual gift of healing, through the anointing and prayer of the elders of the church, through modern medical science, and through traditional treatments that have no non-Christian (pagan or Muslim) orientation. In all cases, these actions are to be undertaken in faith, believing that God can use those means (and those people) to effect a cure if that is his will.” Although some of her conclusions are debatable, her suggestions form a good starting point for discussing health and healing in TE in Africa.

S. O. Abogunrin, et al. (2004) edited an important book on biblical healing in the African context. With a total of 24 chapters, the book looks at applying biblical texts for promoting health and healing in Africa. Nearly all the contributors are agreed that faith/religion/spirituality is important for health and healing in the African context. Introducing the book, Abogunrin (2004:8) notes that since the traditional world of Africa compares well with the biblical world, many African Christians still believe in and seek miraculous healing. In light of this observation, Abogunrin calls upon the government and the church to work together to promote holistic health for the people. This justifies the call for TE to seriously engage health and healing.

### **Recommendations and Conclusion**

This paper has argued for inclusion and/or strengthening of health and healing in TE in Africa using field findings and literature review. Much of the literature on health and healing in TE focuses on the Christian church, the Bible and HIV and AIDS. Journal articles, book chapters and books that address themes on health and healing do so without directly addressing how the themes should be addressed in theological education. There is need for TE to engage with health and healing holistically. A curriculum that addresses the interaction of the various health systems in Africa is needed. Such a curriculum should focus on providing all health practitioners and health administrators with deep TE of health and healing from a multi-faith perspective. As Wahl (2013:271) says, “theological institutions in Africa need to see themselves as teaching institutions that are closely linked to the context of their local faith community.” The question might be on how theological training institutions can reach out to trainee medical practitioners with a theology of health and healing. This should, however, not be a big problem in Africa where a number of churches have established universities that offer medical and health training. It should be easy for such training institutions to introduce a course or two that deal(s) with theology of health and healing. Health providers need an appreciation of the religious beliefs of their clients and how these affect the clients’ health seeking practices.

Coming on to seminaries and other theological training institutions such as University departments of Religion and Theology, it is important to underline that TE curriculum should address the needs of the people. TE curriculum should address health and healing issues especially as these are at the centre of Christian practice in Africa today. The abuse that some church clergy have made of healing has put the name of the church into disrepute. Church ministers have put the health of congregants seeking healing at risk by asking them to drink deadly concoctions, by spraying them with insecticides or asking them to drink certain dangerous chemicals. What comes out clear from these actions by the ministers is lack of basic knowledge on health and healing. TE should therefore provide courses and modules on health and healing for trainee pastors to have basic knowledge on health and healing. It is our assumption that this knowledge will curtail the abuse and encourage church ministers to collaborate with other health practitioners in the provision of holistic health services.

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**Lovemore Togarasei** (PhD) is Professor of Religious Studies at the Zimbabwe Open University where he teaches courses in biblical studies. He has also taught at the universities of Zimbabwe and Botswana. He has published widely and undertaken

consultancy work in the areas of religion and health, gender, politics, prosperity gospel, leadership and popular culture. His latest edited book is *Lobola in Southern Africa* (Palgrave Macmillan, 2020). E-mail: ltogarasei@gmail.com.

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## REFERENCES

AACC, 2019. All Africa Conference of Churches 2019-2023 Strategy, Nairobi: DorApos Designers,

Abogunrin, S. O., Akao, J. O., Akintunde, D. O., Toryough, G. N. and Oguntoye, P. A. (eds.), 2004. *Biblical Healing in African Context*, Nigeria: Philarem Corporate Printers.

Abogunrin, S. O. 2004. Biblical Healing in African Context, in Abogunrin, S. O., Akao, J. O., Akintunde, D. O., Toryough, G. N. and Oguntoye, P. A. (eds.), *Biblical Healing in African Context*, Nigeria: Philarem Corporate Printers.

Adedoyin, O. O. and Shangodoyin, Kehinde. 2010. Concepts and practices of outcomes-based education for effective educational system in Botswana, *European Journal of Social Science* 13, 161-170.

Banks, Robert. 1999. *Reenvisioning Theological Education: Exploring a Missional Alternative to Current Models*, Grand Rapids, Eerdmans.

Bartmann, Peter Beate Jakob, Ulrich Laepple, Dietrich Werner, 2008. Health, Healing and Spirituality. The Future of the Church's Ministry of Healing. A German position paper offering ecumenical, diaconal and missiological perspectives on a holistic understanding of Christian witness for healing in western societies, ([www.oikoumene.org/en/folder/documents-pdf/2008-11-07Health\\_Healing\\_and\\_Spirituality.pdf](http://www.oikoumene.org/en/folder/documents-pdf/2008-11-07Health_Healing_and_Spirituality.pdf), accessed 19 April 2018).

Cheeseman, G. 1993. Competing Paradigms in Theological Education Today, *Evangelical Review of Theology*.

Chitando, Ezra and Klagba, Charles (eds.), 2013. *In the Name of Jesus: Healing in the Age of HIV*, Geneva: WCC Publications.

Chitando, Ezra. 2009. Equipped and ready to serve? Transforming theological and religious studies in Africa. Paper presented at the Joint Conference of Academics Societies in the fields of religion and theology, Stellenbosch, University of Stellenbosch.

Dossou, Marcellin S. 2013. Healing and HIV: a theological proposal, Chitando, Ezra and Klagba, Charles (eds.), *In the Name of Jesus: Healing in the Age of HIV*, Geneva: WCC Publications, 171-178.

Faloyan, Abraham. 2017. What is the purpose of theological education? (<https://sckool.org/what-is-the-purpose-of-theological-education-abraham-faloyan-c.html>, accessed 20 April 2018).

Gatwa, T. 2009. Transcultural global mission: an agenda for theological education in Africa. Paper presented at the Joint Conference of Academics Societies in the fields of religion and theology, Stellenbosch, University of Stellenbosch.

Gerloff, R. 2009. The African diaspora and the shaping of Christianity in Africa: perspectives on religion, migration, identity, theological education and collaboration. Paper presented at the Joint Conference of Academics Societies in the fields of religion and theology, Stellenbosch, University of Stellenbosch.

Hadebe, Nothando M. 2007. *A Theology of Healing in the HIV&AIDS era*, Geneva: WCC Publications.

Hill, Judith L. 2007. Health, Sickness and Healing in the New Testament: a brief theology, *Africa Journal of Evangelical Theology* 26.2, 151-196.

Kelsey, D. 1992. *To Understand God Truly: What's Theological About a Theological School*, Louisville: John Knox Press.

Naidoo, Marylin. 2008. The call for spiritual formation in protestant theological institutions in South Africa. *Acta Theologica* 11, 128-146.

Noelliste, Diememe. 1995. Towards a Theology of Theological Education, in *Evangelical Review of Theology*, 19:3, July.

Nyende, Peter. 2013. Ethnicity in Theological Education in Africa, in Werner, D. et al. (eds.), *Handbook of Theological Education in Africa*, 600-610.

Pilch, John J. 2000. *Healing in the New Testament: Insights from Medical and Mediterranean anthropology*, Minneapolis: Fortress Press.

Wahl, W.P. 2013. Towards relevant theological education in Africa: comparing the international discourse with contextual challenges, *Acta Theologica* 33:1, 266-285.

Walls, Andrew F. 2002. Christian scholarship in Africa in the twenty-first century, *Transformation* 19.4, 217-228.

Werner, Dietrich. 2008. Magna Carta on ecumenical formation in theological education in the 21<sup>st</sup> century- 10 key convictions. *Ministerial Formation* 110:82-88.

