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Subject: proposal towards a
comprehensive research
project on traditional
healing in Botswana today

Leiden, 2/18/94

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Dear Mr Permanent Secretary,

On the basis of the very productive and pleasant conversation we had in your office, on February 2, 1994, I am pleased to present to you, for your comments and criticism towards a for definitive formulation, the following draft proposal:

PROPOSED RESEARCH PROGRAMME:

TRADITIONAL HEALING IN BOTSWANA TODAY

Introduction

Since the pioneering work, in the early 1980s, by F. Staugard* (who was a medical doctor sympathetic to traditional healing, rather than a qualified anthropologist) little

- Cf.
Staugard, F.,
1985 *Traditional healers: Traditional medicine in Botswana*, Gaborone: Ipelegeng Publishers.
1986 'Traditional health care in Botswana', in: Last, M., & G.L. Chavunduka (eds.), 1986, *The professionalisation of African medicine*, Manchester: Manchester University Press and International African Institute, pp. 51-86.
1987 *Traditional medicine in Botswana: The traditional pharmacopoeia*, Gaborone: Ipelegeng Publishers^ **check this entry**]
1991 [**popular version of the entire project, check title**], Gaborone: Ipelegeng Publishers
Anderson, S. & F. Staugard
1986 *Traditional midwives: Traditional medicine in Botswana*, Gaborone: Ipelegeng Publishers.

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research work has been done on traditional healing in Botswana. This despite the fact that for a large number of Batswana the utilization of traditional medicine is still a matter of course, and there is no sign that this state of affairs will change rapidly in the near future. Insight in the form and functioning of traditional medicine, and in patterns of selective utilization of both modern and traditional medicine, is of the greatest importance to modern physicians who are actually involved in curative and preventive medicine in Botswana. For such modern practitioners are in many ways confronted with the effects of traditional practices, and with patients' attitudes and cognitions as informed by such practices. The importance of traditional medicine would also require planners and policy-makers in the medical field to have a working knowledge of traditional medicine. For more than a decade now the World Health Organization has advocated the view that modern and traditional medicine should be actively integrated by health policies at the national level. This, along with the desire for security, recognition and professional protection in the face of modern state law (after a period when traditional medicine was virtually outlawed under the colonial government) has brought new vitality to the various organizations of traditional healers, and has prompted them to seek more close association with the ministry of health and with the various modern health institutions in the country. This again forces modern health agencies, and their policy makers, to reconsider traditional medicine.

Anthropological research offers both the methodologies, the theories and (since the anthropologist is usually not himself or herself committed to western medicine in the same way modern physicians are) the professional attitude of detached attention suitable to produce the kind of systematic and penetrating knowledge that is required at this point in time. The programme outlined here seeks to direct this anthropological potential to crucial topics in traditional medicine in Botswana today.

The programme director

The programme director, Professor Wim M.J. van Binsbergen, has carried out research on African religion and therapy in various African locations (rural Tunisia, urban and rural Zambia, rural Guinea-Bissau, urban and rural Botswana) since 1968; he is an international authority in this field. Since 1988 he has been engaged in sociological research into 'The growth of urban society in Francistown, Botswana'. This project, funded by the African Studies Centre, Leiden University, The Netherlands, is undertaken under the aegis of the Ministry of Local Government, Lands and Housing, Republic of Botswana. As an aspect of his current research, he has looked deeply into traditional healing (particularly herbalists, *basangoma*, and healing personnel of independent Christian churches, i.e. *baprofiti*) in Francistown and at the national level in Botswana. Among the relevant topics he was concerned with people's strategies of selective use of both modern health facilities and traditional healing. He has published a number of papers on Botswana relating to these topics, copies of which are enclosed.² He is currently working on the

² Cf.
 van Binsbergen, W.M.J.
 1990 'Church, cult, and lodge: In quest of therapeutic meaning in Francistown, Botswana', paper presented at the 6th Satterthwaite Colloquium on African Religion and Ritual, Cumbria (U.K.), 21-24 April 1990, 58 p.
 1991 'Becoming a *sangoma*: Religious anthropological field-work in Francistown, Botswana', *Journal of Religion in Africa*, 21, 4: 309-344.
 1993 a. 'African Independent churches and the state in Botswana', in M. Bax & A. de Koster, eds., *Power and prayer: Essays on Religion and politics*, CentREPOL-VU Studies 2, Amsterdam: VU (Free University) University Press, pp. 24-56.
 b. 'Four-tablet divination as trans-regional medical technology in Southern Africa: Mechanics, origin, spread and contemporary significance', paper prepared for the conference on , 'Symbols of change: Trans-regional culture and local practice in

publication of the final results from the Francistown project, including a Botswana-published report on 'Aspects of the HIV/AIDS epidemic and general sexual behaviour in Francistown, Botswana', and a book on 'Four Tablets: A Southern African divination system in its transregional and historical context'. Thus the programme director commands six years of experience in Botswana socio-medical research. Moreover he is himself a qualified traditional healer (certified member of the Kwame/Legwame Traditional Association since 1990), and he practices as such in Botswana on a regular basis.

As a member of the African Studies Centre, and as a professor of anthropology in the Free University, Amsterdam, The Netherlands, the programme director is in a position to add a supervisory and coordinating capacity to his own personal activities as a researcher in Botswana.

Format of the proposed project

Specifically, we are proposing a sustained project on traditional healing in Botswana, which will enable a series of young researchers (holding bachelor's degrees in anthropology and related subjects, and training for their master's degrees) to carry out short-term (three to six months) research on selected topics in traditional healing in Botswana, under the aegis of the Ministry of Health, and in such a way that the results will be relevant to current issues in health care and health policy in Botswana. In order to ensure such relevance, the project will have the following features:

— identification and selection of topics will be done in close consultation between the Ministry of Health and the programme director. The programme director will also be responsible for the selection of researchers, as well as for the supervision of the research, particularly in the preparatory and writing-up phases. Since the programme director is not normally residing in Botswana, the Ministry of Health will facilitate the identification of local supervisors for the periods of field research.

— application of research permits for each individual researcher, with the Office of the President, Republic of Botswana, will only take place after that researcher's formal research proposal (an English-language document consisting of an academic argument not exceeding 12 pages or 35,000 characters, to which a full bibliography, time table and budget estimate have to be added) has been approved by both the Ministry of Health and the programme director.

— researchers are to submit five copies of their full report, in English, within a year after completion of the fieldwork; the report is to be accompanied by a summary and list of policy implications and recommendations not exceeding five pages.

Funding

So far the project does not possess its own funding, nor does it particularly need any.

The programme director's travelling and other logistic requirements will be met in the context of his general activities as an African Studies Centre researcher and as a Free University Professor. This, however, under the present circumstances excludes

Southern Africa', Berlin, Freie Universitat, 7-10 January, 1993, 44 pp.; shorter versions also read at the Annual Conference, Association for Anthropology in Southern Africa, University of Durban-Westville, 16-19 September 1992, at the Symposium on 'Diagnosis and Divination', Amsterdam, Anthropological Sociological Centre, 27 November 1992, and as seminar paper, African Studies Centre, 14 January 1993; shortened version forthcoming in *Journal of Southern African Studies*.

- c. 'Making sense of urban space in Francistown, Botswana', in: P.J.M. Nas, ed., *Urban symbolism*, Leiden: Brill, Studies in Human Societies, volume 8, pp. 184-228.
- in prep a. *Four tablets: A Southern African divination system in its transregional and historical context*.
- b. *Aspects of the HIV/AIDS epidemic and general sexual behaviour in Francistown, Botswana*, Gaborone: Applied Research Unit, Ministry of Local Government, Lands and Housing/ Leiden: African Studies Centre.

specific travelling to Botswana for the sole purpose of this programme and of such supervisory tasks as it may entail.

The typical researcher within this project will be an M.A. student reading anthropology at a Netherlands university and requiring, in that context, a minimum of three months of field-work and a thesis written on that basis. Apart from a minimal faculty subsidy more or less covering the cost of intercontinental travel, such a researcher is under the conditions generally prevailing in the Netherlands expected to pay his or her research (including board and lodging, local transport, research assistance, stationery and public relations) entirely out of personal funds, a scholarship etc. This means that the programme is virtually self-supporting. It also means that large-scale, quantitative survey methods are excluded. This is not so for methodological or theoretical reasons: although there is an obvious case for qualitative, in-depth research in the case of traditional healing, quantitative approaches represent a virtually indispensable complement to qualitative methods, especially in the context of urban mass society such as is increasingly the setting of traditional healing in Botswana today. The reason for exclusive reliance on qualitative face-to-face research methods is entirely practical: the financial format of the project can only accommodate low-cost participant observation research of the standard anthropological type. Since traditional medicine is largely a practice for and with the common people of Botswana, the fact that each researcher will operate on a shoestring may in fact be conducive to the kind of contacts and relationships which are required for maximum 'rapport' and insight. Meanwhile we have to realize that suffering, divination, therapy, ritual, church life, even if they have publically mediated aspects, tend to be considered as rather private in Botswana, and even if approachable in short-term anthropological research pose formidable problems of linguistic and cultural competence and interpretation. It is therefore fair to admit that the programme presently proposed, based on short-term field-work of self-funding junior researchers, cannot have the ambition to effectively explore the entire width and depth of traditional medicine in Botswana. Many aspects could only be meaningfully approached by experienced researchers with a sound background in Botswana language and culture, and through field-work measured in years rather than months. With this substantial qualification, however, considering the present paucity of up-to-date information on traditional medicine in Botswana, the programme may still be expected to yield useful and timely information.

The programme does not offer standard solutions for accommodation and research assistance of researchers when in the field. Affordable solutions will be found in the awareness that requirements and locations will differ from topic to topic.

However, not every researcher participating in this project would have to conform with this profile of the typical Netherlands M.A. student paying his or her own way. The participation of suitably qualified Botswana researchers bringing their own funding will be greatly welcomed, as will similar participants from other countries. The selection of researchers remains the prerogative of the programme director in consultation with the Ministry of Health; selection implies that preparation, field-work and writing-up will be supervised by the programme director, usually in association with one or two other scholars of the researcher's home institution.

Within this largely self-supporting format, there will however soon be room for additional funding e.g. towards

- publication of the research findings,
- the undertaking of more massive research tasks which would defy the low-cost participant observation approach,
- the creation of a computerized data base for traditional practitioners, bibliographies, materia media, cases etc.; and
- the organization of seminars and conferences.

Here, the resources and contacts both of the Ministry of Health, and of the African Studies Centre and the Free University, could be further explored for mutual benefit.

Individual topics

The programme was triggered when contacts between the Ministry of Health and the programme director were established for the benefit of an initial project in which the researcher Ms Fenna Horstmann, B.A.3 carries out

— *A sociological study of nurses at the Nyangabgwe hospital, Francistown.*

Fieldwork for this project is being undertaken from November 1993 to March 1994.

Meanwhile, the first research to be carried out specifically under the programme proposed here, is to be that by Mr Guus Heilbron, B.A., who is registered for an M.A. at the Free University and who will conduct a study of:

— *The production, marketing and usages of African pseudo-patent or parallel medicines on the Botswana pharmaceutical market.*

This involves materia medica which are manufactured, named (by such names as 'Amandla', 'Duiwelsdrek' etc.), packaged, offered for sale through mail order catalogues, advertisements and via such formal outlets as the pharmacy and drugstore, with all the trappings of western patent medicine, yet emphatically basing — at least by implication — their efficacy not on western pharmacological principles but on African medicinal traditions. Much of this medicine is produced in neighbouring South Africa, and the production and marketing aspect of the research will have to extend to that country. Much of this type of medicine is utilized in Botswana by specialist traditional healers (especially herbalists and baprofit). The forms and rationale of such specialist usage remains to be assessed, as does the usage of these parallel medicines in the hands of medical laymen, both at their own initiative for self-medication, and at the instigation of traditional medical practitioners.

Out of the broad range of possible topics, the following few may be singled out for attention in the near future:

Traditional medicine in Botswana: the nature of medical knowledge

One major problem arising in the contact between modern medicine and traditional medicine is that the representatives of the former (physicians, policy-makers) tend to project onto traditional medicine models concerning the nature of medical knowledge, diagnosis and curative practice which derive from modern medicine and which totally distort the true nature of traditional medicine. Traditional medicine as practiced in Botswana is not a unified, integrated, formalized and explicitized body of accepted theories, and their systematic application in diagnostic and curative action, about the human body, mind and environment, learned by heart by, and stored (as in analogy with medical textbooks and computerized expert systems) in the memory of, every traditional practitioner, and ready to be tapped by academic interviews or observation. Instead, traditional medicine in Botswana is a protean, largely implicit, kaleidoscopic array of historically

Combining qualifications and an appointment as a radiology technician, with the M.A. study in anthropology at the Free University; in preparation for the present research project, Ms Horstmann on an African Studies Centre temporary appointment carried out the data entry of the programme director's quantitative data on Francistown, which largely reflect on the town's medical sociology.

and culturally heterogeneous traditions — many of which we are only now beginning to identify — which translate a general cosmology (not necessarily one that can be identified as coterminous with Tswana or Kalanga 'ethnic' culture, and not necessarily fully shared by the client!) into symbolically effective therapeutic situations including divination. All individual practitioners represent a slightly different selection and personal reconstitution of this heterogeneous package, and the necessity to establish oneself in the public opinion within a highly competitive traditional medical market puts an extra premium on the healer's publicly mediated idiosyncrasies in attire, paraphernalia, bedside manner, aetiological pronouncements, choice of therapies etc. Part of the translation between cosmology and concrete treatment is indeed routinized, standardized and hence institutionalized into a shared medical system — e.g. divination with the four-tablet sets or the astragali-based sets tends to discern the same, similarly named patterns all over Botswana and adjacent countries, and many materia media are swapped or traded between practitioners under standard names and for standard applications. However, this is the mere skeleton of a traditional medical system, always applied by the individual therapist in an idiosyncratic fashion, and always combined with a great amount of 'bricolage' (the strictly individual and original application of an underlying shared cultural model, with novel results) which allows the practitioner to legitimately design (often in an idiom of dreaming or other forms of divine or ancestral inspiration) some of his or her own medicines and therapies from scratch, and to admit a large amount of improvisation and apparent inconsistency into the actual practice. Such 'bricolage' also opens the door for the admission, within the individual practice, of such heterogeneous cultural and symbolic elements as do manifestly not derive from the practitioner's home culture: elements deriving from Christian, European or Asian traditions, from modern medicine, from globally circulating contemporary images as mediated by the electronic media (as is relevant in the context of HIV/AIDS). In a changing post-traditional Botswana open to globalizing economic, political and cultural influences, through all these means the therapist remains capable of capturing the client's receptivity and building up the symbolic efficacy which (far more than the pharmacological or physical nature of the therapist's intervention) constitutes the essence of the traditional therapeutic session. An exploration of traditional medical knowledge along these lines can help to build a proper basis for modern/traditional contacts free from avoidable distortion.

The healing practices of independent Christian churches in Botswana

A considerable amount of 'traditional', at any rate non-cosmopolitan therapy goes on within the independent Christian churches, but so far we have relatively little information about the types of diagnosis and healing practiced there, the ways in which these are structured and legitimated by reference — if and when such is the case — to the Christian faith, their relationship with non-Christian traditional healing, the specific aetiologies adopted in the churches, the power relations underpinning healing in this context, the variation between churches, etc. The general pattern appears to be that independent churches consist of a core membership sharing a common ideological outlook, worshipping together and keeping up the church organization, around which core exists a diffuse halo, of rapidly shifting personnel composition, of people who are only attracted by the church's healing ministry, and who are not organizationally or ideologically committed to that particular church. What are the specific relationships between core and halo? Is the core membership mainly

recruited from the halo? What forms of support, comfort, but also intimidation and exploitation, may be extended to the church members and therapeutic clients? If the divinatory and healing practices are so much embedded in a church idiom, how could they be opened up to objective outside monitoring in the interest of both patients and practitioners?

— *The professionalization of traditional medicine in Botswana: associations of traditional healers, and the prospects for state registration*

The Societies Act provides the framework for the state control of voluntary associations, including healing churches, associations of traditional practitioners etc.* Although the Registrar of Societies seeks to extend his authority to curb such exploitative, undemocratic or unhealthy practices as may occasionally occur within those organizational contexts, this state control is not very effective, for various reasons having to do both with the democratic nature of Botswana with its emphasis on human rights, and with the very entrenched, time-honoured and socially accepted repertoire of power which is represented (under the trappings of modern, state-registered organizations) by independent churches and traditional practitioners. The great extent of people's shopping around between modern and traditional health agencies suggests the necessity for close contact and co-operation between both types of agencies, if not the necessity of a qualified state control such as was developed over the centuries with regard to modern practitioners. Yet, while the traditional practitioners' professional organizations do provide a focus for such contact, they at the same time constitute an effective barrier behind which the individual practitioners would appear to be legitimated, confirmed and more or less protected beyond the formal letter of the law. How do healers' guilds cope with the problems of professional rivalry, avoidance, secretiveness, occasional charlatanism? Are they effectively the normative and disciplinary bodies one might expect them to be by analogy with modern physicians professional organizations? An inventory of the actual situation of traditional professional organizations, their internal functioning as well as their relations with the state, modern health authorities, law-enforcement agencies and the general public, will set the framework for research on this topic, at the end of which specific policy recommendations can be formulated.

— *The role of the traditional practitioner in the HTV/AIDS epidemic.*

This role would appear to be ambivalent and perhaps largely negative. On the one hand the traditional practitioner can be expected to have the health interest of his or her clients at heart, and as such traditional practitioners may adopt the general, health-policy supported cautionary attitude concerning HIV, safe sex, use of condoms etc.; they may even distribute technical information and free condoms as made available by the modern health agencies. On the other hand, and more importantly, the traditional practitioner because of his or her particular interests in the medical market, and as an active and vocal partisan of a particular local cosmology in the interpretation of disease and healing, may reinforce, in the minds and activities of the clients, practices and interpretations which in fact

counteract anti-HIV propaganda and stimulate further spread of the epidemic. These factors include the fact that many traditional practitioners openly deny the radically new and incurable nature of HIV/AIDS, claiming instead that this is only a new name for a taboo-related or sex-related disease they have always known and have always been able to cure. Also the fact that many traditional practitioners are being consulted particularly in the context of love affairs, impotence, aphrodisiacs, rivalry over lovers and relating acts of sorcery, etc., makes them in many respects, and notwithstanding positive exceptions, a mainstay in the maintenance, both ideologically and practically, of a level of general promiscuity on which the HIV epidemic thrives. These are at present merely hypotheses, to be tested in concrete and detailed research, as a basis for specific policy recommendations.

Further topics will be identified in the near future in consultation between the Ministry of Health and the programme director, in such a way that we shall try to accommodate, whenever possible, such themes as are topical among health personnel and policy makers in Botswana today, as well as salient themes from the ongoing Francistown research, and personal preferences among prospective participating researchers.

Conclusion

This draft proposal of course merely represents an invitation of further comments towards a more definitive formulation which will more properly reflect the views of all parties concerned. Looking forward, therefore, to your reactions to this proposal, I beg to remain,

Yours sincerely,

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