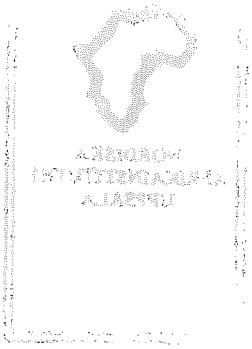
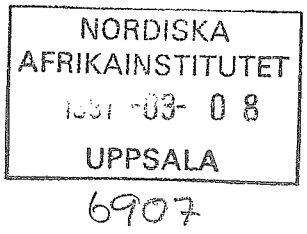


THE BATSWANAS' ENCOUNTER WITH WESTERN MEDICINE

Cooperation or Confrontation?

BY

LIV HARAM



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PREFACE

This study is presented as a thesis for the cand. polit. degree in social anthropology, at the University of Bergen, Norway.

The field work was carried out in the village of Pilikwe in the Mahalapye region in the Central District of Botswana, for a period of 12 months; 1985/-86. [1]

I am especially grateful to the villagers of Pilikwe and Seleka who made this study possible as well as joyful. Most of all I will thank Mme Bridget Lecage with whom I shared my happiest as well as the hardest times. By her gentle behaviour and her patient interpretation she let me into peoples thoughts. The local nurses Mme Gaolaolwe Morewabone and Mme Angelina Ditsela, helped me practically in every way and made it possible for me to get a grip of the formal sphere of medicine. For my inquiry into the Tswana sphere of health my friendship with Mme Masane Olopeng, was a 'goldmine' both through her work as a moprofiti in the church as well as her marriage to a Tswana ngaka. Throughout the field-research I got acquainted with a number of baprofiti and dingaka. There are, however especially two, who generously gave me their spare time and taught me about their work: Rre Metse and his congregation of the Zionist Christian Church, and Rre Moloto who introduces me to his dingaka colleagues. I am also very grateful to the medical officer Staugård, who generously helped me in every way. Whenever I felt frustrated and took some days off at Gaborone, the medical anthropologist Sandra Anderson gave me professional advice and support.

As writing is a long and lonely endeavour only a few of those who deserve thanks can be mentioned here: I will thank my advisor Ørnulf Gulbrandsen at the department of social anthropology who has given me freedom to pursue my own ideas, and Tord Larsen for professional backing. My friendship with Knut Ågotnes has been of great importance: He has been listening to the stories about 'my people', and our discussions

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[1]. *For a period of two months I stayed in Seleka village -with approximately 1500 inhabitants- about an hour drive to the east of Pilikwe.*

have inspired me throughout the process of writing.

My field work was financed by grants from The Norwegian Research Council and The Scandinavian Institute of African Studies. I gratefully acknowledge their support. When returning home longing for my friends in Botswana, the scholarship that financed my library research at the African Institute at Uppsala gave me the push to start the difficult process of writing.

Bergen, November 1988.

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CHAPTER ONE
INTRODUCTION

General introduction

Generally speaking my thesis deals with contradictions and meeting between cultures. I will focus upon Tswana medicine encountered by Western medicine.

From a health care view-point, the present situation in Botswana is typical of most countries in Africa, and indeed to a lesser extent of most countries in the world. There are two parallel medical systems of rather different nature, both in extensive use. On the one hand, there is the Western medicine, or so-called biomedicine -which was introduced to Botswana by the missionaries during the protectorate era, and which has grown dramatically since then, particularly since gaining of independence in 1966.[1] On the other hand, there is an equally active system of Tswana medicine, as practised by the various types of ngaka ya setswana; the priest- healer. Then we have the moprofiti; prophet-healer, who practices so-called faith healing in the many Independent African Churches.

The Batswana find themselves in two, distinctively cultures; the tribal culture and the so-called western civilization. This fact has implications for almost all spheres of life. Health care is one of the fields in which the contradictions is most clearly shown.

In the introduction I will very briefly outline the policy of The Ministry of Health in Botswana to integrate so-called traditional medicine with the formal health care system. This policy is according to the strategy of the World Health Organization whose goal is: "Health for all by the year 2000". Secondly, I will give a case from a health seminar to illustrate some of the problems which the implementation of this policy creates. On this background, I will then sketch the steps I will take throughout my thesis when trying to grasp the context of medical pluralism.

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[1]. *The Batswana were encountered by Western medicine a century and half ago through the missionaries. Western medicine was less advanced at that time, and in many respect more like a folk medical system.*

WHO and "Health for all by the year 2000" [2]

In the late seventies, the Thirtieth World Health Assembly of the World Health Organization passed a resolution promoting training and research in traditional systems of medicine. Thus, since 1976 and, notably, in the Declaration of Alma Ata (1978), interest in traditional medicine has arisen. Local experts who have always served their community is now regarded as valuable local resource which has hitherto been ignored. The 'traditional healer' is seen as a co-operating part in a health team:

> Primary health care relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community (WHO /UNICEF 1978).

The traditional healer is also looked upon as potentially inexpensive providers or promoters of primary health care. According to WHO:

> A traditional healer is a person who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability.

WHO's policy in the Botswana context

Compared to other African countries the Ministry of Health in Botswana began to implement WHO's integrating policy quite early. The first reference to a new official policy towards traditional healers in Botswana appears in The National Development Plan of 1976-1981, section 14.86, which reads as follows:

> Although not part of the modern health care system the traditional healer (ngaka) performs a significant role in Botswana especially in the rural areas...the policy of the Ministry is to evaluate further the contribution of traditional healers to the health care system of the country and possibly then to seek ways of closer co-operation and consultation.

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[2]. *In May 1977 the Thirtieth World Assembly adopted a resolution where it was decided that the main social target of governments and of WHO in the coming decades should be the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. This policy is popularly known as "Health for all by the year 2000".*

Thus, they have taken a positive stand and have started to devote substantial efforts to the recognition, promotion and development aimed at integrating 'traditional medicine' with the formal health care system. In the National Development Plan of 1979 -1984 the above constructive attitude has been further developed, with section 13.28 chapter 13 reading:

> There are large number of traditional practitioners of various types who are frequently consulted on health and personal matters. The Ministry of Health will continue its policy of gradually strengthening links with traditional practitioners - both diviners/ herbalists and faith healers. The emphasis will be put on improving mutual understanding especially about the practices and techniques of the traditional practitioners. No full-scale integration is envisaged, but referrals between modern health care services and traditional practitioners will be encouraged where appropriate (my italics).

According to the National Development Plan 1976 - 81, the policy of the Ministry is to evaluate the contribution of traditional healers to the health care system of the country and to seek ways of closer cooperation and consultation. It also seeks to promote traditional health services and perhaps even to expand them if, and only if, they can productively complement modern services.

The health seminar

One of the strategies adopted by the Ministry og Health in Botswana to "improve mutual understanding" (National Development Plan of 1979-1984) has been to arrange health seminars. The following illustration drawn from a health seminar where all the various participants are represented, shows both the 'setting' of the cooperative efforts and some of the basic problems involved.

The formal or professional sector as represented by a Regional Health Team (RHT) invites practitioners from the traditional medical sphere, or, Tswana medicine. There are various types of Tswana healers. First, there is the dingaka tsa setswana (sing. ngaka ya setswana), who most common only combines a set of bones('ditaola') when performing the duration with the knowledge and use of Tswana herbs. Secondly, we have the baprofiti, or prophet-healers (sing. moprofiti), who are the religious, faith healers in the numerous Independent African Churches. I will return to the various categories of Tswana healers in chapter two and three, however, for now it suffices to know that the moprofiti form a distinct group which is in many ways different from the group of

dingaka tsa setswana. Whereas the moprofiti is always closely linked to a Church the ngaka ya setswana usually will not have any Church affiliation. While female baprofiti are quite common, it is much more rare for a woman to practice as a ngaka ya setswana. Both the dingaka and the baprofiti were represented at the seminar. Members of the Village Development Committee (VDC) and the Village Health Committee (VHC), teachers and of course, headmen and chiefs from all the nearby villages were also present.

The RHT, who are responsible for teaching health care, started by appealing to all the participants to work hand- in- hand for the sake of patients so as to attain "health for all" of the Batswana. There were various themes in the health-seminar program, such as sanitation, nutrition, first-aid, family planning, as well as pregnancy and birth. However, the main subjects were diseases like tuberculosis (TB), sexually transmitted diseases (STDs), and infantile diarrhoea. As in many African countries these diseases are among the most prevalent in Botswana. An account of the interaction between the RHT and the participants during their discussion of tuberculosis (TB), will illuminate some of the important features of the complex medical situation.

The RHT's TB specialist begun his lecture by asking the participants about their knowledge of TB or kgothola e thona; 'the big cough', which is how the clinic people name TB in Setswana. The first one to raise his hand is one of the dingaka tsa setswana: "When a child is born in a wrong position", he says, "then the child, the mother, and the father will get 'the big cough' which we call tibamo. Some people started laughing and so did the TB specialist. A woman who was neither a moprofiti nor a ngaka says: "The big cough could come from the mines." (Many Batswana men have worked and are still working in the mines of South-Africa.) Someone else replied : "When the wind is blowing and you get sand and dust in your mouth, you will start coughing. "And another said: "You will get the disease through bad blood." "By using the same spoon as a TB patient you yourself will also become a TB patient", somebody else stated. Another: "It could be caused by sorcery (boloi)." And still another: "If someone having 'the big cough', coughs and spits on the ground, the next passer-by who steps on the spittle, will also get 'the big cough'."

While the participants discussed tibamo and 'the big cough', the TB-teacher had started to write his message on the blackboard: 1) the number of the TB-patients in

Botswana, 2) the number of those who die from TB, and 3) the cost for Botswana to treat people suffering from the disease of TB. And he continued to write: sign/symptom: loss of apatite or loss of weight; cough /sputum, sweating during night. He further wrote that the disease is caused by bacteria and he explained that one cannot see the bacteria with one's own eye, but requires a special instrument which is called a microscope to see it. Further, he said one can prevent this disease by coming to the clinic to get the BCG-vaccination. The TB-patient can be treated by coming to the clinic either by an 18 month daily tablet-course; or by the short-term-treatment when one takes injections for three months and tablets for the following three. He explained that TB-patients have to come to the clinic every day throughout their treatment. And he continued: "It is just a waste of time to go to the moprofiti and the ngaka. They will try to keep the patient because of their desire for money. Those using the bones (used by the diviners through a divination of the case) will throw them and tell the patient that s/he is suffering from sejeso (food poisoning caused by sorcery) and that poison has eaten up their lungs. People only waste money by going to them, and as TB is contagious they will spread the disease to others as long as they don't take any treatment. TB is not sejeso, and it is not spread by blood. It is only the clinic people who know how to treat this disease. I am not saying that our ngaka and moprofiti can't heal diseases; even I go to them now and then."

A woman then asked the RHT-teacher why they do not tell the ngaka and the moprofiti that they cannot treat TB, and that it is only the clinic people who know this disease? The teacher replied by telling her that they have tried to tell both the moprofiti and the ngaka, but such things take a long time to dissapear. He said it is like the preaching of the Bible. The gospel has been preached for many years, yet there are still people who do not believe. Then one of the moprofiti stood up and said that he has brought his son who was suffering from this disease to some of his relatives in Gaborone (the capital of Botswana). Whereby the teacher replies by telling him that TB-patient should not be chased away. The people continued to talk about 'the big cough' (TB), and tibamo and discussed whether it is the same disease or if they differed from each other. One said that we should not talk about 'the big cough' and tibamo as if they were the same disease; 'the big cough' is when someone coughs with bacteria, and tibamo is when a child is born siina; 'in wrong position' and can spread the cough to it's parents.

The problem

All parties at the seminar were concerned with health and illness. They were concentrating on the diseases of TB. or, 'the big cough': a) sign / symptom, b) causal explanation, and c) types of treatment. However, at the same time they seem to be talking about different things. There was obviously a measure of disagreement among the various groups on the topics discussed.

This small glimpse of the situation is illustrating one type of meeting between Western and Tswana medicine. Such a meeting involves not only symptoms and treatment in a limited sense, but different world-views, conceptions of diseases, and causal frameworks. The seminar will make the background for my further inquiry into the complex relationship of medical pluralism as it is expressed in social life. Throughout my thesis I will focus upon different types of meetings to illustrate the multiplicity/ variety in the encounter. The encounter takes place through social interaction between the ngaka, the moprofiti in the Tswana health sphere, the health personnel in the formal sphere of health, the patient- who switches between these various medical alternatives- and the social environment to all these actors.

By looking into how people handle the medical plural situation, one can see how the cultural meeting is expressed through social behaviour. There are many actors involved in the encounter, however, I will primarily describe the encounter between the two medical systems from the Batswana point of view. I find this perspective most appropriate as it is the Batswana who are encountered with new and different ways of understanding and dealing with health and illness. How these ways are effecting the Batswana medical behaviour can, however, only be adequately understood in the light of the Tswana medical system as part of Tswana culture and social relations.

My point of departure is the Batswana patient. His/ her dual use of medical alternatives brings the medical systems into contact. Hence, the patient leads the different medical systems into contact through her alternate choices of the medical alternatives. As the patient throughout his/ her health seeking behaviour is widely using both types of treatment alternatives this creates a situation which the Tswana healers will have to adjust to. Whereas the patient in the context of medical pluralism is given a greater possibility of choices when dealing with health and illness, the Tswana healer, on the

other hand, is in a different position.[3]

At the seminar the representatives of Western medicine, the RHT preached the philosophy of sharing the patients between the different practitioners for the benefit of all. The seminar thus raises the question of cooperation and integration between the different groups of practitioners. Assuming there is an official intent of referring patients between the various practitioners and hence interaction between the different systems, what are the processes making such articulation possible, and are such adaptation only taking place on the premises of the one system?

The seminar is an example of a situation of social interaction in medical matters which in a way could be seen as successful. However, the seminar falls short of anything like mutual understanding among the different practitioners. Is this due to cultural dimension; to the fact that their knowledge is built on such different medical explanations and modes of thought as that between biomedicine and folk-medicine? Does this different frame of reference create a situation of an unequal situation between the parties involved? Will Tswana medicine come out as a system existing alongside a medical system which has a monopoly and exclusive rights in answering the question of what is right and wrong concerning health and illness? How do the various types of Tswana healers respond to such a situation? How do they resolve predicaments; how do they work to keep their role as healers on the medical arena? The Tswana healer might find his position threatened in the encounter. If he does not play his cards carefully, his position as a healer might become superfluous. Therefore, the Tswana healer will have to consider his position towards the representatives of Western medicine as well as the patient to keep his/ her position on the medical arena.

Combining the perspectives of both the Tswana healers in creating their strategies in the encounter, and the patient when choosing between medical alternatives we can see how an important dimension of Tswana culture maintains and changes itself in the encounter. Therefore, I will focus upon the Batswana; the patient, as well as the ngaka and moprofiti to see how they handle the challenge of medical pluralism.

Hence, the purpose of my study is twofold: I will look into the behaviour of health

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[3]. *I must hasten to say though that the context of medical pluralism might also bring about difficulties and situations of conflict for the patient when encountered by new medical knowledge and types of treatment.*

seeking people; how they shuttle between treatment alternatives throughout the health seeking process. My intent is not to give a complete exposition of Tswana medicine as a system of thought, neither will I describe it fully as a social system. Rather, I will focus upon some important aspects in the relationship between the cognitive and behavioural fields.

A sketch of the exposition

My aim is to expose the encounter as fully as possible, to make a grip on it in its totality. I will approach it from different angels and different levels.

In chapter two, I will look into the role and significance of traditional Tswana medicine and the ngaka, in order to provide an background for the contemporary context of medical pluralism. This background account of the traditional society will show us some of the old institutional structures which ones gave an all- embracing support to the practice of Tswana medicine. In the next chapter, I will look into to the ngaka's contemporary role as well as his 'colleagues' on the plural medical arena. Hence, in chapter three I will map out the medical arena, that is, the various medical alternatives available for the Batswana in the village. In chapter four, I will look into how the Batswana give causal explanation by focusing upon their conception of contagion exemplified by the disease of TB, or 'the big cough'. In chapter five, I will try to see how Tswana medicine more generally explain the connection between cause and effect relating to misfortune, death, and diseases; etiology. My point of departure here will be the lack of understanding between the various parts at the health seminar. I will then try to compare the two medical systems as ideal systems, in order to highlight their different nature; their 'paradigms'. I will, however, argue that an exposition of medical ideas, even in a broad cultural context, is not sufficient for an understanding of medical behaviour. This can only be fully understood in a temporal and spacial context, in other words, the actual health seeking behaviour must be studied in relation to social constraints and opportunities. Therefore, in chapter six, I will look into the patient's health seeking behaviour in the context of medical pluralism. I will illustrate the health situation by three disease histories discussing the patient flexible and pragmatic use of medical alternatives. By focusing upon the patients' multiple and simultaneous use of medical alternatives, I will try to discuss some factors influencing their choice for the treatment

alternatives available on the medical arena. In chapter seven, I will discuss the Tswana healers and their strategies when encountered by the representatives of Western medicine. I will focus upon the various types of Tswana healers and how they try to adapt under the impact of Western medicine on the medical arena. In chapter eight, the concluding chapter I will review the implementation of WHO's integrative policy and try to discuss it in relation to cultural change and maintenance.

The fieldwork process

After the rather tough period of preparations before I left for Botswana, it was a relief at last to enter the field and to settle down among the villagers of Pilikwe. I let myself be carried into the every day life of the Motswana-woman: While dancing and singing I followed them in all kinds of household activities while they patiently learned me their language and way of life.[4] The very morning I came to Pilikwe, I told the chief and the people gathered in the kgotla about my research.[5]

The first stage of my filed-research was not primarily a period of systematic inquiry. During this period of time, besides helping out at the clinic and chatting with patients, along with friends I also regularly went to church services in the Independent Churches where I gradually grew acquainted to The Zionist Christian Church and the context of faith healing.

The second stage became a more busy time, where I more systematically made interviews with the various types of Tswana healers as well as participated in their treatment of patients. After having been at the health seminar at Seleka, a village about an hour drive to the east of Pilikwe, I stayed in the village for two months as I saw this as an unique possibility to make further inquiries into the problems of the implementation of the integrative health policy of Botswana. Besides, in Seleka I met with a ngaka, whom presented me to his colleagues in the area and hence, helped me

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[4]. *Before I went to Botswana I attended a four week course in setswana - the national language of Botswana which was of great help during my field research.*

[5]. *Although I was always met with openness in my inquiry about Tswana medicine, both the Tswana specialists as well as people in general found it difficult to see why I had interest in the ngaka's knowledge and practice when not wanting to become one, and further, people in the various churches argued that the best way to learn about faith healing and the church life was by being baptized.*

to gain knowledge about Tswana medicine and practice.

Some methodological considerations

Schapera's rich description about the Tswana way of life as well as Staugård's analyses of 'The traditional healer' helped me to 'see' the focus of my problem during the time of preparation. The method of gathering data to elucidate problems and to get answers to my questions are preliminary consisting of participant observation. Further, I have been using unstructured interviews to get an understanding on how the health seeking person thinks about, perceives, and interprets the disease situation. Thus the primary source of data has been the case stories of sick people, and the interviews with the various types of Tswana specialists as well as observation of the patient's alternate use of therapeutic alternatives. Stories about health and illness have a life of their own, and is not constructed by the anthropologists strange questions: They are told among people themselves and are as such important in the maintenance and change of a people's conceptualization of health and illness.

Even though health and illness is of social concern, a person being ill and the steps taken when seeking help is often hidden from the outsiders.
Moreover, the Batswana have a saying: "The stranger is a good doctor", which socially mean that people could travel long distance when seeking help and (medical) treatment. Hence, people consulting the dingaka in the village could come from far away. They would stay there just for a day or two, and as it was often both difficult to be aware of their consultation and making intimate interviews with total strangers I often felt the situation difficult. The most important, and difficult task was to gain confidence of the (sick) individual and their social groups; to convince them that they would not suffer because of what I would see and what they revealed to me. This meant keeping company continuously with them in their homes, and other places of healing. Whereas I easily could both observe as well as gain further information about the patient's consultation in the formal sphere of health, and to a certain degree when people consulted the faith healing churches for problems and diseases, it was much more difficult to get hold of a person when seeking a Tswana ngaka.

Since I do not have any medical training it is difficult to relate to the biological components of health and illness. Hence, I depended upon a certain cooperation with

the local clinic and health personnel. However, my primary interest has been to get an understanding of how the patient herself/ himself thinks about, perceives and, goes about during the health seeking behaviour.(See Devons and Gluckman 1964.) Further, my task has not been to find out whether the Tswana specialist 'effectively' cure diseases, but to learn about their type of medicine, and to see how they resolve predicaments when encountered by the representatives of Western medicine.

Even though the identical loci are made known in the text, I have in some case studies changed individual's name in order to disguise their identity.

In order to provide background for the recent changes and thus, a better understanding of the situation of today, it is necessary to look back in time. Therefore, before looking into the contemporary situation, it is necessary to see how the ngaka's role has changed throughout time. From having a central position in the everyday Tswana community life, his role has changed dramatically up till today where there are many additional (competing) categories of 'medical persons' on the health arena where he traditionally was the single one.

CHAPTER TWO

THE ROLE OF THE NGAKA YA SETSWANA IN A HISTORICAL PERSPECTIVE

Introduction

In this chapter an attempt will be made to give an understanding of the role and significance of traditional Tswana medicine and the ngaka in the traditional Tswana community leading up to the contemporary situation where the treatment of sick people is no longer the exclusive right of the ngaka ya setswana. I will look into the role of the Tswana traditional ngaka in order to provide background for the recent changes. This background account of the traditional society will show us some of the old institutional structures which ones gave an all- embracing support to the practice of Tswana medicine. Although the social context of the ngaka has changed, the following description is to a large degree also valid for the contemporary situation. Thus, the general role of the ngaka as a healer is still very much the same in his relationship with the individual patient (his/ her family and friends).

Tswana cosmology

A basic understanding of the Tswana cosmology is germane to understand the role and significance of the Tswana ngaka, priest-healer, in the traditional Tswana community.

The essence of Tswana cosmology is based on their concept of the supreme being Modimo; God or Creator.[1] Here we must restrict ourselves to consider the belief in modimo in relation to his influence on the well-being of the Batswana. According to Schapera (1984: 58-61), Modimo was their guardian and 'The only Creator'. He was seen as the 'Cause of all things' as well as 'the giver of all things'. It was held that Modimo could hold back rain, send lightening and cause death in different ways.

The chief and his closest family were considered direct descendants of Modimo,

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[1]. *Both Seeley (1973) and Comaroff (1974) have a long discussion concerning the Tswana concept of Modimo and the difficulties in obtaining any clear idea of his traditional attributes has been affected by missionary teaching.*

however, he was considered too remote for the chief and his family to take direct contact with him. The badimo; the ancestors, however, could act as mediator to Modimo. More central to the concept of health and the total well being of the Batswana -and closely allied to Modimo, is that of the badimo or the ancestors. According to Tswana cosmology, the dead members of the tribe, becoming badimo, would continue to keep a close eye upon their relatives and even guide them in their village life. According to Willoughby, in his study: "The Soul of the Bantu", the badimo were seen as the guardians of tribal morality. According to how their descendants treated them, they would so to speak 'remind' them by casting misfortune or diseases upon them as well as their life-stocks, or by bringing fortune and happiness for those who treated them with respect. (Willoughby, 1970: 176) Whereas major events such as drought and rainfall, affecting all the members of the tribe were attributed to Modimo, illness and misfortune, or luck affecting the individual would be ascribed to badimo. While the people's Badimo, only were responsible for the individual welfare of their descendants, the Badimo of the chief, however, held power over the destiny of the tribe as a whole. Even though the chief as the earthly representative of his own Badimo commanded great respect in the tribe and was responsible for a number of communal rites, he was very often assisted by the ngaka ya setswana while conducting these rites. (Schapera: 1984.)

In addition to these beings, the Batswana also believe in baloi; sorcerers. The Batswana distinguish between baloi ba motshegare; 'sorcerers by day', and baloi ba bosigo, 'sorcerers by night'. Whereas the day sorcerer are ordinary people, the night sorcerers seem to be more fictional. Both types of sorcerers are using dithlare, Tswana herbs, in the purpose of killing or injuring his victim. (Schapera, 1984: 65) A moloi, a person practising baloi, works with various techniques: The most feared one is go jeso, ('that which is fed') food-poisoning, which causes an internal growth in the body (sejeso). A moloi can also cause diseases by burying (bad) medicine into the ground: A moloi will then make a cross in the ground where he has buried the (bad) medicine and when his victim steps on it, it will penetrate the sole of the foot and cause a disease such as TB. or leg ache depending on the moloi's will. He decides how his victim is to suffer, and his

purpose is to kill.(See chapter seven)[2]

The role of the ngaka in the traditional community

Traditionally then, all that which constituted The Tswana universe was the domain of the ngaka ya setswana. He was to take care of the social and moral, as well as the physical well- being of the individual and his family. Further, people asked him for help concerning protection of their homestead, cattle, and crops.

Along with the chief the ngaka ya setswana would also have a central role conducting various types of communal rites for the wellbeing of the total tribe. Of prime importance was the making of rain; go fetlha pula. In addition, the ngaka ya setswana would also be consulted to give a cause of the death of a person, to ascertain the prospect of a journey or a marriage or the whereabouts of missing cattle. Thus, Tswana medicine also has a prophylactic measure. Moreover, he helped to obtain wives or husbands, or could even set one's husband, wife or beloved against a successful rival in love. Almost anything was possible with the right medicine, thus he could help people to find a job, help children who fail at school, or make the crops to grow.

The ambivalent role of the ngaka ya setswana

However, the role of the ngaka was a somewhat ambivalent as he had the power and knowledge of both curing and harming. He could use his knowledge to kill people. A person wanting to harm another, that is a moloi; sorcerer, would come to his yard and ask for his help, or the ngaka could perform such rituals on his own behalf with the purpose to hurt some of his enemies. Hence, the ngaka could be a moloi himself. For instance, while he protected the homestead, field, cattle and individual from sorcery, or other hostile influences, he or someone else assisted by a ngaka ya setswana, could perform boloi; sorcery, to invert the positive purpose. The role of the ngaka was crucial as he was the one who could mediate between the living and dead. If misfortune or disease was caused by supernatural sanction, he placated the ancestors through healing rituals. Through his knowledge and power he could restore the disrupted relationship

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[2]. *Using the terminology of Evans- Pritchard (1985),in his analysis of the Azande, we can speak of the night sorcerers as 'wizard' and the day sorcerers as 'sorcerers'.*

between the living and the dead both on the individual and communal level.

As we have seen, traditional Tswana medicine- both its curing and harming potentiality- is closely linked to the people's total view of the universe and the meaning of life and death. Further, the realms of the ngaka ya setswana went beyond, or transcended the limitation of Western medicine, or more correct, the ngaka handled matters in addition to the sphere of Western medicine.

The various types of dingaka tsa setswana

The ngaka's domain was called bongaka; the knowledge and practice of the ngaka ya setswana. There are several different types, but the most common ones are the dingaka tsa ditaola, 'horned ngaka', and the dingaka tsa ditshotswa; 'hornless ngaka' or herbalist. The ngaka ya ditaola, knows the secret of the divining bones, and use this as a remedy when divining a certain problem as well as his knowledge about ditlhare; Tswana herbs, or medicine, when treating a case. The ngaka ya ditshotswa, however, in lack of the secret knowledge of go thela bola; the throwing and interpretation of the divining bones, mainly has to rely upon the patients complains as well as acquired experience when treating them. I will return to the various working methods by the dingaka more thoroughly in the following chapter.

It was primarily the ngaka ya ditaola by virtue of his knowledge of the divination (go thela bola), who was the chief's personal adviser. However, as we have seen above, this secret knowledge also set him in an ambivalent position in the Tswana society as he could invert the use of the ditlhare for destructive purposes. Usually a ngaka would have a small area of problems and diseases which he mastered better than other dingaka; each would have his specialties. Thus there were a hierarchy among the dingaka according to their domain of knowledge. For example, there were some who because of their special knowledge acquired the title dingaka tsa morafe; the priest-healer of the tribe'. These men renowned for their special skills were generally employed by the chief to assist in the various communal rites in the Tswana community (before the missionary came into the arena of communal life).

The role of the missionary

The ngaka first encountered Western medicine in the early nineteenth century in

the presence of the missionary, as he was the one to introduce Western medicine among the Tswana tribes. However, it is important to keep in mind that the medicine practised by the missionaries was very different from what we know as Western medicine of today. According to Seeley's (1973) historical account of Tswana medicine, the acceptance and eventual assimilation of both Western medicine and the missionary by the Tswana was a rather easy process; (as) The missionary and his relationship to the Christian God resembled so much the Tswana ngaka and his relationship to the modimo. (See the dialogue between Livingstone and a Tswana ngaka, Seeley 1973:99-102.) Whereas the missionary practised and presented their medicine within a Christian framework; as they healed people in the name of God, the batswana practised and presented their medicine in a Tswana framework ; as they healed people in the name of the modimo and the badimo. Thus, Seeley states that:

> (the parallel established in the eyes of the Tswana between the Christian God and his servants the missionaries, and the modimo and the dingaka of their own society was an obvious one...) ...the missionaries possessed all the requisite qualification to fill the role of the traditional Tswana ngaka (1973:88).

The missionaries applied their medical knowledge as an instrument to gain converts to Christianity (which we shall see later on is very much the purpose of the moprofiti in the Independent African Churches. (See chapter three and seven) Livingstone who was the first medical doctor and missionary to live among the Tswana (in the period 1840 - 1873) took an interest in Tswana medical ideas and practices, an interest which (according to Seeley) resulted in a reciprocal relationship with the dingaka. While the Tswana sought him for help and advice, Livingstone sought their aid in finding indigenous herbs and roots to enlarge his otherwise so limited supply of English medicine. Thus, the missionary resembled very much the Tswana ngaka; a priest-healer.

The witchcraft proclamation

Even though the missionary and the Tswana ngaka agreed upon God / Modimo as an agent for illness, the missionary condemned the other Tswana agents of illness and misfortune, baloi and badimo, and substituted the Christian concepts of divine retribution, and "The Will of God". (Seeley 1973:60-100.)

Many chiefs soon saw the white Christian missionaries as politically useful and often converted to Christianity for this reason. This process allowed the missionary to take over

the role of the dingaka as advisors to the chiefs. However, although the role of the ngaka was attenuate or weakened at the national (tribal) and official level, he still played a central role at the local level -in the everyday life of the Batswana. The official view at the time of traditional medicine is clearly expressed in the "Annual Report" 1927, read as follow:

> Witchcraft and the influence of native medicine men continue to play a very important part in the lives of most of the native inhabitants and are responsible for much suffering. It is the aim of the Administration to so develop the medical services that these evil factors will be replaced by confidence in qualified medical men.

However, as Seeley states, the Administration took no steps at the time to investigate the complexity that makes up Tswana medicine. Tswana medicine was condemned as superstitions, and the group of dingaka tsa setswana was seen as 'witch-doctors', whose purpose, the Administrators claimed, was to hurt their fellow tribesmen through black magic and witchcraft. And then, in 1927, the Administration condemned Tswana medicine through the act of the "Witchcraft Proclamation", which prohibited the dingaka tsa setswana from practising. (Seeley, 1973: 60-139) The "Witchcraft Proclamation" was aimed directly at the 'witch-doctor' and his supernatural manipulation and mystical healing technique. The ngaka who only dealt with herbalism, (ngaka ya ditshotshwa) however, where still free to practice. However, the ngaka ya ditaola kept up with his work, as well, or as Schapera experienced:

> But the practice of magic still persists strongly. Professional magicians (dingaka) continue to flourish everywhere, and despite widely- expressed scepticism of their claims few are the people who do not resort to them on occasion (1958:5).

By the influence of the missionaries, though, many of the Tswana communal rites were abolished and the ngaka ya setswana lost much of his former significance.

The Independent African Churches and faith healing

The Independent African Churches have their historical background in South Africa where they arose as offshoots from white controlled mission churches. The Afrikaans, also called Boer, brought with them a Calvinistic variety of Christianity to South-Africa and used this ideology to protect their own interest- thereby being discriminating towards the natives or the black people, which were looked upon as inferior to the white race. As a reaction to this practice the Independent African

Churches mushroomed; first in South Africa and later on in the whole of southern Africa. Hence, the Independent African Churches, and faith-healing proliferated in Botswana as in other Southern- African countries, causing some concern to the Government. I will deal more thoroughly with this type of churches as well as the role of the moprofiti in chapter three and seven, for now however, I will only deal with Administrators attitudes towards their practice of faith-healing.

In May 1958, Seretse Khama had the following to say about their presence in the country:

> "We have now acquired a number of religious sects. These people think for some reason that they can heal by faith. They maintain that scientific medicine is not effective (...) They also have a political angle -still connected with medicine."(Quoted from Seeley, 1973 :177)

However, nothing was done by either by the Protectorate nor later on by the Independent Government to stop the healing practice of Separatist Churches. Later on, in 1969 they were allowed to practice if they had registered with the District Council or the Chief. (Seeley, 1973:178)

The importation of Western medicine to Botswana

In this context Western medicine was imported to Botswana (this time as medicine and not primarily as Christianity) to replace what was regarded as inferior and ineffective indigenous medicine or rather; 'witchcraft', 'superstition' and 'black magic'. By importing Western medicine to Africa both colonial administrators, and later on the government were hoping to improve peoples health situation. The Administrators believed that the Western medical facilities they provided would combat, and eventually supersede, both traditional healers and traditional medical beliefs. The Dingaka tsa setswana was thus believed to gradually fade away. However, in spite of the fact that material conditions for medical help for the individual improved radically, these conditions failed to give the expected improvement in peoples actual health conditions.

> Medical workers who wish to pour the new wine of scientific ideas into these vessels often forget that they are not empty. Popular health culture is the wine that fills them, and ignoring this often result in spilling the new wine on the ground. Thus, one may refer to the fallacy of the empty vessel (Skåra, 1980:60).

The Administrators gradually had to acknowledge that Western medicine and thus, new

knowledge concerning health and illness could not be filled into 'empty vessels'. Polgar refers to the Biblical picture where it is pointed out how wrong it is to fill new wine into old vessels. The Administrators and health workers were not aware of these old vessels - which in this context are Batswana's knowledge about health and illness which is closely linked to Tswana social and cultural life. Such knowledge had to compete with preexisting conceptions of health and illness generally conflicting with the new knowledge (Alver 1984; Foster 1978; Sandberg and Skåra 1980; Staugård 1986). Thus, serious doubts were raised about the effectiveness of modern medicine in its predominantly curative form as an instrument for the attainment of the goal of Health For All. And questions of whether we ought to re-evaluate traditional medicine universally and whether, especially in the developing countries, a co-operation between modern and traditional medicine should replace the present confrontation. (Staugård 1986:6.)
It is within this context that we should understand the change in policy towards indigenous medicine, and a gradually awareness of popular health knowledge as something which has to be reckoned with in any strategy to reach the goal "Health for All".

There is probably additional reasons for the changing attitudes towards traditional medicine and its practitioners by WHO and The Ministry of health in Botswana: For example, one has come to see Tswana medicine as a symbol for Tswana tradition. Thus it has gained in importance as the Batswana's awareness of their own ethnic identity has grown in the efforts to maintain the distinct character of the Tswana culture have been increased.

Conclusion

In the traditional community the sphere of medicine included more than just the curing of diseases. Further, Tswana medicine through the significant role of the ngaka ya setswana formed an integrating function in the daily life of the community.

I have now pointed at some main factors which have brought about changes in the role and position of the ngaka ya setswana. His relationship with the chief has changed profoundly with the chief's new political and administrative position caused by changes in the local administration as well as power-relationships. Due to processes of modernization and specialization the manifold roles of the ngaka ya setswana have step

by step been taken over by other specialists in the Tswana community. Other professions like missionary, government administrators, veterinary, and agronomists have gradually stepped into his shoes. Hence his many roles have so to speak gradually been peeled off by other specialist groups. Further, the domain of health and illness is no more the exclusive right of the ngaka ya setswana. From having a central position in the everyday Tswana community life, his role has changed dramatically up till to day where there are many other (competing) on the health arena where he traditionally was the single one. Both the moprofiti-in the so-called faith-healing churches- as well as medical doctors, and clinical nurse -in the formal health sphere have entered the medical arena of health and illness.

In addition, there is the intent by The Ministry of Health to integrate the so-called traditional healers with the formal sphere of health (through a cooperation to gain "Health for all Batswana by the year 2000"). These changes have also had profound implication for the Batswana, that is; the user of medical treatment. The patient is in a context of medical pluralism, where he is given medical alternatives for whom to consult. Therefore, before getting into the interrelations between these actors- as well as the user of the various medical alternatives- I will map out the context of medical pluralism.

CHAPTER THREE
THE VILLAGE AND THE MEDICAL ARENA

Medical pluralism

As mentioned in the introduction there is a complex medical situation in the village. The co-existence of different ways of perceiving, explaining and, treating health and illness has been termed medical pluralism. Scholars of medical anthropology have distinguished between two types of medical pluralism: The complex societies like Asia, where there is a coexistence of several medical traditions. Then there is the situation - like that of Botswana- where Western medicine has been exported to the colonized world to replace what was regarded as inferior and primitive medical systems. (Whyte, 1982: 2056.)

In this chapter, I will map out the medical arena, or put differently; the alternatives available for the people in the village when they suffer from problems and diseases. As it is the patient through his/ her alternate use of medical alternatives who brings the medical systems into contact, I will return to the interaction between the medial systems. (see chapter six) Further, I will deal with the interaction between the various specialists when discussing the different strategies used by the Tswana healers when encountered by the representatives of Western medicine. (see chapter seven)

Pilikwe village

In 1949 a conflict emerged among the Bamangwato as their leader Seretse Khama, whom later became Botswana's first president, wanted to marry the Englishwoman Ruth Williams. Seretse was at the time studying in England and his chief-in- lieu, Tshekedi, disliked this idea and called for a meeting which resulted in a split between those that could not accept the marriage and hence followed Tshekedi, and those who still wanted Seretse as their chief. Tshekedi was said to be wanting to steal the chieftainship from Seretse and the situation became so tense between the Bamangwato that Tshekedi and his followers went into voluntary exile to avoid a

bloodshed. To make a long story short, those who agreed with Tshekedi left the village and lived for some years in Rametsana, in Kweneng district, before they returned to their home-land and founded Pilikwe village in 1953. Most of the people who moved along with Tshekedi to Pilikwe belonged to the upper crust of Serowe society.[1] Soon they build the first school and some years later, as early as 1965, they built the first dispensary.[2] People from other villages and tribes also settled down in Pilikwe. As the conflict between Tshekedi and Seretse later was settled, some returned to Serowe.

To day Pilikwe village has a population of about 1200 people (sensus from 1982). The village is made up of four smaller locations or, wards (kgotla pl. dikgotla) where each ward is constituted by family groups. The ward is an important social entity under the leadership of a headman. The ward forms a circular settlement, surrounding an open space in the centre. This space contains one or more kraals, a fenced off enclosure, where cattle and goats are kept. The household is the basic unit usually consisting of man and wife as well as their unmarried children. Traditionally each ward were based on agnatic kinship and patrilocal households. To day however, many of the women do not marry, but settle in their mother's household, who again might not be married, together with their children. (see Gulbrandsen (1985) and his discussion of 'female-headed households'.) One or more rondavels -circular, thatched-roofed clay houses- situated within a compound, surrounded by a fence or low-wall, accommodates the household. In almost every yard there was usually a (modern:) four-cornered house. All activities such as cooking and other household work take place outside the huts.

The organization of modern health facilities

Even though Botswana inherited a largely curative hospital based health care delivery system by the Independence -in 1966-, most people did not have access to these facilities. However, during the period from 1973-78 the Government, helped by donor

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[1]. *Bessie Head (1981), an author who used to live in Serowe, comments on this occasion: 'The historical story was the last of the migrations in the old African tradition - a tradition established over the centuries to avert blood shed in a crisis and underlying the basic non-violent nature of African society as it was then. This gives the lie to white historians who, for their own ends, damned African people as savages (1981: 95-9).*

[2]. *Tshekedi's wife was an educated nurse and also ran the village first dispensary.*

agencies outside the country, managed to build up a network of basic health facilities throughout the country. The aim is that no Batswana should have more than 15 km distance to the nearest health-facility. The country is having a decentralized health care system, which is divided into 14 health districts, where each district have a hospital with its specialists and a Regional Medical Officer (RMO). He will be the team leader for the Regional Health Team (RHT) which will provide for professional supervision and are also a part of the Ministry of Health. The RHT will travel a lot in the region arranging health seminars and do health education. The RMO will among other activities mostly travel around in the district visiting clinics, which is the next level in the modern health care system.

The clinic is staffed by nurses at various levels and where there is a maternity ward, there will also be a midwife. The clinic will also be staffed with a Family Welfare Educator (FWE). Family Welfare Educators must have at least a primary school level of education, and are selected in the first instance by a Village Development Committee (VDC). The FWE will be a woman selected from within the village, suggested by the Village Development Committee (VDC). She will be given a training course of 11 weeks, in the rudiments of personal and public health, nutrition, health education, child care and family planning before returning to the village. the FWE is also taught how to recognize and treat a few diseases, such as scabies, how to identify and cope with malnutrition in children, and how to follow up tuberculosis patients and their contacts. Ideally she is to function as a bridge builder between the clinic (and health post - see below) and the village by mainly educating her community by her (daily) home - visits. However, in many cases she functions more like a "mini-nurse" at the clinic or health post.

As far as health facilities are concerned, the lowest level is the health post which is staffed by a FWE.[3] All health posts are visited by the clinic people who are supervising and collecting patients from these health posts under the clinic in a certain area- in order to complement the work of the FWE. As mentioned above, the clinic will then be visited by health- people from the health centre or hospital, and in cases of serious cases brought to the health centre by the clinic car. The clinics will in turn be

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[3]. *Any rural village which has a population of 500-1000 people should have a health post and a FWE, and larger villages should also have a number of Family Welfare Educators.*

visited by the RMO and the Regional Public health nurse. Thus, the formal health care system is arranged in district entities, and is built on a system where one refer patients from simple to more complicated treatment situations.[4] To seek consultation and / or treatment in the modern health sector will cost the patient 45 thebe (about 0,2 pound) including medicine, throughout the whole period of disease. All the health personnel working in the formal health sphere are school educated. (Staugård, 1985:33-7, National Development Plan from 1979-1984.) The present structure of the health care facilities is illustrated in figure 1. p. 40.

The clinic in Pilikwe

Pilikwe village got its clinic in the 1970's and a few years ago they also got a maternity ward.[5] The clinic is situated in the centre of the village; that is close to the kgotla. The kgotla is the centre of the villagers' public life, where cases are tried and officials meetings are held. The staff at Pilikwe consisted of five nurses, among whom two were educated midwives, and two Family Welfare Educators (FWE), who both were women from the village. In addition, there were two women mainly working as cleaning assistants. The clinic had a clinic car, which was frequently used for bringing staff and patient to and from in the area. The clinic people were all Batswana. According to the structure and organization of health facilities, there were some smaller clinics as well as health posts in the area which were under supervision of Pilikwe clinic and its staff. Further, as Pilikwe clinic is under the Mahalapye region, once every fourth-night the clinic was visited by the Regional Health Officer (RMO) from Mahalapye.[6] According to the Government policy, the nurses were from time to other replaced from one area

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[4]. *In 1984 there were 14 general hospitals, one mental hospital, seven health centres, 123 clinics, 239 health posts and 389 "mobile stops". The missions operate a total of three hospitals and seven clinics. The private sector employers provide direct health services to their employees in nine cases at present.*

[5]. *During my stay in the village all women but one gave birth at the clinic. She was staying at the field some miles from the clinic and gave birth in the traditional way.*

[6]. *The RMO, popularly called Dr. George by the clinic-people and the village people, was an Asian. He mainly checked the tuberculosis patients, as well as other severe cases, whom could not be helped by the clinic nurses.*

to another. Thus, during my one year stay in Pilikwe all nurses but one were replaced. Therefore, a nurse in contrast to the FWE would just accidentally be from the village or the area herself. The nurse in Botswana holds a high position. For the village people she is one of those who have managed to make something of herself, she is modern and different from the ordinary villagers. Besides, uneducated people in the village looked upon the nurse with envy and jealousy. Being a nurse is a hard life, she is working long hours at the clinic, and is as well frequently called at nights.

Besides taking care of patients in the village and its nearest environment, the clinic had additional duties: As part of the drought relief program, the Government, supported through Foreign Aid, provide for the vulnerable and the destitute which is mainly young women with children and the old and sick. There are five categories of people who are given food at the clinic: Pregnant women, Children under five, malnourished children, TB-patients, and destitute. Once a month these groups were given a portion of corn meal and a litre of cooking- oil. This arrangement, apart from helping the most needed with a certain food supply, also makes the village people more acquainted with the clinic and the modern type of health facilities.

Another way to make people more acquainted with the clinic, is by arranging parties at the clinic; "to make the village-people see that the clinic is not only injections", as one of the nurses expressed it. The village was also closely attached to the village kgotla, not only as it was located next to it, but the clinic staff also had a close cooperation with the chief. For example, whenever there were an important meeting at the kgotla, the patients at the clinic would then virtually be ordered to attend the meeting before they were attended to at the clinic. Furthermore, at special occasions, for example at Christmas, the clinic staff along with the teachers and the kgotla- people would arrange parties at the clinic. Besides, one could say that the clinic almost worked like a market or a meeting place. It was not uncommon that people -not being ill- came along to the clinic, either just to take a chat with other people, or to sell some of their products.[7]

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[7]. *Some would for example, sell dried pane; caterpillar, vegetables, or home-made cakes.*

The Tswana sphere of medicine

As already indicated in the previous chapter Tswana medicine is articulated with the culture in a specific way. The Ministry of health refers to the profession of the ngaka as well as the moprofiti as 'traditional healers'. I will, however, refer to them as Tswana healers. Further, as the moprofiti is distinctly different from the 'traditional' role of the ngaka, their roles cannot simply be merged as one. Hence, under the sphere of Tswana medicine I will deal with the moprofiti and his congregation, and the ngaka and his healing practice separately.

The faith healer and his congregation

As we have sen in the previous chapter, the so- called Independent African Churches mushroomed, first in South- Africa and later on in the whole of Southern Africa. [8] Faith- healing, although a rather new phenomenon, has grown rapidly in Botswana, as well as in all of Southern Africa. In 1983 there were registered 159 such Church societies belonging to the Zionist movement or related churches in South -Africa with 519 branches (sections) all together in Botswana.

Hence, only in Pilikwe village there where five different types of faith healing churches with their own congregation:

'African Borne Full Gospel Church',

'St. John Apostolic Faith Mission of Botswana',

'Holy Bontle Apostolic Church in Zion',

'Pentacostel Holiness Church of Botswana',

'Heremone church' and,

'The Zion Christian Church of Botswana' (ZCC).

In addition to the faith-healing churches, there were other church associations: The Roman Catholic Church, United Christian Church of Southern Africa (UCCSA) and, Seventh Day Adventist Church. Contrasting the Independent African types of churches, these congregation do not practice faith healing. Rather, they are very much against this

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[8]. *First we got the so-called Ethiopian church- movement, and later on we got the Zionist Churches, which performed faith-healing, spirit possession and cleaning rituals as the most important parts of their worship.(See Sundkler, 1961)*

practice. However, many of its members are frequently to be seen in the faith healing churches where they are helped with various types of problems. Whereas the upper crest of the villagers is joining the European churches, the Independent churches are more frequently constituted by the ordinary village people without education. There is a larger proportion of female members in the Independent Churches. Yet with few exceptions, all leadership roles in the churches are filled by men. The only female leader among the churches in Pilikwe was that of St. John Apostolic Faith Mission of Botswana. [9]

The congregations are usually very small in size and are linked to others over a wide area - most of them having their headquarters in South- Africa. At certain times of the year, the congregation will arrange a pilgrimage. The church of the ZCC, for example, arranged 'pilgrimage' to Morea three times a year. Morea, just outside Petersburg in South Africa, is an old missionary station, which is the headquarters of the congregation of the ZCC. At such pilgrimage, besides getting new members baptized, and giving the others new strength, the church leaders are guided politically. As the title indicate, these churches help people through faith healing. In fact the practice is of such an importance that some have come to call these churches for hospitals rather than churches (see Sundkler, 1976)

The methods of treatment applied by the moprofiti are very different from those practised by the Tswana ngaka. As the moprofiti is primarily treating people through the instruction given by God or The Holy Spirit, his medical knowledge is very poor and of little importance. I will focus upon the moprofiti, his healing practice and the various medical remedies being used, in chapter seven.

The context of faith healing: A Sunday Service in the Zionist Christian Church

Even though I stayed in the village for eleven months, I never learned the exact time for church services. Contrary to the European church, The United Christian Church of South Africa, which began its service eleven sharp on Sunday mornings, the services in the faith- healing churches could start any time between two and five o'clock in the afternoon, however, one never knew in advance.

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[9]. *The leader of this congregation had previously been a member of the UCCSA. She was a teacher at the primary school in the village, and also had theological training.*

For my first visit to the ZCC's Sunday service, however, I was invited by a friend of mine. Sentsitshwe- a woman at about 40- who was not herself a member, but went regularly to "Rra. Metse's church" as people in the village called this church congregation. Before I was allowed to go to church, however, I was told to put on a jacket or a scarf and a dukwe; a hair scarf. According to the ZCC's customs, or rules, a woman should cover up her shoulders and hair when going to church. So, both dressed in our finest Sunday costume, we went off to the service.

By the sound of singing men and women I understood that we were approaching the Church. Although I did not have any exact ideas about the church of the ZCC, my first surprise was not to find any church building at all. There, seemingly in the middle of nowhere, or rather in the middle of the bush the member of the ZCC had built their church; a square fenced with thorn trees- looking more like a big goat crawl to me. Inside the crawl the church choir, composed of women of all ages were singing and dancing; stepping back and forward in a complicated pattern full of energy and joy. They were dressed in uniforms, the eldests' different from the youngers' ones: bright yellow shirts with long sleeves and dark green woollen skirts and matching dukwe; hair scarf, to cover their hair. The younger women were dressed in long blue dresses. Thick, black leather shoes helped them making the sound of the rhythm as they stepped back and forward. For the ZCC, the dancing was one of their main activities in their worship. Hence, outside the church- crawl the young men were singing a different hymn while dancing separate in a circle; now high athletic jumps, then in the next moment down to the earth with their hands and feet moving around. They were really trying to show their very finest art as if they where competing who could make the highest and complicated jumps and steps. The younger boys- at about 5-6 years old were also joining, trying to do their best by mimicking the elder ones. The earth was marked by hollows underneath their big white shoes, lathered with car tyre made especially for this purpose, and as such a part of their church costume. All of them, both men and boys, were dressed in white khaki.[10] Meanwhile ordinary church-goers sat scattered about; men usually separated

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[10]. *Some people in the village not belonging to the ZCC, were talking about the members of the ZCC, who were so clever in dancing. Those in the village belonging to the UCCSA, on the other hand, considered it as improper for a congregation to put so much effort into the dancing part: "It is a church, though", they said rather disgustingly.*

from women and children. Some were just listening to the song or looking at the dancers while other talked with each other. Then an old man, came stumping along towards me with a stick in his hand and his back bowing forward, while greeting: "Kgosong!" (The Lesotho word for Kagisho); 'Peace be with you', and he reached out his hand to greet me according to the church custom: While holding his left hand on his right arm he shook my hand, not just once as is the ordinary way of greeting, but three times. He presented himself as the moruti; the leader of the church. People were coming continuously, everybody going through the greeting ceremony before they sat down in the sand joining the others. Some of them came with big bottles with labels such as "scotch whisky" and the like, on top of their heads! Sentsitshwe soon explained to me that people having problems bring with them water for the moruti; the leader, to bless it.[11] Then one of the leaders, standing by the entrance, rings a cow- bell three times; "Come for church!" The leaders, the men's dancing group and the church choir in this row start entering the church. On the 'door entrance' one by one is sprinkled by water. The one who called for service has also brought with him a bucket filled with water, and as we enter the door entrance he dips his fingers into the water and sprinkles our faces. Some are even sprinkled several times in their face, on their chest, at their back and some are even lifting up their feet for the sprinkler to splash some under their feet, as well.[12] - Then the row divides; the men are walking over to the left where they are taking a seat on an old trunk, put in the shadow of a big tree just for this purpose. As we were walking, I had obviously taken a step in the wrong direction; a woman behind me kindly directed me while pointing at some stones laying in the sand. To me these stones seemed

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[11]. *Mr. Metse later explained to me that church goers are bringing with them bottles filled with ordinary water. The moruti will then pray for it and hence turn it into holy water which is then used as medicine. Most members are having a variety of bottles - one for each illness. One is for head -ache; another for stomach-pain, etc. The blessed water is taken home to be sipped occasionally, the dosage may be "one sip three times a day".*

[12]. *Later on Mr. Metse explained this practice to me:*
"There are lots of people coming to church. People are different; they are coming from different places. However, when everybody is sprinkled with holy water we all become equal. We do not know where people come from and how they are. If they enter before being made equal they can cause other to suffer as well."
Mr. Metse is talking about bad and good, or, hot and cold blood, and the Batswana's ideas about contagious pollution and the spread of ill-health from one to the other. (I will deal with these ideas in chapter four)

to be just randomly scattered, however, they were marking the women's entrance. According to the custom, the women are taking a seat in the sand facing the group of men sitting just opposite. The youngest children are sitting among the women while the elder ones are sitting between us and the group of men. Then Keafetole, the cleaning assistant at the clinic asked me to come with her to the 'altar', marked with a circle in the sand, where we kneeled down and left each our five thebe while saying a short prayer. As we return to our seats others do the same. Then, Miriam, the leader's wife, started a rousing hymn. She was soon accompanied by the church-choir and then the whole congregation are tuning in. Very few of the members having the hymn-book, however that does not seem to be a problem as Miriam as well as other women takes shift as leader of the singing, while the rest are repeating breathlessly.[13] Then suddenly everybody went into a kneeling position whereby the praying started. Everybody is praying aloud, not one at a time, but everybody take part at the same time. They do it in such a way that I get the impression that each and everyone tries to outdo the other. The prayer goes on and on, in a varying loudliness; now loud, then in a whisper. When the praying was just about to fade away one of the woman would just start all over again with a new strength in the same high speed and soon the rest of the congregation would join in as well. Then seemingly in the middle of the prayer one of the leader would shout "Hallelujah!", whereby the congregation would answer: "Amen!" Then one of the elder men is stepping forward and starts to preach after having read the text from the Bible with very much difficulty. During the sermon women would cry out "Hallelujah!", sometimes followed up by a hymn by the whole congregation and brought to an end by more singing of Hallelujah's and Amen's. While the moruti is still preaching, the moprofiti started working: They were giving some high sneezing and snores, indicating the presence of The Holy Spirit. Soon they started shaking their bodies to and from, now and then shouting; "Ke bona", 'I can see'. The Moa, The Holy Spirit, gradually worked them up and then, unable to sit quiet, one of them stands up slightly waiving her body towards a young woman and her little daughter. The moprofiti then suddenly stopped in front of this young woman with her little child on her lap, clapping her hands while bowing, snoring and sneezing. Together the three of them went aside, to the left of the

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13. *The hymnbook is texted in Lesotho- a language quite similar to Setswana.*

congregation followed by a fourth person - one of the men leaders. All of them are then kneeling down facing each other in a closed circle. The moprofiti, filled with The Holy Spirit, starts talking in tongues at an enormous speed, while the man is interpreting. Together they divine the person's problem. The interpreter is also told by the moprofiti, what kind of remedies and treatment is needed for the person to be cured or helped with his / her problem.[14] Then as suddenly as the moprofiti starts, she stops; she has delivered her message and the prophet half walking half dancing while shaking her body to and from, returns to the congregation. However, she has not finished her work; suddenly she stops in front of another person; claps her hands, whereupon they both go to the prophesy area. The interpreter returns to tell the moruti the divination and type of treatment that is to be given to the person. The person who has just been prophesied returns to his place joining the service. Meanwhile the leaders, one after the other, are preaching from the Bible; mostly The Old Testament. One of them who is unable to read, is helped by an assistant. Now and then the church choir or seemingly anyone of the congregation, break in with a "Hallelujah!", or a hymn. Now and then people are giving testimonies or confessions.

Then Mr. Metse, the minister of the church, rose up and asked those of us who wanted to be blessed to come forward. Almost all of the congregation, children first, went forward, whereafter Mr. Metse gave us all a gentle clap with his small stick. While clapping us on our head, breast, shoulders and stomach he called down upon us the blessing of The Holy Spirit. Finally all were blessed, and while singing; Sarialore se o sefofofa; the song about the blind old man: The blind man says, standing by the road:

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[14]. *The woman in question was just visiting her sister living in this village. As she was a member of this church association, she joined the service during her stay in the village. After the church service the woman told me what she had been told by the maprofiti. Her child had stomach problem and a slight temperature. The mother was advised by the maprofiti to take her child with her to the moruti's yard the following morning for some treatment: A blue thread should be twined together with two pieces of cloth which should then be tied around the child's stomach. The child's problem was said to be caused by God. The woman went to the moruti's yard the following morning as she was told to by the maprofiti, however, as the moruti did not have a blue thread he could not perform the treatment. The woman then just told me that if her daughter did not recover she would take her to the clinic for treatment, and then when she returned to her home village she would ask the moruti for the treatment advised by the maprofiti.*
The maprofiti had also told her that she should not worry for her family back home, as they were all well. In this case the woman had not in advance told the moruti or the moprofiti about her daughter's problem, nor had she told them about her worries for her family back home.

"My father, help me to see with my eyes, to walk just like others, and to call your name! I am happy. I can see with my eyes!" we left the church in a joyful dance.

The Tswana ngaka

I have already dealt with the cultural and social role of the ngaka in chapter two. Here I will give a more specific outline of their sphere of practice. I will also give a case which will illustrate the ngaka's method for divination; go thela bola, as well as the treatment of a patient suffering from the diseases of dikotho, epilepsy.

As already mentioned in chapter two there are various types of Tswana dingaka. I will however, mainly deal with the ngaka ya ditaola; horned ngaka, and the ngaka ya ditchotswa; 'hornless ngaka' or herbalist (see chapter two). The dingaka-profession is open to both men and women, though the former are in fact much more numerous. Whereas the profession used to be confined to certain families, within which it was handed down from parent to child, to day this practice seems to be more rare. Anybody wishing to can learn by asking some dingaka of good repute to instruct him. Further, whereas the chief in the traditional society had a certain control, since he, with the aid of the tribal ngaka, selected promising youths and saw that they were duly trained, there seems to be more openness for anyone to practice to day.

There are different methods of divination, but the most common one is go thela bola - the throwing of the bones, which is the ngaka's way of setting the problem and types of treatment and remedies needed. (See Schapera (1976: 74), for a richer description of this method.) As we shall see below, the divination is ascertaining 1) the type of disease/ problem, 2) the cause of the disease/ problem, 3) the remedial action required (both the type and amount of herbs needed for the treatment, 3) whether the healer himself will manage to cure or whether he will have to refer the person to another healer (including the clinic). In addition, the bone thrower might as well be consulted to give the cause of the death of a person, to ascertain prospect of a journey or a marriage, or the whereabouts of missing cattle. Hence, divination will also be used in a prophylactic measure.

In addition to these types of bones, I also experienced some dingaka who combined the ditaola, bones, with marbles and sea- shells, according to the will of the ngaka to whom the sets belonged. The dingaka among whom I worked complained about

this change in practice as they claimed that many among the dingaka of today are quacks. Even though their profession should be protected by their association: The dingaka tsa setswana, many practice without being a member of this association.

I met seven dingaka in Pilikwe village, however, four of them were living at the field the whole year through.[15] This could of course be seen in connection with the well established clinic in the village, however, on the whole there seems to be a general trend to settle at the field.[16] In contrast to the faith healers, the ngaka is usually working individually, however, he could cooperate somewhat with another ngaka, and they would also refer patients among themselves. There is a certain hierarchy among them; whereas one ngaka would be known for the treatment of dikotho, another would have special knowledge of how to treat sejeso; food poisoning caused by a moloi; sorcerer, or the protection of one's cattle or crops against the evil will of a sorcerer.

In addition to these specialists, there are some elderly women in the village, who are considered to be more competent for the treatment of diseases among infants and children. They have usually inherited special knowledge through a knowledgeable mother. These women were also called upon in a birth situation.

The treatment of dikotho by a Tswana ngaka

This case will illustrate some of the ngaka's working methods, like the act of divination; the throwing of the bones, interpretation, and the treatment of a patient who is considered to be suffering from the disease of dikotho, epilepsy.

Kgabo, a six year old boy has been suffering for some months.
The parents have been worrying about him and people in the village have advised them to take their son to Mr. Moloto, who is considered, by most people in the village, to be

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15. *The Batswana have a 'three-homes- system': Whereas they are living in the village during winter time, they move to the fields (or lands) which could be some miles from the village during the ploughing and harvest season. Then further away are the cattle-post, which is tended all year round by younger boys or servants. People in the village travel constantly from the village to the lands and to the cattle-post.*

16. *As already indicated in the introduction (the process of field-work), this caused me a lot of frustration during my field research and made me decide to stay in the village of Seleka for two months of my field- period. The village of Seleka was about an hour drive -to the east-from Pilikwe, with a population of about 1500 people. The village had a health post (under the supervision of Pilikwe clinic) staffed by a nurse and a FWE.*

the best Tswana ngaka in the region. Most people, whom the parents had been talking with, considered Kgabo to suffer from the disease of dikotho; epilepsy.[17] Everybody in the village had advised them to take their child to Mr. Moloto. Hence, one late afternoon while my assistant and I were visiting Mr. Moloto and his family, Rrakgabo; the father to Kgabo, came to ask Mr. Moloto for help. Rrakgabo told Mr. Moloto about his son: " Every month when the moon is growing Kgabo gets an attack (fit); he falls down, first shaking all over and then looking as if he is dead, even though we can hear his heart beating", the father explains addressed to Mr. Moloto. Before he left they had made an appointment for the following morning. Rragkabo was also told to bring with him a white sheep, which should be used as part of the treatment.

Early the next morning, while the sun was still rising, my assistant and I went over to Mr. Moloto's to attend the treatment of Kgabo. As we enter the yard we call a "Ko-ko" just to announce our visit. Mrs. Moloto who is sitting outside by the fire place together with her son and another young man, which turns out to be Mr. Moloto's assistant, calls : Tsenang!; 'come in'.[18] We are soon showed to the (modern) four-cornered house in the yard where we find Mr. Moloto and his assistant busy preparing for the treatment. We greet each other and my assistant, Bridget, and I are asked to take a seat on the big modern bed. The room is otherwise furnished with a table, two camping chairs and a ward-robe. Mr. Moloto is telling us that the patient's father has, according to the treatment, already been here with a nest which together with the Tswana ditlhare; roots, is to be used in the treatment as medicine. Rrakgabo is soon expected back with his son and a sheep which will be used as part of the treatment. Mr. Moloto goes for his 'doctor- bag' where he has lots of different kinds of ditlhare; roots. He pulls out several plastic bags whereby some of its content is added to the mixture in the big plastic bag. They also add some dried faeces from a dove considered to have special effect when treating dikotho. Through the open door I can see Rrakgabo and Kgabo coming into the yard with a white sheep. Mr. Moloto leaves us to greet them and they all go over to

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[17]. *The disease of dikotho; epilepsy, are by the Batswana considered to be a very difficult disease to cure. However, in contrast to the inability of Western medicine to prevent the attack and thus consider the disease un-curable, some of the Tswana dingaka claim to be capable of curing the disease.*

[18] *Mr. Moloto's assistant is staying with him to learn from him and thus become a ngaka ya ditaola.*

the shadow made by the big courtyard tree where they tie the sheep.

The act of divination

Mr. Moloto then collect his goatskin and together the three of them enter the hut: With weeping read eyes Kgabo is still on the verge of tears, and with the help of his father sits down on the floor in between his father's feet. Rrakgabo tells us afterwards that the boy feared he was to be killed by the ngaka. Mr. Moloto lays down his goatskin with the hairy side facing down, just between the three of them, and takes up a small leather bag containing the ditaola -the bones used for the divination. According to the act of divination he asks Kgabo to blow into the bag: The ditaola should now be influenced by the patient's moa; breath or spirit. Mr. Moloto then throws the ditaola onto the goatskin and they fell down helter- shelter, seemingly with no message at all. However, for Mr. Moloto they are making an understandable pattern. He carefully moves one of the bones which has fallen outside the goat-skin back onto it. Then Mr. Moloto start talking with the ditaola in the dingaka's secret language. He keeps on talking with the bones for some time before he start interpreting them: "I can see a disease; the disease of dikotho. The bones are telling me that the child dies and wakes up again. The disease is in the chest. It is blood. It is frozen blood in the heart. The bones are telling me that the child will be cured. It is not boloi, it is only a disease (ke bolwetse, hela). The child is going to be ok if you keep to the treatment." And he continues; "My son and my assistant will perform the treatment as I do not feel well to day. They will also set the price as they are the ones to treat the patient and not me. Now I will only charge you for the throwing of the bones - the divination. If it had been the simplest disease I would have charged you 1. pula (about 0,5 pound), however, now we are going to heal a disease in which your son is dying (he is referring to the fit), and we are making him to wake up. Yesterday when you came to my yard to ask for help to treat your son I told you that we needed an all white sheep, however, you have brought with you one with a black head, so we will have to make something to make the sheep become white all over."[19] While Mr. Moloto informs Rrakgabo about his son's illness the father constantly comforts his child ; caressing him as he pat him on his head and shoulder. Mr. Moloto

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[19]. *Just before killing it they covered the sheep's head with ash making it look all white.*

assures him that his son will become well again if he keeps to the food restrictions.[20] When he is totally healed we will ask you for pula 40,00 (about 20 pound). We charge this high amount of money as we will have to go to Ramokgonami, the neighbour village about half an hour drive, to collect the roots." Rrakgabo agrees to the charge.

Mr. Moloto has thrown the bones, and settled the divination; it is dikotho, caused by God. The bones have also told him how to treat Kgabo; what kind of roots, how much. Further, Mr Moloto has told that he will manage to heal Kgabo, if the patient sticks to the food - restriction. They have also settled the payment. (It is already mid-day.)

The preparation for the treatment

Just before the killing of the sheep, Kgabo is asked to blow into the sheep's mouth (to transfer his moa or breath to the sheep). The sheep's head is then covered up with ashes (to make him look white all over). The sheep's blood is tapped into a basin before it is hanged up in the courtyard tree where its skin is stripped off. When the two assistants start cutting it up, the rest of us return to the hut and soon after Mr. Moloto also returns with the sheep's lungs and heart. He and his assistant cut some small pieces of each part and put it on the lebea; a potsherd; a piece of broken pot on which a bit of fire is carried. Then he takes two different kinds of roots from his herb sack which he mixes with the pieces of lung and heart laying on the lebea. He explains that he uses these part of the sheep as it is these part of the body that dikotho effects. [21] While Kgabo is served a small dish of the sheep liver prepared outside at the fireplace by Mrs. Moloto, the rest of us are served home-made beer.

Go urumela; the smoking treatment

Then all of us go outside again where the assistant and Mr. Moloto's son has prepared for the medicine; a small steady smoke comes up from the mixture on the

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[20]. *During the course of treatment the patient is restricted from eating anything sour, like sour milk, and sour porridge. Further, he is not allowed to eat chicken, or hen.*

[21]. *Mr. Moloto also explains that some dingaka believe goat is the most effective to cure dikotho however, he himself only uses sheep.*

lebea. Kgabo is asked to take off his sweater and to kneel over the smoke. He obviously fear the smoke and cries a bit whereupon his father kneel down with him. Both of them are then covered with a big blanket. After less than a minute the assistant carefully lifts the blanket examining whether the smoke is too dense for the child. After some time Kgabo cries and tells us that he wants to urinate. He is told that the treatment is soon over, but if he has to urinate he is told just to do it on the spot. Mr. Moloto is also testing the smoke now and then and after about 5-10 minutes the go uremela - smoke treatment- is done. Rrakgabo looks very relieved, obviously having feared this part of the treatment. Mrs. Moloto then remove the charcoal from the lebea, take a stone and start to ground the burned roots. All of us are then asked to take a seat in the hut and soon we are served a nice dish with lots of sheep- liver. After the meal, Mr. Moloto returns to the hut with the grounded roots and a big basin full of sheep- faeces. While still waiting for Kgabo to finish his portion, Mr. Moloto strews the herb mixture on top of the sheep faeces, whereafter he stirs it carefully with a small stick. Kgabo is then asked to stand (naked) on the goat skin, and Mr. Moloto starts smearing his body with the mixture: The whole body is smeared, including his face and head which has been shaved by Mrs. Moloto. Then Mr. Moloto makes a protective device from some pieces of thread, which he is dipping into the faeces whereby he ties them to Kgabo's wrists, ankles and neck. The faeces smeared on his body has already dried up and he is asked to put on his clothes. His father helps him while comforting him telling him that to night he will sleep with his father. Rrakgabo looks tired, his son however, runs off to his play- mates. After being told to return the following morning for the child to be bathed, Rrakgabo also leaves the yard.Unfortunately, I was hindered to follow up the treatment, as Kgabo and his family left the village.

I have presented the context of medical pluralism as different and separate spheres: The formal health sphere represented by the clinic in the village is treated as separate from the Tswana sphere of health. Further, I have made an distinction in the Tswana sphere of health, between the Tswana ngaka, and the moprofiti. [22] We must

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[22]. *Kleinman and the model of the health care system.*
According to Kleinman -one of the leading medical anthropologists: The single most important concept for cross-cultural medicine is a radical appreciation that in all societies health care activities are more or less interrelated. Therefore, they need to be studied in a holistic manner as socially organized responses to disease that constitute a special cultural system: the health

keep in mind though, that even though these are analytical concepts they are not concretely seperate spheres, which the ease with which, for example, Keafetole participates in each of the spheres: Keafetole, a woman at about 50 years of age, grew to become one of my best friends in the village. She was working as a cleaning assistant at the clinic and I first learned to know her as such. However, as we learned to know each other better she introduced me to her church, the Zionist Christian Church, where she was working as a moprofiti. Later on, I also learned to know her husband, who for most parts of the year was living at the field, and was practising as a ngaka. Moreover, Keafetole's mother, was a well reputed old woman who was considered to have special knowledge on the diseases among children. (see chapter six)

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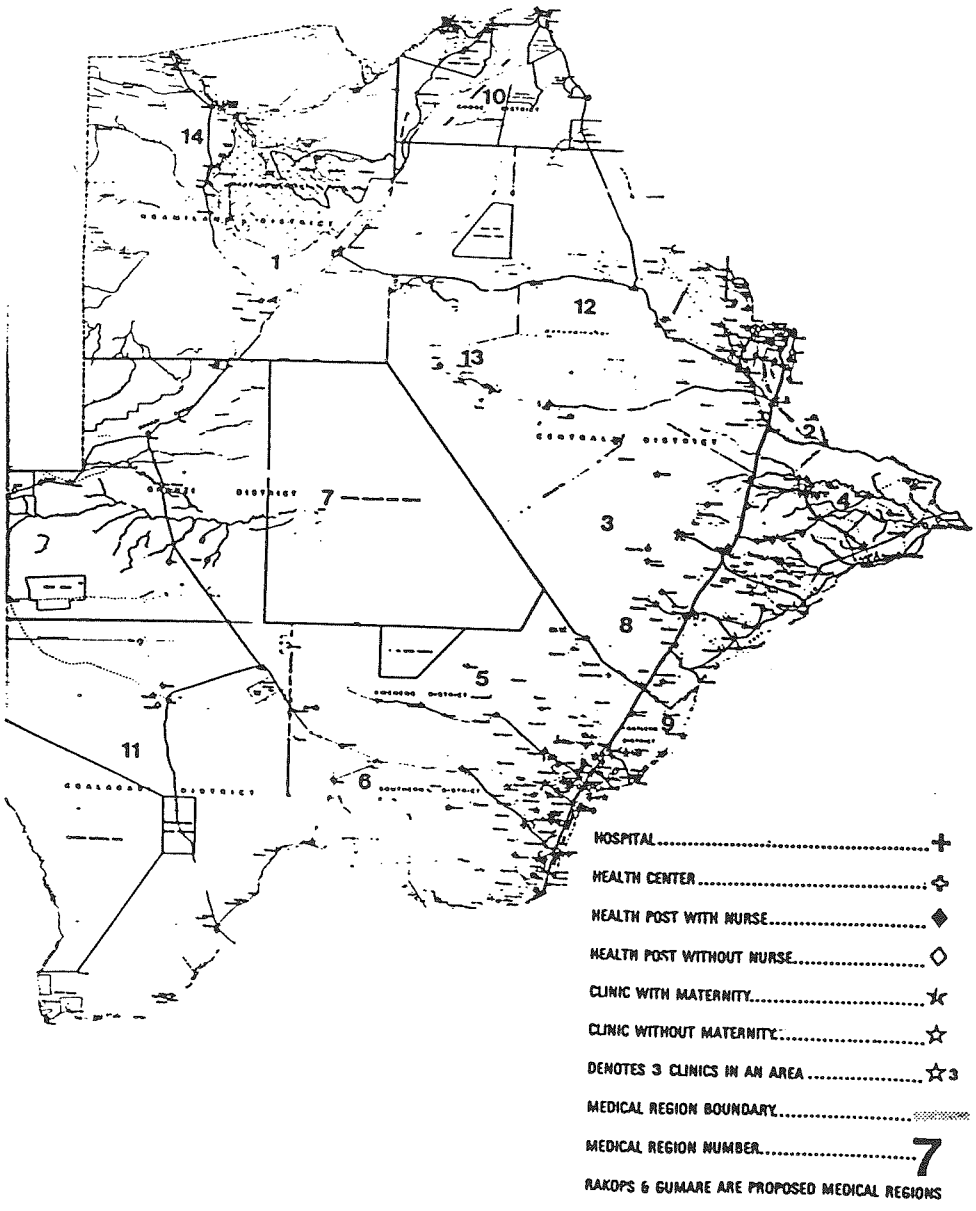
care system (1980: 24). Further, a health care system has an inner structure composed of three overlapping spheres:
Kleinman refers to these as the popular, professional, and folk sector. The popular or personal sphere of health care is by far the largest, however, the least studied and the poorest understood. The sector contains several levels: individual, family, relatives and friends, and the informal network of non-specialists. It is within this sector or sphere that disease is at first perceived, labeled, and interpreted and a special form of care is applied. The second sector of the health care system is the professional sector, comprising the organized healing profession, represented by the health personnel at the clinic. The ngaka and the moprofiti belong to the folk sector which is the third sector of the health care system. (Kleinman, 1980: 50 -60.)

Figure One: Distribution of health services

Source: Central Statistics Office, 1984.



CHAPTER FOUR
CONTAGION: A MEETING POINT BETWEEN TSWANA AND WESTERN MEDICINE?

Introduction

In this chapter I want to review the dialogue at the health seminar and the discussion of the disease of tuberculosis. Listening to the various participants, we very soon realize that there must be a difference between the Batswana way of perceiving and understanding health and illness and that of the clinic people, or Western medicine. When the discussion of the topic came to its end one of the participant summoned up the dialogue in these word; "We should not talk about 'the big cough' and tibamo as if they were the same disease; The big cough is when someone coughs with bacteria, however, tibamo is when a child is born 'in the wrong position', and can spread 'the big cough' to its parents."

The participant quoted above is talking about contagion, however she is conceptualizing contagion differently from that of Western medicine with its idea of bacterial transmission.

By focusing upon the disease of TB 'the big cough' and , I will try to find out what according to Tswana thought causes a child to be born 'in the wrong position', and further, why is a child considered to be contagious, and thus can get 'the big cough' later on, or even spread the disease to its parents?

Tswana ideas of contagion

The first one to give an explanation of 'the big cough' is a ngaka who thought that it is caused by a child born in 'the wrong position' (siina). According to Tswana thought, this means that the child does not rotate spontaneously at birth, but "falls onto its stomach facedown". When this happens, the child and the parents could get a cough called tibamo which will develop into 'the big cough' or TB if proper Tswana

treatment is not initiated right away [1]. According to the Tswana thought a child is born go siame; in a 'good position' if it rotates spontaneously and "falls onto its back with its head facing upwards". Thus, if the child comes siina, the child is considered to be ill, having the disease of tibamo, and treatment is needed. (If the cord is curled around the child's neck, tibamo treatment is also needed.)

Biomedicine and the nurses and midwives at the maternity ward do not consider siina as abnormal. Thus they will not tell the newly confined woman (motsetse) in Tswana idiomns whether she has had a normal or abnormal birth, and no remedial treatment is performed when the motsetse and her child come home. It has become more and more common for women to give birth at clinics and hospitals and there is a general belief that this is the reason why so many Batswana are suffering from TB.

But why is a child borne siina; in 'the wrong position'? According to Tswana thought, there is something wrong with the pregnant woman's uterus, which is caused by 'bad blood'; madi a maswe. Children who are borne siina have gotten this disease from their mother. She has during pregnancy either had a disease in the uterus or contracted it from the father who may have had sexual intercourse with someone other than his wife. According to the Batswana, there are certain types of persons who in special "states" have hot and dangerous blood and thereby could cause diseases. These includes:

1) A pregnant woman (particularly the three first months of her pregnancy).
2) A menstruating woman.
3) A moswagadi; a widow or widower.
4) A moswana, a woman who has lost her child just after the birth or by abortion.

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[1]. Tibamo is treated during the period of botsetse (confinement), where the child has its nails and hair cut. These are burnt to ashes and added to porridgre into which powdered sternal bones of ostrich and kudu as well as the herb tshabe tsabokuku has already been mixed. this is then given to the child and dthe parents to eat. Tibamo treatment for a grown up person is somewhat different: 1) Roots are burnt to powder while the patient inhales the smoke, 2) then some of the powder is taken by the patient as a cigarette. 3) the rest of the powder is taken through porridge eor mixed with tea for weeks or months. (The treatment of tibamo might vary some from one healer to the other.)

having her period is not allowed to be prophesied, and therefore both the moprofiti, as well as the congregation, will understand why you had to refuse her proposal."

Later on I also learned that a woman during her menstrual period, or after a miscarriage and hence a moswana, a widow/ widower, a newly conceived mother; a motsetse, all should preferably not attend a church service before getting cleaned. Thus, whereas the various Tswana dingaka explain their practices according to Tswana custom: "this is how we Batswana should do things, it is our culture" etc. the baprofiti, as well as church members, on the other hand, always explain their practices according to the Bible, with special reference to the Old Testament and Leviticus.

The close link between sexual behaviour and disease in Tswana thought is based on the belief that men and women will mix blood during intercourse. Hot and bad blood will not mix well with healthy blood; the blood of the both the lovers will 'fight each other' and cause the blood to clot and (eventually) cause some sort of disease or misfortune.

Josepha, the leader of the Heremon Church (One of the many Independent African Churches) and a moprofiti explained it this way:

> When you cook some meat, and before serving it mix it with raw meat, would that taste nice? No! And it is exactly the same thing with, for example, a moswana (a woman who has miscarried, or lost her child). It is not good to have sexual intercourse with her. Their blood will not mix nicely as they have different blood.

According to Tswana thought then, a menstruating woman, a woman who has aborted and, a confined woman, all have "unclean" blood which they have to expurgate before they can once again be healthy and normal. In his analysis of 'Blood and its sinister qualities', Levy-Bruhl saw the close connection between menstrual blood and miscarriage as menstrual blood has the potentiality of making life. (19* : 292 & 310 - 311) This is also stated by Page & Page:

> The importance of menstruation as an indicator of woman's continuing capacity to conceive is clearly recognized in tribal societies. Inspections of the numerous ethnographic accounts of theories of menstruation and of theories of conception shows widespread agreement that menstrual bleeding is a natural process by which the womb is cleansed in preparation for future conception and that this same blood is used during pregnancy to help develop and nourish the fetus. As a Navaho informant put it, "The menstruation is to make the baby" (209-10).

5) A motsetse; a woman who has just given birth and the immediate post partum period is called a motsetse. Both she and the newborn child will be partly separated from the rest of society for one to three months; the time of botsetse (Confinement). There are many restrictions on these persons, and if they transgress them (and thereby do meila) they can cause disease both to themselves and to others which may even lead to death. All these persons have maoto a moleto or 'burning legs'. They are considered unclean and hot, having bad and dangerous blood, and therefore are polluted and potential carriers of diseases. Or as Ngubane (1977:97) in her study of Zulu medicine says:

> A person is not 'polluted' because she has 'sinned' but she 'sins' and is automatically punishable if she does not observe a proper behaviour pattern when she is polluted.

Leach (1968) and Turner (1970), among others, see such persons as being marginal in society; they are in an abnormal state; they are 'betwixt and between'. They are dangerous because of their marginal and ambiguous position; their existence creates doubt about the borderline between health and illness. Or to quote Ngubane:

> They are dangerous because they are marginal and ambiguous; their existence generates doubt about the difference between normal and abnormal, health and sickness; they represent as it were "gateways to death"...(Ngubane 1977 :99).

These people can cause and spread diseases through sexual intercourse. They can also cause disease and misfortune, to themselves and others, by being present in certain places or in special situations.

In the Botswana context, these blood-beliefs are re-vitalised through the many baprofiti and their members of the Independent African Churches and their gospel and practices. In fact, I first met with this practice in one of the church services: During a church service I refused to be prophesied by a moprofiti as I felt the situation rather new and a bit difficult. However, as the Batswana consider the will of the moprofiti to be the will of god or the Holy Spirit, I started to worry whether I had done something wrong, and thus I asked one of my best friends who by her 'strange' answer set an end to my worries; "No, you yourself are the one to decide whether you will be prophesied or not. Anyway, the church-people will assume that you were having your menstrual period. You see, according to the church custom a woman

But, why is a widow or a widower considered to be unclean? Why do they have bad, hot and dangerous blood? According to the belief that men and women mix blood during sexual intercourse, the man and woman will acquire the same blood as they become more familiar with each other. When the husband or the wife dies, the widow or widower will already have hot blood because it also contains some of the dead person's blood. Whether they are married or not is insignificant in the context of pollution; if they have had children together the parents are considered as having one blood.

But why is a pregnant woman hot, and why especially hot during the first three months of her pregnancy? According to Tswana belief, a child is created from the woman's blood (i.e. the menstruation blood which stops during pregnancy) and the man's semen. (In setswana madi means both blood and semen.) During the first three months of pregnancy the embryo is still regarded as only blood, and it is only in the fourth month that this blood develops into human form. (See also Schapera 1971:194 -195). The idea/ conception that menstrual bleeding is a natural biological process by which the womb is cleansed in preparation for future conception shows widespread cultural acceptance. Moreeover, this very blood is used during pregnancy to help develop and nourish the fetus. The menstruation is, so to speak, the raw-material of the baby. (Paige and Paige, 1981:210). If the pregnant woman has intercourse with someone who is not the father of the child during these first three months of her pregnancy, their blood will not mix well, but, rather, will fight each other and clot because of the conflict in the mixture. The lover's blood will harm the embryo, and this is one of the reasons for a child to be born in 'the wrong position'(siina). A siina child is a weak child, and is susceptible to tibamo or 'the big cough', and also to almost any kind of disease. Such children are given treatment to prevent them from becoming ill. Their mothers and the fathers also need treatment, as their blood was "unclean" when conception took place and are consequently responsible for and the cause of the children being born in 'the wrong position'(siina). Thus, together they will all take the treatment for tibamo.

Conclusion: Different conceptions of contagion

I have tried to show that to come to grip with Tswana conception of contagion, we have to go beyond or rather seek outside the domain of Western bacteriology. First, when seeking contagion in a wider context, we are able to see that according to the Batswana, disease and ill-health are not limited to organic disorder, nor is their concept of contagion based on the transmission of bacteria or even any kind of material agent. Tswana ideas of hot and cold blood, however, are central to their conceptions of contagion or defilement. The blood is seen as the prime agent for the maintenance of health: Whereas a healthy person has bright, fluid, cold and good blood, a person having thick, black, frozen, hot and bad blood, is ill or in one way or other looked upon as being different and abnormal.

Therefore, although different from the biomedical concept of contagion, the Batswana also have conceptions of what causes 'the big cough', and they also consider this disease to be very contagious, or go ghetela, as they themselves put it.

Tswana theories of 'contagion' must be understood in relation to ideas about the mixture of opposites (hot versus cold), not as a version of a bacteriological theory. That mixture of opposites produces pollution is part of a general theory of taboo, espoused by e.g. Mary Douglas.

The bacterial transmission of disease was a great discovery and created a revolution within the history of medicine. Mary Douglas, in her book 'Purity and Danger'(1966), argues that Europeans, because of the bacterial theory, have difficulties in thinking of dirt and hygiene except in the context of pathogenicity:

> There are two notable differences between our contemporary European ideas of defilement and those, say, of primitive cultures. One is that dirt avoidance for us is a matter of hygiene or aesthetics and is not related to our religion. (...)The second difference is that our idea of dirt is dominated by the knowledge of pathogenic organisms (1966:35).

Hygiene was not invented by the discovery of the microbes and their pathological properties. The knowledge of hygiene as well as preventive is very old. Studies of conceptions of hygiene in different cultures show that these conceptions are closely related to religious and moral rules. Hence; 'Dirt is a matter out of place", Mary Douglas says. In its social context, this means that matter not placeable within the

accepted order is labelled impure. Mary Douglas shows us the importance of getting beyond this very strict way of perceiving dirt "before it was transformed by bacteriology", to be able to see the similarities between the two:

> We must be able to make the effort to think back beyond the last 100 years and to analyze the bases of dirt-avoidance, before it was transformed by bacteriology; for example, before spitting deftly into a spittoon was counted unhygienic (1966: 35).

Therefore, we must look for the Tswana conception of contagion in a wider context than that of biomedicine.

CHAPTER FIVE
ETIOLOGY IN CONTEXT

Introduction

Again I shall use the seminar and the discussion of the disease of TB; 'the big cough' and tibamo as my point of departure. When listening to the various participants, we very soon realize the difference between the Batswana way of perceiving and understanding health and illness and that of the clinic people or Western medicine.

In the previous chapter we have seen how the Batswana give causal explanations by focusing upon their conception of contagion. In this chapter I will try to get a closer grip on Tswana medicine by focusing more generally upon causal explanations concerning health and illness; etiology. I will discuss Tswana medicine as a system of thought in contrast to Western medicine. However, with reference to the focus of this study, the question soon arise: how far does such a discussion take us towards an understanding of health seeking behaviour? When the participants are asked about their knowledge concerning TB or kgotola e thona, 'the big cough', by the RHT teacher they are giving various explanation of this disease. (See chapter one) They say it has to do with the birth-situation; siina, 'wrong position' of the child at birth or it could come from the mines; which they then refer to as TB ya meini. The disease could have something to do with madi a maswe or 'bad blood'. Boloi; sorcery, could also cause you to suffer from TB ya boloi. Or another variant caused by boloi, sorcery; TB a sejeso, which is TB caused by food-poisoning by a moloi, sorcerer. Further, it could also be spread to a person if he uses the spoon of a TB-patient, or by sharing blankets with a TB-patient or stepping on a TB patient's spittle. Or it could also come with the wind or the dust. Thus, the participants are given many and various explanations when describing the disease of TB 'the big cough' and tibamo.

Are these various explanations, given by the participants at the seminar, contradictory to each other? Or, could it rather be the fact that all the various explanations are 'valid', and thus are considered as part of the correct account of how

the disease of TB; 'the big cough' and tibamo is perceived and explained by the Batswana? If so, how is it possible that they can give many and apparently differently explanations, which are all part of their perception of 'the big cough', concerning a disease which the bio-medical system would ascribe only to the transmission of tubercle-bacilli? [1]

With biomedicine as its model, medical anthropology has been searching for the patterns of etiology in indigenous medicine;

> The rules governing how human beings describe, explain and perceive the connection between cause and effect behind misfortune, death and disease. (Sachs, 1987:67). (my translation)

Thus, when setting up patterns of etiology, it is common to use the criteria: cause and symptom. According to a paradigm, or through a process of isolating and inferring one could locate; (1) One cause for one (or one set of) symptom(s) (mono- causality), (2) causes are somatic (one-dimensionality), and (3) Each cause and symptom can be isolated and precisely defined. Through a special method one could then make disease taxonomies whereby one could isolate and define disease entities. Tacitly understood is the idea that these criteria being used for setting up such patterns, or taxonomies are universal.[2] Further, when having located these patterns of indigenous etiology, one has believed that given a set of symptoms one can predict the folk diagnosis.

In this chapter I will discuss whether it is possible, in the first place, to use these criteria to identify the patterns of indigenous etiology? And similarly, is it possible to predict folk diagnosis (and health behaviour) based on the criteria of cause and symptom as it is used in this restricted biomedical context?

'Diseases from the blankets', or sexually transmitted diseases (STDs)

To elucidate the problems of finding the patterns of indigenous etiology I will first give some example of the 'diseases from the blanket', before returning to the discussion

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[1]. *Although the disease of TB. is very much a social disease being more prevalent under poor social- hygienic conditions, in bio-medicine the disease is defined as being caused by the spread of tubercle-bacilli.*

[2]. *Implicit in this method for finding disease etiology is the concept of universality.*

of TB and tibamo. The Batswana have an enormous variety of what they call bolwetse wa dikobo, which is frequently translated as sexually transmitted diseases (STD) by the practitioners of biomedicine.

To gain knowledge about Tswana medicine, I started off by interviewing the Tswana ngaka and the moprofiti. [3] In addition to gain knowledge about Tswana medicine, my aim was to find the patterns in their classification of diseases; etiology.(based on the criteria; cause and symptom). In spite of my attempt to ask questions in such a way as to locate symptom and cause in Tswana medicine, the Tswana specialists described the various diseases in a way which to me seemed very chaotic: I will give some examples (from the 'diseases of the blanket' in Tswana medicine). One of the 'diseases of the blanket', is called by the name of **Letselakwedi**; If a pregnant woman is having sexual intercourse, with somebody else but the father to her child, he might get the disease of letselakwedi. According to their ideas that the partners are mixing blood during sexual intercourse, the lover's blood will hurt the child causing an early delivery or an abortion. Further, as the child's blood is not the lover's blood, the lover will get problems and start to suffer. He will have difficulties in urinating, as the bad blood will block his urine. In addition, one can also take notice of a special sign; or as the specialist puts it; "If you see a man having water on his nose and upper lip, you can be sure that he is suffering from letselakwedi; blocked urine."

Treatment: Preferable both man and woman should come for treatment. However, if the woman is hiding or refusing to come, it is sufficient for the man to bring some of that woman's belongings; for example some of her clothes. For the treatment to be effective, the ngaka will then mix a bit of this cloth when treating the suffering man.

Okutegile, is another 'sexually transmitted disease'.
"When a man is getting this disease we will say; o kute gile (o kute ga), 'he has taken' this disease from a pregnant or menstruating woman." The man will get pains and difficulties in urinating. According to Tswana medicine, a man will get this disease when having sexual intercourse with a menstruating or pregnant woman. Whereas a menstruating woman always will give a man a disease of the bolwetse wa dikobo; (STD),

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[3].*Being the specialists of Tswana medicine, I assumed that they had a more elaborate and conscious conceptions of diseases than the Batswana in general.*

of various and unpredictable kinds, a pregnant woman can only cause a disease if she is having sexual intercourse with someone else but the father to her child.

Treatment: The man will be given medicine to take the bad blood out of his body, either anally or through vomiting. Then he becomes clean and well.

The diseases of Letalolentsho and bogita

If a man is having sexual intercourse with a moswagadi, widow, he will take the disease of letalolentsho. There are many restrictions laid on a widow/ widower the first year after the partner's death. If these restrictions are transgressed, various sorts of diseases or misfortune might hit both the widow /widower as well as her /his family, the yard and their belongings. These various types of disasters when happening in this context are called bogita, by the Batswana. Therefore, to prevent bogita the whole yard should receive preventive treatment. However, if for example a married man meets a moswagadi, a widow, before having taken this preventive treatment, they are both doing meila; it should not be done or it is forbidden, they are transgressing the taboos for how a widow or widower should behave after the partners death. Before having sexual intercourse both of them should take the preventive treatment; which is a ritually cleansing treatment to clean out the bad blood left in the widow or widower's blood. It may also cause their families to suffer, even to die. The disease may also affect the cattle or the goats. The disease of bohita may 'go around the yard', as they put it. According to the belief that man and woman mix blood during sexual intercourse, man and woman will acquire the same blood as they get more familiar with each other. When the husband or the wife dies, the widow or widower will already have hot blood because it also contains some of dead person's blood. Whether they are married or not is not significant in the context of pollution, but if they have had children together they are considered as having one blood and hence, the living partner will have some of the dead partner's blood in his/ her body, which is considered bad and polluted.

Rasipipi

If a man is having sexual intercourse with a menstruating woman, he will get a 'disease from the blanket', and he might get the disease called rasipipi. The bad blood will get to the man and cause rasipipi. Even to 'go under the blankets' ('having sexual

intercourse' with a woman having menstruating pains can cause her partner to suffer from rasipipi. Someone says that having many girlfriends one will get rasipipi. "People are having different blood, thus, visiting lots of people the blood will not mix nicely. As we are all having different blood, it will cause the blood to fight if someone is having many girlfriends." But I ask him; as you say we are all having different blood what then about man and wife, will their blood fight each other as well?. No, as you are man and wife you will get used to each other and have one blood. [4]

Analysis

As you might understand, setting up the criteria cause and symptom for the making of etiology patterns, I very soon got totally lost. It was obvious to me that even though I gained more information about Tswana medicine, my simple categorization could not grasp their classification.

However, even though I could not find the patterns I was searching for, the experience was a very important one as I gained more knowledge about the differences between the two medical systems. I started to make reflection upon why we set up these criteria, and why we get lost by using them when searching for indigenous etiology.

My reflections touched upon two, but interrelated questions.

1). The concept of cause and symptom in biomedicine or in Western science in general.

2). The belief that this concept (of cause and symptom) is universal.

The roots of our criteria of cause and symptom is to be found in the history of Western medicine. For a long time biologists and medical doctors were seeking to solve the riddle of disease according to a special paradigm stressing the set interrelations between cause and symptom.

Throughout the history of medicine there has been a disagreement as to whether a specific disease is caused by a single factor or is a result of a constellations of factors acting simultaneously. Pasteur created a break-through for this programm, as Capra, in 'The Turning Point', writes:

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[4]. *While the sores are still inside the body, the disease will be called rasipipi, however, later on when the sores shows up outside the body, they will name it thonono. The disease of Rasipipi is the most dangerous of the two.*

> ...as a result the germ theory of disease - the doctrine that specific diseases are caused by specific microbes - was swiftly accepted by the medical profession. The concept of specific etiology was formulated precisely by the physician Robert Kock, who postulated a set of criteria needed to prove conclusively that a particular microbe caused a specific disease (1985:124).

Further, the science of medicine has gone hand in hand with that of biology, hence Linnea and his classification -system also gained acceptance in the science of medicine:

> The identification of microbes with diseases provided a method for isolating and defining disease entities, and thus taxonomy of diseases was established not unlike the taxonomy of plants and animals. Furthermore, the idea of a disease being caused by a single factor was in perfect agreement with the Cartesian view of living organism as machines whose breakdown can be traced back to the malfunctioning of a single mechanism (1985:124).

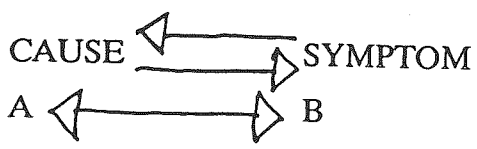
Therefore, one of the reasons why I did not find the patterns I was searching for, I believe, is that they are attached to the Western scientific way of identifying diseases. Our medical tradition isolates, defines, and connect symptom and cause in a way that is foreign to Tswana medicine.

Let us briefly look into the different medical systems to see what characterise them in their conception and treatment of diseases, or rather their various ways of acquiring experience and further knowledge about health and illness. To elucidate the difference between them, I want to look closer into their various methods of tracing causes of disease. We have to be aware of the significantly different principles used by the two medical systems when tracing causes of disease. As I see it, one of the key differences between the medical systems is to be found here.

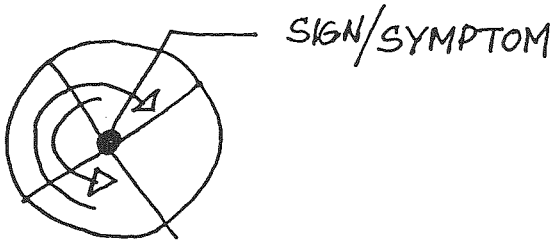
Let us start with the Western doctor and his methods for tracing the patient's problem. Ideally, or the most optimal situation, at least, for the Western doctor is to be able to isolate some special elements. He wants to place the focus of his study object in a "cleanest" possible context; the clinical context, where he can remove all the disturbing elements to come up with his diagnosis. Although the patient is a part of the medical context, ideally the diagnose should focus on the disease only, overlooking the diseased person. Thus, the Western doctor begins his diagnosis by an identification of symptom(s). He tries to restrict those aspects of the patient which, according to his medical training, is of relevance: The symptom, and primarily those of a somatic (physical), and preferable measurable, character is what he primarily is searching for.

As we have seen above the ngaka and the moprofiti have their special methods

for diagnosing; the divination process, which deals with ways of connecting cause and symptom significantly different from that of the Western doctor. In an continuously dialogue between the specialist and the patient (family and friend) and the divining bones, the specialist is trying to trace the sufferer's problem. Whereas the ngaka usually uses the divination bones as an instrument, the moprofiti get into contact with Modimo; God, or, Moa; The Holy Spirit, or, might as well use the Bible as his remedy, when tracing the cause of the problem. Whereas the instrument of the Western doctor ideally measures a precisely defined phenomenon, the divination 'instrument' of the Tswana ngaka and the moprofiti is of a qualitative, suggestive character. Whereas the Western doctor might take an X- ray or measure the blood pressure, which makes him able to locate, and read the problem unambiguously, the Tswana specialist will throw his divining bones several times and through a continuous dialogue between the involved partners reach at a conclusion. He will elicit a lot of information about the patient's behaviour prior to the outbreak of the disease. Throughout this process the specialist will gain lots of relevant information in addition to what a Western doctor would call symptoms, thus the connection between symptom and cause becomes complex and ambiguous. Therefore, although the Tswana medical specialist both relates to cause and symptom as well as he distinguishes between symptom and cause, he does not isolate the symptom and, hence, infer from that the disease, as the Western doctor will do. But in his divination both aspects are incorporated. Thus, there is significant differences in how the two medical systems investigate or explore the connection between cause and symptom. When the Tswana ngaka, and the moprofiti, look at the connecting line between symptom and cause (the lines will be many), they have to relate to more complex relations between the two. Within the causal aspects also lies the psycho-social context, and accordingly each case has to be deduced from a wide range of possible causes. Hence, whereas the Tswana ngaka's and the moprofiti's methods of divination is of a hermeneutic character often resulting in a blend of different kinds of causes, the Western doctor will be looking for one cause of a somatic kind. On the basic of such an approach the Western doctor can both infer from symptom to cause and from cause to symptom:



Given scientific established knowledge about symptoms and causes, one symptom, or set of symptoms, ideally is connected with one specific cause; A is sufficient to read B, and B is sufficient to read A. The Tswana specialist, on the other hand, will have to relate to new information as it is revealed through the divination process, and integrate all the elements into a continually evolving, open-ended system of reasoning of a hermeneutic and unpredictable character:



The Western medical system, and the indigenous or Tswana medical system, have developed two different ways of defining 'truth' and 'reality'. Whereas the Western paradigm, 'the biomedical model', can be characterised by conceptions as rationalistic, reductionistic, and analytical, conceptions as empirical, holistic, and synthetical characterises the paradigm of Tswana medicine, and folk medicine in general. Kleinman (1978) calls the model for folk medicine an 'ethno-medical model':

> Whereas the biomedical model reduces health and sickness to a mechanical status divorced from person and social context, the ethno-medical model interprets them as labels of social status, inextricably bound within networks of meaning that tie them to general cultural norms and concrete interpersonal transactions (:74).

On the basis of such an approach Tswana (Folk) medicine formulates its medical conceptions and causes of disease, and places them in a coherent; but complex whole with a multitude of factors both inside and outside the patient. These factors, however, are not isolated, defined and systematized in a corpus of knowledge comparable to Western medicine. The 'factors' and boundaries are 'blurred' and the way they are related to each other is both specific to a given case and more difficult to establish. However, through my work with the Tswana specialists, and by the help of Spradley's "Making a domain analyses" (1980: 85-100), I managed to trace some patterns in Tswana etiology. From the examples given above we can see that the ideas of pollution combined with the transgression of taboo; meila, is central to the way the Batswana perceive and explain the 'diseases of the blanket'. Further, as we have seen in the previous chapter

there are certain types of people, who in special contexts are considered contagious, and hence will cause people to suffer from diseases.

However, why is it so difficult to classify these diseases on Western lines? Whereas Western medicine can classify a disease on the criteria of cause, and thus make the category of STD because they are contagious and transferred through sexual intercourse, this cannot be done in Tswana medicine. Even though the cause; the ideas of pollution, is central when defining the diseases of the blankets, these diseases cannot be classified on this criteria, only. Firstly, there is a certain disagreement among the Tswana specialists as to whether these types of persons were the only to cause bolwetse wa dikobo, STD. Some would claim that these diseases could also be caused by boloi; sorcery. Secondly, and more significantly, these polluted persons, referred to above, can also cause several other types of diseases not classified as bolwetse wa dikobo; STD. For example if a menstruating woman is visiting a motsetse; a newly conceived woman with her newborn child, she could cause the child to suffer from thlogwana; which is a very common disease among infants in Botswana. " The disease is immediately caused by a depression of the anterior fontanelle and the consequences of this depression will be continuously vomiting and diarrhoea" (Staugård; 1985:71).

Or a moswagadi; widow, or widower, might also cause a child in botsetse; confinement/ seclusion, to suffer or even to die. A moswagadi; widow / widower, can cause a lot of diseases, as for example, the disease of seromo: If the disease hits a child, it will get small sores and rushes all over the skin, and also cause the child to have stomach-pain (as some of the sores are inside the body). The disease can go to any person, if he fears the moswagadi; widow / widower.

Further, whereas one in biomedicine can classify diseases on the symptomatic criteria only, as we distinguish between gonorrhoea and syphilis on the criteria of symptoms, this is not possible in Tswana medicine. In Tswana medicine, the same symptom or even constellation of symptoms may appear in diseases they label differently, like for example the disease of letselakwedi and okutegile.

Whereas there is a fixed (one-dimensional) line between specific causes and symptoms in Western medicine, there is no such fixed relationship in Tswana medicine. When the Tswana ngaka and moprofiti diagnoses diseases he has to take into consideration both the various symptoms and the social and moral context of the persons involved. The

special link, or combination between the two will make up the correct divination. (and treatment.)

Treatment: Whereas the Western doctor will give an identical treatment if the symptoms of a certain disease in a number of patients are found to be identical (no matter which patient is to be treated or where), the Tswana will design his treatment on the basis of the special combination of 'causal' and symptomatic elements in the given case.

Having explored the difference between the medical systems concerning their way of acquiring knowledge, we can now return to the health seminar, and the lecture or, discussion of TB and tibamo. When asked to describe the disease of TB 'the big cough' and tibamo, they employ both symptomatic and causal criteria. Even though they describe the symptoms, they also have to talk about something else, and something in addition to the clinic people; the social-moral condition of the sufferer and why they consider a person to suffer from TB 'the big cough' and tibamo. Therefore, in the context of Tswana etiology, one and the same symptom, the 'bad cough', might be caused by various agents:

1). Meila; transgression of taboo, siina / tibamo.

2). Moloi; caused by a sorcerer.

3). One may catch it from a TB- patient if one eats with the same spoon, sleeps under the same blanket; having sexual intercourse, stamps on a TB-patient's spittle, 4) TB ya meini, which could be caused by boloi, sorcery.

5). The disease of TB and tibamo might also come with the wind or the dust, and they will then refer to it as a disease that 'just happen', and as such (sometimes) be said to come from Modimo; God.

According to Tswana thought, the disease of TB and tibamo can come to a person in various ways and they will call the disease with various names accordingly. Therefore, symptoms which in biomedical terms are identical will in Tswana medicine be explained as different diseases according to the sufferer's social and moral situation. For example; TB a sejeso; TB caused by boloi; sorcery, or, (TB a) Tibamo; TB caused by an abnormal birth, or, TB ya meini; TB caused by the hard work, or the dust in the mines. And different treatment is needed accordingly.

Further, as we have seen above, in accordance with Tswana etiology, the same

agents, or causes, can also cause other symptoms or ailments.
It is the special combination, or link between cause and symptom that decides the divination; how they label the disease and consequently what kind of treatment is needed to gain health. Or rather, it will be more correct to say that the Tswana specialist bases his divination on the creative interpretation of the special link between cause and symptom in the social matrix within which the disease occurs.

Conclusion

In this chapter I have showed how one get trapped when searching for classifications of indigenous etiology by using the criteria of cause separated from symptom because Tswana medicine in contrast to Western medicine, consider both cause and symptom when classifying diseases. In other words, whereas we make a sharp distinction between cause and symptom, the Batswana, perceive both cause and symptom simultaneously as they deal with cause and effect as something belonging to one continuous and indivisible process.
Further, and most significantly in this context there exist no fixed relationship between specific causes and symptoms, or, as Comaroff also experienced among the Barolong, in South-Africa:

> Most affliction recognized by the Tshidi seem to be attributable to any of a number of potential causes; and each category of causal agent is believed capable of producing most known symptoms. In terms of Tshidi thought, the assignation of cause is the priority in the management and classification of affliction...There is no given specific relationship between symptom and cause; this must be deduced in each instance (Comaroff, 1978 a.: 5- 6).

Therefore, as each case must be deduced in each instance, because there is no fixed relationship between cause and symptom, I will claim that it is not possible to predict the folk diagnosis, and health seeking behaviour, on the criteria of symptom, nor on that of cause alone.

As I see it, this factor is linked to another criteria set up by Western thought. By focusing on the patient's physical sign(s), according to Western etiology, we are lead into another trap; leaving out the sufferer as a social person.
In accordance with the paradigm and its criteria of objectivity of Western biomedicine, the diagnosis should focus on the disease only, overlooking the diseased person. In this context the person and his social situation is not only irrelevant, but could even be

misleading. The symptom can be located as an atom, and from that the disease can be inferred.

Making analyses to come up with taxonomies of indigenous etiology, in my opinion, gives a frozen or static picture of health and illness. According to Western medicine and its paradigm for acquiring knowledge, it is possible to understand and explain connections in a static context; to isolate the disease as such in a clinical context. However, to understand Tswana medicine one has to discover the Batswana and their medical reasoning and behaviour through a process in the social and cultural context. For example, illness episodes which are interpreted as bolwetse, hela; 'ordinary' or, 'natural', at one stage could at another stage, not necessarily later on though, be explained in terms of sorcery or as sanctions from the ancestors.

When making classification of indigenous medicine scholars, attributed to their legal training, have also tended to over- systematize the patterns of indigenous etiology playing down more natural elements / causes, and thus have attributed all kind of diseases of indigenous etiology to supernatural agents. However, the Batswana also think of diseases like something that 'just happens', and consider sometimes some diseases to be just natural and thus, do not go to the level of etiology. In Western medicine, the line or connection from diagnose to treatment (health seeking behaviour) is a direct, or, of a one- dimensional character. The health- seeking behaviour is, so to speak, defined by this one-dimensional line, which make up the diagnose. This may account for the slight interest in studying health seeking behaviour in Western medicine (countries). In Tswana medicine, as we have seen, there is no such simple link between the elements, and thus the health seeking behaviour will be of a more flexible character or, rather of unpredictable character. Even though as I have argued that disease etiologies gives a frozen or static picture of health and illness, the etiological account will make the necessary background for the further inquiry into how the Batswana deal with health and illness in the context of medical pluralism.

> The most successful attempts in the study of medical systems have tended to examine illness and healing as elements of a single behavioural sequence, rather than as disembodied events. As writers such as Geertz and Gellner have suggested, the logic of a repertoire of knowledge emerges most effectively from observation in the context of action (Comaroff, 1978 b.: 251, my italics).

It follows from this that rather than giving attention to how diseases are classified as

such; etiology, we must look into the process of health-seeking behaviour and how people i.e.; patients and their closest network talk about health and illness, how they evaluate and choose between medical alternatives.

Another way to analyze medical systems then, is to go beyond the patterns of etiology, and rather look at the suffering person in his social environment. How does s/he perceive the situation, and further; how does s/he go about to gain health. To be able to understand health seeking behaviour among the Batswana, I will argue that health and illness and its management must and can only be appropriately viewed as a process, not an event. The meaning of therapeutic behaviour only emerges when it is comprehended in its temporal context of beliefs and practices; as a process of interaction. Chrisman, amongst others, talks about the health seeking process, which he says; 'is a concept that may provide a comprehensive scheme for examining people's reaction to sickness'. And further:

> for describing the events that take place when a person is sick is health seeking behaviour, the steps taken by an individual who perceive a need for help as he or she attempts to solve a health problem (1977 :353).

Hence, when studying medical systems and health seeking behaviour, in addition to the patient's physical signs and social relationships, a third factor is crucial to the unfolding of therapeutic action; the process of interaction, unfolding through the passage of time. Therefore, in the next chapter I will look into how a person in his social environment behave when being ill. I will argue that being ill, taking care of health is something going over a period of time, where the person(s) involved might suffer various sorts of diseases, and seeks various types of treatment alternatives throughout the health seeking process.

CHAPTER SIX

THE PATIENT IN THE CONTEXT OF MEDICAL PLURALISM

Medical pluralism and flexible use

Medical anthropological studies of the patients and their use of medical treatments have tended to emphasize their flexibility and pragmatic attitude throughout the health seeking process, which facilitates the use of alternative resources in a medical plural situation. Thus, Press, Schwarz, Garrison, and many others have demonstrated that individuals are capable of 'dual use' of distinct medical systems. (Press 1980 :47)

According to Seeley (1973: 238) the Batswana were eclectic as well as pragmatic in their choice of therapeutic alternatives before the encounter with Western medicine, and even consulted practitioners other than their own. Seeley considers these qualities to be of great importance for the Batswana's capability of dual use in the contemporary context of medical pluralism:

> ...this eclecticism facilitated the acceptance of both missionaries in the nineteenth century and Western medicine, as practised by both government and mission doctors, in the twentieth century, and combined with the pragmatic attitude which the Tswana display toward seeking medical aid, could provide the medical explanation for the coexistence of Western medicine in Botswana (Seeley, 1973: 238).

Accordingly, one may assume that the Batswana are open and adaptable to changes in the medical context. However, even though they are open and flexible that does not necessarily mean that they use medical alternatives randomly; put together and combined like shreds and patches. The very word 'flexible' make us see a person floating around in the system taking whatever treatment available in a rather pragmatic fashion. However, the patient is an individual in a social and cultural environment which lends the medical alternatives, however diverse, of specific cultural and social significance. Consequently, we must ask, what is the character of their flexibility? In what ways are they flexible? Do they practice dual use randomly, or is their any pattern in their choice of medical alternatives? Is it possible to locate types of situations where the Batswana consult clinical treatment, on the one hand, and types of situations where they prefer

Tswana treatment, on the other hand? Some researchers claim there is a pattern in how the patient utilizes the various forms of treatment. They claim to locate a pattern for health seeking behaviour depending on the degree of seriousness of disease: first use of home remedies, then the traditional sector, and at last the clinic/ hospital. (Honigman, 1973: 1042-1063) Even though we know that most patients starts with treatment in the home sphere, is it true that the degree of seriousness of disease is the only pattern-generating factor? [1] Or, is the patient's health seeking behaviour also influenced by social factors, such as the availability of health service and, decision-making among family and friends in the closest environment? And what effect do cultural factors have?

We have seen that Tswana and Western disease etiology; perceptions and causal explanations of health and illness, differ in many ways. Thus, how will culturally based perceptions of health and illness influence the patient's health seeking behaviour? How does the patient, his family and friends, make sense of given episodes of illness? How can we explain the way they choose among and evaluate the available treatments?

In this chapter, then, the subject is the patient's health seeking behaviour. I will focus on his encounter with the clinic people, and discuss the encounter in relation to the complex medical setting within which it is taking place. I will primarily try to understand how the patient herself perceives and interprets her situation by following the patients' case stories. The most interesting finding in my study of the Batswana's health seeking behaviour is their simultaneous use of therapeutic alternatives. By focusing upon their simultaneous use of medical alternatives, medical pluralism and its consequences upon the health seeking behaviour emerges most effectively where the patient is practising dual or even multiple use simultaneously.

The three case stories

The case of Tebelelo

From the health seminar we have seen how the Batswana talk about the disease of TB / tibamo. Therefore, my first disease story is about Tebelelo who is suffering from the disease of TB ya tibamo; 'TB from the wrong position', as she herself label her

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[1]. *According to Kleinman referring to research being conducted in the United States and Taiwan, approximately 80% of all treatment is handled with home remedies, or what Kleinman terms 'the popular sector of health care'. (Kleinman, 1980:50)*

disease.

Tebelelo is a woman at about 25 years old. Her husband lives in South-Africa where he is working in the mines. Tebelelo with their (common) children, is living with her parents-in-law. Her husband comes home less then once a year for a month before he returns to South-Africa. Tebelelo went to the clinic after having been suffering for a longer period of a what she called a 'bad and serious cough'. At the clinic she was given some tablets; mainly C-vitamins, however, as the cough did not ease off, she returned to the clinic a month later. She then took the TB-test, which turned out to be positive, and Tebelelo is then sent to the regional hospital at Mahalapye for a more thorough examination. She has been going to the clinic every morning for 6 months to take her medicine (so that the clinic people could to actually see that she takes and swallow her medicine). She is being treated by the 'short-term treatment' which only lasts six months, in contrast to the 'long-term- treatment' which take 18 months of treatment.[2]

At the same time, as she is taking the clinic treatment, she is also drinking medicine which she is given at one of the local faith healing churches. Every morning and before she goes to bed she drinks water, which has been prayed for at the church, and thus, as they perceive it, is 'holy water', which will make her stronger. At the church she is also taking the treatment of sewasho; which is a (ritually) cleansing bath. The bath is meant to wash away the 'blackness', her bad blood, or the moa; spirit, in her body. Tebelelo also consulted a Tswana ngaka, which according to the divination considers her to be suffering from tibamo (This disease is explained in chapter four) because her youngest child was borne siina; in 'the wrong position'. She is then taking some treatment for tibamo.

Tebelelo also consulted another Tswana ngaka. He threw the ditaola; the set of divining- bones, and found her to be suffering from sejeso: According to Tswana medicine she has been food-poisoned by a moloi and is then considered to be suffering from the disease of TB a sejeso. However, Tebelelo did not take this treatment. Tebelelo completed the TB-treatment at the clinic, whereafter she is sent for another TB test, which is negative. When her husband returns from South Africa, both of them - together

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[2]. *Especially when treating TB.-patients with the long term treatment - taking 18 months- the clinic-people have often been faced with the problem that the patient refuses to take the tablets.*

with their youngest child will then be given the treatment of TB ya tibamo by the Tswana ngaka.

The case of Sethalthla:

Sethlathla is a an old woman soon to reach the age of 80.

Sethlathla was one of my nearest neighbours, and I saw her around almost daily. She is living with her blind husband, her daughter-in-law and her grandchildren. Whenever I met her she was always complaining about an aching pain in her head and neck, as well as pains in her legs. Through the local nurse I also learned that she was suffering from high blood pressure. Suffering from headache and pains in her legs she went to one of the local faith healing churches in the village. Sethlathla wanted to get some treatment to release her pain. She wanted to know 'what is going on'; what was really wrong with her health. At the church the moprofiti told her that she was suffering because of 'people that walk at night'; the evil acts of a sorcerer, and the whole congregation came to her home yard where she was given some preventive treatment. She is also given additional treatment at the moruti's yard for her complains. The second time she is consulting the moprofiti, she does not give her any causal explanation for her complains, however, she is given some treatment and, advised to seek help in her own church which is having a congregation at Mahalapye (the nearest adminstration centre about half an hour drive from the village). She is also told by the moprofiti that she will never really recover from her complaints. At the same time, she is also consulting the clinic for medical remedies to release her pain. At the clinic it was found that she was having a high blood pressure, and she was given the appropriate treatment. Although she is taking the clinic treatment of high blood pressure, her aching pain, however, does not ease off. Now and then when her pain is unbearable she goes to the shop where she buys Compral; headache tablets, which release her pain for some time. She also treat herself by wrapping a big cloth around her head, which she from time to time refresh by wringing out the cloth in cold water (before she again wrap it around her head). Whenever I saw her around she was always wearing this cloth, which she put under her headdress. (Even though she does not consider the clinic treatment to release her pain,) Whenever her tablet course is through and hence, scheduled for another control she (still) returns to the clinic. Her blood pressure is then measured, and she is given more tablets for her disease of high blood

pressure.

Although her blood pressure is getting better and is almost to a normal, Sethlathla is still suffering, and she is planning to consult the church once more for treatment. She is also considering to consult a Tswana ngaka (which she so far has not been able to).

The case of Mmasethunya and her daughter

Mmasethunya (; 'the mother to Sethunya') is an unmarried woman at about 25 years old and the mother to one child, a girl. Mmasethunya has taken two out of five years of Primary School, but is now taking a one year break in her education for economic reasons. She is living with her mother, who is also unmarried. (Mmasethunya's brothers is living in the mother's yard as well.)

As most women in the village (of Pilikwe) Mmasethunya gave birth to her first-born at the maternity ward at the clinic. However, the child was very thin, and Mmasethunya and her mother, as well as people around, started worrying what could be wrong. During almost two years Mmasethunya takes her child to several health specialists. According to the clinical system Mmasethunya brings her child for the regularly monthly child care check-ups at the clinic, where the child is found to be underweight. Mmasethunya then seeks help among Tswana specialists; from a woman in the village who is considered a specialist on diseases for children. She considers the child to suffer from tibamo, and according to Tswana medicine gives both Mmasethunya and the child the preventive treatment of tibamo.

At the same time Mmasethunya as most women in the village treats her child with home remedies; gives her child some medicine which she buys at the local shop, hoping that the 'shop- medicine will help her child to put on weight. However, the child does not put on weight, and worse; when the child is seven months old, she refuses to suck her mother's milk, even though Mmasethunya has more then plenty. Dr. David, at the clinic, then test the child's sputum, blood and urine, but nothing shows up to be abnormal with the child's health. He just advises them to go to the cattle-post where they can drink milk daily. Mmasethunya then returns to the Tswana specialist -to the same woman, who then consider her child to suffer from the diseases ntsana and dintantenyana, hence giving them the appropriate treatment.

During summertime when the family stays at the field some three-four miles from

the village, Mmasethunya takes her child to another woman specialist on diseases of the children who is living close to Mmasethunya's family at the field. She also consider the child to suffer from dintantenyana and ntsana and give the treatment accordingly. Later on when the family stays at the cattle-post Mmasethunya consult a health specialist of the San people. He considered the child to be free from diseases, however, he cooked some sebethe; liver, and told them that the child would become fit and fat if it got proper food. The child was now about one and a half years old.

Discussion

The cases given above illustrate the patients' dual and flexible use. They are consulting various health specialist in the health care system, thus they are switching between medical alternatives.[3] All of them practice dual or rather, multiple use of treatment alternatives, thus they draw upon various medical treatments, even simultaneously, throughout the health seeking process. At a first glance it seems as if they practice dual use rather randomly. However, a closer look reveal a pattern in their behaviour. It is not identical, though, but shows some variation.

Let us now look closer into these cases and try to consider some of the factors influencing the patients' behaviour in the context of medical pluralism as they are revealed throughout their health seeking process.

The Batswana encountering western medicine as it is expressed in the clinic consultation

The three patients we are going to discuss have all a positive attitude towards Western medicine as it is represented by the clinical staff and Dr. David, the RMO at the clinic. All of them come regularly for treatment and check ups: Tebelelo comes every morning to take her TB treatment, Mmasethunya takes her child for the monthly check-ups, and Sethlathla returns to the clinic when her tablet course is through and hence, scheduled for another test of her high blood pressure. However, we know that all of them are simultaneously seeking alternative treatment. In a treatment situation communication problems often arise because healers and lay-men do not understand

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[3]. *There is nothing special as to the cases given concerning their dual use of medical alternatives in the health care system. Switching between various health specialist was very common in the village.*

each other. Further, this is most common to occur where Western medical doctors communicate with lay-men outside the Western culture.

Let us then take a closer look at Sethlathla's (case 2) encounter with Western medicine as it is expressed in the clinic consultation between her and Dr. David. At this stage Sethlathla has been taken the clinic treatment for high blood pressure for approximately six months, and according to her medical card her high blood pressure is getting better. However, she is still suffering from an aching pain in her legs and she is having headache.

The clinic consultation

The RMO; Dr. David has as usual seen the TB- patients first, as he says, " they need to be encouraged." He is now sitting in his office; tapping at the desk with his pen while waiting for the next patient to enter. Then Sethlathla enters; and Dr. David reach out his hand - not to greet her though, but for her medical card. While Dr. David is reading through her medical history (all written up on her card), Sethlathla takes a seat and starts taking off her jacket and without a word being uttered by Dr. David she lays her hand on his desk; just in the right position for him to measure her blood pressure. Dr. David then places the instrument on her arm and for the first time during the consultation he talks to Sethlathla, not facing her though as he in lack of setswana language addresses himself to the local nurse who interprets to Sethlathla. Sethlathla is told to eat less porridge, and more vegetables. However, where is she to get vegetables in these times of drought!) And most important; she should not put salt on her food. Before the nurse has finished interpreting, Dr. David turns towards me telling me about the bad food habits of the Batswana: "Batswana eat all too much salt. When I tell them to cut salt they only, if best comes to the best, cut out to salt their dish, but they still put in salt while cooking!" And he continues: "During summertime this habit is not so bad as they sweat a lot, however during winter- time when they do not sweat they are still using the same amount of salt!" Then he returns to his work not asking the nurse to interpret; looking at the instrument and addressed to the patient ; "Go siame" (O.K), rap up the instrument and starts to write on the medical card while Sethlathla puts on her jacket. Once more Dr. David says; "Go siame," returning her card to Sethlathla. And she leaves the office getting another tablet-course by the Family Welfare Educator (F.W.E.)

sitting in the dispensary next-door.

During the consultation, Dr. David hardly feels a need to deal with his patient. To him everything of (medical) importance is written on her medical card. When he turns towards her it is just to measure her blood pressure. Then he sets the diagnose and confirms that she is still suffering from high blood pressure.

In the context of medical pluralism with the co- existence of both Tswana and Western conceptions of health and illness one could assume that the patient has one set of ideas and conception of health and illness, the ngaka and the moprofiti theirs, and the clinic people yet another. The patient is in contact with different belief systems as she switches between medical alternatives. She is encountered with various explanations and treatment alternatives as she moves between them. Thus, how does Sethlathla negotiate with, or make sense of, the various situations in the course of gaining health? How does Sethlathla make sense of the clinic consultation; how does she interpret Dr. David's diagnose and the clinic treatment for high blood pressure? What kind of implication does it have for her health seeking behaviour?

Sethlathla's perception of her disease

Some days after the clinic consultation, I return to Srethlathal's yard. She is sitting in the shadow of her hut, and she has wrapped a big, white cloth around her head. She shows me a bowl of water explaining that when the pain is really bad she wrings out the cloth in cold water before she puts it on her head. It is kept there for hours, usually for most of the day, only now and then freshened by cold water. Sethlathla explain to me; "It releases some of the pain. You see, I do not really believe in the clinic medicine. Although I take the tablets three times daily as I am told at the clinic, they do not help me because the pain is still there. Thus, Sethlathlka herself feels she is suffering from headache and aching legs, not what Dr. David at the clinic calls high blood pressure. So when she asks for medical treatment she wants medicine to release her aching pain: "I believe that these tablets are only to help my BP (blood pressure). They are not for my aching pain. Sometimes one of the nurses gives me some tablets of Paramount, but they do not help at all." Sometimes it is so bad that I will have to go to the 'Co-op' (the local shop) to buy Compral- and then my head becomes better right away." According to her medical card, which the patient - as part of the clinic system- brings with him home, she

is gradually recovering. (Does she feel any improvement?) "I do not know the disease of BP (high blood pressure), I only know that I am still having the painful ache. I do not know whether my BP is worse or better, all I know is that I have taken the tablets for many months, but my pain is still there. I told the clinic people that the tablets do not go to my head, they go to my stomach."

Even though Sethlathla takes the clinic treatment for high blood pressure and somehow considers the treatment to make her recover, she connects her aching pains with the quality of her blood somewhat differently from that of Dr. David (and Western medicine). As we have seen in chapter four, the blood will have various qualities according to the person's health situation. Hence, whereas a person in good health will have 'bright', 'fluid' and 'good' blood, a person with 'clumpy', 'frozen', 'black', or 'dark' blood, on the other hand, will be having health problems. Further, as expressed by Sethlathla, the blood is capable of transferring a 'disease' (here the pain) from one place in the body to another: "Before I started suffering from headache and leg pains, I had pain in my left knee. Now I believe that this blood has gone up to my head causing the pain in my head and neck." Based upon the Tswana idea about blood and it's qualities, Sethlathla interprets Dr. David treatment in her own terms; "Dr. David is always checking my BP- explaining to me that the blood; (the pain) has gone to my head." Hence, Sethlathla relates her aching pain to her bad blood; it is bad blood which is causing her pain. Sethlathla is told at the clinic that she is suffering from high blood pressure, and she takes the treatment as she is told that it will cure her problem. However, even though Sethlathla considers the clinic treatment to be good for her high blood pressure- which she conceptualize differently from the clinic people, she is convinced that the clinic treatment will not relieve her pain.

While she is still taking the clinic treatment for high blood pressure she returns to the faith healing church to ask the moprofiti and moruti for help once more.

The church 'consultation'

At her first consultation in the church, the moprofiti prophesied her problem to be caused by boloi; sorcery. Sethlathla does not really take comfort in this explanation, or in her own words: "I myself do not believe that a moloi can cause diseases. Ever since I was born I have been told that there are moloi around, but I have never seen one."

Sethlathla considers her problem to be 'an ordinary disease' (Ke bolwetse, hela; it is just a disease) that might come to anyone. [4] However, as she says; I can not refuse this idea completely because a moloi is a person and you can never be certain." Hence, after the church service the whole congregation came to her yard in an attempt to pacify the evil act of boloi, as well as to protect her yard against further (evil) attempts by the sorcerer to hurt her. (See appendix I) According to the moprofiti's explanation Sethlathla had stepped on moloi's blood. She explained that the moloi had put some blood (mixed with bad medicine) inside my yard just outside my hut. She did not say moloi, but "people that walk at night". [5]

Sethlathla is at this stage also given additional treatment:

During the divination, the moprofiti; prophet-diviner, told me to go to the shop to buy coffee and vaseline and bring it with me to the moruti's (Rra. Metse). He then prayed for the vaseline and coffee (it thereby becomes holy and is then used for medical purpose), whereby I went home with the (holy) medicine and prepared the treatment as I was told to: I mixed the blessed coffee and vaseline. Some of the mixture I boiled in water and then steamed my head over the heated mixture. In setswana we call this treatment go uremela; you cover up your head and face over the heated mixture for the vapour to be more effective. When the vapour hit my face and head, I even felt a worse pain. Then after I finished this part of the treatment I smeared on the coffee and vaseline mixture on my neck. I treated myself every evening for a week- then I had finished up the medicine (coffee and vaseline).

At the second consultation at the church Sethlathla is not given a explanation of her problems during the prophesying act. She is told that she will never really recover, however, she is advised to go to her own church congregation. Further, she is told by the moprofiti to put her church belt under her pillow during the night sleep. She is told to

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[4]. *The Batswana talks about 'bolwetse, hela'; only a disease, which indicates that the disease might come to anybody, and is as such not a disease caused by sorcery, or badimo; the ancestors.*

[5]. *According to Tswana thought a moloi; sorcerer, can cause his victim to suffer from a disease by burying bad medicine into the ground. A moloi; sorcerer, will then make a cross in the ground where he has buried the bad medicine and when his / her victim steps on it, it will penetrate the soul of the foot and cause a disease such as TB. a sejeso, or leg ache depending on the moloi's; sorcerer's, will. He decides how his victim is to suffer and his purpose is to kill.*

have faith in God, as she is the only one to help and cure her. Then, she is also told (by the moprofiti) to go to the moruti's yard the following morning, for him to sprinkle her head with holy water. Further, he should also pray for her with the 'white paper' while lying it on her head.[6]

The following day, Sethlathla goes to the moruti's yard and is then treated according to the moprofiti's saying. However, Sethlathla ask for additional treatment: "I asked him to pull out some blood from my head." By the use of a long needle (used to prickle the skin) the moruti pulled out some blood (bad blood) through Sethlathla's nose.

Sethlathla's treatment expectation

Among the Batswana there is a general belief that whereas the Western type of medicine has an almost immediate effect upon health problems, Tswana medicine, on the other hand, is working very slowly.[7] Accordingly, Sethlathla expected the clinic treatment to relieve her pain almost immediately. However, her (clinic) treatment expectation is not fulfilled. As Sethlathla, as most people, do not expect the Tswana treatment to have an immediate effect, she is more patient towards the Tswana treatment and the Tswana specialist. Tswana type of treatment takes time, and often has to be repeated before the patient feels any recovering. Therefore, even though Sethlathla's pain is not relieved either by the clinic treatment, nor by the Tswana treatment, she is still taking comfort in the Tswana type of treatment. Hence, Sethlathla is planning to repeat this type of treatment.

To sum up

Investigations in the West (Alver, 1982), have shown the importance of a positive relationship between the patient and the specialist for a successful outcome of the treatment. If there is a lack of understanding between the two parts, that is, when the patient and the specialist have different conceptions and explanations of diseases, what

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6. *The Zionist Christian Church makes use of three different types of paper; green, white and, brown. The paper is believed to have a healing effect, as they are made holy by Lekonyana- the church bishop in Petersburg. 'White paper' is a small piece of paper from a newspaper.*

7. *This belief and way of differentiating between indigenous versus Western medicine is, for example, found among the Mandari of Southern Sudan. (Buxton, 1973.)*

Kleinman refers to as EM (explanatory model), the treatment will not be successful to the same degree as if both parts had a common frame of reference. According to Kleinman (1980), the interaction between the specialist and the patient is crucial to the effectiveness of treatment.

As the faith healing churches have adopted many of the treatment methods used by the various Tswana dingaka, these methods are well known for Sethlathla. (In addition Sethlathla has for many years been a member of a faith healing church.) Both their various explanations as well as the treatment offered is understandable for Sethlathla. She can negotiate with the moprofiti and the moruti and she can therefore relate to her disease problem in a meaningful way. The baprofiti's explanations are very much corresponding with the patient's, and they can therefore explain Sethlathla's diseases in an well-known framework. Further, even though Sethlathla does not really agree to the moloi explanation, she can consider its truth value and choose whether to accept it or not. At her second consultation in the church, the moprofiti considers Sethlathla's disease to be due to a weakness of her old age, and thus tells her that she will not really recover. However, in addition to the various treatments given at the church, Sethlathla is most of all met with comfort and understanding.

In contrast to the clinic consultation Sethlathla can use her own terms when dealing with her health problems. Therefore, she can talk about good and bad blood according to their common cultural reference and thus, be understood. Based upon the ideas that she is having bad blood in her body which she, so to say, must get rid off before the pain can leave her body, she then ask for the needle -treatment. Further, the moruti comply with her suggestion of pulling out the bad blood in her body. Sethlathla is fully aware of the fact that it is in vain to ask the clinic-people for such a treatment. Sethlathla does not understand her disease as it is diagnosed by Dr. David, neither the way the nurses relate to her problem by giving her tablets that 'do not work at all'.

The characteristic about a patient explanatory model, according to Kleinman, is that they change rather frequent. The popular medical knowledge is 'diffuse' and in contrast to the 'institutional' medical knowledge very inclusive:

> They are plastic enough to cover a wide range of experiences and imprecise enough to be refuted by specific happenings (1980:109).

However, even if Sethlathla, to some extent, should have a mental preparedness to

understand her health problems in a new and different way, cultural and language factors, compounded by the highhanded behaviour of Dr. David, put an effective barrier to any such development. As it is, she makes evaluation of the treatment primary in terms of her own perception of her disease. Her conceptualization of her health problem is still based upon her ideas about good and bad blood: Bad blood must be taken out of the body before she can regain a good health condition. Sethlathla, as most Batswana, are afraid of or, feel embarrassed when talking about their health problem with the clinic people in their own terms. They fear being criticized or made fools of by the clinic people.

(However, did the 'needle-treatment' relieve her pain?) "No, when I came home I even felt the pain worse. I was aching a lot. But you see, this kind of treatment does not work right away. You are not healed right away, but only after some time it really relieves the pain, so I should go again one of these days."

As we have seen above, Sethlathla seeks treatment alternatives to fulfill her treatment expectation. Although she is drawing upon both medical systems in a seemingly easy way, she is not entirely satisfied. This has, of course, to do with the fact that her symptoms are still there, but it may also be due to lack to an integrative conceptual grasp of her problem.

In the case of Tebelelo, which we will now look into, such a cognitive integration seems to take place.

Tebelelo's health seeking behaviour

Tebelelo consults various health specialist, however, whereas she is accepting some treatment she refuses to take other types of treatment suggested. Hence, why does she take the TB- course at the clinic, and further, why does she simultaneously draw upon Tswana treatment of TB ya tibamo, whereas she refuses the Tswana treatment of TB ya boloi? There are many factors in Tebelelo's health seeking behaviour that need explanation. I will look into some of these factors. However, I will concentrate upon one phenomenon; the classification of Tswana versus European diseases in the encounter between Tswana and European medicine as it is expressed throughout her health seeking process.

One of the Tswana dingaka, whom Tebelelo consulted, considered her to suffer

from the disease of tibamo, as her child, he claimed, was born siina; in the 'wrong position'. As we have already seen above in chapter four, according to Tswana idea siina means that the child doesn't rotate spontaneously at birth, but falls onto its stomach facedown.[8] When this happens, the child and the parents could get a cough called tibamo which will develop in to 'the big cough', or TB if proper Tswana treatment is not instigated right away.

Further, we have also seen that the Batswana's perception of TB; 'the big cough', is not corresponding with the Western etiology of TB. However, some of the explanations given at the seminar could also be taken as signs that some of the Batswana have a certain notion of Western disease etiology. Young women; mothers of young children, makes up the group of people which is most frequently exposed to the Western knowledge and type of treatment as they regularly come to the clinic both during pregnancy, childbirth and child- care treatment. Therefore, it is likely that they have a perception and ways of dealing with health and illness which could hold both Tswana disease etiology, as well as, a certain knowledge of the clinic treatment. Therefore, much likely Tebelelo's perception of health and illness is influenced both by the clinic-people as well as the Tswana sphere of health. Accordingly, how does it influence her health behaviour? If it is composed of both Tswana and Western perception, how does she then draw upon the available medical alternatives?

Tswana and European diseases

In Tswana medicine it is common to distinguish between Tswana and European diseases, which the Batswana respectively name; bolwetse wa setswana and bolwetse wa sekgoa. Commonly the various Tswana healers as well as the Batswana in general refer to a European disease 'as an ailment imported to Botswana by the colonialists and as such unknown to the Batswana before their encounter with the Western civilization. On the other hand, a Tswana disease is regarded as cultural specific generally incomprehensible to Western medicine'. (Staugård, 1985:70; Ulin, 1975:97-8.) Accordingly, the disease of TB is a European disease, whereas for example the diseases of siina and tibamo, are considered to be specific Tswana diseases and as such outside the reach

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8. *According to Tswana idea this is due to meila; the transgressing of moral taboos, by the parents during the woman's pregnancy.*

of the clinic people. It is generally held by the Batswana that the clinic people neither understand nor have any remedies for this type of diseases, and accordingly these diseases are the domain of Tswana medicine. As we have seen the clinic people do not take notice of siina, as it according to Western medicine is medically irrelevant whether the child falls onto it's stomach or, onto it's back by birth. Tebelelo knew about siina when she delivered at the clinic. However, as she is fully aware of the fact that the clinic people do not consider siina as something abnormal, she does not actualize (this part of) her explanatory models. Or, as she explains it herself: "You see, we can not ask the nurses at the clinic, because they do not know this disease. Or rather, if we ask them they will just tell us that siina; the 'wrong position' is not a disease." Later on, approximately two years after the birth at the clinic, Tebelelo is found to be suffering from the disease of TB; 'the big cough'. Accordingly, Tebelelo starts the six months treatment of TB given at the clinic, however, simultaneously she seeks additional help and treatment by the Tswana specialists.

Why and how is it possible for Tebelelo to draw upon medical alternatives, and why does she not according to the cultural categories of Tswana and European diseases exclusively choose either clinic treatment, or Tswana treatment?

Tebelelo and her closest environment

To get a better understanding of what is happening during her health seeking process it is necessary to look into her social environment.

As Tebelelo's husband is away most of the year, her father-in-law is of great importance considering the advise and decision- making during her health seeking behaviour. Her father- in- law is a Tswana ngaka, a herbalist. Actually he was the first one of the Tswana dingaka in the village willing to co-operate with the formal health sphere. Thus, he has been to some of the health seminars arranged by the RHT. According to Tebelelo's father -in-law he considers the Tswana healers to know the disease of tibamo, whereas the clinic people know the disease of TB. However, he considers the diseases to 'go together', as he says.

Generally there is a certain disagreement or incoherence of view among the various Tswana healers as to whether TB, the big cough, and tibamo are: 1) one and the same disease; or 2) whether tibamo is the first sign and the first stage of TB; or 3)

whether they are two different diseases, with each having their own specific cause and treatment. This variety in their perception could be seen in relation to the role of the integrative policy, practiced by the RHT and clinic people, for example at health seminars,- where the various Tswana healers are exposed to a new and different type of knowledge and explanations. Further, as I have shown in chapter five, this seemingly incoherence should also be seen in connection with a indigenous process of divination, which by principe is very different compared to the Western principe of diagnose.
Further, it was always very difficult to get hold of the Tswana healers' conception of TB and tibamo. On the whole, I got the impression that they where confused about the differences. Even though most of them would explicate the nature of tibamo, and some even the disease of TB, however, most of them where confused about the connection between the two types of diseases. For example, some asked me to tell them the difference.

1) As mentioned above some would say that TB and tibamo are the same disease and accordingly treat it as tibamo or, refer the patient to the clinic for treatment.

2) Other consider the disease of TB as a complication of tibamo, 'the big cough' will develop as a consequence of having omitted normal Tswana treatment at birth. They will treat the cause as being born in 'the wrong position'; siina, and eventually they will refer the patient to the clinic to verify whether the patient is still ill or not. If you haven't taken the preventive treatment at birth it will develop to TB. (But how is he to know?) I will throw the bones (used when divining the case) which will tell me all I need to know. If (they say) it is an old tibamo, I will tell the patient I can't manage and refer him to the clinic."

3) Then there are those who, by differentiating between Tswana- and European diseases, think that TB and tibamo are two different diseases. Thus, the implication of such a classification seems to be that a person suffering from tuberculosis will be referred to the clinic. On the other hand, the disease called tibamo is classified as one of the most prevalent of the Tswana diseases and as such will only be sufficiently treated by the Tswana healers.

As we have seen Tebelelo consulted two Tswana dingaka whom both labelled her disease different from the clinic people. Whereas the one of the dingaka considered her to be suffering from the disease of tibamo, the other one considered 'the big cough' to

be caused by boloi; the evil acts of sorcery. This lack of correspondence between the various explanations could of course have brought about a confrontation between the persons involved when Tebelelo is switching around between medical alternatives.

Tebelelo is at this time already under the clinic treatment. Both she as well as her closest environment, her father-in-law, consider the clinic people to know the disease of TB. However, simultaneously they also considered her to be suffering of 'the big cough' as she did not take the Tswana treatment after having given birth to a child in 'the wrong position'. Thus, she is not considered to be suffering exclusively from either TB or tibamo. Tebelelo is suffering from the disease of TB ya tibamo, and accordingly she needs the clinic treatment as well as Tswana treatment.

Tebelelo also consulted a Tswana ngaka, who claimed her to be suffering from TB a sejeso; the big cough caused by food -poisoning by a sorcerer.[9] First of all; it is not uncommon to refuse the ngaka's divination and type of treatment if the persons involved find it unreasonable. Further, very much due to the new type of TB treatment; the short term treatment, Tebelelo does not feel so weak and dizzy as she would have been if she had to take the long term treatment. In addition Tebelelo is also a young woman, strongly built and the every day walk to the clinic takes her less than an hour back and forward. She is also socially in a rather good position compared to many other in the village, she is married having a husband with celery income. Further, by living in her in-law's yard she can also draw upon their help for children care as well as help in the daily work in the home yard. If Tebelelo, on the other hand, had dropped out of the clinic treatment by for example her preference of some type of Tswana treatment, she would have been picked up by the organization of the formal health sphere. According to the clinic system she would have been visited by the FWE, whom would have reminded her of the necessity of her clinic treatment. Such factors may explain why she refused the boloi-treatment and further, why she kept to the clinic treatment. Or as she puts it herself; " At that time I was given some help at the clinic, and I felt I was already recovering."

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9. *A moloi, works with various remedies and techniques. The most feared one is go jesa; to eat, or, to give to eat, which causes an internal growth in the body; sejeso.*
In the case of TB. a sejeso, the poise will go the victim's lungs (and cause an internal growth). The lungs will so to say be eaten (up) by the poison, which will then cause the victim to suffer from 'the big cough'.

Hybrid forms, or new treatment combinations

We have seen the that the Batswana make a distinction between Tswana and European diseases: between those diseases that can be cured by the clinic people, and those type of diseases that can be cured exclusively by the treatment of Tswana healers. But Tebelelo and her advisers, does not differentiate between Tswana and European diseases in such a fashion that she has to take either clinic treatment or Tswana treatment. Neither does she replace the old type of treatment with the new type. She draws upon both to gain health.

In the context of medical pluralism it seems that the patient has created a cultural combination which makes it possible for him to draw upon both clinic as well as Tswana treatment.[10] One could say that the health seeking process have become more composite and complex; a conglomerate of Western and Tswana medicine. In the same way as Tebelelo considered it useless to ask the clinic people about siina in the birth situation, she also knows that the clinic people do not consider tibamo as a disease. Consequently, she does not actualize this part of her conceptual framework in the formal sphere of health. In addition to freely taking whatever treatment available, due to her composite conception of the disease, she does not experience a conflict situation in the encounter between the various therapeutic alternatives. Rather, various parts of her conceptualization is actualized in different situation. In this case at least the lack of correspondence between the different persons' ideas of health and illness; the disease of TB and tibamo, does not amount to a problem. Tebelelo might freely shop around without getting any hard clash between her own conceptual framework and that of the specialists' she consult when suffering from the disease of TB ya tibamo, as she herself as well as her social environment name the disease.

The concept of contagion and the disease of 'TB ya tibamo'

As part of the clinic treatment Tebelelo is sent for another TB-test just to confirm that she is now free from the tubercle-bacilli. Thus, she is considered in good health and

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10. *Kleinman terms such combined forms 'hybrid popular contruction', however, this word has a negative connotation of something that does not have the ability to persist as such, or rather that it will soon die. (Kleinman, 1980: 93.)*

according to our Western conception of contagion, she can not transfer the tubercle bacilli to any one. As part of the clinic system, though, she should come for control after three months.

According to Tswana ideas of contagion, which is closely linked up with their ideas of bad (hot) and cold (good) blood, however, she is not considered to be completely cured. Even though Tebelelo is free from 'the big cough', she is still considered contagious. According to Tswana medicine, which correspond with Tebelelo's ideas of contagion, she is go getela; contagious, and will accordingly transfer the disease to others. She is not contagious and dangerous to everybody though, she might only transfer the disease to her own child and husband. Thus, if they do not take the proper Tswana treatment of tibamo- preventing tibamo to develop, at least one of the three will sooner or later get the disease of TB ya tibamo.

As we have seen in chapter four, the Batswana's conception of contagion is closely linked to sexual behaviour and morality: It is the transgression of certain taboos, which according to Tswana medicine causes the child to be born siina; and then will set forward contagion. If the involved partners do not make up for the immoral act meila; 'it is forbidden', they are potential carrier of polluted contagion, and can thus transfer the disease to one of the other persons involved. As Tebelelo's husband was not around, when she first fell ill she was given some treatment by the Tswana ngaka. (see appendix I) However, as soon as Tebelelo's husband returns home all three of them will take this treatment. According to Tswana medicine, then and only then are they properly treated, and thus sure not to get this disease again. The Tswana treatment will illuminate the contagious danger, and none of them will later get the disease of 'the big cough'.

By the case of Tebelelo I have tried to illustrate that the seemingly different etiological categories of respectively Tswana and European diseases, are not necessarily rigourous cultural forms like watertight compartment. Rather, by looking into the context of health seeking behaviour we discover that the border between them are transgressible, as well as combinable. Hence, seemingly different cultural categories then, can be integrated into a new form; TB ya tibamo, as Tebelelo labels her disease.

As we have seen above the Batswana make a distinction between Tswana and European diseases. (Whereas they consider the European diseases to be curable in the formal sphere of health, they hold that Tswana diseases will only respond effectively to

the treatment of Tswana healers.)
However, as we have seen in the case of Tebelelo these categories might not only be combined, but also integrated.

The case of Mmasethunya and her sick daughter also touch upon the Batswana's differentiation between Tswana and European diseases, however, the involved persons deal with this situation differently from what we have seen in the case of Tebelelo. As in the case of Sethlathla, Mmasethunya combines the two systems only with some difficulties. In this case, however, this is not primarily due to a lack of conceptual integration. Social constraints between the persons involved seems to be a much more important factor.

The case of Mmasethunya and her child

Mmasethunya has given birth to her child at the clinic. She also takes her child regularly for the monthly check-ups at the clinic. As her child is diagnosed to be under-weight at the clinic, she is offered advice and treatment for her child. However, she refuses to take this treatment and further, she prefers to seek help and treatment in the Tswana medical sphere. But, even though she refuses to take the clinic treatment for malnourished children, she simultaneously comes for the regularly monthly check-ups at the clinic.

Firstly, let us try to find out why Mmasethunya, as most mothers in the village, refuse the clinic treatment on the one hand, whereas they, on the other hand, comes regularly for the monthly check-ups at the clinic.
To approach to the problem, we should look into the clinic setting.

Drought relief programme and food supply at the clinic

As part of the drought relief programme, the Government, supported through Foreign Aid, provide for the vulnerable and the destitute which is mainly young women with children, the old, and the sick. According to the feeding programme provided at the clinic, those who are underweight or malnourished should come to the clinic every

morning for a proper meal.[11] However, many mothers, like Mmasethunya, refuse to take this feeding offer. Mmasethunya voices a common attitude to this situation when she says: "Whenever, I came to the clinic for the monthly check-ups, the clinic people just told me that my child was underweight. They told me to cook proper food, and wanted me to come to the clinic every morning to learn how to cook, and also advised me to eat a proper meal there together with my child!" And she keeps on; "The clinic people explain to us, (mothers) that if a child do not have good appetite, it needs special care and attendance while eating. A good mother, they say, should look after her child to make sure s/he is eating. The nurses accuse us for not caring for our children!"
When Mmasethunya, as well as many other mothers, hear such statements (that they are not cooking proper food, or that they are not caring for their children), it is hurting the pride they take in the love and care for their child (ren). It is not uncommon that the nurses as well as the Family Welfare Educators (FWE) are younger than the mothers, and they feel that it is wrong that someone younger should advice and even correct one who is elder. Further, whereas some of the nurses at the clinic have not born any child yet, there are mothers with five-six children and thus, consequently consider themselves to have experience concerning child-care. Accordingly, some wonder; who knows best!

A disease or malnutrition

"How can it be possible to treat a sick child by learning the mother how to cook?" A mother as well as the clinic staff starts worrying when a child is found to be underweight. According to the Batswana, a child should be fat and strong looking. However, in contrast to the clinic-people they do not consider the child's weak health to be caused by malnutrition as such. When a child is thin and tiny, the mothers or the batswana in general consider the problem to be of a different order. They consider the child to be suffering from one or more of the Tswana diseases. Also, as we have seen in the case of Tebelelo, the Batswana consider the clinic people to be ignorant of this type of diseases. Hence, most women in the village are just laughing at the clinic people's ignorance of a child's care: "How is it possible that they can just tell the mothers to come

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[11]. *The feeding program is considered by the Government, as well as clinic-people, as a way to fight the war against the malnourishment - especially during the difficult time of drought among the Batswana.*

to the clinic to learn how to cook proper food, when the child is suffering from a disease!"

As Mmasethunya, as well as most mothers, do not connect the child's problem with malnutrition as such, she does not consider the feeding program to give any treatment, or, as she put it herself: "At the clinic they did not give me anything at all. (She might have expected to be given either an injection, or some type of tablets) They told me to come with my child every morning to the clinic for the two of us to have a proper meal. I was told that I should learn how to cook proper food!" And she explains further; "You see the nurses at the clinic do not know the Tswana diseases." Therefore, the common/ shared idea that the clinic people are ignorant of Tswana diseases is confirmed to Mmasethunya when her own child is suffering.

Why do the mothers or the Batswana react towards the clinic people in such a way: is it mainly due to a difference in their disease etiology, or could it be due to the clinic people's rather insensitive and superior behaviour towards the mothers? That is; is the lack of communication in the encounter mainly due to medical considerations (lack of correspondence between disease etiologies) or, is it rather a question of the social relationship between the mothers and the clinic people? Let us then briefly deal with the Batswana's perception of what the problem is when the child is thin and tiny.

Diseases among children (Malwetsana ya bana)

When a child is thin and tiny the Batswana consider the child to be suffering from one or more of the diseases they term malwetsana ya bana; lit.; 'the smallest diseases of the children'. These diseases are always connected with the mother's (and / or the father's) health situation. All of the malwetsana ya bana belong to the group of Tswana diseases, which we know are considered by the Batswana to be outside the reach of the clinic medicine.

Although there are many malwetsana ya bana which are linked to perceptions of health and illness in a complex way, I will deal with them very briefly. We have already discussed one or two of these diseases; siina and tibamo. According to the Batswana it is considered best for the child's health to get the mother's milk as long as possible, and it is not uncommon for a child to be breast- fed in its second or even third year. When a child is born siina; 'in the wrong position', the mother's milk can be dangerous for the

child's health. It is held that the milk will become sour, and consequently cause the child's stomach to grow big, and eventually the child will refuse to suck her mother's milk. The milk could be affected in other ways, too. According to the Batswana a breast-feeding woman should not run around 'seeing', that is, having sexual intercourse with many men. If she meets other men than the father to the child, it is held that her milk will get dirty. Then, when the child is drinking the mother's milk, which is now mixed with blood; 'dirt', from other men, the milk will affect the child's health, and might get the disease of dintantenyana: The child will get very thin; having a big head and a big belly. Even the child's faeces will smell badly. " When we see such a child, they say, "we just know that the child's mother is running around seeing other men." Or, as some expressed it; "A child should be heavy to lift. Then we know that the child's mother is giving her child a good and nourishing milk. She is clean and healthy and does not run around with other men, but stays in her yard, taking care of her child." According to Tswana custom the mother is doing meila; (lit. it is forbidden), transgressing taboos for how a mother should behave during the breast-feeding period, especially the first year after child birth.

Considering this lack of etiological correspondence between the Batswana and the clinic people's, why then does Mmasethunya, as well as most mothers, still come to the clinic for the monthly check-ups with their children? As we have seen from the cases above, the well organized clinic system explains parts of this behaviour. Those among the mothers missing the check-ups would be sanctioned by the FWE. Either they will be scolded when returning to the clinic, or they will be visited by the FWE - doing their regular home-visits in the village- where the mothers will be reminded of the necessity of the regularly check-ups for the welfare of their child(ren). As most mothers regularly come for the check-ups, there is seldom a need for the FWEs to go around in the village reminding the mothers. However, even though most mothers come regularly for the monthly check ups, there are very few who use the feeding programme. Thus, even though Mmasethunya, as most mothers of underweight children, consider the clinic people to be ignorant of Tswana diseases, they still consider the clinic to be of importance (for the child's health).

Let us look closer into Mmasethunya's environment and how she and the Batswana deal with a child's health in a context of medical pluralism.

Mmasethunya and her environment

Among the Batswana, as in all cultures, the time of infancy is considered to be a special vulnerable time. In addition to different type of precautions, they have also various types of medical remedies to treat the child's ill- health. Diseases among infants and children are considered to be the domain of elderly women in the village since they have gained special knowledge through experience with their own children and grand-children.

Mmasethunya is a young woman who has just given birth to her firstborn and is consequently advised by her elders. A woman then starts learning from her closest environment about the problems of infant children when becoming a mother herself. Thus Mmasethunya is relying very much upon her mother as well as other women in the neighborhood, and their advice. There are some elderly women who are considered to be more competent than others. They have usually 'inherited' special knowledge through a knowledgeable mother, or another relative in the village, who in turn were considered to have a 'cold hand'; a clever hand when treating the malwetsana ya bana. Advised by her mother, Mmasethunya consulted one of these special knowledgeable women in the village. As Mmasethunya gave birth at the clinic and did not take the preventive treatment of (siina) tibamo, both she as well as her mother considered the (traditional) explanation reasonable and accordingly both Mmasethunya and her child took the treatment. However, when the child did not recover and even stopped sucking only seven months old, the specialist then considered the child to be suffering of the diseases of dintantenyana and ntsana, and both mother and child took the treatment accordingly. (The diseases and the treatment of ntsana and dintantenyana are described in appendix I)

According to the Batswana way of perceiving a connection between siina and the mother's milk, Mmasethunya's child is considered to be suffering from the diseases of ntsana and dintantenyana, and they both take the appropriate treatment. Mmasethunya's elder sister - and the mother to four children -is living in Mmasethunya's neighborhood. As Mmasethunya's sister also has been helped by her neighbor when her children have been suffering, this specialist is also called for when Mmasethunya's child is found to be too thin and tiny. As this specialist is having a certain knowledge about the use of 'shop

medicine', he can offer a different and rather new type of treatment. This specialist is an elderly man, whom for years have been working in the mines of South Africa. While staying there he has learned to use the 'shop medicine'.[12] When I first became aware of the 'shop medicine', and asked about its use, one woman told me; "When a woman starts getting children, she should always have this medicine in her yard." The use is very common, especially when mothers are preventing and treating the child's health during infancy. Hence, at the same time as Mmasethunya are repeatedly treated by the two Tswana specialists, she is also advised to treat her child daily with 'shop medicine' in the home sphere. Then every month, according to schedule, the child's health will be checked at the clinic. In addition the child is also vaccinated against some infectious diseases, such as polio, diphtheria and tuberculosis. If the child is still found to be underweight, they will repeat home treatment as well as (re)turn to the Tswana specialist and ask for (more) treatment. Thus, it seems that the mothers are mostly using the clinic as a control-instance for their children's health. That is; mothers will treat their children at home both with Tswana herbs and shop medicine under the guidance of some elderly women who are considered to be the specialists of malwetsana ya bana.

As I see it, the main reason for the mothers to refuse the clinic feeding-offer is the clinic people's superior behaviour, and the humiliation this is inflicting on the mothers of the underweight and malnourished children. The refusal is not primarily due to different medical explanations. It was very common to hear the mothers complain about the bad-behavioured nurses, and whenever I was at the clinic during the children's welfare day, I was really astonished by the clinic people's way of treating the mothers. For example, during my stay in the village, a woman, who had similar problem with her tiny half year old daughter, felt this harsh attitude by the clinic people so intolerable that she preferred to send her daughter to her mother's family. They were living in Maun, a days journey away from Pilikwe. However, as her maternal family had their cattle-post closer to the village, the mother considered this arrangement better than if she should have to take her child to the clinic every morning to be fed.

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12. *This type of medicine was available at the shop, and was usually termed 'Collin's medicine' after the owner of the shop. (Collin was a South African Boer, and sold this type of medicine which was produced in South-Africa.) There was an enormous variety, even of various fabricates of this type of medicine.*

The role of the FWE

According to WHO's intention, the role of the FWE should create contact between the clinic and the village people. However, the intended "bridge -builder" (FWE) very soon becomes a "stranger" within her own environment. Even though the FWE is a child of the village, she very soon forget her "childhood", and start acting as if she was better than the villager, and becomes more like a mini-nurse at the clinic. Whereas the nurses usually live next door to the clinic, the FWE, by living among the village people is supposed to have a better understanding of the situation. But even though one of the FWEs is living next door to Mmasethunya's family (and is married to Mmasethunya's mother's brother), she never consult her for help. Actually the only real "bridge-builder" at the clinic was the cleaning assistant, Keafetole. She was also a moprofiti in the 'Zionist Christian Church' (ZCC). Her husband was a Tswana ngaka, and her mother was a specialist of treating diseases among children. Keafetole now and then referred mothers, or patient in general to the Tswana sphere of treatment.

One could say that the mothers approach both medical systems when caring for their children's health. However, Mmasethunya does not draw upon both types of treatment in order to combine them, like Tebelelo, who suffered from TB ya tibamo. Rather, she, as well as most mothers, take the Tswana type of treatment exclusively, and only use the clinic as a kind of control instance for the child's health and well being.

If treatment fail do they question the system?

Mmasethunya's choice of treatment seems to be made irrespective of such factors as, whether she is close to the modern facilities or not. Whether she is at the cattle post or in the village, she is seeking help outside the formal sphere of health. Moreover, this behaviour does not seem to be influenced by the result of the treatment. Even though the child does not become fit and fat after the first Tswana treatment, Mmasethunya returns to the same specialist, and even when Mmasethunya's child is in a critical situation, for instance when the child stop sucking only seven months old, she sticks to the Tswana treatment. Thus, it seems that Mmasethunya and her closest environment do not question the truth of the specialist's knowledge when it 'fails' and then turn to the clinic. This could partly be due to the fact that the child's disease situation is changing throug-

hout the health seeking process. Linked to the change in the child's health situation, the specialist then change divination and treatment accordingly. And further, even though the child still do not take to the mother's breast, Mmasethunya , when staying at the field consult another Tswana specialist. She sets the same divination as the other specialist and the treatment is then repeated. Thus, even though the treatment does not help the child to recover, Mmasethunya and her mother does not seem to question the treatment system as such; She does not start wondering whether it is true that the Tswana specialist are the only one to know the diseases; malwetsana ya bana. Rather, very often the Batswana in such a situation would reason that the patient's health would have been much worse if they had not taken the treatment at all. This way of accounting for their medical experiences, could be due to the very nature of a patient's perception of her situation. According to Kleinman popular explanatory models of health and illness are very diffuse and in contrast to the 'institutional' medical knowledge very inclusive:

> They are plastic enough to cover a wide range of experiences and imprecise enough not to be refuted by specific happenings (1980: 109).

In spite of not taking the mothers milk, Mmasethunya's child grows up, and is happily running around with her playmates. Although Mmasethunya is still worried for her child, she has taken comfort in Dr. David's explanation that her child is just a tiny one. Further, whereas she feels humiliated by the clinic people's feeding offer, and still complains about their lack of knowledge concerning the child's health situation, she talks with admiration about Dr. Gorge who whenever passing by the village stopped at their yard and gave them meat.[13]

Conclusion

In this chapter my point of departure has been the patient and her encounter with Western medicine in the context of medical pluralism. I have tried to focus upon the patient's health seeking behaviour as she herself perceives and handle the situation.

The health seeking process marks a difficult and critical time for the patient and her social environment. Therefore, one could assume that a patient being ill will try all

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[13]. *Faced with the problem that very few of the mothers in the village make use of the feeding programme, the clinic staff have now decided that the offer should be open both for mothers with underweight children as well as for the well-nourished children. Unfortunately I left the village some weeks after this changing strategy by the clinic-people.*

kinds of remedies or forms of treatment haphazardly. However, in the introduction of this chapter I pointed at the importance of finding out the patterns of the patient's flexibility.

In my discussion I have tried to focus upon question such as: How does the context of medical pluralism where the teaching of new knowledge about health and illness plays such a conspicuous part influence the patient's health care practice? Based upon the discussion of the three cases above I will try to locate some patterns in the patient's health seeking behaviour.

1) Is there a relationship between the type of treatment chosen and the degree of seriousness of the disease?

As mentioned in the introduction to this chapter some researcher claim to have located a pattern according to which the degree of seriousness systematically determines the choice of treatment. However, as I have tried to show, the patient is progressing through a complex course of therapy, where she moves from clinic treatment to home remedies, from home remedies to the moprofiti in the faith healing churches, from them to the Tswana ngaka, and from him/ her back again to, for example, the clinic treatment. Janzen (1978) in his study of medical pluralism in Lower Zaire has shown similar complexity in the patient's health seeking behaviour.[14]

2) Is there a relationship between the choice of therapy to the type of disease?

It seems that the patient, her family and friends, have their own ideas of what kind of specialist to consult in various situations. Thus, there seems to be a relationship between the type of disease, or problem, and the type of treatment preference.

> Observers have pointed out that people in developing areas tend to distinguish the kinds of illness that can be cured by the physicians from those that will respond only to the therapy of local healers (Lieban, 1973: 1056).

Tswana versus European diseases

As we have seen one of these categories goes along the lines of the Batswana's

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[14]. *Janzen describes six cases in detail, with each one progressing through a complex course of therapy, moving from hospital to magician, from magician to clan reunion, and then to a healing cult.*

conceptualization of Tswana versus European diseases. However, for the patient it is not necessarily so much a question of one or the other, rather it is more a question of what type of therapy is to be sought from each specialist. Therefore, they do not seem to choose exclusively either Tswana or European type of treatment. Rather, in a single case of disease the patient might draw upon both types of treatment.

> This popular logic is different from scientific medical reasoning in that it integrates modern medical and traditional premises and does not distinguish between their truth value or the treatment options they lead to...Whereas modern medical logic discriminates among different diagnosis with a single treatment, the popular medical logic enumerates all the problems that are most feared and matches each with a specific remedy. Clearly these are very different ways of reasoning about sickness (Kleinman 1980:94).

Further, as we have seen these disease categories are not watertight compartments, but can be reclassified and combined as the patient switches between medical alternatives.

In the case of Tebelelo I have shown how a patient perceive and deal with the disease of TB ya tibamo. In the course of treatment, Tswana types of treatment is combined with that of Western medicine, e.g.; the disease of tuberculosis is, so to say, mixed with tibamo. However, based upon this cognitive distinction between Tswana and European diseases the patient and his closest environment will know whom to consult for the various treatment needed. That is; a patient will not turn to the clinic people for the treatment of siina and tibamo.

3) Is there a relationship between the degree of shared health beliefs between the specialist and the patient to the patient's preference and choice of treatment alternatives?

The patient is in contact with various and different beliefs and treatment systems as she switches between medical alternatives. Further, as we have seen, the patient combines modern clinic treatment with indigenous forms of medical care, thus, she is practicing combined forms of treatment throughout the same course of treatment. The lack of correspondence between the patient's explanations of health and illness and the clinic people's, does not seem to be of crucial importance to the patient's attitude towards clinic treatment. Even though this lack of correspondence creates a certain degree of misunderstanding, and thus produce anger and a feeling of humiliation, the patients still take the clinic treatment. As I see it, this is very much due to the role of the clinic. To

a certain degree one could say that the clinic people are almost in control of the patient's course of treatment. They can intervene, and hence almost control that the patient takes and complete the clinic treatment. However, as the clinic consultation brings forward communication problems the patient is feeling humiliated and dissatisfied with the therapy. Therefore, even in the cases where the explanation and conception of health and illness have important common points as in the case of Sethlathla, the patient prefers to seek the Tswana type of treatment where she is being understood and have the possibility to express her own perception of her health problem. According to Kleinman, the patient will simply take a shift between her conceptual framework when switching from various medical spheres:

> Contact with another system of meaning and norms may mean simply a shift between conceptual frameworks and behavioral styles the patient himself possesses or has had experience with and can negotiate with (Kleinman 1980:99).

However, I will claim that due to cultural and medical barriers, or different value frameworks, the patient often do not find herself able or willing to negotiate with the clinic people. They are very often afraid of being ridiculed because their ideas about health and illness appear to be nonsense from the clinic people's point of view.The patient therefore often keep quiet in the clinic consultation and takes whatever treatment is offered. Further, whenever I asked a patient on his way home from the clinic, it was not uncommon to hear statements like: "They did not tell me why I was suffering, or what my problem was, they just gave me some medicine." Therefore, as the patient has his own interpretation of 'what is going on', which in contrast to the clinic people is consider as something abnormal, or as a disease, he simultaneously takes additional treatment in the Tswana medical sphere. In this respect the consultation- setting has a crucial effect upon the patient's health seeking behaviour, or as Chrisman states:

> The structural condition under which consultants are chosen and the nature of their shared health beliefs greatly influence this process (1977: 358).

In the native context the patient can agree or disagree with the treatment suggested, and further, she can make suggestions for treatment according to her own perception of the problem.

4. Factors in addition to the medical ones that are influencing the patient's choice and preference for treatment alternatives.

The cases above shows a patient's dual and simultaneous use of therapeutic alternatives. However, in the case of Mmasethunya the patient to a certain degree avoid the clinic treatment. That is; whereas she refuse some clinic treatment (the feeding offer) she simultaneously use the check ups at the clinic when caring for her child's health. As I have shown, this is partly due to etiological factors (Tswana versus European diseases), however, mostly I will claim her eclectic use of treatment alternatives is mainly due to social factors. Due to the clinic people's rather ignorant and superior behaviour, she refuse to take the feeding treatment at the clinic.

The neutral sphere of the clinic

During my first days in the village, and really throughout my field-research I was amazed by the huge number of people coming to the clinic. Especially during winter-time, when most people are living in the village in contrast to the summer-time when they usually stays at the field, the clinic where crowded by people in all ages.

Whether one is a moprofiti in one of the faith healing churches, or is a Tswana ngaka, the clinic is considered to be a common good for all Batswana. It is common to hear the statement: 'The clinic is our common good'. In many ways the clinic seems to be a neutral sphere, where all Batswana can seek medical treatment. Thus, no one seems to get stigmatized by seeking clinic treatment. This could answer for some of the reasons to why the Batswana seem to make clinic treatment their first choice in the course of treatment.

The clinic medicine is more effective than Tswana medicine

Further, it seems that the Batswana recognise the effectiveness of Western medicine. As we have seen in the case of Sethlathla, the Western type of medicine is held to work faster and be more effective than Tswana type of medicine. This seems to be well recognized by all Batswana, and could to a certain degree explain why the Batswana seem to rush to the clinic for the smallest complains.

The dynamic character of health seeking behaviour

The health seeking behaviour is of a dynamic character, where the patient through confrontation and negotiation with the various medical specialists as well as his closest environment is learning about health and illness. The patient might consider behaviour in the past; reevaluate treatment actions, which might influence her further health seeking behaviour, or she might advice his nearest according to his own experience. An individual may call upon other in the social environment, or rather, people in his closest environment will come to the patient and try to identify his problem, and advice her about the type of treatment needed. Chavunduku (1973) in his study of the Shona in Zimbabwe has shown how the patient's choice of specialists is greatly influenced by her family and friends. Further, according to Janzen (1978) 'the therapy managing group', composing mainly of the sick person's kinsfolk, are the ones who decide whom to consult on each stage of the course of treatment.

Even though the patient in the context of medical pluralism is integrating new types of treatment alternatives, finding the patterns of their flexibility is the theoretical challenge.

Medical behaviour and its influence upon existing ideas of health and illness

According to the Batswana's dual use of therapeutic alternatives one could assume that several systems of beliefs are coexisting in the Batswana's world view. That is; that the Batswana's health beliefs, in the context of medical pluralism, are consisting of both Tswana and Western knowledge of health and illness. Further, these conceptions will not exclude one another, but will be activated in different situations. In the case of Tebelelo for example, it seems that the patient do not replace old knowledge and type of treatment with the new one, rather she seems to combine the two. Thus, she is drawing upon medical alternatives in her health seeking behaviour. To a certain extent one could say that her medical behaviour becomes more complex as she has to do both and to fullfil the requirement needed to gain health. However, although the patient is shopping around integrating new types of treatment, that does not necessarily mean that she has achieved an understanding of the Western perception of health and illness.

CHAPTER SEVEN

THE TSWANA HEALER ENCOUNTERED BY WESTERN MEDICINE

Introduction

In this chapter I will focus upon the role of the Tswana healer under the impact of Western medicine. I will try to locate some strategies which he draws upon when being urged to work 'hand- in- hand' with the clinic people to reach 'Health for All Batswana'. I will show how the Tswana healer through various strategies both tries to reach the clinic people as well as he is marking out a domain, where he considers himself to be the only specialist for some particular types of diseases.

We have seen how the patients shuttle between medical alternatives, and on the whole they seem to be readily integrating new types of treatment. Furthermore, through the integrative policy implemented by the representatives of Western medicine, the healer has been met with an additional request; he should cooperate with the representatives of Western medicine. Hence, it would be interesting to see how the various types of Tswana healers respond in their encounter with changing circumstances.

As we have seen at the seminar the representatives of Western medicine, the RHT and the clinic staff preached the philosophy of sharing the patients between the different practitioners, for the benefit of all. If the Tswana healer followed the advice of the RHT and referred all his patients to the clinic, he would simultaneously threaten his own role as a healer. Firstly, then let us see how the various types of Tswana healers respond in their encounter and interaction with the representatives of western medicine. How does he resolve predicaments, and how does he go about in the encounter; how does he work to keep his role as a healer on the medical arena? These are some of the questions I will deal with when discussing the role of the healer under the impact of Western medicine. However, firstly, I will briefly touch upon how the role of the healer has been dealt with and analyzed under the impact of cultural change.

The role of the (traditional) healer has been a focus of study for years among scholars of anthropology (and before that in religious studies). In the article: 'Role

Adaptation: traditional curers under the impact of Western medicine', Landy (1978), criticises scholars for their lack of focus upon the curer; 'the process of becoming a curer, of recruitment to the role, or the articulation of the curer's role with the social system (except usually the religious system). Further, according to Landy, scholars have mostly dealt with the curer's role under the impact of Western medicine, mainly 'in terms of conflict and strain', and further; 'these are seen as almost arising from cultural contact (p.219).

> But in the case of role change in response to the stimulus of competing values and technology of another, economically more potent culture, this question has seldom been handled except in terms of conflict and strain, and these are seen as almost arising from culture contact (op. cit. 219).

Hence, less attention has been given to his active creativity under the impact of change. By referring to Gould's analysis of the Sherupur, Landy argues that the curer's role should not be seen only as passive receptor of Western medicine -or culture i.e. bio-medicine, but as an incorporating cultural agent and a creator of new cultural syntheses. The Tswana healer has worked under the impact of Western medicine for more than a century. For the last years, some five six years, however - through the implementation of WHO's integrative policy, the healer is met with an additional request; he should co-operate with the representatives of the Western medicine.

Therefore, in the contemporary situation there is an explicit request for cooperation where the various parties involved actually meets, and not merely meet indirectly through the patients as he switches between medical alternatives.

Let us now then look into the mechanisms which the healer is making use of in the encounter both directly as it is expressed at health seminars and indirectly through the treatment of patients.

Secularization of the knowledge and practice of the Tswana ngaka

There seems to be a tendency towards a secularization of the bongaka; the knowledge and practice of the Tswana priest-healer. The process of secularization express itself in the legitimization of their profession and the charging for treatment.

Legitimization of bongaka

While dingaka in earlier times claimed their knowledge and healing strength given

them from the badimo; ancestors, there now seems to be a clear process of secularization of their profession. (Schapera, 1969: 160.) The Tswana dingaka, among whom I worked, tended to compare their medical training and knowledge with that of the ngaka ya sekgoa; the European doctor. In earlier times the Badimo; ancestors, then visualized themselves through a dream, 'calling' upon the dreaming person to become a ngaka. However, throughout my work with the Tswana dingaka, there was just one, (out of 20), who claimed his bongaka knowledge given him by the Badimo; the ancestors. Most of the dingaka smiled by this idea, asking me; "How could that be possible! Have you not yourself gone to school to learn to read and write! That is what we have to do as well, we can not be taught through a dream with the ancestors!" Further, they were given long explanations as to how they became a Tswana ngaka, whereby the main argument usually went like this: "We like the ngaka ya sekgoa; European doctors, have to go to school. We have also been taught through years of training with a well educated ngaka. Some of us have even been trained by several dingaka."

The dingaka tsa setswana; The priest-healer association.

One could say that the secularization of their profession started with the organization of the dingaka through the Dingaka tsa setswana; The dingaka association, in the late 1960's. (Dennis, 1970: 62.) More than half of the group of the Tswana dingaka, among whom I worked were members of this association, proudly wearing their membership card on their breast pocket. To become a member of this association, they have to go through an examination. By a comity constituted of well reputated dingaka, the ngaka in question is asked to treat 3-4 patients, suffering from various kinds of diseases. If the ngaka proof capable, he will be given his membership, and will then become the legal owner and bearer of the membership card. To keep up their membership they have to pay a yearly fee of 5 pula (about pound 2,50). Those among the dingaka who were not members, argued that the fee were too high. However, whether they were members or not, all of them did not only under-communicate, but further, argued against their profession as something sacral, and in stead stressed their similarity with their colleague; the ngaka ya sekgoa; European doctor: "Similar to them, we also have to go to school for training." When talking about secularization of the profession, we must keep in mind, though, that it is not their actual training that has

changed. As well as a ngaka to day has to go through long training to become a good and well-educated ngaka and not a 'quack', one also had to do so in the olden times. Or in the words of Livingstone, who stayed among the Batswana more than hundred years ago:

> Those doctor who have inherited their profession as an heirloom from their fathers and grandfathers generally possess some valuable knowledge, the result of long and close observation; but if a man cannot say that the art is in his family he may be considered a quack! (1857:130).

Schapera (1969, 160-2) also describes how promising youth were elected in the tribe and went through years of training before he was considered to be a reliable and well-educated ngaka.

Charging for treatment

The secularization of their profession is also indicated through the way of charging of treatment, that is both the type of chargement as well as the way of charging. Whereas the dingaka in the olden times charged payment in full not until after the cure had been affected, to day there seem to be a clear tendency toward charging - for at least some of the treatment- right away, and thus without knowing the outcome of the treatment. (Seeley, 1972: 64). Although the charge for setting the treatment, which is done through the divination, various a bit from one ngaka to the other, most usually the fee is set to 1 or 2 p. This amount of money is charged right away. Then, depending upon the seriousness or complexity of the person's problem, and hence, the complexity or duration for the necessary treatment, the ngaka's fee will weary accordingly. Similar to their way of legitimizing their profession, they also compare their kind of work with that of the clinic people when charging for treatment: "The clinic people get paid monthly whether they menage to cure people or not, thus, I myself must take payment when I attend to patients." Further, whereas the ngaka in the olden time was paid in kind, to day there seem to be a clear tendency of getting paid in money. (Seeley, 1972: 64-5) Those among the healers, who still seemed to be satisfied by the customary way of charging are the elderly women in the village who are considered to be specialist on malwetsana ya bana; diseases among infant and children. Or, as one of them put it: "I am only helping people. Some of those I have treated will not even return to say thankyou, whereas others will return bringing with them some eggs, or a chicken.

In accordance with WHO's cooperating policy, there has also been a more or less serious discussion as to whether the "traditional healers" should be paid monthly by the Government. As he is seen and referred to as "a local health specialist" with whom the formal health sphere should seek cooperation, one has also raised the question as to whether he should be paid by the Government. When the ideas of cooperation was implemented in the early 1980's one of the 'traditional midwives' in the village, was one of the first "traditional healers" in Pilikwe village willing to work hand in hand with the clinic people. She has been to several health seminars, and has also exchanged knowledge and practices with the clinic people specially concerning child-birth. According to her own story, she worked long hours, even the hole night through at the maternity-ward helping the midwife at the clinic, however, she never get paid for her work. "Why should I work long hours without payment whereas the nurses get paid!" These days she refuses to come along with the labouring women to the clinic.

From urban African societies one can read about more dramatic changes of secularization. For example, from Ghana, Twumasi (1975: 120), tells about how traditional healers are changing their roles by adopting European doctor's artifacts, such as; telephones, visiting cards, waiting rooms, and white overall coats. The healers argues that they have adopted such modern artifacts to attract urban citicense, as it gives the traditional healer 'a modern look'.

The role of the moprofiti in the faith healing churches

As some of the baprofiti have earlier on been practising as a ngaka, one could look upon the role of the moruti as an extreme role- adaptation. Whereas most of them have changed their repertoire completely, and hence have neglected their old knowledge; the use of the divining bones- when setting the divination- as well as the ditlhare; Tswana herbs, there are but a few baprofiti who are practising a combination. Below I will return to those baprofiti who have- through a long career- managed to combine the use of ditlhare as well as the use of the diving bones in their faith healing practice.

Firstly, I will now look into the role and the healing practice of the moprofiti. Whereas there is a tendency of secularization in the Tswana ngaka's role, the moprofiti, on the other hand, put effort, or, importance in the sacrality of his role. Whereas the ngaka, on the one hand, will smile about the idea that he has been 'called' by the

Badimo, and rather, stress the secularity of his role, the moruti, on the other hand, will stress the sacrality of his role. Or more correctly, it is by virtue of being 'called' by God, or The Holy Spirit, that gives him the special power and strength. It is exactly his/ her miraculous way of becoming a moruti that sets him apart, and gives him his healing qualities from above. Therefore, it becomes very important for a moprofiti to have a long and serious story where (s)he in convincing and well chosen words tells his members, or hopefully soon to become members, about how God helped him through his disease, and healed him in a miraculous way. Thus, all the baprofiti will have long and dramatic stories about how they became a God's servant, and later on a baprofiti in the church. The typical story of a moprofiti, or a member of the faith-healing church begins with an illness of himself, his kin or friends. Even though not all of them compare themselves with Joshua, who fought against the will of God, and thus were punished before he decided to serve Him, they have all been fighting against Him. They have neglected His first call, and thus God had to punish them more severely- most often through a severe disease episode with fever fantasies hovering between life and death, before realising God's power, and then took faith in Him, and has ever after been His true servant.

The story of a moprofiti

Mr. Metse and his wife, Miriam, became members of such a church through their problems during Miriam's pregnancy. Later on Mr. Metse became a moruti and to day he is the moruti of the 'Zionist Christian Church' (ZCC) in the village.

"It all started when my wife, Miriam, was seven months pregnant. She was lying in bed these days as she had difficulties in walking. One day she was visited by a friend who was a member of the Zionist church. When they talked about Miriam's problems and disease her visitor advised her to go to the Zionist for help, as she said: "They know how to help people who are suffering and they really do wonderful things!" So when I came home from the pub late in the evening and drunk as usual, my wife asked me to take her to the Zionist, for them to pray for her. I got really furious; why should we go to the Zionist; these kind of people can not do anything! They just cheat people! And I told her that she was crazy to consider such an idea as to go to the Zionist for help. However, Miriam begged me, and in the end I gave in. Hoping she by that time would think better of it (during the night sleep), I promised her to go with her the following morning. The

next morning I still didn't like the idea and even though I had given Miriam my word, I didn't really want to help her. Thus, I did not saddle the donkeys. And well aware of the fact that she would not menage to walk, I just went to her bed saying: "Stand up and (let us) go." Miriam rose up from the bed and I gave her a stick and said to her:"Let us go, this is the way!" Coming outside, Miriam was surprised not to find the donkeys, realising that I refused her wishes and that she had to menage on her own all the way to the Zionist Church. However, she just started walking! Even though she managed better than I had expected (her to), I was still sure that she couldn't menage all the way to the Zionist Church. However, soon I had to admit that she was given the strength to walk. Her faith in the Zionist (God) healed her. When we reached the church, I told the moruti; the church-leader, that I had brought a malwetse; a patient -my wife, and I asked him to pray for her. He answered Miriam: "You are late. The baby inside your stomach is already dead". Then they asked her how many months she had, (How many months she was pregnant) and she told them: "Seven". "You are late", they answered. "You will give birth, but the child will live only for two or three days." The ninth month Miriam gave birth to a baby-boy - our first borne. However, after four days the child wouldn't suck her breast and he was crying. On the sixth day I took the child with me to the Zionist Church; "We told you that the child would be borne, but would soon die." And on the seventh day our child died just as they said. Later I started wondering how the Zionists could know, and also how they could make my wife walk. I went to the church to ask them, and I was given the answer: "If you have faith in God, you will be healed. You will be given a new child; a baby boy, if you have faith in God". Two years later my wife gave birth to a baby-boy." Rra. Metse's face are shining as he is telling his story his wife sitting next to him has forgiven him long time ago. With joyfulness and hallelujah he ends his happy story; "We called him Godfrey."

Analysis

The story is having a clear message: By believing strongly enough, wonders might happen. It is one and only the faith in God which can heal. Miriam believes, thus, she is given the strength to walk all the way to church. Rra. Metse, on the other hand is not only in lack of faith, but he is also trying to set himself up against the will of Miriam and hence, the will of God. Consequently they are not being healed. Rra. Metse and Miriam

got their punishment from God; they came too late and their first-born died. Some time after Rra. Metse starts thinking: How could the ZCC-people tell the truth; prophesy. He also wonder how Miriam got the strength to walk. He returns to the ZZC, which then promise him another child; a baby-boy, if he has faith in God. Their prophesy became true and Rra. Metse is left with no doubt. He gains faith in God and becomes a member and later on the moruti of the ZCC; leader in the Church.

It is also very typical for such a story that the baptized earlier on in life lead a life in sin and lack of faith in God. Thus, Rra. Metse stress that he is " coming home late drunk from the pub:" Miriam believes, thus, she is gaining the strength to walk. It is the faith in God that heals and cures. On the other side, having no faith, or rather doubt, no medicine can cure whatsoever. Therefore, it is the faith in God and that alone that heals people. Or, as Miriam puts it: "Our best medicine is faith in God". Mr. Metse, on the other hand, who not only is in lack of faith, but worse; set himself up against the will of God, had to be punished: they are coming too late and their child dies. However, according to the Bible the prophet in the church preaches forgiveness for the sinners: they are promised another child, yet only if they are having faith. Mr. and Mrs. metse are given the faith, and they are given another child as the prophet so truly had spoken: "We were given a son and we named him Godfrey."

Jesus as the healing ideal

Whereas God in Biblical times gave special power and healing -strength to Jesus- through the Holy Spirit- God is now using the moruti and moprofiti as his servants. Whereas the Tswana ngaka will have a considerable amount of medical knowledge treating various diseases by a variety of ditlhare, the moruti do not need to have such knowledge. While the Tswana ngaka will put effort and proud into his medical knowledge, the moprofiti, on the other hand, will lay the patients problems in His hands and according to His will treat him by whatever God finds necessary. Therefore, as the moprofiti have been called by God- been set apart from others and given special strength- he is in no need of the earthly knowledge of the Tswana ngaka, God and only God will know the 'patient's' best, or what is required for him to be healed. Or, as one of the moruti put it: "I am not myself healing people. It is the work of God. He is only using me as his servant." Whereas the Tswana ngaka is claiming his special knowledge

because he has been taught through years in school, the moprofiti however, cannot be taught to become a healer. One is a healer or, one is not.

> Whatever gift each of you may have received, use it in the service to one another, like good stewards dispensing the grace of God in its varied forms. Are you a speaker? Speak as if you uttered oracles of God. Do you give service? Give it as in the strength which God supplies. In all things so act that the glory may be God's through Jesus Christ; to him belong glory and power for ever and ever. Amen (The Bible, 1. Peter, 2. 10-12).

With the Bible as their main reference and Jesus as their healing ideal, the moruti stands for a different healing practice compared to that of the Tswana ngaka.

"The Bible is my ditaola; divining bones"

Whereas the Tswana ngaka uses the ditaola; the divining bones, when setting the divination, the moruti uses the Bible, or the moprofiti, to locate the person(s)'s problems and the type of treatment necessary to heal the sufferer's problem. Whereas the Tswana ngaka set himself apart through a dialogue in a secret language, the moprofiti, set himself apart through a secret language. By the help of the moa; The Holy Spirit, he will through a dialogue -in tongues- talk with God, and come up with the cause and necessary remedies needed for the person(s)'s problem(s).

Although there are some varieties among the various faith healing churches, and their use of medicine, there are, however, great similarities in their practice of faith healing. I will now briefly look into the most common types of 'medicine' being used in the faith healing churches.

"Our best medicine is faith in God"

As their name indicate, The Holy Gospel and their faith in God is their first medicine when helping and healing people.

"Water is the master of the world"

The use of water is very central in the church. As we have seen every church service starts by the sprinkling of water by the entrance of the church: The one calling for service will always bring with him a bucket full of water, he will sprinkle the faces to all of those coming for church. Some are even sprinkled several times in their face, on their chest, at their back and some are even lifting up their feet for the sprinkler to

splash some under their feet. This ritual or practice by sprinkling all before entering the church is explained by Mr. Metse:

> There are lots of people coming to church. People are different; they are coming from different places. However, when everybody is sprinkled with holy water we all become equal. We do not know where people come from and how they are. If they enter before being made equal they can cause other to suffer as well.

Mr. Metse is talking about bad and good, or, hot and cold blood, and their ideas about pollution and the spread of ill-health from one to the other. We have seen that church members will bring with them bottles filled with water for the moruti; the minister, to bless the water and thus, ordinary water will turn into blessed water which is used as medicine. Most church- goers will have a variety of bottles, one bottle for each illness, or problem, such as one bottle for head-ache, another for stomach ache, or leg ache, and so on. The blessed water is taken home to be sipped occasionally, the dosage may be: 'one sip three times a day'. It was a everyday sight in the village to see people walking to and from with bottles filled with water on their head. A moprofiti will also call himself a ngaka ya metse; priest healer of (using) the water, which should indicate the importance of water in their healing practice. Once I sat talking with Mr. Metse, the moruti; leader, of the ZCC in the village, he asked me whether I knew the meaning of his sir-name. I was well aware of the meaning, however, before I managed to answer, he proudly announced: "Water!" And he continued;

> Water, is the master of the world. Jesus said 'Come and drink the water!' Where there is no water, there is no life. People will die without water. Therefore water is the first medicine.

And he keeps on:

> All dingaka make the use of water in their medicine: The Tswana ngaka uses it when he mixes the ditlhare; medicine, the ngaka ya sekgoa; the European doctor, uses it in his practice. And, Jesus said come and drink the water and you will be healed. Therefore, water is the key to all kind of medicine.

This explanation of water as the first medicine, also illustrates Mr. Metse's way of comparing himself and his role as a healer with that of other types of healers: Even though they practice different types of medicines, they have something in common in their practice as dingaka; the use of water. Further, for the moprofiti and their church congregation, water is not simply water, that is, they will differentiate between 'water from the tap', 'water from the dam', and 'water from the river', in their healing practice.

Salt as medicine

As the Bible is their main reference, the moruti will usually legitimize their practice and the use of the different type of 'medicine' by quoting -by heart- from the Bible. For example why they make the use of salt in their healing ritual:

> The people of the city said to Elisha, 'You can see how pleasantly our city is situated, but the water is polluted and the country is troubled with miscarriages.' He said, 'Fetch me a new bowl and put some salt in it.' When they had fetched it, he went out to the spring and, throwing the salt into it, he said, 'This is the word of the Lord: "I purify this water. It shall cause no more death or miscarriage." 'The water has remained pure till this day, in fulfilment of Elisha's word (The Bible; 2 Kings, 2. 19-23).

Salt is mostly used when preventing the evil acts of sorcery. In the case of Sethlathla, for example, the moprofiti sprinkled her yard with a mixture of salt and coffee when protecting her yard from another attack of moloi. In addition to the Gospel; the faith in God, water, and salt, the moprofiti will also make the use of a variety of other remedies when healing people. Most of these remedies are usually bought at the local shop as, for example, tee, coffee, vaseline, salt, ment. spirit to mention some. Similar to their way of differentiating between different types of water, they also distinguish between different brands of tee and coffee. However, it is the word of God, through the divination, which decides what brand to be used in each case.

As there is an enormous variety of faith healing churches, there are accordingly a wide variety of faith healers both how they became a God's servant as well as their practising of healing. Further, there is also a variety in their type of remedies being used in their faith healing practice.

In addition, there are also some baprofiti, who are buying more exotic remedies in the nearest adminstration canter, or even go as far as to South- Africa. Hence, some are using, for example, bathing salt, glitter powder, and different types of colour paste in their healing practice. All remedies, however, will have to be made holy; blessed through a prayer by the moruti before it turn into powerful medicine.

The concept of good and bad medicine in Tswana culture (medicine)

In this part I will firstly, look into the concept of good and bad medicine in Tswana culture, whereby I will give a case to illustrate this distinction.

Secondly, I will look into the concept of good and bad medicine in the church as they according to the Bible, can not practice the use of bad medicine contrasting the practice of the Tswana ngaka. In Western medicine we define medicine as: "the art and science of the prevention and cure of disease" (The Advanced Learner's Dictionary of Current English, 1973:611). (my italics) According to Tswana medicine, however, sethlare; roots, or, herbs, -often used as a synonym for 'medicine'- has a wider connotation. In Tswana medicine - as in many other African indigenous medical systems - the concept of medicine have both a positive and a negative aspect. (Ngubane, 1977:22.) Tswana medicine thus might be used both in the purpose of healing and harming. Accordingly, the Batswana differ between healing and destructive medicine which they talk about as "good" and "bad" medicine. Destructive medicine is practised with the intent and purpose of hurting and eventually to kill. Medicine used in this context is directed towards harming a particular victim, the motives being those of envy, malice and jealousy. By the manipulation of ditlhare or medicine the moloi; sorcerer, then achieves to hurt his victim bringing about illness and eventual death. It is not however, necessarily the medicine as such that is having a poisonous effect or quality, rather it is the persons's evil will that is vital upon the outcome or the effect. If the moloi; the sorcerer is successful in his attempt, the victim will suffer in one way or other depending upon the moloi's will. The victim might get stomach-pain, or he and his family might be hit by an accident as, for example, the burning down of their houses, the cattle might die or suffer severe illness, or one in the family might start to suffer from TB ya moloi; tuberculosis caused by a sorcerer, just to mention a few. Thus, there is always the deliberate intent behind the activities of the sorcerer.

The two-step treatment of diseases caused by sorcery

According to the Batswana it is very difficult to treat diseases which is caused by boloi; the act of a sorcerer (moloi). The treatment is a kind of two -step treatment; firstly, one has to pacify the cause of the disease, by getting rid of the evil medicine inserted into the victim's body by the evil act of boloi; sorcery. Then, secondly, and only if the cause is pacified - the bolwetse, hela; the disease only, can be successfully treated.

The first step of the treatment is dangerous for the ngaka when performing the treatment: As he has to draw out the evil medicine from the sufferer's body, he so to

speak set this medicine out into free space. It is the ngaka's power as well as his will, that decides whether this bad medicine should be pacified, in a way made dead, or, whether he wishes to send the bad medicine in return to the evil-doer and thereby is trying to hurt him back. If his power is not strong enough, it may even hurt himself, either right there, or, if the moloi, once more return the bad medicine through his evil acts. To elucidate this point I will just give a brief example from a person suffering from the disease of sejeso; ('that which is fed') food-poisoning caused by sorcery and the necessary treatment.

1) The treatment of sejeso; food poisoning caused by sorcery

In the late afternoon an elderly woman came to Mr. Lekopanye, a ngaka ya ditaola; priest- healer using the divining bones, and asked him for help as she was suffering from stomach-pains and asked Mr. Lekopanye for help.[1]

The ngaka- by setting the divination- considered the patient's stomach pain to be caused by boloi; sorcery. The patient, on the other hand, considered her pain to be caused by 'bad blood'. Mr. Lekopanye consulted the bones once more, however, he concluded that she was suffering from sejeso: The patient had been given poisoned food by a moloi, sorcerer, which caused her terrible stomach pain. The bones had also told Mr. Lekopanye that he would be able to treat this disease and thus, to cure the patient. Through the divination he has also seen that the patient has been to the clinic with her problem without getting cured. [2]

Early the next morning when I came to Mr. Lekopanye's yard, he was already in full activity preparing the treatment. The old woman together with three other patients who had all slept in the ngaka's yard, sat scattered around waiting for their treatment;

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[1]. *As the ngaka, through the divination is given important information as to how to treat the patient, what kind of medicine to be used, the quantities, and duration of the treatment etc., most dingaka prefer to settle the divination one day ahead to prepare himself for the treatment. Usually he also consider it best to treat the patient early in the morning, as early as 5 o'clock, and thus be finished with all his patients before the sun is too hot.*

[2]. *Sometimes the bones will tell the ngaka that although he menage to see the disease, through the divination, he himself is not able to cure this case and consequently has to refer the patient to another Tswana ngaka, or to the clinic for treatment.*

a boy, at about 4-5 years old, and his father were sitting by the fire place still drinking their morning tea.[3] Further, a young man coming all the way from South- Africa to seek help for his problem, sat waiting in the yard as well. (According to the ngaka, all of them were suffering from sejeso; food-poisoning caused by sorcery.) The ngaka sat squatting by another fire preparing the medicine. He had painted himself with ashes; a small line on his forehead and each cheek, which should protect him against the evil act of boloi. As he was going to pull out the bad medicine inserted into the patient's body, by the act of boloi; sorcery, he sat himself into danger as the medicine could in turn hit him. As my assistant and I were to overview the treatment, we also had to be protected, as well as the patient. Painted with ashes and thus protected we could all take part of the treatment. The boiled medicine to pull out the poisoning medicine was ready and Mr. Lekopanye gave the old woman a cup to drink. The patient went aside and sat by the shadow waiting for the reaction of the medicine. Mr. Lekopanye explained that the medicine was very strong as it should concentrate the evil medicine in the poisoned body, and make her vomit the whole lot of it almost instantly. If the patient should recover, nothing of the bad medicine could be left in the body. Hence, after less then five minutes the old woman vomited a concentrated clot, which Mr. Moloto proudly showed to us. I was amazed; the poisoned clot resembled a crocodile which Mr. Moloto took as evidence that the patient's pain was caused by moloi, a sorcerer. According to the Batswana, the sorcerer's medicine is believed to turn into a substance resembling a crocodile or a lion or a snake. And further, it is this miniature animal which then so to speak eats up the sufferer's body from the inside causing him to suffer and eventually to die.(See also Schapera, 1934: 295.) Therefore, everybody involved in the treatment seemed to be satisfied, as they had been given the evidence that the divining bones had told them the truth: the patient was suffering from sejeso; not 'bad blood', as the old woman herself considered to be her problem.

2) Treatment of 'bolwetse, hela'

Although the evil medicine was now satisfactory removed, and thus the cause of

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[3]. *As it is very important for the treatment of sejeso to be effective, the ngaka has to make sure that the patient takes the medicine on an empty stomach, therefore the patient has stayed in the ngaka's yard during the night.*

her problem were pacified, the treatment, however, was not finished.
The patient returned to the shadow while Mr. Lekopanye started to prepare the medicine which should cure her stomach problem. After some mixing of medicines and some more boiling Mr. Lekopanye gave the patient the boiled mixture to drink.
This medicine is to heal the sores in the stomach, which has been caused by sejeso; food-poisoning.

The ambivalent role of the Tswana ngaka

Although most people know the use of some herbs, the ngaka is the specialist on this area. Seeley (1973) writes about the role of the ngaka as being ambivalent because of his power of both curing and harming:

> The ngaka was a Janus figure, his role, and the medicine he practised, somewhat ambivalent. While he possessed the knowledge of medicines which could be used in a positive, constructive manner, he could potentially invert their use for destructive purposes (Seeley 1973:62).

As the ngaka is the specialist on this area, any person wanting to inflict harm upon other must obtain such destructive ditlhare from a ngaka, who is then hired to practice sorcery. It is exactly this ambivalent role of the tswana ngaka-having the potentiality of both curing and harming, which the fait-healers react upon and has to mark himself against.

The concept of good and bad medicine in the church

As we have seen the concept of medicine has both a positive and a negative aspect in the practice of Tswana medicine and culture. The moprofiti, however, only with some exceptions which we will look into below, do not practice the use of ditlhare, as it according to them is 'bad' medicine. According to the Bible and Jesus as their healing ideal, they can only practice the use of medicine in the purpose of healing people. As Jesus through faith in God healed people in miraculous ways, the moprofiti should do the same. As Tswana ditlhare have the potentiality of harming people, even to kill, the use of ditlhare becomes something negative for the faith healing churches. When the ngaka perform this treatment he has the power of returning the bad medicine back to the evil-doer with the purpose of harming the evil-doer in return. According to the Bible and the Word of God, however, it is a sin to harm other people, or to take revenge. And further, as one of the baprofiti express it- by another quotation from the Bible; "Our best

medicine in the church in preventing boloi; evil acts of sorcery, is to preach; 'You should love your enemy as much as yourself.'" And further; "Even though someone (moloi) is hurting you, you should not take revenge, but forgive that persons evil behaviour." However, even though most dingaka will stress that they usually pacify the evil medicine when treating such cases, the moprofiti -and perhaps rightly so-do not trust the ngaka's word. Or like Seane, a moprofiti in the ZCC puts it:

> You, see some of the ditlhare; roots, being used by the ngaka when treating problems being caused by moloi; a sorcerer, have the power to revenge. When the moloi's victim take the medicine of pulling out the evil medicine, it will simultaneously go back to the moloi causing him to suffer in return. Therefore, this type of ditlhare should not be used by the moprofiti.

For the moprofiti and his members, then all types of ditlhare have becomes not only something ambivalent having both the capacity of healing and killing, but according to them all ditlhare are 'bad' medicine as they have the potentiality of harming and killing people. Therefore, all use of ditlhare has become negative and is further, abandoned in the faith healing churches. The church people talk about all Tswana ditlhare, as practised by the ngaka, as "bad" medicine. The distinction between ditlhare as something of both a good and a bad quality is no longer there. They talk about all ditlhare as bad and evil. Further, among church -people, the distinction between good and bad medicine is a distinction between church medicine, which is 'good' medicine, and Tswana ditlhare, which is considered to be 'bad' medicine.

"In the church we do not believe in Boloi"

One could assume that those among the Batswana who took faith in the holy gospel would so to say "loose" the believe in Boloi. It was not uncommon to hear members of the faith- healing churches claiming that they neither feared nor believed in boloi after having become a Christian. They would claim that ; "God is the most powerful." However, even though "God is the Master of the world", boloi is still around, even among church members. Therefore, one way or other they as well as non-members will have to relate themselves to the threat of boloi; sorcery, and its consequences. With the faith in God as being the strongest and hence, the 'Master of the world', or as they usually would put it; "Christ is the most powerful". Hence, the usual instrument against sorcery is "The word of God".

Combination as a type of role adaptation

As we have seen the Tswana ngaka can also completely change his role and repertoire by becoming a moprofiti in the church. However, as we shall see he can also re-synthesize his knowledge and experience by combining it, for example, with the role of the moprofiti. This form for role-adaptation seems to be a more complicated process, however, if he plays his cards carefully there seems to be a possibility for such a combination in the context of medical pluralism. As the faith healing churches do not accept the use of Tswana ditlhare, they accordingly exclude those who in one way or other is trying to use the ditlhare in their faith healing practice.

For example Lehore, to day practising as a Tswana ngaka, has once been practising faith healing in 'The Holy Gospel Church'. One night while still practising as a faith -healer he was called by the ancestors through a dream ('dreaming the badimo'). According to his own story the Badimo; ancestors, visualized themselves and called him to become a ngaka teaching him the use of ditlhare.[4] When Lehore told the moruti-in his church- about his experience, he was told to choose: He could stay in the church and help people in the worship of God, however, if he wanted to follow his ancestor's will and hence, practice the use of ditlhare he was simply told to leave the church.

There are some, however, who menage to go around these rules set up by the church -leaders; and hence, practice their knowledge of ditlhare simultaneously as they worship God in the faith- healing churches. I will now briefly look into two careers exemplified by one moruti in the church of 'The Mother Apostolic Faith Mission', and the other one ; a moruti in the 'Heremone Church'. Both of them combine the use of ditlhare in the their faith healing practice. Both called themselves moruti, however, people -both members and non-members of the faith-healing churches- looked upon them as different from anybody else. However, even though they were considered neither a real moruti, nor a real ngaka, they were greatly respected and used by both members and non-members in the village.

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4. *This ngaka was the only one among whom I worked who claimed his knowledge given him from the badimo, and the one whom I referred to in the part when discussing the secularization of the role of the ngaka. As he did not know the use of the ditaola, he was helped by the badimo to set the divination, and further, he argued, they helped him to find the right type of dithlare to treat the patient in question.*

The moprofiti of 'The Mother Apostolic Faith Mission' and his career

Lukas, a man about 50 years old has a long career as a healer. For many years - before he was called to serve Jesus and hence, to practice faith-healing - he was practising as a Tswana ngaka ya ditaola, being taught by many well known dingaka. However, while still practising as a ngaka, he was called to serve God; to end his work as a ngaka, and to start faith-healing: "God called upon me through the Moa; the Holy Spirit to work for Him, however, I refused by his first call and he punished me by sending a disease." As Lukas did not give in for the will of God he suffered for years. However, in the end, after years of dreams and visions it lead him to one conclusion: To give up his practice as a ngaka, and further, to join the church and heal people in the name of God. It was also during this period that his power of healing was (mysteriously) revealed to him. In contrast to earlier life practising as a ngaka, when he, according to himself, both cured as well as harmed people, he has now become a good person; healing people in the name of Jesus Christ. However, whereas Lukas is no longer using the divining bones, but is using the Bible for this purpose, he is still making the use of ditlhare in his faith healing practice. Even though there is usually no cooperation between the group of dingaka and the baprofiti, Lukas, however, is having a close co-operation with a well reputed ngaka ya ditaola living in the same village. Both of them refer patient to each other, and they even discuss the patient's problem and the use of ditlhare. Further, whenever Lukas is in need of some ditlhare, he will ask the ngaka to collect them for him. However, according to the church rules he is not allowed to make use of the ditlhare. Hence, Lukas will put the ditlhare into his doctor-bag together with his Bible, different types of church medicine such as tee and coffee, and then after a fortnight or so he will pray for the ditlhare, and hence, they become usable and accepted medicine. The ditlhare's potentiality of harming will so to speak be taken out by God's power. Thus, bad, or illegal medicine according to the church, is transformed into good and legal medicine, which he then might use to heal people in the word of God.

The moprofiti (and moruti; leader) of the Heremone Church and his career

Josepha, originally a Ntebele, from Zimbabwe, about 30 years old, has also gone through a long and serious disease hovering between life and death before he in a

miraculous way got healed, started to learn about medicine, and later became a faith healer in the 'Heremone Church'. According to his story, he started to learn about medicine while still suffering: He learned the knowledge of ditaola and ditlhare from a Tswana ngaka. While staying in South-Africa and Zimbabwe he also learned different methods of divination, which is called khudu; tortoise, and looks like a small leather-bag. Inside the bag there are hair from a wild cat (tsipa), and three different types of ditlhare, as well as some pearls. When using the khudu for setting the divination he will communicate with them in Ntebele-language. Josepha firstly, entered the church of the ZCC (Zionist Christian Church, however, Lekonyana-the bishop did not accept his type of work. He was told either to work according to the rules of the church; to stop using the ditaola, khudu, and the ditlhare, or to leave the church of the ZCC. However, Josepha was not willing to leave this healing practice and after some time he found the 'Heremone Church' whose leaders gave credit to his type of medical practice, and Josepha then joined the church. As this church did not have a congregation in the village, Josepha soon started a branch of the Heremone church, and is now the leader of a small congregation usually having their services in Josepha's yard. He and his family are all staying at the field the whole year through, some miles outside the village.

These combining roles give the healer a richer repertoire in the context of medical pluralism. In his treatment he can, for instance, still make use of the Tswana ditlhare which is usually condemned by the faith-healing churches. As long as they have been ritually purified, and thus given a new meaning: i.e. by burning the ditlhare to ashes, or by praying, they become 'good' medicine and usable. Or he can continue to use the old method of throwing and reading the bones when diagnosing the problem, on the condition that he somehow incorporates the use of the Bible with this method.

Easy and difficult diseases

The Tswana healers as well as the Batswana in general distinguish between 'easy' and 'difficult' diseases. An easy disease is usually explained in these terms:

> Sometimes when we do not know why someone is suffering or, where the disease has come from we just say ke bolwetse, hela; it is 'just/ only a disease'." (The adv. hela, means only, just.)

Generally one could say that bolwetse, hela, are those diseases whose whose origin may

not be known or, rather, as the Batswana express it themselves; 'the diseases that will just come to a person', like for example mokwane, measles among children. There are some diseases or, rather, there are certain situations when the Batswana consider it 'natural' for a person to suffer from a disease, as they say; 'there are times when diseases will just come and go'. Further, when the Batswana says: ke bolwetse, hela it means both that the disease is 'only'(hela) a disease, hence, easy to treat, but it also express their attitude towards more complicated diseases, which is not considered to be 'only a disease'. Hence, the Batswana distinguish between easy and more complicated once when saying: ga se bolwetse, ke boloi; 'it is not a disease, it is sorcery'.

However, as we have seen in chapter five considering the multiplicity of factors involved when setting the divination, we have to keep in mind that some of these very same diseases, or rather signs, might as well in another situation be perceived and dealt with as a disease caused by sorcery, or the ancestors. Along these lines, and in the view of the Tswana healers the 'easy diseases' can be treated by all dingaka, including the clinic people. However, the 'difficult diseases', can only be understood and treated by the Tswana healers. It not uncommon among the Tswana healers to refer their patient to the clinic people, either for parts of the treatment or to treat single aspects of the disease. Usually when discussing this topic with the Tswana healers, they tend to argue that as the patient is suffering from bolwetse, hela, the clinic people would menage. Some would even argue that the patient may recover more quickly through the use of clinic medicine.

The implication of such a classification, or distinction, seems to be that whereas a person suffering from an 'easy' disease might be referred to the clinic for treatment, a person suffering from a more difficult disease will be treated by the Tswana healers. Hence, by this dichotomy between easy and difficult diseases, the Tswana healers have the possibility of referring difficult or problematic cases to the clinic without loosing respect among them.

Further, we have seen that the potentiality of Tswana ditlhare set the Tswana ngaka in an ambivalent position, as he is the only one having the knowledge and power of both harming and curing. When the Batswana, for example, talk about some diseases like sejeso, food-poisoning caused by sorcery or, diseases caused by sorcery in general they have a clear notion that such diseases can only effectively be cured by a Tswana

specialist. Further, the Batswana have the belief that the clinic people in such cases will operate the patient, however, as the clinic people according to the Batswana do not know the act of boloi, sorcery, nor have this type of medicine, they can consequently not treat diseases of this type. They are laughing at the ignorance of the clinic people (simultaneously as they are shivering just by the though of an operation)

Tswana and European diseases

As we have seen above, in chapter six when discussing the case of Tebelelo and Mmasethunya's daughter, the Batswana distinguish between Tswana and European diseases. For the Tswana healers these various explanation or, approaches, as a response by the tswana healers in the adoption to changing circumstances: 1) As mentioned above, some would say that TB and tibamo are the same disease and they treat it as tibamo or they would handle it as TB and refer the patient to the clinic for treatment. 2) Others think that TB is a complication of tibamo i.e. 'the big cough' will develop as a consequence of having omitted normal Tswana treatment at birth. They will treat the cause as being born 'in the wrong position' (siina), and eventually they will refer the patient to the clinic to verify whether he is still ill or not. Or, they might, for instance, call the disease 'TB ya tibamo'; TB from (caused by) 'the wrong position' and the patient is accordingly in need of both clinic treatment, as well as Tswana treatment. Or as Lekopanye, a ngaka, put it: "I know the TB that goes with siina (meaning that he knows how to treat tibamo). However, if you have not taken preventive treatment at birth it will develop to TB. (But how is he to know?) I will throw the bones (used when diagnosing the case) which will tell me all I need to know. If (they say) it is an old tibamo, I will tell the patient I can't manage and refer him to the clinic." 3) Then there are those who, by differentiating between "Tswana"- and "European diseases" (bolwetse wa setswana and bolwetse wa sekgoa), think that TB and tibamo are two different diseases.

The implication of such a classification seems to be that a person suffering from tuberculosis will be referred to the clinic. On the other hand, the disease called tibamo is classified as one of the most prevalent of the "Tswana diseases". However, as we have seen in the case of Tebelelo for example, and her disease of TB ya tibamo, as she herself called the disease, neither she nor the Tswana ngaka whom she consulted considered her to be suffering exclusively from either a European or a Tswana disease. She is

suffering from both, or as her father-in-law, also a Tswana ngaka, considers these diseases 'to go together', she is in need of both Tswana and clinic treatment.

In the case of Sethunya and her suffering daughter, on the other hand, we have also seen that they consider the child to be suffering exclusively from a Tswana disease; the diseases which they term malwetsana ya bana; diseases among children.

To sum up:

As we have seen the various types of dingaka and the baprofiti encounter the changing situation in various ways: 1) He can secularize his profession as a healer, and hence make his role analogue and comparable with his colleague; the ngaka ya sekgoa; the European trained doctors and the clinic staff. 2) The ngaka can further, change his repertoire completely by becoming a moprofiti; practising faith-healing, and hence, stress the sacrality of his role and healing strength and, use new type of medicine in his healing practice. 3) Or if he plays his cards carefully, he can combine the two roles by becoming a 'different' faith healer, and combine his old knowledge with new types of methods, and medical remedies. 4) All types of healers can discriminate between diseases; i.e. they can differ between Tswana and European diseases, as for example between TB and tibamo. 5) Further, they can distinguish between easy and difficult diseases. Both the distinction between easy and difficult diseases, as well as the distinction between Tswana and European gives the Tswana healers an opportunity to refer the patients to the clinic people for treatment (most likely those patient whom they fail to cure) without loosing their reputation as a healer. Further, in such situations where the patient has been taken the clinic treatment without getting cured, and then turn to a Tswana healer, the healer commonly will consider the patient to be suffering from either the category of Tswana disease or the difficult ones.

CHAPTER EIGHT

CONCLUSION TSWANA MEDICINE: A CASE OF UNEQUAL COOPERATION

A review of the formal health policy and the integration of Tswana medicine

In the concluding chapter I will review WHO's integrative policy and its implication upon Tswana medicine and culture as it is expressed in the encounter between the various parties involved. As we have seen above both parities are seeking ways of closer co-operation. By referring to what has been revealed above, as well as, by giving further examples I will discuss the problems involved in arriving at 'mutual understanding' between the representatives of the two medical systems.

As we have seen in the introduction The Ministry of Health in Botswana started early the implementation of WHO's integrating policy. In, for example, the National Development Plan of 1979- 1984 the policy is explicitly stressed: "The Ministry of Health will continue its policy of gradually strengthening links with traditional practitioners -both diviners / herbalists and faith healers." And further; "The emphasis will be put on improving mutual understanding." And with an eye to referrals between the various health specialist, it says: "will be encouraged where appropriate." As we have seen, one of the strategies adopted to integrate the Tswana healers in the formal health sphere is to arrange health seminars. Whereas the representatives of the formal health sphere arrange health seminars or, are giving health talks at the clinic or, in the village-kgotla, they will always stress the need for co-operation and trust between the various types of health workers to reach the goal: "Health for All Batswana." Hence, the ideal is to be co-operative, tolerant and accepting towards Tswana medicine and its practitioners.

In the forthcoming discussion I will consider what import the different medical explanations and modes of thoughts have on the endeavour to obtain 'mutual understanding' and cooperation among the various practitioners: Do the partners involved adjust to each other frame of reference? Or, is it Tswana medicine that is marginal in that it exists alongside a medical system which has a monopoly and exclusive rights in answering the question of what is right and wrong concerning health and illness?

As we have seen from the case given of the dialogue at the seminar, the representatives of the formal health sphere talk tongue in cheek. For example, when discussing the diseases of TB at the seminar, one from the Regional Health Team (RHT), said; "It is just a waste of time to go to the traditional healers." Further, they accuse the traditional healers for a desire for money, and even though the representatives of Western medicine they admit that they themselves makes use of the traditional healers: "people only waste money by going to them!"

One also get the impression that it is only the Tswana healers that should refer their patient, or better, whenever a patient consults a Tswana healer, the healer should instantly refer the patient to the clinic. During my field-research I only once met with a patient whom by the clinic people was suggested to consult a Tswana healer, which was in the case of Sethlathla - discussed above. However, before I return to the discussion I will give some further examples to elucidate the relationship between the representatives of Western medicine and Tswana medicine.

Motshameko ka malwetse a dikobo; a role play on STD

As part of the health education the clinic people helped by other people in the village such as members of 'The Village health Committee' or 'The Village Development Committee', perform motshameko; role- plays. Such role- plays could for example be played during a health day at the kgotla, or at a health seminar. The idea of co-operation and the philosophy of 'working hand-in-hand' for the patient's best- voiced by the formal health sphere-is clearly expressed in this motshameko; role play. The story told is always very simple, and could for example run like this: A man and a woman, together with some others are sitting at a Chubuku-store; a local beer-shop often run by women in their yard. After some time they are getting very drunk, and the man and woman get inside a hut where we clearly understand that they are having sexual intercourse, and after some time the man start suffering. First, then, he goes to the moprofiti, where he is sprinkled with huge amount of holy water, he is prayed for, and he also getting some holy water to drink. However, he does not recover. Then he goes to the Tswana ngaka, who throw his bones, and tell the man that he is suffering from boloi. The patient pays a lot of money, and get some medicine. However, he is still suffering. After some arguing back and forth with his girl-friend, he decides to go to the clinic. There they set the

diagnose; he is suffering from STD. He is asked to bring with him his girl-friend and they both return to the clinic where they are given treatment, and soon they recover.

The clinic people's or the formal health sphere's attitude towards Tswana medicine, as I see it, is clearly expressed in this sketch or role play. The moral goes: "Let the patient try the various health-specialists; let him see for himself, and then in the end he will realize what is the right treatment. This attitude is also clearly expressed among the clinic people. As one of the Family Welfare Educators (FWE) said; "We can only reach the patient through his own experience; he has to learn through trial and error. Then, in the end he will realize what type of treatment is worth-while".

The dialogue about dikotho; epilepsy

Under the heading of mental illnesses (malwetse a tlhaloganyo) the RHT-team deals with the case of epilepsy, or, dikotho as they name it in Setswana. Some of the Tswana healers consider themselves capable of treating the disease of dikotho. We have also seen the treatment of dikotho by one Tswana ngaka, in the case of Kgabo, in chapter three.

I will now briefly outline the dialogue at the health seminar when dealing with the disease of dikotho, epilepsy. Similar to the teaching of TB the specialist on mental ill-nesses starts her lecture by asking the participants about their knowledge of dikotho; epilepsy, and what they consider to be the cause of the disease. Some of the answers given are: Too much blood, problems or worries, or, sores in the lungs. Someone is explaining: "If a pregnant woman is having too many boy- friends, the child might be born siina; in 'the wrong position', which might cause the child to suffer from dikotho; epilepsy." The teacher at first replies by telling the participants that the diseases is not infectious and can not be caught like the disease of TB. And she continues: "We do not know all about this disease and we are not certain about what causes people to suffer from dikotho. However, we assume that people can start suffering from dikotho, after a shock, for example in a car accident.

We also consider it to be a close connection between thosola (one of the many diseases from the blanket; a sexual transmitted disease) and the disease of epilepsy. It may come from brain damage at birth, or, high fever in infancy." Then she asks the participants if they know the symptoms of dikotho; epilepsy. Whereby some of the participants answer:

Falling down, saliva is coming out from the mouth, the tongue is coming out, and the body will be shaking. The teacher replies by telling them that these are symptoms of the fit (attack). And she continuous: "A person suffering from epilepsy will get some symptoms before the actual attack is there, like dizziness, stomach- pain, the feel of bad smell, and aching in arms and legs. When the attack comes, however, the patient do not feel any pain. Fits may come hours, days, weeks, or months apart and a person suffering from epilepsy seems otherwise fairly healthy.

Further, the teacher is given them advice for how to treat a dikotho patient during a fit, and she insist that they should bring a dikotho patient to the clinic. And she keeps on: "We do not have any medicine to cure epilepsy, There is only medicine to help prevent fits. Whereas some infants will get over the disease, for others the medicine must often be taken for life." Then one of the Tswana ngaka rises up proudly telling that he has been suffering from Dikotho, however, he has been completely cured by another Tswana ngaka. The RHT-team, as well as some among the participants start laughing, and the teacher repeat that the disease of epilepsy can not be cured, one can only prevent the fits. The group of Tswana healers do not reply.

Throughout the lecturing of dikotho I was more or less horrified by the way the RHT -team treated the participants and especially the group of dingaka and the baprofiti. What had happened to the content of the opening speech made by the RHT; what about the ideas of co-operation and the philosophy of 'working hand -in - hand' with the traditional healers. How could the representatives of the formal health sphere expect to nourish co-operation between the traditional healers and the clinic people when neglecting their cooperative partners and their knowledge concerning health and illness!

Some weeks later I attended the treatment of dikotho by a Tswana ngaka. (see the case of Kgabo in chapter three.) As the Tswana ngaka had been to the health seminar, I asked him about his attitude to this disease: "At the seminar we learned that the clinic people do not know how to treat dikotho. They told us that they did not have any medicine for this disease. Even though I told them of my experience they just told us that it was impossible to cure dikotho." The Tswana ngaka laughs and continues: "However, we Batswana know that this disease can be treated. I have experienced it myself." And he keeps on: "As we are all dingaka; doctors, working hand-in -hand (he

is referring both to the clinic people as well as his own group of Tswana dingaka), and the clinic people only knows how to prevent the attacks of dikotho, the clinic people should refer these patients to those among the Tswana dingaka who know how to treat this disease completely." Throughout my work with the various Tswana healers, this interpretation of the dikotho- dialogue was not a unique one. It seems that the statement made by the nurse that; 'there is no medicine for dikotho', was understood and interpreted by the Tswana healers as: 'the medicine ya sekgoa; European medicine, does not have any medicine to cure the disease of epilepsy.' I was really surprised by this interpretation. How was it possible for them to come up with such an interpretation of the situation and the statement?

The unique and specific above the general and universal

We have seen above the Batswana distinguish between Tswana and European diseases. Further, the clinic people are said to be ignorant of the Tswana diseases, the Batswana do not consider the clinic people to believe in, or to be aware of most of their agents of illness. And as they consequently do not have remedies for this disease, the Batswana consider it to be in vain to turn to the clinic people for help. The various Tswana diseases are ailments which are specific to them as being Batswana who, as such, are different from other people, such as the Europeans. This fact is clearly expressed by Mr. Mpoeleng, a ngaka ya ditaola: He started to suffer from pain in his kidneys, because he had sexual intercourse with a moswagadi; a widow, or as he explain it himself; "I got such swollen legs I could not even put on my shoes. Then, I went to Mahalapye hospital,(the regional hospital) yet after more than one month of treatment, I was still suffering. Then people told me that diseases dira; done, by a widow can only be treated by a Tswana ngaka. During the hospital treatment I got much better in my kidneys, but I myself had to treat my swollen legs." After telling how he treated himself, helped by another Tswana ngaka, he explains; "You see, as the disease was caused by a widow having hot blood (as the widow was not yet ritually cleaned after her husband death, she caused him to suffer through sexual intercourse) it is only Tswana ditlhare; herbs, that can cure this disease." And he explains further; "At the clinic or hospital they will just tell you that you are too fat, and give you an injection."

Indeed, the philosophy that as Batswana they are different from the Europeans

does not stop there: They further differentiate among the Batswana people: Or like Josepha, a moruti and moprofiti in the 'Heremone Church', explains it:

> "If you were a Bakgatla, or, a Kgalanga say from Francistown, a Ntebele from Zimbabwe (living in Botswana), or a Bamangwato from Serowe, and you were suffering from moa (the faith healers talk about the disease of moa when they are having mental disturbances and is as such usually caused by the ancestors), you need to go to your own people to be cured. If you treat me with your culture (he is addressing me), I will not ever become cured. We are different people, therefore, one can only be healed by once own culture."

Accordingly, Tswana medicine for the Batswana, consists of many co-existing medical sub-systems; each with its special type of knowledge and forms of treatment. In addition, there is an awareness of individual differences that require special consideration as to the appropriate treatment for each specific case. Or as expressed by a newly confined mother, who is treating her child with Tswana ditlhare; medicine, before taking her child to the clinic for the monthly check-up:

> "We Batswana are different; we protect our children with different methods: some would go to the Tswana ngaka, some will turn to the church for protective treatment, while others will buy medicine at the shop."

Hence, the philosophy that human being are radically different from one another, goes beyond ethnicity; even to the level of each human beings.

In Western medicine patients suffering from the same disease will be given the same treatment (whether one is a European or a Batswana a Norwegian or a Bangwato). Tswana medicine, on the other hand, operates with different sub-systems, each appropriate to a specific ethnic, congregational, and geographical group. Even each individual can be singled out for special treatment in these terms. This way of reasoning is expressed most sharply by the faith healers: Whereas the Tswana ngaka will give the same type of treatment, for example, for the disease of tibamo, the faith healers will cure this disease differently in each case. Or as expressed by, a moprofiti in the church of 'St. John Apostolic Faith Mission':

> "Even though two persons are suffering from the same disease, I can not treat them equally. Each person is unique, no one is alike. We all need different treatment as one and each of us are special."

As I see it, the interpretation of the 'dialogue' about epilepsy by the Tswana healers should be understood in this context. As the Tswana healers consider biomedicine to be just one of many varieties of medicine, they did not take the teacher's statement to mean

that there is no medicine whatsoever that can cure epilepsy.

Limited by the paradigm of bio-medicine; that defines it as a type of medicine which is generally and universally valid, both the RHT-team and I myself interpreted this statement different from the Tswana healers. Hence, the Tswana healers do not consider the new and different explanations and treatments they encounter as providing new knowledge that is more valid than their own. For the Batswana, it is not a question of either biomedicine or Tswana medicine. They would rather argue that there are various medical systems, each with its particular sphere of validity. As there is an awareness of individual differences in Tswana medicine, there is a need for different types of medicine to treat particular diseases afflicting particular peoples. Accordingly, the Tswana healer can legitimize his Tswana medicine on the idea that it is unique and special for the Batswana. And as the Batswana consider themselves as unique and different from the European, as well as other African peoples, there is a need for their special Tswana medicine and their specialists for the Batswana. Further, whereas the Tswana ngaka will have his special knowledge and treatment, the various faith- healers will claim their superiority in the treatment of disease. Whereas there are some diseases which are considered to be the exclusive domain of the clinic people, the healers seem to be aware that their knowledge are limited, and my impression is that they often seem to be concerned about it. Simultaneously, however, they consider their particular medicine as the only effective medicine for some particular diseases.

Even though there is a real situation of competition on the medical arena which has consequences for the professional everyday conduct of the Tswana healers, the plural medical philosophy prevents them to give their own medical system a privileged status. In this respect the Tswana healers are the only true practitioners of a plural medical situation; where they seek co-operation on the criteria of equality.

Such factors as these explain why Tswana practitioners are able to adapt eclectic strategies when they are faced with other bodies of knowledge concerning health and illness.

Conclusion

As the institutional boundaries between the various practitioners scene are still under negotiation, it is difficult to be definite about what will happen to the domain of

Tswana medicine faced with the growing strength of the formal sphere of health. My discussion of some of the salient points in the encounter, however, shows some of the elements that may effect the future outcome of these negotiations.

There are both integrating as well as differentiating processes in the encounter between Tswana and Western medicine. Hence, we could say that there are various processes which concern the articulation and disarticulation of medical systems.

Accommodation to the presence of biomedicine

In chapter six we have seen that the patient can maintain a parallel set of orientation and in fact be positively oriented both to various types of Tswana practices as well as to clinic types of treatment. Whereas she shows herself capable of dual (multiple) use, readily undergoing clinic treatment, she at the same time accepts Tswana treatment. Whereas she in some cases takes both clinic- as well as Tswana treatment, in other situations she might either reject suggested clinic treatment, or only take part-treatment at the clinic. This could of course simply mean that the patient has availed herself selectively of its technology, and as such has resulted in no changes in the basic cognitive structure.[1]

I will now briefly try to discuss whether the ideas preached by the health personnel at the seminar and at the clinic are integrated into the Tswana knowledge about health and illness: Are the new ideas about contagion and bacterial transmission incorporated into the Tswana conception of contagion? In the article; 'Feed a cold, starve a fever', Helman (1978), shows how folk models of infection in an English suburban context are used as a conceptual framework in understanding the biomedical model of the germ theory of disease. In her analyses she shows how the germ theory is integrated into the folk model 'without challenging its basic premises'. Further, she argues that at the interface between general practitioner and patient, the biomedical model of disease is 'adapted' in such a way as to 'make sense' in terms of the folk model of illness (1978: 108). As we have seen in chapter four, the Batswana conceptualization of contagion is different from the germ theory of disease. Put differently; they belong to

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[1]. *We learn much about folk illnesses and cures, and that Western practitioners may be used (See Press 1969) but the way 'scientific' diseases are integrated into people's belief systems is largely unknown (Chrisman, 1977: 352).*

quite different conceptual frameworks or systems of ideas. Among the Batswana ideas and practices of hot and cold blood is very central in their conceptualization of contagion.

Further, as I have briefly mentioned in chapter four, the traditional ideas of hot and cold blood are strengthened through the faith healing practice in the many Independent African churches, as they have revitalized the ideas and practices by referring to The Old Testament and Leviticus.[2]

On the face of it, the Batswana have a certain knowledge or awareness of the idea of bacterial transmission. Thus, one will often hear statements such as; 'a TB-patient should always use a handkerchief when he blows his nose or, hold it in front of his mouth when coughing', or even better: 'he should not spit openly, but use an empty tin for this purpose'. Much likely such slogans as, 'eat with one spoon', and do not share your dish with a TB-patient' are echoes of the RHT lectures and health talks at the clinic, or at best, rules or advice for how to behave at specific situations. These can not necessarily be taken as signs of understanding of the theory of bacterial transmission. In the Batswana context, then, in spite of hearing such statements most Batswana are convinced that it is impossible to catch TB: i.e. it cannot harm you unless you were born in 'the wrong position' (siina) and neglected local Tswana treatment. If such treatment has been performed, the cough cannot affect you no matter how much you expose yourself to a person suffering from TB or 'the big cough'. Accordingly, some of the dingaka and baprofiti think that the tibamo treatment taken just after birth will act almost as a BCG vaccination at the clinic, or instead rather better; This is how a moprofiti explained it: "The various types of treatment work differently; A child being vaccinated at the clinic can still catch the big cough, and we see a lot of it, however we know that a child who is given proper Tswana treatment for tibamo will never ever get 'the big cough'. Thus, according to the Batswana, TB, or 'the big cough', can come to a person in various ways. We have seen that it can also reach you through the evil acts of the moloi either through your mouth by sejeso (food poisoning) or through the sole of your foot when stepping on evil medicine. Similarly most Tswana also consider it dangerous and contagious to step on a TB-patient's spittle, or as one of the participant

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[2]. *See Leviticus, Chapter 12- 16.*

at the seminar put it; "it will penetrate the sole of your foot and cause you to suffer from TB."

Tswana medicine both rejects and integrates new elements when it is exposed to other interpretations of health and illness. Thus, ideas about contagion might be integrated into (already) existing ideas about contagion. Put differently, when the Batswana talk about the contagious danger of TB or for example, sexually transmitted diseases, they conceptualize it in their own terms, that is, ideas about 'hot' and 'cold' blood. Hence, it seems that ideas of contagion and bacterial transmission are filtered through the screen of Tswana ideas-and neither replace nor destroy existing ideas of 'truth' and 'reality' and are made consonant with their notions of contagion and with the idea that good blood is of paramount importance in the maintenance of health. Or as one of the participants at the health seminar put it: "It is dangerous to step on a TB-patient's spittle; it will penetrate the sole of your foot <enter your blood>, and cause you to suffer from TB." (see Haram, 1987)

Processes of re-codification; dichotomization and complimentarization

We have seen that the Tswana healers might react differently under the impact of Western medicine. As I see it, some of these processes have something in common, and further, they can be compared with processes of ethnic incorporation.

In his analyses of the Lappish people encountered by the Norwegians, Eidheim (1977), is focusing upon some integrative processes which the Lappish people were using when negotiating identity with the majority group of the Norwegians. In the Botswana context, the healers take elements from their own culture and compare them with corresponding equivalent elements in what they see as European culture ('complementarization'). At the same time, as they find the equivalence- 'complementarity'- they also find the difference between them as Batswana as apposed to the Europeans, where they are 'dichotomizing' between themselves and their profession as something different from the Europeans and their type of medicine (clinic medicine). Through such processes of 're-codification' they are, so to speak, negotiating social and cultural identity. Or, as expressed by Eidheim:

...in this process of ethnic incorporation idioms have been established (through

> processes of re-codification) and made available to serve a double organizational end, (1) to complementarize the two ethnic groups in order to facilitate the establishment of inter-ethnic relations based on equality and (2) to dichotomize the group so that Lappish ethnic designata can be shared and made object of transactions of incorporation by Lappish people (1977: 79).

Simultaneously, as these processes are used by the Tswana healers towards the representatives of Western medicine, it seems to be equally important for them to find both the equality as well as the differences among themselves. That is; to mark out differences among the various groups of Tswana healers.

Processes of compartmentalization

Both the Tswana healers as well as the Batswana in general tends to compartmentalize between various types of diseases. That is, they differ between 'easy' and 'difficult' and 'Tswana' and 'European' diseases. As we have seen in chapter six, the consequences of such an compartmentalization are that the patient might partly or fully reject the clinic treatment in the health seeking process. Further, as we have seen in chapter seven, the healer might label problematic cases either 'European' or an 'easy' one, whereby he might refer the patient to the clinic without loosing respect among his patients.

Role adaptation

In the encounter the healer might also secularize his profession and hence stress his similarity with the profession of the Western trained doctor. The healer has also proven himself capable of more dramatic role adaptation: Either he might completely change his role by becoming a moprofiti in one of the Independent African churches, or by a combination of the two role-repertoires. In these changing processes he manage to reconcile the new with the old. Thus, he is able to modify his profession in step with changing situations.

Continuity and modification in the healing role

In chapter I we have seen how the ngaka lost much of his significance through the impact of the missionaries and the chief's converting to Christianity. (Hence, his position as the chief's adviser and assistant in communal rituals got lost as the missionaries conde-

mned communal rituals.) Seeley (1971) argues that the missionaries were easily accepted among the Batswana due to the fact that they practised and presented their medicine in a Tswana framework: They healed people in the name of God. The healing practice of the faith healers could be seen as a continuity of this healing tradition, as they apply their medical knowledge as an instrument to gain converts to Christianity, and thereby gain members to their congregation. Whereas one could say that the ngaka lost his 'congregation' in the village people, the faith healers have a community wherein they heal people according to their religious beliefs; the church congregation. Further, many of the communal rituals which were condemned by the missionaries are practised in the faith healing churches, although they are given a partly new expression. For example, whereas the chief in the olden times - assisted by the dingaka - practised the ritual of go phetla pula, the rain-making ritual, the faith healers are now arranging services especially for this purpose. Hence, some communal rituals are revitalized in the faith healing churches. For example, in stead of practising traditional rituals for the badimo; the ancestors, the church congregation practice rites like sethabelo, or gosja; 'saying thank you with bread or prayer'. Most of the faith healing churches will have somewhat ambiguous relation to the (concept of) badimo. Due to their interpretation of the Bible, some tend to think about the badimo as idols. Others, however, will openly both accept their badimo, as well as addressing them through rites. However, all of the faith healing churches have changed these rituals and given them a different form, which they legitimize by referring to The Old Testament. They will heal people very much identical with the traditional ritual of go pasa, a healing ritual to placate the ancestors. However, in stead of using beer as in the old rite, they will use holy water while reading from the Bible.[3]

The Tswana ngaka, on the other hand, seems to have one exclusive sphere where no one can overdo him; the domain of sorcery. Whereas all types of Tswana healers control the domain of preventing sorcery, the ngaka seems to be the one of totally control of the domain of sorcery. Even though some of the faith healers also claim to have the knowledge and power of sorcery, people in general seem to agree that the ngaka's medicine; ditlhare is the strongest and the only medicine capable of rendering

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[3]. *See, for example, Leviticus, Chapter two, four and, five.*

the evil acts of sorcery. The Batswana, especially the healers, will laugh at the clinic people who consider it possible to cure a disease caused by sorcery with an operation (simultaneously as they are shivering by the thought).

The struggle of the paradigms

The various strategies described above could be seen as suggestions made by the healers of reaching agreement under the impact of Western medicine.

Similar to the Lappish people, the Tswana healer adresses the clinic people through a strengthening of the similarity between the two cultures: 'Whereas you are having your type of medicine, we have our specialties, and both of us are dealing with health and illness; hence, we are all (dingaka) doctors.' The Tswana healers are so to speak negotiating identity in the encounter with the representatives of Western medicine. However, they are not accepted, and are even met with refusal by the representatives of Western medicine. To start with these integrative processes seem to be successful: The Tswana healers accept invitations and participate at health seminars. On the whole, they are sincerely willing to co-operate, and are positive towards a dialogue and an exchange of medical knowledge. However, in the lengthening of this dialogue a conflict is brought about. When the clinic people meet their cooperative partners addressing them according to their ideology of seeking closer cooperation; asking them about their knowledge, the Tswana healers are met with laughter and superiority. Further, the clinic people are telling them that they are only dealing with magic, sorcery and are quacks. Whereas the Tswana healer is told to refer his patients to the clinic, and in some situations do so, the clinic people, on the other hand, do not fulfil their part of the contract. That is, the clinic people are not referring their patients to the Tswana healers. Thus, implicitly the healer is told that he is not having any medical knowledge at all. Even in a situation where Western medicine do not have remedies or is in lack of knowledge, as in the case of epilepsy, the clinic people can not reach ut their hands and truly seek their cooperative partners for medical advice. According to their paradigm; Western medicine is the only true medical system, and as they do not yet have medicine to cure epilepsy, there is no medical system what so ever capable of curing this disease. Therefore, whereas the clinic people ideally should work to 'improve mutual understanding' through a co-operation with the 'traditional healers', in their daily work, however, they are stigmatizing and ma-

king stereotypes of the Tswana healers and their type of work. Recalling the dialogue at the seminar; "The ngaka is only trying to get hold of the patient's money." Or; "he is only telling you that you are suffering because of sorcery." In the role play, it is clearly expressed that the faith healers only treat diseases through sprinkling of holy water and the laying of hand. Further, the patient do not get cured until he takes 'proper' medicine; clinic treatment.

When the Ministry of Health represented by the clinic people or the Regional Health Team (RHT) in their implementation of WHO's policy "seek ways of closer co-operation and consultation" with the practitioners of Tswana medicine, they are confronted with ideas which do not belong to the domain of the Western concept of health and illness. Sorcery and magic are to them supernatural phenomenon to which they will not, or rather; cannot relate as it is something outside the Western paradigm of medicine.

In the dialogue between the parties involved something complicated is taking place which is different from those integrating processes between the Lappish people and the Norwegians. Hence, my comparison of the Botswana context with the Lappish situation, comes short. I will claim that just because we are dealing with integration between medical systems the situation becomes more complicated than the encounter between the Norwegians and the Lappish people.

Due to the claims of biomedicine to universal validity, integrative health policy formulation tends to become more complex and difficult than those integrative processes between the Lappish people and the Norwegians. The representatives of biomedicine cannot relinquish their claim in the encounter with folk medicine, unless traditional healers accept the fact that their own medicine is a culturally specific description of biological processes whose 'literal' description is to be found in modern biomedicine. If a medical doctor were to accept native medicine as an adequate alternative medical system, he would derogate from the very foundations of his discipline.

As we have seen in chapter one, the Tswana dingaka and their type of work were condemned in the 'Witchcraft proclamation'. However, the attitude towards the traditional healers gradually changed and for the last few years the Government through the integrative health policy, is now seeking closer cooperation with the traditional healers. Hence, that which once were considered as quackery, should now be seen as medicine, and its practitioners should no longer be seen as quacks, but as health workers.

Whereas an anthropologist might compare Tswana medicine with Western medicine, as various medical systems, the Western trained clinic people, due to their Western paradigm of medicine, can not compare - through processes of dichotomization and complementarization-, their type of work with that of the Tswana healers.

Implicit in my thesis is the issue of closed versus open systems of thought, that is; whether folk-medicine is a closed medical system which does not allow change when it encounters another system based on another line of thought and practice, or if it is open and capable of change. Traditional medicine in Africa, or folk medicine in general, has been looked upon as a closed system while so-called scientific or Western medicine has been looked upon as open. Horton discusses this division between open and closed systems in his article "African Traditional Thought and Western Science":

> ...in traditional culture there is no developed awareness of alternatives to the established body of theoretical tenets; whereas in scientifically oriented cultures, such an awareness is highly developed. It is this difference we refer to when we say that traditional cultures are 'closed' and scientifically cultures are 'open' (1967:155).

His view has been criticised by many scholars, also within the study of medical anthropology who have shown that so-called traditional, or, "...folk medicine is an open system capable of responding to human needs as they arise in space and time (in contrast to official medicine which is locked into a system of a priory assumptions") (Alver 1982:124). Furthermore, it might be biomedicine which is exclusive and which faces problems in adapting to alternatives in perception and treatment of health and illness. (Fabrega 1972; Kleinman 1980; Whyte 1982). However, even though there has been a long and interesting discussion as to whether Western medicine is more open than systems of folk medicine, my interest has not been to discuss whether Tswana medicine is more open than Western medicine, or vice versa. Rather, I have tried to show that both integration implying 'openness' as well as rejection implying 'closeness'occur when Tswana medicine meets biomedicine.

Further, when incorporating new ideas and practices about health and illness the Batswana do not reject their internal ideas and practices. Rather, both the Tswana healers and the Batswana in general meet this new body of knowledge and practices by adjusting it to already existing categories of thought and practices, or regarding it as valuable for only particular ailments. For instance, even though the patients' health-

seeking behaviour (as in some cases of TB it seems to change as most are attending the clinic treatment, they would simultan eously attend to the Tswana treatment as it is held that only Tswana treatment will illuminate the contagious danger. In other words; Tswana (medicine) culture is rather inclusive; allowing elements from the outside to be integrated without replacing or destroying ideas of 'truth' and 'reality'.

We have seen how the various Tswana healers are trying to adapt in the encounter through processes of dichotomization and complementarization. We have seen how the situation resemble the encounter between the minority group of the Lappish people and the majority of the Norwegians. However, even though the healers have proven themselves capable of change and are seeking ways of keeping their role as healers, there is a situation of incompatibility between those involved. Hence, in the implication of the health policy there is a lack of clarification, which is due to the complexity of cooperation between such different medical systems. I have argued that the paradigm of biomedicine renders it practically impossible for the clinic people to dichotomize and complementarize their profession and work with Tswana medicine and its practitioners.

We have seen how the various Tswana healers are trying to adapt to the medical-medicinal systems and its ideas through different strategies. By looking upon the Tswana healer as one who confronts the reality of today it enables us to see how he reconciles the old with the new in the encounter. In various ways, they strive to maintain their role as healers. In performing this type of work, and continuously adapting to new circumstances they have the great advantage of being Batswana themselves, and as such they are familiar with their people's world-view and how they perceive health and illness. Or as Landy puts it:

> It is from the culture of his membership group that he draws his sanctions as a healer, and from the maintenance of its values and practices that he retains the legitimization of his role (Landy 1978:236).

Further, by looking into the actual health seeking behaviour of the Batswana we have seen how they choose between medical alternatives and hence, avail themselves of both clinic-as well as Tswana treatment. Therefore, with reference to the open-closed discussion mentioned above, I will argue that Tswana medicine -like any cultural system, has an internal structure which permits adaptation to changing social circumstances. There are many and simultaneously processes in the encounter. The Batswana

incorporate something while rejecting other, thus there are processes of eclecticism, that is; some is adjusted while some might be refused. Tswana medicine as any folk medical system is embedded in the culture at large and therefore exposed to general cultural and social processes. It seems that it is exactly the character of folk medicine in contrast to the Western medical system that gives Tswana medicine its possibility to change under the impact of Western medicine.

APPENDIX I

1). The case of Sethlathla

It was a special Sunday service as the congregation was visited by a minister from Gaborone. As usual there were lots of people having problems and thus where prophesied by the baprofiti. Sethlathla was one of them and as we have heard through her own story, the moprofiti, considered the cause of her problem to be the act of boloi, sorcery. Hence, after the church service the congregation went for a tour around the village to heal some of those who had been prophesied by the baprofiti, at the service. The whole congregation made up a long procession. The Minister from Gaborone went in the front with his big black crossed stick. He was followed by the men who were dancing along, behind came the women's church choir. Ordinary members and those of us who were not baptized made up the rear. We were more running than walking, while singing joyfully.

Our second stop was at Sethlathla's yard. Sethlathla was already at home sitting around the fire-place together with her husband and her daughter-in-law, and her children. As Sethlathla was told by the moprofiti, that the congregation should come to protect her yard against boloi; the evil acts of a sorcerer, and to pray for her and her family, they were expecting us. We all stopped in front of the gate and the daughter-in-law came towards us handing a bucket of water and a bowl to the Minister from Gaborone. Through a prayer he blessed the water and started to sprinkle the holy water in front of him. At the yard's entrance he drew a cross in the sand. As he started to move along he continuously sprinkled water; throwing water in front of himself as he entered the yard, heading towards one of the rondavels. The whole congregation followed. In front of the lolwapa; the front court of the hut, the Minister stopped once again and sprinkled water first in a cross in front of the entrance and then he threw water all around inside the front court of the hut. The congregation were still following up behind him while singing. People were gaining strength from the holy spirit through the singing and clapping of hands. Happy and full of joy they were stamping their feet to the ground as if to show off the moloi, telling him that God is the most powerful. The Minister then started to make a mixture out of water and salt. He stirred it well with his long black stick before he started throwing the mixture around the hut, onto it's wall and even onto the roof.(Mr. Metse, the moprofiti and moruti of the ZCC explained this kind of treatment to me later on: If there has been a moloi, at your yard we will then mix sand taken from the river, salt and coffee and throw the mixture all around your yard. This should prevent the moloi; sorcerer, to return to your yard. Or, if the moloi should try once more to hurt you by coming to your yard, you will be surprised to see him just falling down unable to hurt you.) The Minister also sprinkled water onto Sethlathla, her daughter- in -law and the children before they entered the hut. Sethlathla's husband, a blind old man, is helped inside the hut. The Minister, the church leaders, and some of the congregation entered the hut where the old, blind man, his wife; Sethlathla, together with their family were kneeling on the floor. The hut is nicely decorated for this occasion. Both the walls and the floor is smeared with cow dung in

nice patterns. The Minister started to pray for the blind man and his family calling down upon them the protection of the holy spirit, asking God to help them. Assisted by the congregation, the inaudible prayer went on and on, as is the custom among the ZCC, while those of the congregation standing outside were continuously singing hymns.

2) The case of Tebelelo (and the treatment of TB ya tibamo.)

First of all, she was given the treatment of go urumela; the 'smoke treatment': The ngaka collected the various roots and remedies needed and put them onto the lebea to produce smoke. Tebelelo was then asked to kneel over the smoke and was also covered up with a blanket for the smoke to be more effective. For about five minutes then she was asked to inhale the medical smoke. Then the ngaka grounded the burned roots, which Tebelelo should take in her tea, or porridge, or just eat them dry.

3). The case of Mmasethunya and her child

The disease of ntsana:

When a child does not eat like Mmasethunya's child, have a slight temperature and looks dull, they will give the treatment of ntsana. Also when a child shows the behaviour of picking on its eyelids and nose, they believe the child is suffering from ntsana. If the child does not get this treatment rather quickly, the child will start vomiting, or also get diarrhoea and head ache.

The treatment:

The healer will use a herb called leetsana; a small green flower. The mother is holding her child waiting for a fly to come and sit on the child's body, then when the fly is there the mother should cover the fly with the herb. Then the mother should cut her own's and the child's nails anal also take one of the child's eyelid-hair and the healer will mix this together with the herb. The healer will then put the mixture on the lebea, and give the child the smoke treatment (go urumela). Both the mother and the child is covered up with a blanket while knelling over the smoking mixture. (The mother should just control that the child does not get too much smoke.) Then the healer will make small cuts on all the child's joints and put the mixture with some vaseline in all these joints. The rest of the powder is given to the child to drink mixed in milk, or water.
The disease of dintantenyana is described: " A child is born so very thin that one can see the veins."

The treatment:

The healer uses the roots of leswe, motetane, and montantenyana, which are all wild vegetables. These roots will be boiled with milk, and the child should drink the decoction every day until it starts recovering. The healer will then take the rest-over from the roots, and the tin, which has been used to prepare the medicine with her to the bush and throw all of it in a hole, and must then return without looking back.

APPENDIX II

GLOSSERY

FWE: Family Welfare Educater

RMO: Regional Medical Officer, or the regional medical doctor.

RHT: Regional Health Team.

STD: Sexually transmitted diseases.

TB: Tuberculosis.

VD: Veneral diseases.

Badimo: Ancestors

Baprofiti: A prophet in the 'Independent African Churches'.

Boloi: sorcery, or the acts of a sorcerer.

Bolwetse, hela: 'Just a disease'. Category of diseases distinguished from those caused by sorcer. Often translated by the Batswana themselves as a natural disease.

Bolwetse wa setswana: A Tswana disease, distinguished from a European disease.

Bolwetse wa Sekgoa: A European disease.

Bongaka: Doctoring, the art of Tswana medical knowledge.

Botsetse: The practice of seclusion of mother and child after birth.

Ditaola: the bones being used for divination (by the ngaka ya ditaola).

Dikotho: the disease of epilepsy.

Ditlhare: (sing. tlhare) tree, root, herb or, Tswana medicine.

Go phasa: a healing ritual to placate the ancestors.

Go phetla pula: 'to ask for rain': the rain making ritual.

Gosha: The members of the Zionist Christian Church use this word for 'saying prayers'.

Kgosi: Chief.

Kgotla: the court or meeting place for the villagers.

Khhudu: A small leather bag which is used as an instrument for divination.

Kraal: Afrikaans word, used in Botswana, meaning fenced off enclosure where cattle or other animals are kept.

Malwetse: Diseases, or a group of diseases.

Malwetsana ya bana: diseases among infants and children.

Meila: 'it is forbidden'; acts of transgressing certin taboos.

Moa or Moea: Spirits (also used for breath).

Mokwane: measles (among children).

Moloi: sorcerer.

Moprofiti: (pl. baprofiti) the prophet- healer, or faith healer in The Independant African Churches.

Moruti: (pl. baruti) lit; a person who is teaching /preaching. The priest-leader in the Independant African Churches.

Moswagadi: Widow or widower.

Moswana: A woman who has miscarried or lost her child.

Motsetse: A newly confined woman.

Ngaka: (pl. dingaka) Tswana priest-healer.

Ngaka ya ditaola: Tswana priest healer/ doctor who practise divination.

Ngaka ya Sekgoa: Europesan or school trained doctor.

Sejeso: ('that which is fed'); food poisoning caused by sorcery.

Sethabelo: Say prayer.

Siina: a child which is born facedown, that is failing to rotate spontaneuously, is considered to be born 'in the wrong position'.

Thosolo: Syphilis, or one of the 'diseases of the blanket' (STD)

Tibamo: Tswana disease considered contagious, caused, for example, by the delivery of a child in wrong position (siina).

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