COMPLEMENTARY AND ALTERNATIVE MEDICINE IN BOTSWANA: INSIGHTS FROM PRACTITIONERS AND CLIENTS

Kabo Letlhogile *
University of Botswana
email: kalet@rocketmail.com

Segolame Kaelo
University of Botswana.
email: segolamekaelo@gmail.com

Motshedisi Sabone
University of Botswana.
email: SABONEMB@ub.ac.bw

Abstract
Many people in Africa and the world at large continue to use their traditional health care systems along with the dominant western health care system. In response, the World Health Organization encourages and supports integration of the traditional and the western health care systems. The exercise reported here was an effort to acquaint graduate psychiatric nursing students to the place of traditional medicine in meeting the health care needs of clients. The paper is informed by literature review and dialogues with healers and users of the system. It is evident that clients use traditional medicine use it along with western health system. However, there has been very little effort in Botswana to integrate the two systems. The authors recommend strengthening of the efforts to incorporate traditional healing in graduate nursing curricula, increased research on traditional medicine, and regulation of the traditional health care practice.
Key words: Traditional doctors Botswana, complementary and alternative medicine Botswana, traditional healing practices, regulation of traditional medicine Botswana, traditional healing and curriculum Botswana.

Background and Introduction
Complementary and alternative medicine (CAM) is increasingly gaining recognition in health professional's education, research, and practice (Glordano, Engebretson, & Garcia, 2005). The main driving force for recognition of CAM has been the evidence that consumers of health care have continued to use their traditional health care systems even in countries where orthodox medicine has a long history of dominating the health care system (Pinzon-Perez, Palasio, & Farjado, 2012). In US, it has been estimated that more than one third of the population uses complementary and alternative medicine in any given year (Astin, 1998). In a study that sampled psychiatric patients in the US, 64% of patients receiving psychotherapy reported using at least one complementary and alternative therapy in the preceding 12 months (Elkins, Marcus, Rahab, & Durgan, 2005). Some research has pointed out that herbal medicines used in many parts of the world may hold promise for curing diseases that to date, western medicine has not been able to

cure. It is therefore important that such herbs are further researched (Danley, 2006). Danley (2006) further noted that research on medicinal herbs will facilitate their preservation.
The term "complementary and alternative medicine" has been defined as a broad range of healing practices that are not part of the politically dominant health care system of a given country at a given historical epoch (Caspi, Sechret, Pitluck, Marshal, Bell, & Nichter, 2003). "Alternative" in the label denotes non-conventional while "complementary" denotes concurrent use of the system along with the dominant system, such that the two complement one another (Caspi et al.) Whereas the nomenclature "CAM" is frequently used in countries such as the US, in Botswana and other developing counties, the nomenclature "traditional medicine" is usually used; and is defined as the sum total of knowledge and practices of illness prevention and healing informed by beliefs of the indigenous people (Sato, 2012). For this paper, CAM, traditional medicine, traditional health practice, and traditional healing will be used interchangeably.
Many people in Africa continue to use their traditional health care practices along with the dominant western health care system (Kajawul, Chingarande, Jack, Word, & Taylor, 2016). It has been estimated that about 80% of the population in developed countries use traditional medicine (World Health Organization, 2013). Responding to the demands for CAM observed in population trends, the World Health Organization (WHO) encourages and supports national health systems' integration of CAM into the western health care system.
Several countries have responded to incorporating CAM in their health care systems through strategies such as education of health care professional, promulgation of policy and legislation, and research. Educational programs need to graduate practitioners who can be able to communicate with populations who use CAM along with western heath care medicine and effectively work with them in addressing their health problems. Policies and laws must be able to guide the side-by-side use of the two systems as well as to indemnify practitioners and protect consumers against unsafe practice. Research on CAM could provide evidence to its efficacy and safety as well as support continuing learning for both practitioners and users of the system. In 2005, the World Health Organization commissioned a survey to determine countries' future needs for CAM related technical support .There were in all 191 countries that participated, among which were Botswana, Kenya, Malawi, Mozambique, South Africa, Tanzania, and Zambia. Only 32% of countries had a policy on traditional medicine.

Other efforts related to recognition of traditional medicine were, policy development in progress, a national program on traditional medicine, a national office on traditional medicine, and an expert committee of traditional medicine. Common areas addressed by the policy were the definition of traditional medicine, implementation strategy for the policy, regulatory aspects, and intellectual property rights for practitioners. Thirty seven percent of the countries had laws and regulation on traditional medicine while 49% reported that regulations were being developed. Although a number of countries had made progress in recognizing traditional medicine, there were problems in regulating traditional medicines and harmonizing them with the dominant paradigm. The main challenges reported were lack of research data, lack of control systems, and lack of expertise (World Health Organization, 2005). India is reported to have made a lot of progress in traditional medicine; with the country having a national policy, curricula, herbal medicine laboratories, research councils, research centers, and a digital library (Sen &

Charkraborty, 2017). However, the country was still experiencing challenges in quality control, pharmacovigilance, irrational use of medicines, and unethical practice (Sen & Charkraborty). The US has made some advancement in that some insurance companies are reported to cover some CAM modalities (Winslow & Shapiro, 2002). However, still in US, one study revealed that even though western health care providers could recommend CAM to their patients, that was not based on any evidence of efficacy and safety of the products (Steward, Pallivalappila, Shetty, Pande, & McLay, 2014); suggesting a need for research on CAM as was also pointed out by some physicians who yearned for more information on CAM that could enable them to advice their patients whenever it was necessary (Winslow & Shapiro, 2002). A number of African counties have also heeded to the WHO's call to integrate indigenous health care practices into the western health care system. In Ghana, the Medical and Dental decree and the Nurses and Midwives decree allow indigenous inhabitants of the country to practice traditional medicine, only prohibiting practices that endanger life. Lesotho regulates the practice of traditional medicine and requires that all those who practice are registered. However, the law applies a number of restrictions on the practice of traditional medicine.

In Botswana, the number of traditional health practitioners is estimated at 3,100; with 95% of those being resident in the rural areas (World health Organization, 2001). There is will on the part of government to integrate traditional medicine into the health care delivery system. For instance, it has been reported that drafting of the traditional health practice bill was in progress (BWgovernment, 2018). However, progress has been slow. Geiselhart (2018) has attributed the poor progress to tension brought about by the interplay of Christian morality, dualism of modernity and tradition, belief in witchcraft, and the firmly established dominant western health care system.
Geiselhart argues that the World Health Organization's call for integration of the two systems is challenged by the assumed supremacy of the western health system that patronizes the traditional health care practice, leaving its practitioners interpreting the so called "cooperation" as attempts of the western health care system to indoctrinate or convert them into what they see as "assumed" superior order. Geiselhart's view is that unless there is a deliberate effort re-conceptualize assumed supremacy of western health care system, or to build bridges that connect the two, it will take a bit of time to bring the two systems closer together (Geiselhart, 2018). In fact Geiselhart's position on integrating the two systems is supported by the report that what the government of Botswana envisages is improved mutual understanding rather than full-scale integration (World Health Organization., 2001).

Complementary and alternative health care practice, or its integration with the western health care system should find a welcoming home in nursing, which along with recognition of the oneness of body, mind and spirit, has holistic, client centered and culturally contextualized care as some of its important pillars (Fisch, 2001). In nursing, each client is considered unique with unique needs that may not be readily apparent until both the client and the nurse engage in a dialogue, where upon the nurse appreciates the client's values, health care needs and preferences, and structures the care accordingly (Fisch, 2001). Nursing education should therefore ensure that its graduate have requisite competences for meeting the health care needs of clients, many of whom use their traditional health care practices along with western medicine.

Nurses' familiarization with communities' traditional health care practices is even critical in psychiatric mental health nursing; as the belief systems and socio-cultural practices have a significant bearing on communities' mental health and their utilization of the western health care system. In fact, the World Health Organization has called upon its member states to incorporate communities' traditional health care practices in their curricula. Probably owing to the absence of a guiding policy on integration of complementary and alternative health care and western health care systems in the Botswana western health care system, nursing education in the country has not responded to World Health Organization's call; at least not as has been reported in countries such as the US (Cutshall et al., 2010) and others (Stewart, Pallivalapppila, Shetty, Pande, McLay, 2014).

Purpose

In this paper, the authors share an effort to expose psychiatric-mental health graduate students to the philosophies and practices of the traditional health care system in Botswana and to stimulate their interest in the area, through literature review augmented with a dialogue with two traditional health care practitioners and two clients of the system. The students were taking a course on therapeutic modalities in psychiatric-mental health nursing and as such, what they learned from the practitioners and clients of the system became part of the course content. Besides providing an opportunity for students' learning, the findings from the exercise could stimulate discussions about incorporating traditional health care practices into nursing curricula among nurse educators in the Botswana and similar contexts.

Methods

The students conducted a desk-top research on complementary and alternative medicine and its role in psychiatric care globally, in Africa, and in Botswana. Because there was not much recent literature found on Botswana, a decision was made to augment available literature with live stories from traditional health care practitioners in the country. A renowned traditional health practitioner was identified in one of the main villages of the country. Another practitioner was identified in the same village but was quite a distance from the first. Dialogues with the practitioners were held separately. Separate dialogues were also held with two persons who had used the services of traditional healers. Data were brought together and conventional (open, not directed by any framework) content analysis was employed to come up with a description of what the informants said about traditional health care practice in Botswana. Ethical clearance for this work was provided by Office of Research and Development at the University of Botswana (Exempt Category, 1 i.e. Research in Educational Settings).

Findings

Dialogue with Traditional Practitioner 1 (TP1)

TP1 has been in traditional medical practice for about 66 years. When he started, western medicine was not as widely available as it currently is. TP1 reported that one has to go through some training in order to learn traditional medicine. He was taught by his father who was himself a traditional health practitioner. It is common practice that a traditional doctor will select from among his children, one who is humble and kind, and teach him how to practice traditional

medicine. TP1 is a member of the Bantu Herbal company of South Africa. However, he is not a member of the Botswana Dingaka Association (an association of traditional health practitioners) because he believes that those who came up with the initiative of creating the association wanted to learn traditional medicine for free from the experienced ones.

TP1 reported that traditional healers can either be herbalists (*dingaka tse di chotswa*) or divine healers (*dingaka tsa dinaka*) or bone throwers. He is a divine healer as he casts bones to diagnose and prescribe an appropriate course of action. Before casting the bones, a person who is to be helped blows air inside the small bag containing the bones (*ditaola*). Small children who cannot blow into the bag will instead have a touch from the healer. In TM's opinion, traditional doctors who do not use bones to diagnose are very dangerous as they just treat blindly or use trial and error. *Ditaola* or bones used in diagnosis have names which include: Jaro (the small one), Mmakgadi (the big one), Kgatshane (the girl), Taola ya tshwene (the witch), Taola ya Phiri (the witch), Taola ya kolobe, Phuduhudu, Phuti, Podi ya phoko, Thakadu (God), Noko/Matshwane (catchers of thieves).

TP1 offers several treatments one of which is "*thobega"* or fracture setting, that can be done even remotely or when the patient is not physically present; in which case a clothing item that the patient has used is used to represent him/her. *Thobega* is done at the bush using roots of certain plants. Some rock or tree branches are used to cover a small hole that is dug as part of the procedure for the safety of people and animals. Because unlike in western medicine in which plasters and x-rays are used, chances of bone mal-alignment could be high.

TM1 also reported that he treats sexually transmitted infections though casting the bones. He can also treat bad luck and this is usually by giving the affected person some medicine that he/she adds to his/her bath water. TM1 also treats "*kgaba*" (bad luck related to parents or close relatives having been hurt or unhappy about something). Kgaba is treated by giving a bath using a herb called "Mosotho" or using a traditional bran. Food poisoning (*sejeso*) is treated by using milk to induce vomiting. Traditional doctors can help make someone's cattle to multiply; and they use guinea fowl's eggs. Another way to make cattle multiply is to make a bull hyperactive in mating; and this is by the use milk from the bull's mother. TP1 often makes a follow-up of his patients in order to assess the progress of the disease and the effectiveness of treatment.

Medicine dosing is by a count of the twigs of a medicinal plant that are tied together to denote a single dose. Powdered medicines can be measured with a teaspoon. The usual dose for sexually transmitted infections is medicine dissolved in a liter of water that is taken three-times-a-day using recommended measure. TM1 emphasized that a traditional healer should never use his practice or medicine to harm a person, even if he may have a conflict with the person. That rather, a traditional doctor must treat all people equally or without discrimination. He noted that rather than being contradictory to one another, western medicine and traditional medicine are complementary; only using different tools to achieve a common objective. For instance, traditional practitioners will not hydrate intravenously, but they give herbs that fortify blood. Similar to the case of western medicine, symptoms can guide the diagnosis and treatment in traditional medicine. In traditional medicine, fever may indicate internal sores or dehydration. Sunken eyes in children indicates a fontanel problem (*tlhogwana*) while abnormal bowel sound may be a sign of umbilical hernia or diarrhea. Children's diarrhea may also accompany spring season and teething. Like in the case of *thobega*, other diseases may be diagnosed through a clothing item rather than the physical presence of the patient.

Regarding mental illnesses, TP1 reported that a person can become mentally ill if he tries to bewitch somebody who is too strong for whatever mechanism is used to harm him/her. Mental illness may be a result of witchcraft or natural causes; with that resulting from witchcraft being easier to treat than the latter. Problems related to the uterus such a shift from its usual position may cause mental illness in females. Mental illness can also result when somebody has stolen and the owner of the stolen goods casts a spell on the thief. Another cause is the boiling of blood in the blood system. Treatment may include sedating substances and massage (provided by an identified female) uterine mal-position. TP1 noted that usually people with mental illness seek the services of traditional healers only after failing to get help from the western health care system.

Dialogue with TP2

TP2 is 68 years old and has been practicing traditional medicine for 47 years. He was trained by his grandfather in another village. He reported that he used to help his grandfather to look for medicinal plants in the bush. In addition to learning from his grandfather, TP2 was trained by renowned practitioners from Botswana and a neighboring country. He also reported to have trained a number of traditional doctors in Botswana and neighboring countries. He was a member of the Botswana Dingaka Association before the association changed leadership and collapsed.

Like TP1, TP2 diagnoses first by bone casting to determine what the patient is suffering from. The names of his ditaola are *Moremogolo, Mmakgadi,Thakadu-e-namagadi, Thakadu-e-tonanyana,* and *Phuti.* When the patient is feverish, all the bones will face down. The bones can also inform him if the patient cannot be treated by a traditional healer and needs to be referred to the clinic or hospital. One can be diagnosed and treated without his/her physical presence, as long as his/her clothing item is availed. This applies to, among other conditions, a fracture.

TP2 treats a number of diseases/conditions including headache, pregnancy related problems, children's ailments, skin conditions, and fractures. He treats food poisoning by giving a medication that neutralizes the poison. He uses a plant called "*kgaba"* to treat "*dikgaba*" or bad luck that befalls people when their relatives are not pleased with them. He can protect new homesteads against bad luck and witches (*go thaa lelwapa*) in order to prevent mishaps such as lightning, and diseases. TP2 is able to program cattle's mating so they will have off-springs of a desired sex.

Following treatment, TP2 makes a follow-up of his patients, and the initial treatment can be augmented with additional medicines if there is no improvement. He reported that he cannot hydrate patients; and that traditional medications work very slowly as compared to the western health system ones. He emphasized the fact that traditional doctors only treat and prevent mishaps; that they do not kill. He said that if a traditional healer uses his medicine to kill a person, that will render the medicine impotent.

As for mental illness, TP2 reported that mental illness can be caused by witchcraft when for instance, a witch applies medication to his/her hand and touches the victim's head. Some can sneak in at night and shave the victim. In females, mental illness can occur when problems related to the uterus affect the brain. Dagga also causes mental illness as it causes the blood to boil in the system thus offending the brain. For mentally people experiencing irregular heartbeat, the heartbeat causes the heart to swell. If the situation is prolonged, the heart gets hurt and blood

flows at an abnormal rate, and as it gets to the head, mental illness ensues. He noted that too much blood in the system explains weight gain in mentally ill people.
Treatment usually follows a diagnostic procedure that identifies the cause of the illness. Illnesses related to the uterus are treated with oral medication. Those due to boiling blood are treated with inhalation medications (*mhitshwana*). There is specific medication for irregular heartbeat.
TP2 can only treat mental illness when it has just started or when it is still new. When it has been there for years, it is difficult for him to treat it. He reports that the treatment he gives acts on the brain. He reduces the medication strength if the patient is weak. He said that a mentally ill person who relapses when plants pollinate or during spring is easy to treat.

Dialogue with Traditional Practitioner Client 1 (TPC1)
TPC1 is aged 63 years with tertiary education. She has been treated for mental illness for over 30 years and has done well managing family and work. Her recall of a first encounter with a traditional healer was when she was discharged from the hospital following her first episode of mental breakdown. The parents had consulted a traditional healer before the patient was discharged from the hospital. The healer had advised that the patient should not go to the parent' home as evil targeted at her had been planted there. She therefore lodged with a relative and only went home on the night of a healing session. There was singing dancing around the fire and the healer advised that any person who knew that he/she had done evil things should not join the dancing. There was a relative who chose not to join the dancing.
The second time TPC1 sought help from traditional health practitioners was when she had heard from colleagues that there was somebody who treated mental illnesses. She was not sick that time but she visited a spiritual healer who used the bible to examine her. The healer told her that someone had planted evil things in her parents' home and that those evil things were targeted at her. The planted things were an egg, an owl, and a black cat. Treatment would be to go and remove the evil things. Unfortunately, the parents were already late; she was no longer living there, and the home was occupied by some siblings. Therefore she was just given a bath. The healer informed her what was happening in her life. For instance, she told her that people believed she was mentally ill but that she (the healer) could see that she was not mentally ill as what she was experiencing was real.

The third time TPC1 went to a healer was when she had a break down and a friend took her to the healer. The healer was probably a *Sangoma* (type of spiritual healer) because she wore multi colored bracelets, used prayer while also using herbal medicines. The friend had a chat with the healer before she was called in, and she does not know what the two were talking about. However, she is worried about the way people treat her when she is sick because they treat her like a child and would even leave her out when planning her own treatment. The healer gave her herbs to boil and drink. She has not used medicines sold in the street because she doubts their safety. She often buys sea salt from the chemist and adds it to her baths to wash off bad luck.
TPC1 has never, in her own will consulted traditional healers during episodes of mental breakdown. This is because she is not usually aware that she is sick when she has a breakdown. Sometimes when she is about to have a breakdown she becomes hyperactive such that she does not like sleeping and she can clean the house during the time that she should be sleeping. Even when family advises that she seeks help, she does not usually cooperate as she never believes

them. Another reason for not wanting to seek psychiatric services is because the medications have side effects that make her lethargic, leaving her with no energy to do anything besides eating and sleeping.

Dialogue with Traditional Practice Client 2 (TPC2)
TPC2 is a 63 year old male pensioner with tertiary education. Unlike TPC1, TPC2 has not been treated for mental illness, or any chronic illness, for that matter. However he regularly seeks the services of traditional health care practitioner for his general welfare including health status, his livestock, and his other valuable estate. In addition to his personal experience, TPC2 knows a lot of people who use the services of traditional hears. Although he has used spiritual healers several times, we wanted to hear more about divine healers or as we had heard a bit about spiritual healers from TPC1. TPC2 reported to have used the services bone throwers quite a lot.

TCP2's understanding about divine healers is that there are two main types – herbalists (tse chotswa) and bone throwers *(tsa dinaka*). With regard to how they become healers, again there are two categories - those who become healers through the influence of ancestors (*badimo*) and those who are trained to be healers. Those who are inspired by the ancestors get instructions from the former with regard to selecting *ditaola* and medicines. There are four main *ditaola* namely Moremogolo and Sejaro (hooves of a cow, Kgadi and Mmakgadi (bones). Some healers may have six or more *ditalola* with those additional to the four primary ones playing a rather supporting role. Traditional healers mainly use herbs for healing. However, some may also have a type of a rock called *Legakwa* dipped into the herbal medicine used in fortifying homesteads and livestock. *Legakwa* is usually buried underground when the healing procedure is completed. Healers who protect homesteads (go upa motse) are often referred to as Ditimamolelo (fire extinguishers) because they protect the home from any harm. Healers who fortify marriages can also be referred to as *Ditimamolelo.* After throwing the bones, a few traditional healers, especially the more mature ones, may report that there is nothing serious about the problem; that there are no evil deeds or witchcraft. However, more often than not, traditional healers will say something threatening that will make the client panic and pop out money in order that the healer can remedy the problem. A healer will tell the client that he foresees *Thwagadima* or a tragic event such as lightning strike, car accident or snake bite – an even with a high potential of causing sudden death.

Usually when the healers' diagnosis identifies witchcraft as the cause of the problem or evil deeds (*Diphera*) they will only describe the witch, the direction or whereabouts of his/her residence, and similar identifiers; rather than call her/him by name. In rare occasions, however, particularly when the healers knows the client's associates very well, he will call the witch by name. As to how the healer proceeds after identifying the witch, the client is asked to choose between two options; option one is to remedy the problem and leave the witch unharmed while option two is to treat in such a way that the evil returns to the source or originator and the supposedly bewitched person remains unharmed. The healer's *ditaola* can also tell if the client is a witch him/herself or if he/she keeps lethal medicine or that which has a potential to kill. Some can request a share of the medicine only to later use it to kill its originator.

TPC2 related some incidents of witchcraft directed at him. In one of the incidents, evil was cast upon his car because he had not cooperated when he was asked to pick something with his car. The evildoers had warned other people not to use the car because accident was awaiting it. He later used the car that has serious accident that though it left her physically unharmed, was repaired with high costs. As he was investigating the cause of the accident, he informed by traditional healer that somebody had taken a sample of soil from the car's trail markings on the ground and used it to cast a spell on the car. The person became sick and the family members insisted that he visits the patient and he complied. He was later to learn that he was not supposed to visit the witch as that would heal him/her. Following the recovery of the thief, the bewitched person would had intermittent pain that though would not be severe, would be bothersome. The pain would only disappear with the death of the witch. As he reflected on the course of events preceding and following the accident, he agreed will what the healer told him.

Another incident of witchcraft directed to him was when he had a project in the village. The healers had informed him that some three jealous women wanted him dead so that the project failed. They had therefore approached a traditional healer who had helped them with a killer medicine. A spiritual healer and a divine healer told him the same story at different times. Two of the witches lost family members dying in two separate car accidents. The other person had a family member in one of the cars that had accidents but was unhurt. A traditional healer died. Piecing everything together, he was convinced the healers related everything just as it happened. The third incident was when he had asked a certain person known to be herbalist to help him when he was not feeling well. The herbalist had given him some medicine that was cautioned not to use by his parents. He therefore did not pay the herbalist because he had not used the medicine. However, the herbalist had time and again reminded him of the unsettled payment.

One day, as he was taking a walk in open stretch of land, he heard a deadly sound that left his ears ringing. He was quite perturbed and when he looked up at the sky, he saw a small cloud that could hardly explain the thunder that nearly knocked him down. He consulted a divine healer and immediately after the healer had thrown the bones he asked him, "do you owe a traditional healer? Then he remembered that there was this herbalist that he never paid for his medicine. The healer treated him, and not long after that, the concerned herbalist died. TPC2 does not see the healers who help him as witches or killers However, their medicine "kicks!" (*o a raga*!) and so evil doers suffer negative consequences. In as far as curing diseases is concerned, TPC2 reported that he did not much that he could share.

Although the healers that TPC2 has experienced have been truthful, he noted that there is a lot of lies involved in the discipline; primarily for making money. He reported that that there are some medicines that people can take that enable them to examine and interpret *ditaola*. However, such people do not know anything about healing; even though they would, following examination and diagnosis, pose as healers and make people pay their money for nothing.

Discussion

The highlights of the dialogues with both the healers and the clients cover induction into the traditional health practice, the diagnostic procedure, and treatment or healing.

Induction into Traditional Healing Practice

From what traditional practitioners shared with the students, it is evident that for one to be a traditional healer, he/she has to go through some training. However, because the knowledge is handed down from parents to off-springs, training tends to be informal or apprenticeship rather than being identifiable by blocked time and physical training space. It is also evident that some screening is done to identify personalities that could make a good healer. One can deduce from the conversation that the content of training could cover the philosophical underpinnings of the discipline, diagnostic tools and how the diagnosis is reached, medicines (mainly plant products), the act of healing, diseases or health problems and related remedies which may be medicinal preparations, rituals, or a combination of the two. It must be noted the dialogue was only with diviners or bone throwers; therefore induction into herbalism and spiritual healing could take departures from the training reported here. For instance, some spiritual healers have reported that they became healers through calling and spiritual intuition (Geiselhart, 2018).

Diagnosis

Traditional healing is informed by the results of a diagnostic procedure. Both of the two healers are bone throwers. They therefore throw bones the ground-landing of which tells them what the problem is, what its cause is, and how it can be remedied. Dennis (1987) observed that ancestors *badimo*) speak to the healer through the bones (*ditaola*), It is noted that the client consulting traditional healers also participates in the diagnosis by blowing into the bag containing the bones before it is emptied on the ground or flat surface. In the case of small children, the healer touches them before throwing the bones. However, the diagnosis may be done without the physical presence of the client, in which case his/her clothing item is used. A dialogue with a client who has used faith healers also suggests participation of the family and clients in diagnosis through joining the singing and dancing ritual. In addition to divine bones, symptoms such as fever, racing heartbeat, and diarrhea also provide a clue to the nature of the problem.

Healing/Treatment

The cause and the duration of the illness are believed to influence the treatment outcome and therefore the best treatment. There are some disease that may be referred to western health care system right away; with some of the determining factors being that the traditional treatment takes a bit longer to act when compared to that of the western health care system; and that traditional practitioners cannot provide intravenous hydration. The practitioners reported two broad causes of diseases, being natural causes and witchcraft or deliberate evil deeds of other people. Treatment is not a one-event undertaking as the healer has to make a follow-up to check the client's response to treatment and to act accordingly. Although the healers that the students engaged addressed their practice in general, not focusing on specific diseases, the students wanted to learn more about mental illness because that was their degree specialty area.
Mental illnesses may be stubborn or easy to treat depending on their cause and duration; with the seasonal, those due to witchcraft, and those of short duration being easier to treat than others. The healers also attribute some mental illnesses to evil acts or transgressions (failure to fulfil some obligations) of the sick person him/herself.
Treatment forms may be topical applications as in baths, preparations to be taken orally, rituals as in dancing and singing that incorporates both diagnosis and healing, aerosols (inhaled

medications) and other approaches such as fracture setting. Phibion and Khudu-Petersen (2016) noted through singing/dancing, *Basarwa* healers communicate with the spirit world to effect healing. The dance/music healing session with participation of family reported by one of the clients has also been reported by Sorketti, 2012, who noted that traditional healing may involve the patient's family and other community members who co-participate in defining the underlying problem and the remedial action. Therefore traditional healing is relational, thus fostering the patient's integration into his/her people and community cohesion (Sorketti, 2012). Sidandi, Mambwe, Zoric, Vanvaria, Vanvaria, & Laryea (1999) made a similar observation that healing may restore social cohesion when an aggrieved person speaks in the voice of the ancestors to call those who misbehave to order.

From what one traditional healer reported, there is demand for discipline on the part of a healer in that healers are cautioned again using their knowledge to harm other people; which is said to be detrimental to the practice as it may render one's medicines impotent. However, from what TPC2 reported, healing may cause harm to others, with clients being told to watch the space as witches die one after another. Linking healing to the death of another person may be a psychological stressor later in life especially when one is facing difficult periods such as serious illness. As spiritual beings, human beings may be tortured by feelings of guilt, believing that their misfortune is a punishment for the life that was lost because of them.
The commonly held knowledge that a healer may not heal him/herself (ngaka ga e ikalafe) can also instill a sense of discipline as it may guard against abuse of the system. Providing services to peers or fellow healers could also promote adherence to good standards of practice as one's practice is open to the scrutiny of others. Spell

What one can note as a striking difference between the western health care system and what was reported in the dialogue with both traditional healers and clients is the belief in witchcraft. However, when one considers psychosocial issues that have a bearing on mental health, jealousy and envy that are reported to drive witchcraft represent disturbed human relations that are believed to contribute to mental ill health in the western health care system. Our awareness that others that we have always counted as our social capital now consider us a threat to their prosperity and social recognition usually leaves us disappointed, powerless, and even fearing for our safety. Perhaps the use of clothing item of an absent person in diagnosis and treatment is mediated by *badimo* or ancestors. However, a mechanism that facilitates the setting of a fracture in the absence of the fractured person was not very clear. What was found in the literature is treatment of pain related to a fractured bone (Monteiro & Tlhabano, 2013). The mechanism of the treatment was referred to as "*thobega*" (Monteiro & Tlhabano, 2013), that in some literature means "fracture setting" (Dennis, 1978) rather than pain relief.

Neither the healers nor the clients who have used the system reported anything about counseling clients on what to do to remain healthy which could cover areas such as eating, drinking, `relating, child rearing, marriage, religion, and avoiding potential hazards. However, one can speculate that the services are provided under the assumption that because the healer and the client are from the same cultural context, they subscribe to the same or similar values with regard to "how to be." For instance, it may be common knowledge that, as Uline (1975) noted, neglect

of filial responsibilities may anger ancestors who may punish people by inflicting disease. One may therefore expect that treatment for a client who is outside the African context may cover counseling on "how to be."

A concern about people who pose as traditional healers and collect a lot of money from unsuspecting individuals that raised by TPC2 is disturbing. This is especially because as long as the discipline of traditional health practice remains unregulated, it will be difficult to tell between a fake and a real healer. The concern was also raised by Bruce (2002) who noted that traditional medicine practice faces invasion by bogus healers who take advantage of desperate people and leave them impoverished.

Implications for Nursing Education

Incorporation of CAM Content in Nursing Education

One must appreciate the effort in nursing education whereby students are socialized to appreciate that clients have their own worldviews that may be different from the philosophies of the western health care system. However, those who have not moved another step to expose their students to alternate health care practices need to consider that. Realizing that it may be difficult to find western health practitioners who are well versed in CAM modalities such that they will be a resource for students, locally available resources such as traditional practitioners who volunteered their time to inform the students about their therapeutic modalities can be a good resource.

Incorporation of CAM in the curricula must not compromise the scientific method that undergirds the western health care system's modalities. Similarly, the study of CAM must not be diluted by the worldviews of the western health care system. Its philosophical underpinnings must be appreciated as they are. We are exposed to different worldviews so that we can tap from each when we solve problems. Education on CAM must continue even after the basic training; and this is important because those who have been in practice for a long time may also need orientation to CAM.

Research on CAM Modalities

There is need for research on CAM modalities especial in academia so that graduate students can get first-hand knowledge from research and use that in providing care to clients upon graduation. The fact that the majority of nurses in Botswana are locals and work they also work with diverse communities in urban, rural, and remote parts of the countries puts them in an advantaged position as may become well versed with traditional health care practices of different communities such that they can learn about CAM practices and use their insight to lead interdisciplinary research teams. Nurse academics can be pivotal members of such research teams. Because CA modalities tend to apply to specific persons under specific situations and contexts (Glordano, Engebretson, & Garcia, 2005), qualitative approaches could provide insight into the indication for a given modality and how it works. The challenge, as Glordano et al. observed, could be generalization of the research findings. However, the findings must be disseminated to studied communities in simple and non-biased terms in order that they can make informed choices when they seek help from the CAM system (Glordano et. al., 2005).

Regulation of CAM

Botswana must follow other countries that regulate the use of CAM. We are cautioned that we do not only study the therapeutic properties of CAM but we also consider the legal, economic and sociocultural implications of integrating it into the politically dominant western health care system (Glordano, Engebretson, & Garcia, 2005). Like the western health care, CAM may have risk factors that demand that both users and practitioners are protected against such possibilities as fatal adverse reaction and litigation. In addition, communities must be protected against economic exploitation by some who may pose as healers when their interest is purely financial gain. Regulation could address such areas as provision of informed consent for those seeking CAM services, service fees, referral of clients within the CAM system and between CAM and western health care systems, and indemnifying practitioners.

Limitations of the Paper

The exercise reported in this paper was not a study but a learning teaching activity for graduate nursing students in response to WHO's call to incorporate CAM in health professional's education. The exercise is therefore short of the scientific rigor that one would find in research. Because the sample is very small, with only a few of the diverse CAM therapeutic modalities examined, we cannot claim generalizability of the findings to other CAM practitioners and clients.

Conclusion

Complementary and alternative medicine (CAM) is increasingly being recognized because not only has its increased use been realized but also because some of its modalities may provide answers to treating disease for which cure has not been found. Responding to the demands for CAM observed in population trends, the World Health Organization (WHO) has pledged technical support and encouraged countries to integrate complementary and alternative health systems' practices into their western national health systems. Although several countries including those in the African region have made some strides in heeding to WHO's call, progress has been slow in Botswana.

Mainly because of its holistic approach to health and healing, the complementary and alternative health care system has a lot in common with nursing; and nursing education can lead in integrating the system in their curricula. The exercise reported in this was an effort to expose graduate psychiatric-mental health nursing students to complementary and alternative health care system in Botswana. Students not only reviewed literature on CAM but they also held dialogues with CAM practitioners and clients in order to acquaint themselves with the situation of CAM in Botswana. Both the practitioners and the clients reported active engagement in the system and saw it as another way of meeting the communities' health care needs. Although the findings of the exercise cannot be generalizable to diverse modalities of the system and client base, they provide important insights into the commonalities and differences between the western health system and CAM that can guide integration of the two systems.

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