TENSIONS IN THE BROKERAGE ROLE Nurses in Botswana¹

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In recent years, concern about the delivery of health services in developing nations has led to a reaffirmation of the role of traditional specialists as health care providers. This reaffirmation of the traditional specialist's role became officially sanctioned at the World Health Organization's Alma-Ata Conference on Primary Care in 1978 (World Health Organization, 1978a). Because the thrust of primary care, as defined by WHO (World Health Care Organization, 1978a), stresses a community-based approach, WHO made a number of recommendations in regard to the possible use of traditional specialists in primary care (World Health Organization, 1978b). Thus, one report included the recommendations that (1) biomedical personnel and students should be acquainted with the principles of traditional medicine and (2) that traditional healers should be retrained for appropriate use in primary care (World Health Organization, 1978c). The first recommendation assumes that biomedical students and personnel, in a given developing country, are not acquainted with the principles of traditional medicine in their country. The second recommendation suggests that the traditional specialists want retraining, that they want to be a part of the biomedical system, and that retraining them for use in biomedicine will make traditional specialists more acceptable to biomedical practitioners. Despite the sanctions of WHO and other funding agencies, the number of programs in developing countries that incorporate traditional specialists into the biomedical system remains small (Pillsbury, 1982).

A number of reasons have been advanced in an effort to understand the problems inherent in linking traditional specialists with the biomed-

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cal system. Neumann and Lauro (1982) note that a major complication to cooperation between ethnomedical and biomedical systems is caused by plural medical systems. *Ethnomedicine* refers to that domain of indigenous medicine that is not precisely derived from the conceptual framework of biomedicine (Hughes, 1968). *Ethnomedical systems* like biomedical systems are "a patterned interrelated body of values and deliberate practices governed by a single paradigm of meaning, identification, prevention, and treatment of sickness" (Press, 1980, p. 47). Ethnomedical and biomedical systems may be mutually influencing; however, their basic values are part of the sociocultural context in which they originate. As a result, identifying and determining which ethnomedical practitioners should be involved in primary care is a problem. Pillsbury (1982) cites structural reasons, for example, lack of implementation of national policy, few evaluation studies on the efficacy of incorporation, and the differing priorities of key decision makers, as sources of resistance to the linking of ethnomedical and biomedical practitioners.

This article reports the results of a qualitative study of the primary roles of nurses in Botswana. The intent of this research was to develop a conceptual explanation of the nurses' views of collaboration with ethnomedical practitioners. This article discusses some of the sociocultural issues that must be recognized before cooperation can occur among health care practitioners in general and, more specifically, in Botswana. It is argued that nurses, the pivotal group of biomedical practitioners in Botswana, occupy the role of primary brokers between traditional *baTswana* culture and biomedicine and that the dialectical tensions generated by the role of broker have caused the nurses to evolve a new synthesis in regard to the place of ethnomedicine in Botswana. The description of nurses in Botswana and how they have dealt with the dialectical contradictions inherent in their role is used as a heuristic device to suggest a basic contradiction in the primary care nurse practitioner's role here in the United States and proposes some possible options for dealing with these contradictions. The questions that guided this study included: (1) What are the primary care roles of nurses in Botswana? (2) How do nurses in Botswana articulate with ethnomedical practitioners in Botswana? (3) Are nurses in Botswana willing to collaborate with ethnomedical practitioners? (4) If they are unwilling to collaborate with ethnomedical practitioners, what are the reasons for their unwillingness?

DATA COLLECTION AND ANALYSIS

The data in this article are derived from anthropological fieldwork in Botswana from 1975-1976. Primary data collection sites include Gaborone, the capital, and Serowe, a large village (population approximately 25,000) in the northeastern section of the country. Methods of data collection included participant observation, observation, and interviews both formal and informal with key informants. Data were collected using field notes. Participant observation was done at both hospitals and rural clinics. Nurses from all levels of the nursing hierarchy were interviewed. Archival research was conducted at the Botswana National Archives and the Hoover Institute for War, Peace and Revolution, Stanford University, Stanford, California.

THE RESEARCH SETTING

The Republic of Botswana is located in Southern Africa. Its total area is about the size of the state of Texas. Completely landlocked, it is bordered on the west by Namibia, on the south and southeast by South Africa, on the northeast by Zimbabwe, and on the north by the Capriva Strip. Geographically, Botswana is part of the southern Central African Plateau and is 3,300 feet above sea level. In the central and southwestern portions of the country, the plateau forms a shallow basin that is occupied by the Khalahari Desert. A semiarid region, the Khalahari makes up approximately two-thirds of the country. The climate in Botswana is generally subtropical. The bulk of the population lives in the eastern part of the country where the highest rainfall, more productive soil, and better grazing land are found. The *baTswana* are pastoralists and agriculturalists. Although generally regarded as a nation of cattle raisers, cattle wealth is unevenly distributed, and a large part of the population is poor. The majority of the *baTswana* live in rural villages, some of which are quite large. Most of the principal villages, where the chiefs have their headquarters, are quite large. The custom of living in large villages has resulted in the *baTswana* adoption of a system of cattle posts and agricultural lands that are appendages to, but great distances from, the village. The principal languages spoken in Botswana are English and *seTswana*.

Biomedical Health Care

The biomedical health care system in Botswana is geared to meet the needs of the country's rural-based population. In the village of Serowe and the surrounding areas of the Central District, biomedical care is provided by both the central government and the Central District Council. The system operates on the premise of hierarchical referral. At the top of the hierarchy are the hospitals. The hospital in Serowe operates under the auspices of the central government. Like all hospitals in Botswana, it serves as a referral center for patients from other biomedical facilities. In addition to providing curative care, the hospital provides preventive care through its ante- and postnatal clinics and tertiary care through its tuberculosis clinic. Next on the referral hierarchy are health centers. Because they are generally located in rural areas far from hospitals, health centers have beds for both maternity and general patients. Better equipped than clinics, the health center offers both curative and preventive care. On the next level of biomedical care are the clinics. Clinics offer outpatient services, preventive care, and most have beds for maternity patients. Most clinics are in the rural areas. The lowest level in the biomedical hierarchy is occupied by health posts. Health posts are equipped to provide a minimum level of curative care, for example, cough syrups and aspirin.

Biomedical Personnel

The three major cadres of biomedical personnel are physicians, nurses, and Family Welfare Educators. At the time of this study, there were approximately 65 physicians, over 400 nurses, and an estimated 60 Family Welfare Educators in Botswana. Approximately 50 of the physicians worked in government hospitals. Of the physicians employed in the government hospitals, 90% were expatriates. Nurses make up the largest number of biomedical personnel in Botswana. The overwhelming majority of the nurses are women, and with the exception of a few expatriate volunteers, they are all either *baTswana* or African recruits who speak *seTswana*. Nurses are frequently referred to as the "backbone" of biomedical care. Two levels of nurses are prepared in Botswana, enrolled nurses (ERNs), similar to licensed practical/vocational nurses in the United States, and registered nurses. Enrolled nurse programs are 2 years in length and cover the same areas as training

programs for registered nurses. The basic differences between the two are that enrolled nurses do not receive as much in-depth training as registered nurses and they are trained to work under the supervision of a registered nurse. Enrolled nurses who receive a merit pass in their posttraining examinations have the opportunity to take a 2-year midwifery course. Enrolled nurse programs are operated by the Ministry of Health in four of the government hospitals.

The other level of nurses prepared in Botswana is registered nurses. Registered nurses are prepared at the National Health Institute of Gaborone. The registered nurse program is 3 years in length and stresses maternal and child health, public health, and mental health. After completion of the program, all registered nurses automatically proceed to midwifery. All registered nurses in Botswana are trained as midwives because they deliver babies in the rural biomedical facilities. Unlike other countries, the *baTswana* do not use traditional birth attendants. In addition to the program that prepares registered nurses, there is a 3-year program at the University of Botswana that prepares registered nurses to become tutors of nursing (H. Karujhe, 1983, personal communication).

The bulk of the nurses in Botswana work for either the central government or the District of Councils in the hospitals and rural biomedical care facilities. These rural facilities are staffed exclusively by nurses and auxiliary personnel. On their initial visit to rural biomedical facilities, patients are seen by a nurse who takes a history of their complaints. Most of the patients are diagnosed and treated by nurses. Those patients who do not respond to treatment are referred to the physician who visits fortnightly. Patients with difficult complaints, for example, urinary retention, congenital deformities, and advanced cases of tuberculosis are referred to the hospital by either the nurse or the physician.

For nurses there are a number of problems associated with working in the rural clinics. Transportation is erratic at best. There is also a lack of equipment and supplies. In addition to seeing patients, nurses also deliver babies and conduct the family planning, child welfare, and antenatal clinics. Their duties in the child welfare clinic include weighing children, advising mothers on diet and hygiene, and giving immunizations. In the antenatal clinic they weigh the prospective mothers, take their blood pressure, test their urine, record the height of the uterus, and listen to fetal heart tones. Nurses also visit the surrounding villages and give immunizations.

Although the nurses lack the large number of diagnostic instruments that characterize biomedicine in the United States, they meet two of the most critical conditions needed to make a diagnosis. First, they share the same sociocultural system as their patients. Thus, they are able to ascertain whether their patients have been seen by a ethnomedical practitioner. Second, because they share the same sociocultural system and language as their patients, communication is greatly enhanced. As a result, the nurses are able to get more detailed and more accurate health histories than expatriate physicians who neither speak *seTswana* nor share the same sociocultural system as their patients. These histories provide the bases for diagnoses.

In Botswana, nurses and Family Welfare Educators (FWEs) are the persons who carry the health message to the people. FWEs are trained at Sebele Training College near Gaborone. These workers are recruited from their villages by the district councils. The requirements to be an FWE are woman, over the age of 20 with at least one child, ability to speak English, and completion of the seventh grade in school. In a 3-month training program, FWEs take basic subjects in first aid, nutrition, family planning, health education, public health (e.g., home visits), diagnosis of simple ailments (e.g., scabies), and community development and social problems. The work relationship between the FWEs and the nurses is a close one. In their work, FWEs refer patients to the nurse.

Ethnomedical Practitioners

It is important to note that, traditionally, the *baTswana* do not make the separation between religion and healing that is usually made in biomedicine. The overall religious belief system of the *baTswana* and the function of this belief system in their lives, will not be discussed in this article.

The ethnomedical system that coexists with biomedicine in Botswana is composed of two major groups, traditional specialists (*dingaka*) and spiritual healers (*dingaka tsa metse*). There are two basic types of traditional specialists—herbalists and diviners. The largest group of traditional specialists are diviners. Diviners diagnose through bone casting and use various herbs in their treatments. Bones (*diatola*) are used by diviners for a variety of purposes. However, in treating sickness, diviners use their bone-casting skills for three major purposes. These

purposes are to determine what is wrong with an individual; to decide whether they can treat an individual or whether the person should be referred to a hospital; and to place an individual's symptoms within a social context, that is, to determine the sociocultural cause of an illness.

In the Serowe area, traditional specialists are men and women who learned their skills from serving an apprenticeship with another healer. Most have been working as independent practitioners for 20 years or more and are 50 years of age or older. Social and cultural transformations in *baTswana* society have created a number of problems for the traditional specialists. The combination of a general lack of apprentices, people not paying their fees, and the competition from spiritual healers have caused the traditional specialists concern about the fate of traditional medicine (*bongaka*) in Botswana. For the most part, traditional medicine is surrounded by secrecy. A major reason for the secrecy surrounding traditional medicine is the pervasive *baTswana* belief in the practice of sorcery. Belief in the practice of sorcery is closely connected with the diviners' use of bones and herbs.

The *baTswana* believe in the practice of sorcery (Evans-Pritchard, 1937). This is not to imply that the *baTswana* are obsessed with sorcery. Within the context of the *baTswana* society, sorcery is a danger that must be faced almost daily (Schapera, 1952a, 1952b). Just as in the United States, we believe that colds can be avoided by exercising certain cautions, the *baTswana* believe that precautions can be taken that are protective against sorcery. As Schapera (1952a, 1952b) notes, the *baTswana* believe that people practice sorcery and that those who practice it are well aware of what they are doing. Furthermore, they believe that any person, male or female, might practice sorcery. In the past, sorcerers and their victims were closely related; sorcery was usually employed in settings of domestic conflict, and the major motive was jealousy. Today, although the major motive for the practice of sorcery remains jealousy, the network for sorcery accusations has extended to include nonkin.

The *baTswana* belief in the practice of sorcery primarily revolves around a condition known as *sejeso*, or *Tswana poisoning*. This poisoning consists of putting some lethal substance in a person's food or drink. The food or drink is then given to the person to be harmed. The *baTswana* connect diviners to sorcery in three ways. First, they believe that diviners can be hired to impose sorcery on an intended victim. Second, they believe that the herbs used in sorcery can be purchased from a diviner. Third, the diviners use the bones to determine whether a

person has been deliberately harmed by another. Although diviners deny practicing sorcery, a number of them say that they can determine whether a person has been ensorcelled and by whom from the bone. However, the *baTswana* reason that anyone who can diagnose sorcery can also perform it.

Spiritual healers (*dingka tsa metse*) are a relatively recent group of ethnomedical practitioners. Historically, spiritual healing in Serowe evolved from African Christian churches of the Zionist and Ethiopian types in South Africa (Barbee, 1979). One important fact about spiritual healers is that they are not independent practitioners. All of them are associated with African Christian churches. Although some healers see patients in their homes, they essentially do their healing under the aegis of some church. In Serowe, the church leaders have syncretized *baTswana* purification rites and taboos with the Christian ritual and emphasize faith healing. In the Serowe area, there are two types of spiritual healers. The first type uses prayer only in healing. The second, far more numerous type, uses prayer in combination with water and ashes. Unlike the diviners, very few of the spiritual healers are trained for their positions. Most became healers as the result of some former experience that "called" them into spiritual healing. Most of these experiences were illness experiences that the healers referred to as *mental illnesses*.

In their diagnoses of illness, spiritual healers depend primarily upon an elicitation of the patient's symptoms, prayer, and opening the Bible. Basic to the treatment approach of spiritual healers is the use of blessed water and prayer. As an adjunct to the use of water, many healers add ashes to the water. The majority use *sewasho*, the ash of cow dung. Several healers say that they use cow dung because cattle eat all types of herbs and grasses.

With two exceptions, both traditional specialists and spiritual healers treat the same symptoms in both adults and children. Spiritual healers specialize in treating chronic disorders, whereas traditional specialists specialize in treating the cause and effects of sorcery. Spiritual healers are most often found in large villages and urban areas because most of their churches are in large population areas. Traditional specialists, like the biomedical system, are more widely dispersed. As component groups of the ethnomedical system, traditional specialists and spiritual healers do not cooperate with each other. The basic relationship between the two groups is one of competitive antagonism.

Patterns of Utilization

Unlike the people of many African countries (Janzen, 1978; Maclean, 1966; Twumasi, 1975) *baTswana* adults do not use herbal remedies for the treatment of common illnesses. When the *baTswana* suffer a common illness, they are quick to use patent medicines. In terms of healing, the *baTswana* recognize the existence of biomedical specialists, traditional specialists, and spiritual healers, and they choose differentially from among these three categories. Each of the three groups of practitioners is viewed by health care consumers as having a particular area of expertise. Thus, trauma, accidents, pregnancy, and birthing are viewed as the province of the biomedical system, and more specifically of nurses. Spiritual healers are seen as specialists in mental illness. The major role of the traditional specialists is viewed as treating the cause and effects of sorcery. Collectively, the *baTswana* believe that all of the groups are competent in treating the same illnesses. However, they do not believe that all three are equally competent to treat all illnesses. In terms of choosing either the biomedical or the ethnomedical system, the *baTswana* base their choice upon their particular illness, the reputation of the practitioner, and their faith that a practitioner can cure their illness. Faith in the efficacy of a particular practitioner requires that the patient not take medications from any of the two systems concomitantly, because the medicines from one would negate the effects of the other. Furthermore, those who use spiritual healers do not go from them to traditional specialists. However, patients who have used traditional specialists feel free to use the ethnomedical system and also the biomedical system.

DISCUSSION

The structure of the biomedical care system in Botswana, with its emphasis on hierarchical referral, places nurses at the critical juncture in the referral network. In the rural biomedical facilities, nurses initiate all referrals to the physician and many referrals to the hospital. Nurses are also at the critical juncture in the hospitals, for it is they who interpret patient complaints and needs to the expatriate physicians. The majority of nurses in Botswana are *baTswana*. Those who are not are *seTswana*-speaking Africans from South Africa. The nurses hold beliefs about health and illness from two domains, that of their culture and that of

biomedicine. This dual belief system, coupled with the nurses' presence at the critical juncture in the biomedical referral network, places the nurses in the role of primary broker between traditional *baTswana* culture and biomedicine.

The position of brokers is an exposed one, because brokers must serve some of the interests of groups operating on both the community and national levels (Wolfe, 1956). In this exposed position, the brokers must cope with the conflicts raised by the collision of these interests. In the rural areas, nurses are community-based members of the biomedical system. As a result, they mediate between the community and the biomedical system.

In their formal and informal dealings with the people, nurses share the same *baTswana* cosmology about health and illness as do the people in the community. At the same time they also hold the biomedical beliefs about health and illness. When the two come into conflict, it is the nurses who act as buffers between the two systems. For example, all the nurses believe that it is a waste of time for patients to seek care from traditional specialists and spiritual healers before seeking biomedical care. However, they also say that denigrating patients for seeking care from the ethnomedical system serves no useful purpose for the biomedical system. In their position as brokers, nurses in Botswana appear to have a greater investment in biomedical beliefs about health and sickness than those of traditional *baTswana* culture. This investment is exemplified by the nature of their complaints. The nurses' complaints concern lack of staff, lack of equipment and supplies, and obstacles to independent practice. The overall focus of their concerns is with factors that they believe intervene with the delivery of biomedical care. This same investment in biomedical beliefs about health and sickness affects their views about cooperation with traditional specialists and spiritual healers.

The nurses are essentially ensnared in a dialectic between traditional and biomedical beliefs. The tensions created by being involved in this dialectic serve to make the nurses extremely ambivalent about cooperating with traditional specialists. Camaroff (1981) identifies three ideological positions available to *baTswana* in South Africa caught in the dialectic between their culture and the wider world. These three positions are (1) reject *baTswana* culture and identify with Western culture, (2) assert the primacy of *baTswana* culture and adopt only useful Western concepts, (3) pursue assimilation of *baTswana* and Western ideology. As an example of the third alternative, Camaroff (1981) gives the syncretism that is exemplified by the Zionist sects.

In Botswana the nurses have mediated the basic contradictions created between their traditional cosmology and their biomedical beliefs in two major ways. A small number of nurses have chosen to reject their culture. These nurses assert the primacy of biomedicine and negate the value of traditional medicine. The majority of nurses have syncretized a position of peaceful coexistence that is based upon the empirical nature of *baTswana* society and with their experiences with traditional medicine. Thus, most of them believe that there is some value in traditional medicine. Those who assert the value of traditional medicine base their beliefs upon empirical evidence, that is, people they know who have been cured by traditional specialists. However, regardless of their ideological position, *all* of the nurses believe that there is a strong connection between traditional specialists and sorcery. As a result, the nurses are either against cooperation with traditional specialists or they believe that use of a traditional specialist is a patient's private affair. In their view, cooperation means that traditional specialists should refer patients to biomedicine, not the reverse.

Socialized in both traditional and biomedical beliefs about health and illness, these nurses are ambivalent at best about cooperation between traditional specialists and biomedicine. Bailey (1969) characterized *brokers* as persons who profit materially from their position. In Botswana, the nurses' ambivalence about cooperation with traditional specialists suggests that brokers do not always profit materially in their role. For them, the broker role creates a dialectical tension that results in either ambivalence toward or rejection of their traditional beliefs. The nurses do not wish to cooperate with spiritual healers, because they view them as being more "religious" than health care providing. That is, they view the role of the spiritual healer as being analogous with religion.

The nurses' view of collaboration with spiritual healers is to allow the healer to come and pray for patients. In general, the nurses have minimal knowledge about the practice of spiritual healing. In a sense, the nurses could be accused of separating religion from healing and thereby violating a *baTswana* tradition. The nurses' view of spiritual healers may be influenced by their social class. Nursing is considered a middle-class occupation in Botswana. Although the nurses identify themselves as "Christians," they do not attend African Christian churches. However, they do attend churches that were originally established by the missionaries.

Those nurses who do not completely reject traditional specialists do not seem to separate healing from religion. Several of these nurses stated, "They [traditional specialists] are a part of our religion."

Although they may recognize the traditional specialists as a part of their religion and accept that traditional specialists heal some people, the pervasive belief in the sorcery precludes nurses from desiring to cooperate with traditional specialists.

CONCLUSION

The situation of nurses in Botswana provides us with a different perspective that may prove to be useful in examining the dialectical tensions present in the nurse practitioner's role. It also provides us with a conceptual base from which to examine how primary care nurse practitioners deal with the contradictions and the tensions that emanate from these contradictions by examining the options that various primary care nurse practitioners exercise in dealing with these contradictions and tensions. A parallel situation exists in the United States in regard to primary care nurse practitioners and the contradictions between medicine and nursing. The basic purpose of medicine is the diagnosis and treatment of disease. On the other hand, "the primary purpose of nursing is to assist people to *cope most effectively with actual or potential changes in daily living and self-care*" (Mitchell, Cammermeyer, Ozuna, & Woods, 1984, p. 5). The content of the dialectic for nurse practitioners, although different from that of the nurses in Botswana, is quite similar in form. Today nurses are educated about the unique strengths of nursing as a discipline and the differences between nursing and medicine. How primary care nurse practitioners will mediate the basic contradictions between these two professions in light of their differences remains to be seen. However, the data from Botswana and South Africa suggest that there are three options open to them: (1) reject nursing and identify with medicine, (2) assert the primacy of nursing and adopt only those medical concepts that are necessary for their practice, or (3) pursue an assimilation of nursing and medicine that will in effect create a new discipline.

NOTE

¹The research on which this article is based was part of a larger project, *Continuities Between the Practices of Traditional and Scientific Botswana Health Care Practitioners*,

Oliver H. Osborne, Principal Investigator, and was funded by the African American Scholars' Council.

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