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The Ethics of Collaboration: Perspectives of Batswana Health Seekers on Health Systems Collaboration

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Abstract

Studies on the importance of the collaboration between medical healthcare professionals with other players from alternative healthcare systems are on the increase across the world. Most of the studies place the patients at the benefiting end of this collaboration. Notwithstanding the amount of research that underscores the significance of this collaboration, on the ground the nature of this collaboration continues to be riddled with challenges and there are pockets of uncharted areas that still need to be explored. For example, research on collaboration of healthcare systems in young and developing countries like Botswana is still far from being adequate. Further, this collaboration still needs to be investigated from perspectives of other players like the health seekers, religious leaders and community leaders. This paper specifically explores perspectives of health seekers in Botswana on the collaboration of medical and religious healthcare systems. The findings from the study carried out among the Batswana health seekers seem to support the view that the collaboration between modern medical system, represented by medical practitioners and religious healthcare systems should be complementary in nature.

KEY WORDS: Health, Healing, Collaboration, Religion, Health-seekers, Beliefs

Introduction

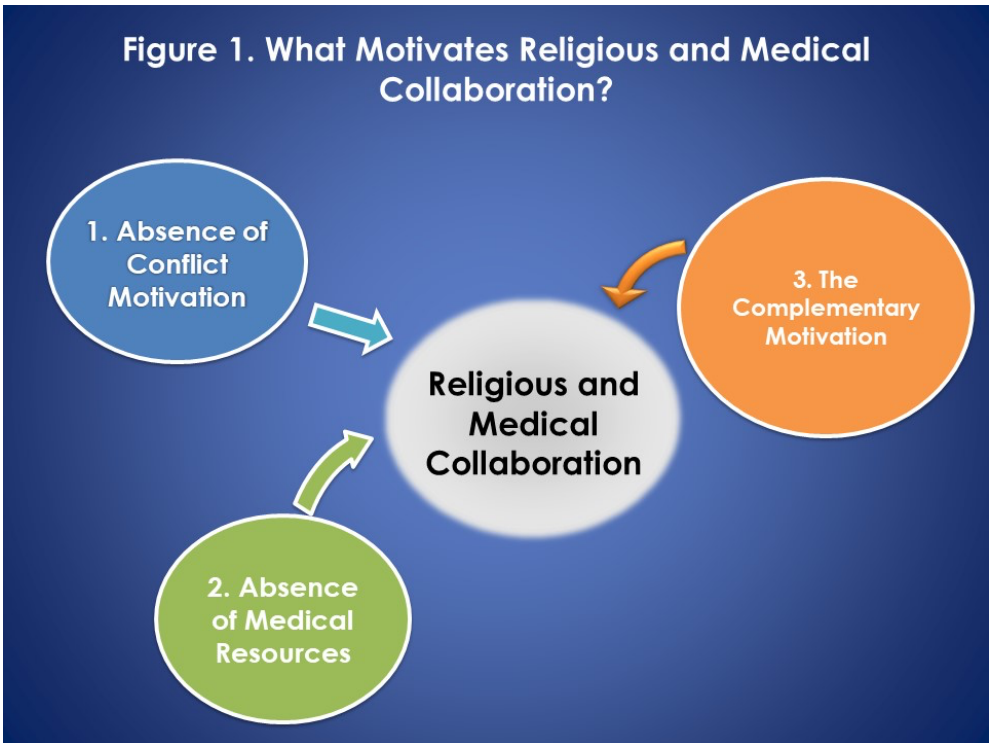
Discussions on spirituality and/or religion are increasingly taking the center stage in both academic dialogues on healthcare, at the same time as a number of medical schools are introducing spirituality programs, courses or topics as part of their curriculum (Puchalski 2009, Post 2009). This increase stems from the fact that spirituality and religious beliefs play a very important role in how people cope with different sicknesses and problems that they face. Further, patients want their medical doctors not only to discuss their spiritual needs with them but also to integrate these spiritual needs in their treatment plans (Puchalski 2009). At the same time, religious beliefs are continuing to prevail across the populations of the world. A study conducted in the US in 2014 showed that more than 70% of adults identified themselves as Christians, while 6.7% identified themselves with other religions like Islam and Hinduism (Zaidi 2018). These figures do not seem to have

changed much in the 2020 census of American religion, where 70% of adults identify themselves as Christian and 5% as followers of other religions (PRRI 2020). In Africa, surveys on religious affiliation show that more than 9 in 10 Africans (95%) identify themselves with a religion (Brian 2020). This means that the greater percentage of the population, and thus the greater percentage of patients identify with one form of religion or another. In dealing with these patients, medical doctors may not ignore the extant religious health systems in the community, because the religious beliefs of the patients are more likely to influence their perceptions towards health and ill-health.

This paper explores the views of different Batswana health-seekers on the collaboration of various health systems in Botswana. The paper begins by exploring debates on collaboration between the medical and religious health systems in extant literature. It particularly develops a three-fold perspective model that explains the motivation behind the collaboration of these two healthcare systems. The paper then ends with a presentation and discussion of the views of health seekers on this collaboration as presented in the study carried out in Botswana.

Literature Review on Collaboration of Health Systems

Literature reveals that collaboration between medical doctors, the clergy and other health systems in any given community is of paramount importance (Koenig, McCullough and Larson 2001). However, the rationale for the collaboration is presented differently in literature. Below, a model which presents three motivations behind the collaboration of healthcare systems has been developed from the review of extant literature. These are distinguished as 'the absence of conflict' motivation, 'the absence of medical resources' motivation, and lastly, 'the complementary' motivation perspective (see figure 1). These motivations for collaboration are critically discussed below. Later, the same motivations will be utilized in discussing the data from the field.



'The Absence of Conflict' Motivation

'The absence of conflict' motivation for collaboration holds that the medical and religious health systems should collaborate especially where there is no conflict between the two. This type of motivation is represented by Koenig et al. (2001) who are of the view that as long as there is no conflict between the religious beliefs of patients and their medical treatment, it is important to support these beliefs in one way or another, as this proves to be good for clinical care. Due to their commitment to protecting patients from harm, physicians find it difficult to accept religious decisions that may subject the patients to adverse health conditions (Curlin et. al. 2005).

However, at the same time, it seems reasonable to say that the patient-clinician relationship demands that the medical practitioner should go beyond 'the absence of conflict' motivation. Even when there seems to be conflict between the patient's religious beliefs and their medical treatment, the clinician needs to collaborate with religious practitioners, helping the patient to find their way through the maze of these seemingly conflicting values. The clinicians should move beyond their comfort zone to empathize with their patients. Collaboration by definition does not imply absence of dissonance. It means recognizing first of all, that there is disagreement, but then, choosing to work together towards a greater goal, in this case, the health of the patient. As Puchalski (2009:804) argues, the "clinician's ability to form a compassionate relationship with the patient is as important as that clinician's ability to diagnose and treat the patient scientifically".

'The Absence of Medical Resources' Motivation

While the preceding argument for supporting a patient's beliefs seems to be limited to instances where there is no conflict between the patient's religious beliefs and medical treatment, others ground the need to take the religious health system into consideration on the socioeconomic position of a given locality. This is the position that religious health systems are important because in some places, these are the only readily available health systems. In this instance, what creates the importance of the other (religious health system) is not the absence of conflict between the two systems, rather the absence of the other system (that is, modern medicine). In this paper, this is called 'the absence of medical resources' motivation for collaboration. Oshodi et al. (2018) argue that in some low- and middle-income countries, there is acute shortage of both human and physical medical resources and infrastructures to properly deal with certain ill-health. This shortage thus necessitates the need for alternative health systems to assist people to attain their health goals. The lack of medical resources in some developing countries and the predominance of faith-based remedies in these countries may not be denied (Samuels, Geibel and Perry 2010). However, basing the medico-religious collaboration on the lack of resources or shortage of medical manpower seems to indirectly water down the significance of the collaboration. This is because one may wonder whether the need for collaboration between the medical and the religious institutions in the healthcare of patients ceases when medical resources become available. Does the importance of religious belief fade away when one is faced with health challenges in places with adequate medical resources? Furthermore, thinking of religious healthcare system in this way seems to imply that consideration of religious beliefs of patients is only important in the absence of modern medicine. Thinking of collaboration from this point of view seems problematic and rather condescending to religious health care systems.

'The Complementary' Motivation

Besides the above perspectives, others argue that what necessitates the collaboration between medical health and other alternative health systems is the fact that different health systems have their own strengths that may be lacking in the other systems. For example, there are limitations in scientific medicine that needs to be complemented by the strengths available in other health systems. It is argued, for example that religious beliefs, as a complementary health system provides patients with the needed resilience and ability to cope with illnesses (Lion et al 2019). Of course, the downside of religious beliefs may be that due to the influence of their religious beliefs some patients may refuse to be assisted through the standard medical processes. However, even in this case the collaboration between the medical practitioners and religious leaders may go a long way in closing the gap.

Emebo (2006) maintains the perspective that there is need for other health systems to complement scientific medicine. He argues that a holistic approach to health care insists that while scientific medicine has made a lot of undeniable successes in the health care, it is not without limitations. Emebo argues that one of the major limitations of Western medicine is that it has been overly 'mechanistic' in its approach to healthcare, that is, treating a human body as if it was a machine, thus leaving out other aspects of a human person, that is, the emotional, the mental and the spiritual aspects. Similarly, Jonas and Jonas note that the common role taken by physicians is that, "The physician makes rounds, looking at the physical components of a patient's illness and body, and ordering tests – but rarely inquiring about their mental and spiritual needs" (Jonas and Jonas 2019:1). Hence, there is need for religious specialists to come alongside the medical practitioners in addressing the aspects that are often left out by the medical practitioner. In this more attractive perspective to collaboration, other health systems like the spiritual domain are not just seen as 'holding the fort' in the absence of Western medicine, but instead the collaboration becomes complementary and timeless in nature. Furthermore, instead of seeing the conflicting perspectives between the medical and the religious healthcare systems as a problem, these differences become the very reason that necessitates the collaboration between the two systems. At this level of collaboration, the practitioners from both ends say to each other, 'We are aware of our different approaches to health, but we share the client, and we also share the goal and the desire of seeing this client being healthy'.

Later on, when discussing the perspectives of health seekers towards the collaboration of healthcare systems in Botswana, it may be interesting to find out how those perspectives are related or unrelated to the motivations identified above. However, regardless of the motivation behind the partnership of the medical institutions and religious or spiritual health systems, it is argued that the collaboration may add value to the present and future health situations of the patients. Koenig et al (2001:445) argue that the partnership may add value, "in terms of ensuring patient compliance, increasing continuity of care and facilitating future referrals."

Collaboration between medical and faith practitioners is important because these two complement each other in addressing the questions that the patient may have regarding their ill-health. The two practitioners do not necessarily provide the same answer to the patient's situation. But it is interesting to note that these different answers are usually complementary rather than contradictory to each other. Jonas and Jonas (2019) note that when a patient makes an inquiry on their condition by asking the 'why' question, the

medical practitioner is more likely to provide physiological answers to the questions. The physician may, for example, answer in terms of the biochemical conditions of the patient, their genealogical circumstances or the risk factors involved in the condition of the patient. Contrastingly, to the same 'why' question, the faith practitioner may provide some existential answers to the condition of the patient.

Failure to collaborate between the various health professionals and spiritual/religious leaders can lead to detrimental consequences on the side of the patients. For example, research shows that many of the inpatients who visit the hospitals have several religious needs during their hospitalization. These religious needs are usually ignored if there is no proper collaboration between medical professionals and religious leaders. Koenig et al. (2001:445), for example observe,

> …more than three quarters of medical inpatients had three or more religious needs during hospitalization. Many of those needs go unaddressed because patients do not volunteer them and health professionals do not ask; unfortunately, this "don't ask, don't tell" policy may be contributing to unnecessary emotional distress and physical morbidity.

Challenges in the Collaboration and how to Promote Collaboration

Having discussed the importance of collaboration between medical and faith practitioners, it is perhaps necessary to also acknowledge some challenges that may persist in realizing this collaboration and also discuss some suggestions that have been made in dealing with some of these challenges. One of the glitches that arise in the medical and faith partnership is the problem of language and communication (Jonas and Jonas 2019). For proper collaboration between medical and faith practitioners, there ought to be a common language of communication between them. For example, it seems that there is no shared understanding on the concepts around the constituents of a human person that need to be addressed, that is, whether practitioners are dealing with the dualist perspective of mind and body or the tripartite notion of spirit, soul and body. These are of course age-long issues that still continue in philosophical debates today, which perhaps demand understanding of different perceptions rather than trying to achieve common answers to them.

It seems that one effective way to promote collaboration between medical and faith practitioners is to instill this partnership earlier on in the life of both medical practitioner trainees and the pastors to-be, where both parties are introduced to the basics of each other's world. Koenig et al. (2001) argue that for collaboration to take place for example between health professionals, and in particular the future physicians and the future pastoral leaders (church leaders), there has to be an earlier interaction when they are undergoing training as students. They should take some courses together and even do some clinical duties together.

Perhaps the above discussion addresses the problems which were cited by others, that physicians do not have the time nor the training to deal with patients' religious beliefs (Sloan 2009). As noted earlier, many medical universities have introduced courses on spirituality to provide future physicians with foundational understanding on these issues. Collaboration is meant to also address the view that physicians do not have the time to deal with patients' religious beliefs. Instead of the physician trying to singlehandedly deal with spiritual matters that the patients have, the community faith leaders could be brought

on board. Hospitals may allow for visitation of community clergy, permit access to religious and spiritual resources such as religious inspirational literature, radio and television based religious programs, permit time for the offering of prayer by religious leaders, and even providing interaction time with patients to discuss their religious or spiritual concerns. One way to establish interaction between healthcare providers and the religious professionals is by establishing a "parish nurse program" (Koenig et al 2001:447). A parish nurse is a professional nurse who is also part of the religious institution(s) in the community. Given her/his ambidextrous position, she/he is able to contextualize and promote healthy lifestyles that take into cognizance both the medical and the religious contexts.

Another important way to promote collaboration is by considering the patients religious history, that is, besides their medical history (Koenig et al. 2001). When a medical practitioner is aware of the religious history of a patient, they are able to support and encourage those religious beliefs and behaviors that may assist the patient in dealing with their ill-health.

Having discussed the significance of the collaboration between medical and religious practitioners as presented in extant literature, the next section discusses perspectives and experiences of the members of the community (health seekers) regarding collaboration between health systems, as presented in a study carried out recently in Botswana. However, this is preceded by a brief discussion on the methodology that guided the study.

Methodology

The discussions of this paper are based on a study carried out in Botswana between July 2018 and September 2019, entitled, "The Impact of Religious Beliefs on Health Seeking and Health Provision Behaviors in Botswana". The study covered perspectives of key players of various health systems, such as medical doctors and nurses, traditional healers and faith healers (church pastors), together with the views of health seekers, on the collaboration of these various health systems. The main aim of the study was to investigate how religious beliefs impact health seeking and health provision behaviors 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. However, the present paper concentrates on the responses of health seekers towards the collaboration of medical practitioners on one hand and traditional healers and faith healers (church pastors) on the other.

Qualitative data (through individual and focus group interviews) and quantitative data (through structured questionnaires) were collected from 826 respondents across the country, covering places like Hukuntsi, Tsabong, Molepolole, Letlhakeng, Gaborone, Mahalapye, Maun, Tutume, Bobonong, and surrounding areas of these major places. Respondents were randomly selected from the general population that affiliates to Christian and traditional beliefs. The data covered the views of health seekers on the relationships of medical practitioners (physicians and nurses), traditional healers (*Dingaka tsa setso*) and faith healers (church pastors and prophets); and also, how these relationships affect them as health seekers. The data was transcribed and coded. It was analyzed through thematic analysis where emerging themes and patterns were recorded.

Findings and Discussion

The findings of the study as presented below show the situation of the collaboration of different health systems from the views of the health-seekers (the general community). The views of the health seekers are based on their interaction with the different health-providers like traditional healers, faith healers (pastors of different churches) and modern medical doctors. The data shows that there are some persisting problems in the collaboration between these various health systems.

Collaboration with Traditional Healers

From the study, it appears that the nature of collaboration between medical healers and traditional healers affects the way the members of the community perceive and respond to these various health systems. For example, it was noted that due to the negative perception medical practitioners have towards traditional healers, many members of the community are embarrassed to show that they seek assistance from traditional healers. They instead secretly seek for the services of traditional healers. Table 1 below shows the views of health seekers towards traditional healers. The responses presented in the table constitute part of the quantitative data, which was presented in a Likert scale of 1 to 5, where 1 represents strongly agree, while 5 denoted strongly disagree.

Table 1: Health seekers' views on why people secretly consult traditional healers

	1. Many people think it is embarrassing to confess that one seeks health service from traditional healers.	2. Many people seek the services of traditional doctors in secret.	3. Medical doctors/nurses should discuss their patients' beliefs and use of traditional medicine.	4. A medical doctor/nurse has discussed with you your beliefs and use of traditional medicine	5. Do you feel free to discuss your beliefs and use of traditional medicine with your doctor/ nurse	6. Your faith allows you to visit traditional healers whenever you are ill.	7. Your faith encourages the use of traditional herbs.	8. Your faith encourages you to seek health from only traditional healers.
Total	2.18	1.78	2.61	3.78	2.90	3.65	3.66	4.31

The first two questions deal with whether health seekers are free to consult with alternative health systems, in this case, with traditional healers. The table above shows that many health seekers agreed that people find seeking health services from traditional healers as embarrassing, thus, they sought the services in secret. Similarly, in the qualitative data collected via interviews, health seekers elaborated that some people are embarrassed to confess that they make use of traditional healers' services and thus they consult them in secret because traditional healers are usually associated with witchcraft; they are labelled as witches and witchdoctors (HUHS001[1]). The negative perception towards traditional healers is confirmed in the different statements made by the respondents. For example, traditional healers are accused of doing "unspeakable things" (FRHS001), which include the view that they are used to bewitch others and that people use them to execute "revenge" on others (MAHS001). There is generally a stigma attached to traditional health

[1] HUHS001: These are anonymous codes used throughout the study to represent the different respondents.

practice (BOHS002). The respondents noted that given that many of the traditional healers are not officially recognized, they may not be liable to account in case some complications arise out of their practice. Hence, they are stigmatized (FRHS003). Further, some churches are said to be preaching against traditional healers, thus exacerbating the stigma towards them in the community (HUHS001).

From the above data there seems to be some looming problems with the collaboration between medical practice and traditional healing practice. While there is a stigma associated with traditional healing practice, people continue to consult them, mostly in secret as demonstrated by the Median=1.78 (agree to strongly agree) in Table 1 above. One wonders whether this secrecy in the consultation of traditional doctors is good for the general health of the patients. Earlier, I identified three motivations behind the collaboration of healthcare systems, which I distinguished as 'the absence of conflict' motivation, 'the absence of medical resources' motivation, and lastly, 'the complementary' motivation perspectives. It appears that the first two motivations towards collaboration may not help to address the problem of embarrassment noted here by the health seekers. Instead, these two types of motivation may perpetuate the embarrassment and secrecy in the patients' consultations with alternative health care. For example, where patients sense some possible conflict between their religious beliefs and modern medicine, they may continue to secretly use such traditional 'reliefs' (like traditional *muti*/medicine). But if they are aware that there is a close complementary collaboration between medical doctors and traditional healers in the community, this may help to arrest the problem of embarrassment towards the use of traditional health systems, and perhaps even help them to speak openly and avoid unnecessary secrecy.

In fact, from the responses of the health seekers on the next question, one may deduce the problems of this secrecy. The next question (question 3) was on the views of health seekers on open discussion of their use of traditional medicine and services. While a few respondents actually affirmed that their medical doctors or nurses asked them about their beliefs and use of traditional medicines, most respondents stated that they are never asked about these (M=3.78, disagree). However, most of the respondents felt that it is important for medical doctors and nurses to ask for this information (M=2.61). From the data obtained through interviews, health seekers gave the following as what they perceive as the reasons why medical practitioners should inquire of the history of the patients' consultations with traditional healers. The respondents argued that if medical practitioners were to inquire on the history of the patients' consultations (including their prior consultations with traditional healers), they will know how best to treat these patients having understood their medical background (FRHS001, BOHS002, and FRHS001). Further, the medical practitioners will be able to appreciate the faith of their patients (BOHS001). Due to their understanding of the entire medical history of the patient, they may be able to avoid administering medication which will be contrary to, or which may react with the traditional medicine that the patients may still be taking (TSHS001).

The reasons forwarded by the health seekers then seem to suggest that it is necessary for medical practitioners to collaborate with traditional healers, if anything, for the sake of the good health of the patients. If there is lack of collaboration, then there may be some gaps in the information which health seekers perceive necessary for their health. Going back to the motivations for the collaboration as discussed in the first sections of this paper, it appears that health seekers are aware of the fact that from time to time, the medical practitioners may have to deal with extant contradictions between the medical plan recommended by the physicians and the religious background of the patients. Hence, we

see responses that suggest that when there is collaboration, "The medical practitioners may be able to avoid administering medication which will be contrary to, or which may react with the traditional medicine that the patients are still taking" (TSHS001). Such a response suggests the importance of the 'complementary' motivation to the collaboration above the other motivations discussed.

This complementary perspective to the collaboration of different healthcare systems is in fact buttressed by the view of the health seekers where they argued that there are certain diseases and health problems that are better dealt with by medical practitioners and those which are better attended by religious specialists like traditional doctors or pastors. They argued for example that there are certain diseases like *phogwana* (sunken fontanelle in babies), traditional poison (*sejeso*), epilepsy (*mototwane*), stroke (*go swa mhama*), syphilis (*rasephiphi),* some sexually transmitted infections (*Go lomiwa*), migraine headache (*tlhogo e tona*), which are better attended by the traditional healers. The table below shows some of these responses. Just as Table 1 above, the results are taken from the quantitative data, which was presented in a Likert scale of 1 to 5, 1 representing strongly agree, while 5 denoted strongly disagree.

Table 2: Health Seekers' Views on Medication

View	**Mean**
When you are ill you always seek help from the hospital/clinic first.	1.55
When you are ill you always seek help from the traditional healer first.	4.11
When you are ill you always seek help from the faith healer (*moruti*) first.	3.02
When you are ill, the type of illness determines where I first seek help.	2.62
Your religion encourages the use of modern medicine	1.72
Your faith encourages the use of healing water, oil or powers from faith healers	2.42
Your religion encourages the use of traditional herbs	3.67
Use of any medicine shows lack of faith in God's healing power.	3.88
A doctor/nurse can treat BP, diabetes and cancer.	2.34
A doctor/nurse can treat mental illness	2.61
A doctor/nurse can treat *thibamo* (when a baby is in a breech position at childbirth)	3.24
A doctors/nurse can treat *boloi* (witchcraft)	4.54
A doctor/nurse can treat *phogwana* (sunken fontanelle in babies)	3.67
A doctor/nurse can treat *boswagadi* (widowhood-related disease)	4.35
A faith healer can treat BP, diabetes and cancer.	3.23
A traditional healer can treat BP, diabetes and cancer.	3.82
A faith healer can treat mental illness.	2.98

The results reveal that health seekers agreed that modern medical services can treat such health problems like BP, diabetes and cancer (M=2.34) and mental illness (M=2.61). They were neutral when it comes to medical doctors' ability to treat *thibamo* (when an unborn baby is in a breech position) (M=3.24) and out rightly disagreed that they can treat *boloi* (witchcraft) (M=4.54), *phogwana* (sunken fontanelle in babies) (M=3.67) and *boswagadi* (widowhood-related disease) (M=4.35). It can be gathered from these results that whilst respondents confirm medical practitioners' capability in treating BP, diabetes, cancer and mental illness, they however, doubt these practitioners' ability in healing Setswana (traditionally) related diseases. These views seem to underscore the need for collaboration of different health practitioners in order for them to complement each other in the promotion of the health of the communities.

In the next section, the collaboration of different health systems is discussed from the experiences of health seekers with faith healers.

Consultation with Faith Healers/Church Pastors

Most respondents said that their churches practiced faith healing through use of mediums such as water (either from the rivers or just tap water) (HUHS001, and FTHS003), oil (GAHS001), *diwacho* (holy ash) (MAHS002), and tea (BOHS001). While a few respondents stated that they only seek health services from their church (TSBHS001, and FTHS003), many of the health seekers stated that they actually seek for health services from other churches as well (HUHS001, GAHS001, and FTHS002).

On the question whether health seekers secretly consult faith healers, it may be interesting to note that unlike in the case of traditional healers, those who consult with faith healers pointed out they are never embarrassed to confess that they seek help from faith healers. Therefore, they do not consult faith healers in secret. This will imply that within the communities under investigation, the stigma attached to consulting traditional healers is not found with consulting church pastors. Besides the view that traditional healers are usually associated with witchcraft as stated above, it is worth noting too that some respondents mentioned that the churches themselves preach against the consultation of traditional healers.

Notwithstanding the above, some respondents pointed out that those who secretly consult faith healers do so because some of the prophets that are consulted are uncertified or their churches are not legally registered (TSHS001). Others secretly consult faith healers because they fear that they may be criticized by their pastors and fellow members for asking for spiritual help from other churches (BOHS001, and BOHS002). For example, one respondent said that the reason for secretly visiting other churches for help is that, "…sometimes members are afraid to disclose that they got assisted from other churches because it will show that the other church is more powerful than theirs" (BOHS001). While the study focused on collaboration between the three health systems, the modern medicine, traditional healing, and faith-healing, this latter comment presents an interesting challenge in the collaboration among churches themselves. Collaborations at this level may be challenged due to denominational competition, the 'more powerful than thou' mentality, which seems to present an obstruction for health seekers to seek for help in the different extant churches.

The health seekers were asked whether they are open to discuss with their medical doctors concerning the use of faith healing remedies. The interviews revealed both affirming responses, (that is, cases where doctors and nurses actually asked their patients of their beliefs and use of faith healing) and denying responses. All the respondents, however, affirmed that they would want their doctors or nurses to ask about their beliefs and use of faith healing. They provided the same reasons given under the consultation of traditional doctors. For instance, they noted that by asking the patients of their history with other health systems, this may avoid a situation where the medication prescribed works contrary to substances that the faith healers have recommended previously. Further, they pointed out that if doctors converse with patients regarding their faith, this may create confidence in the patients, rather than embarrassment when they consult their faith healers.

It is important to note that among those who seek health service from churches, there was a more holistic approach towards health seeking, that is, the respondents would go to the hospital or clinics and then go to the churches if the problem persists (MAHS002, and FRHS001). This is depicted in responses like, "First, I consult modern medical practitioners then I go to church" (FTHS001 and FTHS001). Another related response was that "I first go to the clinic for a diagnosis. If it's possible, then I go to the church then traditional healers, checking where I can get better and be healed" (MAHS002). The same respondent argued that it is important to seek modern medical attention in order to obtain some diagnostic facts on the sickness one is suffering from rather than just assuming spiritual causes, such as witchcraft. Quantitative data too, confirmed the predominance of a holistic approach to health among health seekers, in that most health seekers agreed (M=2.62) that when they are ill, the type of illness determines where they first seek help. These comments too seem to emphasize that according to the health seekers, the best model to the collaboration of different health systems in the community is one based on a 'complementary' motivation discussed in this paper.

Conclusion

From the findings of both traditional medicine and faith healing, health seekers are of the view that there has to be collaboration between medical practitioners and alternative health systems, that is, traditional doctors and faith healers. The stigma attached to consultation of alternative health systems especially traditional healers does not seem to be helping the delivery of health for the patients. The findings suggest that when openness is encouraged, such that health seekers are free to discuss with their medical doctors about the kind of assistance they obtained from other health systems, this will be a step ahead in the right direction. Collaboration between medical doctors and other alternative health providers will help all parties involved to contribute positively to the health plans of the patients. The findings from the study seem to support the 'complementary' motivation model to the collaboration of medical practitioners and religious specialists in the community. This is a collaboration where the significance of alternative health systems is not dependent on nor justified by the absence of modern healthcare. Instead, alternative health systems are seen as timeless partners to modern medicine for as long as religious beliefs are part of human existence.

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