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349

A GLOBALIZED CONTEXT OF TRADITIONAL HEALING PRACTICES IN BOTSWANA

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Abstract: Purpose – This study examines how the globalized context of healers shape traditional healthcare systems in Botswana with regard to the diverse spectrum of global technologies, global epidemics and patients.

Design/methodology/approach – A participatory exploratory study design was chosen combined with a multiple approach to data collection and analysis using consultative and report-back workshops, individual interviews and focus-group discussions.

Findings – Whereas 75 per cent of traditional healers were village-based, 89 per cent of their clients either originated from within or outside of Botswana. Traditional healer's training was found to be a lifelong learning. The traditional healthcare profession is shaped by many influences that characterise the global world. Most traditional healers recognized HIV and AIDS as a "new" global disease to which they had to adapt. Forty-six per cent of healers owned mobile phones, which are used to contact national and international patients, demonstrating the use of modern information technology.



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Originality/value – Contrary to common perceptions of traditional health-care systems as only locally defined, this study presents findings that traditional healing is shaped by and shapes a global health context.

Keywords: *Traditional medicine, Traditional healers, Globalization*

Paper type Research paper

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350

INTRODUCTION

Today almost every corner of the world has been penetrated by economic forces that emphasize free markets, commoditization of public goods, privatization, individualism and competition. This process of economic integration of world production in the search for new markets has been a phenomenon since the second half of the nineteenth century (Harman, 1996) and was the driving force behind the colonization of Africa. The accelerated speed and various expressions of the global economic integration, such as new information technologies gave rise to the concept “globalization”. Globalization is a highly contradictory process. On the one hand, the process has contributed to the development of new technologies with great benefits for humanity and interconnectedness of people across continental divisions. On the other hand, globalization is responsible for the persistence and ever widening gap between the rich and the poor. Global health illustrates both trends.

Despite apparent technological advancement geared towards addressing emergent health problems, the ability for science to bring global health threats under control remains a major challenge. Some global health risks include the spread of (new) communicable diseases as a consequence of intensified migrations, such as HIV and AIDS, other challenges are as a consequence of the replacement of indigenous dietary patterns with exotic foods (Paya, 2005), rapid population growth and mobility and climatic change (Dube and Chimbari, 2011). Amidst all these globalized health challenges, traditional healers in Africa have defined their space, adapted and developed health solutions in variable globalized contexts as Feierman and Janzen (1992) powerfully describe:

Conditions of health and disease have changed fundamentally in most parts of Africa over the past century. Each healing tradition . . . has had to find answers to very new questions. When tuberculosis spread to the

far-flung rural homes of Southern African mine workers, the healing traditions, or rather their practitioners were forced to respond. Healing conceptions and rituals often seem to be addressing the eternal problems of the human condition – what is the nature of evil, of pollution, of danger, of the relationship between the living and the dead, or between people and spirit. But therapeutic practices are used, in most cases, to treat illnesses. If illness changes rapidly, then so, too must healing. . . . Healing is rooted in society; as society changes, healing changes with it. Health and disease are rooted in society. As society changes, these also change. Yet changes in healing must respond to changes in health. Neither of the loops can be understood in isolation.

Thenineteenth century urbanization in Southern Africa provided traditional healers with an opportunity to globalize trade in traditional medicine and to provide services to a growing urban population. In South Africa for instance, as early as the 1930s and 1940s, globalizing developments restructured traditional medical practices, for example through an extensive mail order system (Devenish, 2005). In Botswana, some healers appeal to modernity by borrowing the implements and language of biomedicine; they bottle their herbs and produce and prescribe pills (Andrae-Marobela *et al.*, 2010). In South Africa, some healers expand their practice by adding Indian herbs to their pharmacopoeia (Devenish, 2005).

This paper therefore examines the globalized contexts of traditional healers and how they influence traditional healthcare systems in Botswana. In order to understand this global context, it is essential to determine the socio-economic background of the traditional healers, the diverse spectrum of their patients, issues relating to global epidemics and practices, especially on how all these impact on traditional knowledge systems.

STUDY SITES

The study was conducted in five administrative districts of the country, namely Ngamiland, Central, Kweneng, North-East, and Gantsi (Fig. 1). Central district represents urban and rural livelihood systems in contemporary Botswana. Gantsi district is located in the Western part of Botswana and consist of several historically “immigrant” and indigenous ethnic groups. Ngamiland district is the third largest in the country and has a unique ecosystem, the Okavango Delta, where over 95 per cent

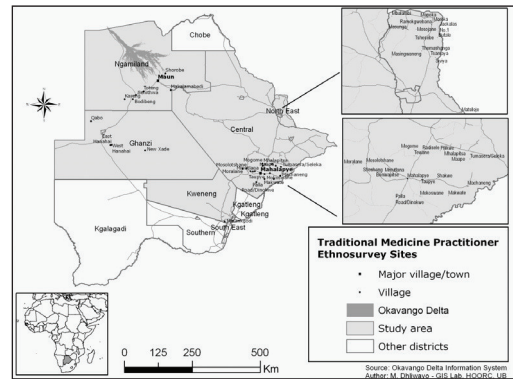


Figure 1:
Study sites

of people depend on wetland resources to sustain their livelihoods. The North-East district is a small administrative district in the country, and has one of the oldest and second-largest urban centres in the country, Francistown. Kweneng district harbours the most populous urban-village in the country, Molepolole, and also has distinctly urban and equally distinctly rural villages which are in close proximity to the country's capital city, Gaborone.

DATA COLLECTION METHODS

Consultative workshops

In preparation for interactions with the traditional healers one-day consultative workshops were held with representatives from 14 villages in Central district, from 4 villages in Gantsi, 8 villages in Ngamiland district, 8 villages in North-East and 3 villages in Kweneng district. Participants in the workshops consisted of traditional healers, community health extension workers, public health education assistants and scientists. The workshops were followed by a face-to-face interviews based on a pre-tested semi-structured questionnaire to collect data regarding the socio-economic background of the healers, pathways of knowledge transfer, patient profile, communication technologies and membership to organized healers associations.

Data was also collected through participant observations and informal in-depth follow-up interviews with traditional healers at work in their homes attending to patients and outside harvesting medicinal

plants in all research sites. These participant observations provided nuances of subjective meanings, of healing stories or narratives and healers' experiences.

RESULTS AND DISCUSSION

353

The context of traditional healers in contemporary Botswana

It is important to understand the social and economic context in which traditional healers operate, in order to determine ways in which globalization has affected their practice and how they are able to respond and continue to make a contribution in the nation's public health sector.

Types of traditional healers

The majority of traditional healers interviewed considered themselves as internally differentiated groups that consist of herbalists, faith healers, faith healers who are also herbalists and herbalists using "ditaola" (a set of bones used as a medium of communication between a traditional healer and ancestral spirits ["*badimo*"] and as a diagnostic tool)(Fig. 2).

The predominance of herbalists in some districts might have its roots in the history of British colonialism since early missionaries in Botswana considered traditional healers who communicated with "*badimo*" as witches and the practice un-Christian (Schapera, 1970). Herbalists on the other hand, were not seen as interfering with or contravening the

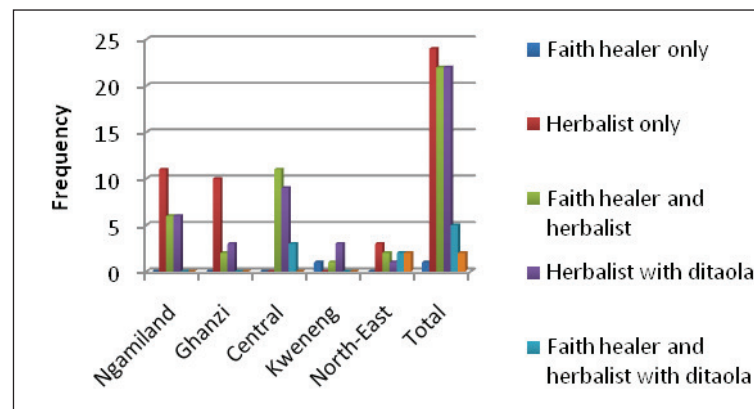


Figure 2:
Different types of
traditional healers

concept of God because they used natural herbs only. This separation of herbalism from healing processes which involve communication with ancestors undermined the totality of belief systems which considered diseases as a consequence of an overall imbalance between the spiritual world and the natural world. Some traditional healers thus eventually and gradually neglected the spiritual aspects of the traditional healing process. The somewhat painful artificial separation of herbalism and divination from spiritual aspects of the healing process was expressed during a consultative workshop in Maun wherein one practitioner lamented:

I am a prophetic healer. I work with spiritual water. I heal through prayers. There are three types of traditional healers. Prophetic healers, herbalists and the ones using "ditaola". But we can work together. Let's not disintegrate. Take all of us as one. We should meet together as one, the spiritual healers and the herbalists. (DK, Maun, 23/08/08).

Informal interviews suggest that some of the traditional healers who use the bible and *ditaola* as diagnostic tools, as well as prescribing spiritual and herbal treatment, consider themselves Christian; others are in fact either "baruti" (pastors) or elders in their respective churches.

Ethnicity of traditional healers

Another level of diversity among traditional healers in Botswana has to do with the ethnic source of traditional knowledge. Ethnicity is generally linked to a geographic location, which then determines how people therein interact and use their environment and natural resources to address their day-to-day needs. Some study sites in the districts demonstrated relative ethnic diversity while other sites considerable relative ethnic homogeneity. Both phenomena are illustrated in Fig.3a and 3b compares Ngamiland district and North-East respectively.

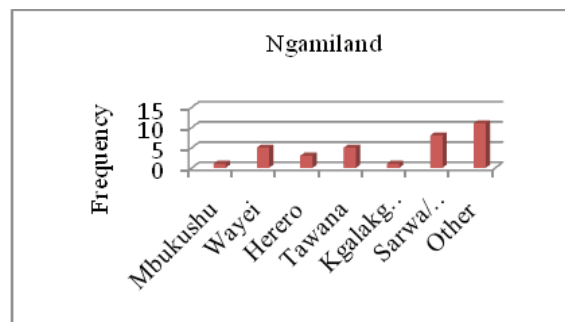
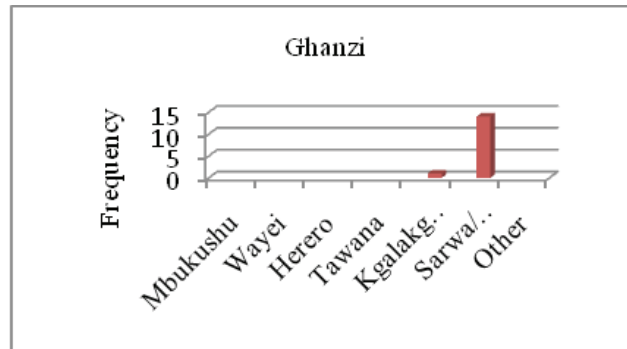


Figure 3a:
Relative diversity

Figure 3b:
Relative
homogeneity



The largest categories of traditional healers in Ngamiland were of ethnic groups originating from other countries in the region such as Zimbabwe, Zambia and Malawi in addition to numerous ethnic groups within the district. The socio-economic statuses of healers thus reflect the blending in of local, national and regional flows of healing knowledge systems and healing practices.

How healers connect with and are marginalized by a globalized world

The study was interested to find out what communication channels, if any, connect traditional healers to a globalised world. Issues of access to telecommunication are therefore pertinent in this regard. Whereas only 3 per cent (n=64) of interviewed traditional healers had access to a household telephone landline, owned either by themselves or a family member, in contrast, 46 per cent owned a mobile phone. This indicates that traditional healers are in pace with technological advancement in the area of telecommunication using new means of technology to stay in contact with their patients and be easily contacted by potential patients (from within and outside Botswana) whom they get through referrals.

It is interesting that even though the wireless mode of communication is widely used to keep the nation abreast with what is happening within the country and beyond, only about a third of traditional healers (34 per cent) have access to a working radio and only 3 per cent have access to a working television. In terms of transport, again only a tiny fraction of the traditional healers (3 per cent) own a car. Some of the remote villages

in the study sites have poor road networks, therefore access to towns and bigger villages where key services are provided can be a challenge, hence the significance of a mobile phone. Though traditional healers do communicate globally, at the same time they are cut from both local and international current affairs, and information reaches them when people in other parts of the country are far ahead.

Pathways of knowledge acquisition transfer and practice

With globalization and urbanization, generations tend to be separated, the youth attending formal school education in towns, while the older generations that have been relying on traditional medical knowledge remain in rural areas. Therefore the study sought to establish how knowledge transfer takes place in a globalized scenario. The overall pattern of knowledge acquisition seems to confirm the original trend of oral intergenerational knowledge transfer (Fig.4). The majority of traditional healers were trained by close family members, who have also been trained by their fathers, mothers, grandfathers and grand mothers.

Most of the traditional healers were trained up to 4 years before they became independent healers. The overall picture indicates that length of practicing varied between one to over 50 years. Close to a third (27 per cent) of traditional healers practiced between 1 to 9 years, while 57 per cent of all interviewed healers had an experience of between 10 and 49 years. Strikingly, also 17 per cent practiced for 50 or more years, which corresponds well with the age distribution amongst the healers. Particularly in more rural areas, such as Ghanzi and North-East district, practicing experience with traditional healing tended to be very long.

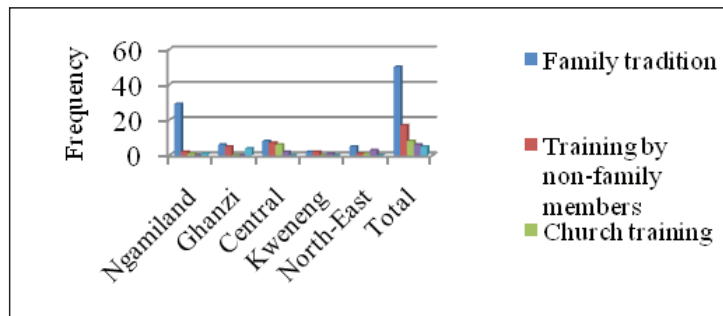


Figure 4:
The mode of
knowledge
acquisition of
traditional healers

Claims that traditional medicine practice is near extinction potentially as a consequence of globalization are not fully supported by the findings of this study. About 40 per cent of interviewed healers were indeed currently training someone, 47 per cent were not. Thirteen per cent did not state whether they were training or not. The majority stated that they were either training a close relative, which in most cases was a wife, children, husband, cousin or non-family members. Training by non-family members included neighbours, social acquaintances, friends, and attachment to a specialist, either inside or outside the country. Informal discussions suggest that several healers, for instance, got their training in South Africa while working in the mines, another went to Mozambique as a novice for specialized skills training, others occasionally go for short-term skill/knowledge appraisal in Namibia and Zambia.

The best of two worlds: local roots and global outreach

To characterise the local/global context in more detail, the study investigated where traditional healers, as well as their clients, originate from. In all districts, 75 per cent of the interviewed traditional healers were originally from the same village where they are based, or from another village in the same district. This clearly indicates that traditional healers are indeed rooted in their communities or at least in their districts and have lived in the current village for a reasonably long time. It would therefore be safe to conclude that traditional healers do have an intimate knowledge of people around them, their cultural and social environment as well as their natural and other resources.

On the other hand, if one looks at their clients/patients the picture differs. Only 11 per cent of the traditional healers stated that their clients come from the same village where the healer is based. Eighty-nine per cent have clients coming from elsewhere, either from villages countrywide or from villages inside and outside of the country and not from villages in the same district. Follow-up interviews suggest that health-seeking behaviour of patients is likely to be influenced by positive recommendations based on the efficacy of treatments and/or specific competencies/specializations of a traditional healer in question. The fact that their clients access them through an informal referral system also indicates rural-urban interactions, and regional dimension beyond immediate geographic locations. Although some patients come from neighboring Botswana, geographically, these are not necessarily from “border-land communities” in close proximity with the healers’ villages,

but rather are from in the hinterland of South Africa or Namibia, thousands of kilometers further away from the borders. This phenomenon demonstrates that they too have a place in the global village.

A globalized disease spectrum

Consulting a diverse spectrum of patients means that traditional healers are confronted with a range of (new) health conditions, diagnosis and treatment, including shifting expectations and service demand of patients. Traditional healers have to adjust and adapt. As Ngaka KK further explains:

There is a new emerging disease, which I can treat, but sometimes I fail to treat it. This disease is called metsi a masweu [white vaginal discharge]. It causes a burning feeling as it releases a discharge in females. The discharge is not thick, but watery. And sometimes the burning discharge can peel off the skin. This kind of disease can be treated with drinking medicine prepared from a medicinal plant and the discharge will stop. I don't know the scientific name of this disease. I discovered it recently in 1999 and then I found myself treating it. If patients ask me what the name of the disease is I tell them that I don't know the disease but I would just help with the medicine I have. I discovered "metsi a masweu" in 1999, so I am not very much familiar with this disease. I treat patients with this disease but I don't ask for payment. I never ask for payment when I know that I am not so confident/competent treating a particular disease. (Ngaka KK, 31/708, Toteng)

Probably the biggest challenge for traditional healers in this regard has been the advent of HIV and AIDS as the major "new" global epidemic, with disastrous human impact, were unlike any other in recent memory (Baylies, 2002; de Waal and Whiteside, 2003). There is limited literature that systematically investigates ways in which traditional healers conceptualize their experience to HIV- and AIDS-related complexities since the first HIV case in Botswana was diagnosed in 1985. Existing publications address issues/concerns/perceptions pertaining to the 1990s when the epidemic peaked in Botswana. Prevailing debates at the time centered mainly on treatment questions, that is, whether HIV and AIDS represented an "old" or a "new" disease, and consequently, whether traditional healers felt confident to treat or not to treat it (Ingstad, 1990, Hargreaves and Mosesane, 2003). To a certain extent, these discussions were rather misplaced and somewhat artificial, as

Hargreaves and Mosesane rightly point out that the first “S” in AIDS stands for “syndrome”, which means that it is, in fact, not a single disease, but a cluster of opportunistic infections that take advantage of a compromised immune system (deficiency). The authors concluded that traditional healers were in fact right in stating that these symptoms are not new (Hargreaves and Mosesane, 2003).

Most of the traditional healers recognise the challenges posed by the HIV and AIDS epidemic and are eager and willing to adapt, adjust and react to take up the challenge. Nevertheless, the very acknowledgement of the disease dynamic is a significantly new phenomenon. But as Musingeh (quoted in Molefi, 1996:47) aptly observed, traditional healers have always adapted to new challenges. These include *inter alia*, sexually transmitted infections (STIs), silicosis, cancer, skin diseases, smallpox and tuberculosis, experiences and health conditions which historically, were not part of the pre-colonial society. However these diseases later became part of the traditional taxonomy over time (Molefi, 1996:47). “New diseases” were gradually transformed and translated to become “old diseases” in the repertoire of traditional healers diagnostic and treatment capability. AIDS related conditions are not likely to be an indefinite exception.

Traditional healers have an awareness of the global health concerns of this age. The fact that different views are held about the treatment of HIV and AIDS demonstrates that healers are able to assess their own abilities alongside with, and in comparison to the modern allopathic healthcare system. It may be argued/assumed that just like modern science, HIV and AIDS is a new disease on which they too are still conducting their “research”. It could also be that, because of the challenges of a lack of legal system for traditional medicinal practice, they are rather treading with caution until such a time that HIV and AIDS acquires a socially accepted status where knowledge is freely shared without fear of facing the law.

CONCLUSION

Contrary to the common perception that sees traditional healthcare systems as locally defined, our findings suggest that traditional healing does play a role in the global picture of health. However, in the same way globalization as such is contradictory, traditional healers place in a global world is contradictory. While on one hand globalization has helped to improve traditional healer’s status, e.g. use of communication technology

for coordinating patients and through trans-boundary training and knowledge exchange, on the other hand, the relatively low economic status and stigmatization of traditional healing preventing access to global knowledge. As much as globalization is not a new phenomenon, traditional healing always adapted to new disease spectra as a consequence of the internationalization of social and institutional relations.

Exposure to new diseases, such as HIV and AIDS, in the context of globalisation, calls for new and diverse methods of treatment/management where traditional healing is recognized as a lively part of global health forces.

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**A globalized
context of
traditional
healing practices
in Botswana**

362
