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

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**Abstract**

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

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

## Background

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

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

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

## Brief overview of Literature

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

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

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

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

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

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

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

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

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

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

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

## Methodology

### *Research Design*

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

### *Study Population*

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

### *Study Areas*

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

### *Samples and Sample Sizes*

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

### *Data Analysis and Synthesis*

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

## Findings

### *Beliefs on Traditional Medicine*

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

"But I wouldn't encourage anyone to use those because they are not really tested…" (MHMP 001).

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

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

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

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

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

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

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

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

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

***Beliefs in Faith Healing***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other respondents had a negative attitude towards faith healing:

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

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

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

***Medical practitioners and prayer***

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

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

Those who are non-Christians responded thus,

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

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

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

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

Institutional expectations also influenced medical practitioners' use of prayer:

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

***Professional and religious influence***

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

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

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

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

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

## Discussion

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

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

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

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

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

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

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

## Conclusion

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

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