CHAPTER I

INTRODUCTION AND GENERAL BACKGROUND

1.1   INTRODUCTION

The health care system needs the support of the community to ensure that health services are utilised. The community members know best what their health problems are and they may even know or suggest ways to solve these problems.

The relationship between the health care system and the community should ideally be a symbiotic one. It is usually assumed that all community members will use the services provided by the health care system. This assumption is not always true. A community may decide not to use health care services for numerous reasons.

When a client arrives at a clinic or hospital, there is an implied intent to use whatever services are available. At this point the client has to some extent disregarded or overcome some barriers, e.g. cultural beliefs that could have prevented him / her from using the health care system. At community level barriers to utilisation of health care services are present in one form or another. They may be cultural, economic or environmental (Haggart 2000:11-12).

The Botswana health care system has a primary health care oriented philosophy, while the individual in the community may have a philosophy that is grounded in culture or religion.

The divergence in philosophies may lead to the provision of inappropriate or inadequate professional health care services making the individual turn to traditional health care based on religion or traditional beliefs and practices for their health needs.

This study examined the beliefs of the Africa Gospel Church and how they influence health-the seeking behaviour of its members.

1.2 CONTEXTUALISING THE STUDY

The geographical area involved in this research is Francistown, Botswana.

1.2.1 Geographical background of Botswana

Botswana is a landlocked country sharing borders with South Africa, Namibia, Zimbabwe and Zambia. The Tropic of Capricorn runs through Botswana. About two-thirds of the country is semi-desert lands (Ministry of Finance and Development Planning 1997:3). Rain falls mostly in summer i.e. October to April and temperatures range between -5^{oC} in winter and 43^{oC} in summer. The climate and soils of Botswana support mostly cattle farming and limited crop production.

Botswana's mid-year population for 2003 is estimated at 1 780 000. It is a multi-ethnic population comprising the Tswana, Bakalanga, Basarwa, Baherero, Asians and Caucasians (Ministry of Finance and Development Planning 1997:3-10).

During the course of the National Development Plan 7, the mining industry contributed over 30% of the Gross Domestic Product, over 70% of national export earnings and nearly 50% of Government revenues (Ministry of Finance and Development Planning 1997:259).

Francistown, where the study was done, is the second largest city in Botswana. It is situated in the north-eastern area of the country. Visitors from Zimbabwe, Zambia, and other North African countries pass through Francistown by road. For many tourists, it is a point of departure for Maung, Kasane, and the Okavango Delta in the northwest of Botswana.

1.2.2   Ethno-history of the Africa Gospel Church

A study of the history of the foundation of the Africa Gospel Church may help towards understanding the health seeking behaviour of its members. The ethno-history of the church is briefly presented here.

1.2.2.1   Foundation of the Africa Gospel Church

The Africa Gospel Church is a breakaway sect of the Apostolic Sabbath Church of God, which was first established in Botswana in 1951. The church started in the then Rhodesia in 1932, and it was known as the African Apostolic Church at that time. Johane Masowe, the founder of the church, was born in Rhodesia in 1915, and died in Tanzania in 1973 (Isichei 1995:225). However, Sundkler and Steed (2000:814) state that he died in Zambia, and was buried in Rusape. He was referred to as "John of the Wilderness" (Isichei 1995:255) and also as "John the Baptist" (Hastings 1994:520). He is reported to have changed his mode of dress and started wearing long white gowns, and carried a staff and a Bible.

Johane Masowe claimed that he had been resurrected and had been instructed to lead the people (Amanze 1994:5; Tshambani 1979:7). The most likely explanation for this resurrection may be that Johane Masowe had a near death experience. (Isichei 1995:255). During this period, the then Rhodesia was under colonial rule, and the locals experienced this as an oppressive political dispensation. Johane Masowe criticised the government, including the mission churches that were established by the white settlers, namely the British. The criticism culminated in his arrest in 1934 and his followers then named him the "*black Christ*" (Tshambani 1979:8). After his death the church split into three, forming the Africa Gospel Church, the Gospel of God Church and Johane Church of God (Amanze 1994:6). Members of these churches are sometimes referred to as Va Postori or Mazezuru.

1.2.2.2   Perspectives of the Africa Gospel Church

The Africa Gospel Church's beliefs about the settlers' religion are similar to Karl-Marx's view that religion acts as a mechanism of social control, maintaining the existing system of exploitation and reinforcing class relationships (O'Donnel 1997:531). Historically, the Church's religious doctrine was based on the Old Testament. They observed its prescriptions on diet, and they kept the Sabbath. Women wore white gowns and turbans and men kept beards and shaven heads (Isichei 1995:256). These practices are still evident today. The Church was rebellious of anything that was not African. They considered their language, Shona, to be the holy language (Tshambani 1979:11). In his research of the Va Postori of Francistown during the 1970's, Tshambani found that polygamy was acceptable and that marriage was endogamous. The ruling on endogamy was changed in 1971 to allow for exogamy (Tshambani 1979:20). Formal education was discouraged because they did not want to mix with outsiders who did not belong to their Church.

The family provided informal education by teaching skills in basketry, carpentry, and metal work so that the Va Postori could be self-supportive in future to avoid working for non-church members. They considered themselves as Israelites, the chosen race, and would not work for non-Israelites. They believed that Africans were poor because of the greed of the European (Knut 1987:92). Although the Va Postori acknowledged the professional health care system, they believed that God heals all and can be reached though prayer. They also refused to immunise their children because of their religious beliefs.

Today the social conditions that were present when the Church was founded no longer exist in Southern Africa. The Botswana Government offers the individual rights to freedom of speech, worship, association and movement (Republic of Botswana 1966. Chapter 1:005). However, this does not mean that attitudes and beliefs have changed.

In this study, the researcher intended to clarify what the current beliefs of members of the Africa Gospel Church are and how they influence their health seeking behaviours. It is clear from previous research that the Church started as an antidote towards anything that was foreign to them and was therefore considered undesirable. It is imperative to understand the current beliefs of the Africa Gospel Church, and how its members view the professional health care system, as well as their health seeking behaviours. If the Africa Gospel Church still prohibits the use of professional health services this could impact negatively on their health. Children within the church could be susceptible to preventable diseases for which they could have been immunised. Women may also experience difficult pregnancies and complications at delivery due to lack of antenatal and postnatal care.

On the one hand, some of their beliefs and practices may be beneficial for the health of the members of the Church. It is important to explicate such beliefs and practices as it could form the basis for developing a culture congruent care strategy.

1.2.3 Dimensions of health care in Botswana

Government, through the Ministry of Health, predominantly runs the health care system in Botswana. There are three divisions under this Ministry, namely:

- Primary health care services,
- Hospital services,
- Human resources for health.

Clinics fall under primary health care and provide services to a large outpatient population. Hierarchically the system is arranged as follows:

- Mobile stop,
- Health post,
- Clinic,
- Primary hospital,
- District hospital,
- Referral hospital.

1.2.3.1   *Primary health care in Botswana*

The professional health care system in Botswana today is primary health care oriented (Ministry of Finance and Development Planning 1997:381). The philosophy of primary health care stresses the importance of involving the community in the development, implementation and evaluation of health services (Poulton 1997:31).

There are four underlying principles of primary health care, namely universal accessibility, community participation, intersectorial co-operation and the use of appropriate technology (Tarimo & Webster [Sa]: 3).

Apart from the professional health care system, a generic or traditional care system also exists. Leininger (1995:79) defines traditional or folk care as, "culturally learned and transmitted lay, indigenous (traditional) or folk (home care) knowledge and skills used to provide assistive, supportive, enabling, and/or facilitative acts (or phenomena) toward or for another individual, group, or institution with evident or anticipated needs to ameliorate or improve a human condition (or well-being), disability, lifeway or to face death". Those who utilise this system use traditional remedies, prescribed by traditional health practitioners, to treat themselves at home. They may also seek the services of faith healers and the clergy, including those who are associated with the Africa Gospel Church.

1.2.3.2   Health and illness: The African perspective

Before the introduction of professional health care in Botswana, the traditional health care system was in place. Traditional carers called *dingaka, (traditional doctors)* provided heath care. This phenomenon is still apparent today.

The mainstay of the African philosophy of health and illness is the reverence and respect of the ancestors (Buhrmann 1989:29). Ancestral spirits (*badimo*), God (*Modimo*), and witches and sorcerers (*baloi*) (Selelo-Kupe 1993:1-2) were, and still are believed to influence health and illness.

At this point it is imperative to discuss the concepts *Modimo, Medimo and Badimo*.

In the traditional religious orientation of the Batswana, Modimo was never conceived of as a person and this fact is borne out by linguistic evidence. Modimo was known as the beginning and the cause of human, animal and even world existence, but not as a human being and even less as a father. It is generally believed that the first Christian missionaries were responsible for injecting the idea of Person and father into the Modimo concept of the Batswana.

The existential experience of Modimo is that of very active energy, initiating action and maintaining interaction. Another dominant idea about the experience of Modimo is that it is the source of all life. Etymologically it will therefore be more correct to refer to "Modimo" as "divinity" or rather "it", rather than "God" or "Him".

The conception that the Batswana have of God is closely linked to their worldview. For the Batswana the maintenance of order in the universe is the central principle. The cosmos, gods, people and things, form a unity. This unity or totality not only forms the primordial foundation for everything but in itself also constitutes a being, an independent existence. The highest and most powerful existence is known as Modimo.

Modimo is identified with creation. Subsequently creation is put in the centre, is deified and personified and becomes creator itself. The logical outcome is that, because they are part of creation, the Batswana become part of divinity. The Tswana saying *Motho ke Modimo* (a person is Modimo) thus intimates that the human being shares that energy of force that is Modimo or divinity.

To the present-day Batswana, Modimo may either be a person or a power. These two expectations may also alternate. Modimo is the personification of the totality and as such "he" may be regarded as a person. However, it is also quite possible that "it" may be regarded as a power.

Since Modimo requires no cultic worship and appears to be rather inactive, "it" may on one level be regarded as far away and too remote to meet human needs. However, in a more mystic sense "he" is present always and everywhere, although he may not enter daily life at all in a practical sense (Krüger, Lubbe & Steyn 2002:42).

Traditionally the Batswana also knew a number of demigods or *medimo.* These partly divine beings were seen as manifestations of the Supreme Being. Since *medimo* linguistically constitute the plural of *modimo,* the latter is one of the demigods. *Modimo* would then be the most important among the *medimo,* but not the only one. At the same time the *medimo* are most probably regarded as personalities who came into existence through the personification of *Modimo*. They should then be seen as different aspects and attributes of *Modimo.* The *medimo* represent and personify *Modimo* in a way that brings the latter closer to the people (Krüger, Lubbe & Steyn 2002:43).

From the early missionaries onwards the tendency has been to associate the ancestors or *badimo* with divinity. However, the etymology of the word "*badimo*" suggests that they are people of *Modimo*. In real African experience the ancestors are people rather than gods. The known realm of activity of the *badimo* is among the

living. Therefore, the experience of contact with *badimo* is about interpersonal contact and does not refer to the appearance of a supernatural being.

The ancestor is a person, not a deity or spirit. The *badimo* are therefore not worshipped. The service that is rendered to the badimo is, in fact, of the same quality and level as that rendered to one's parent while they are living. The logic of this is that the *badimo* are merely our deceased parents.

On the other hand it would be untrue to represent the concept of *badimo* as so human as to strip them of divinity. *Badimo* are, as the word suggests, of *Modimo*, and therefore share in the essence of *Modimo*. The ancestors are people charged with divinity, as indeed every living person is. However, ancestors are no longer subject to the limitations of the flesh, the insights they communicate can therefore be relied upon as of   divine origin and never misleading.

The *badimo* are not *Modimo,* they do not compete with *Modimo.* And yet they are of *Modimo* in the same way as a person is of *Modimo.* Unlike the humans in the flesh, the *badimo* are perfectly moral, just and never partial. They are the guardians of the morality of the community (Krüger, Lubbe & Steyn 2002:43).

The Batswana have always believed in God (*Modimo*), the maker of heaven and earth, and they also believe in '*Badimo'* (ancestral spirits) (Selelo-Kupe, 1993:1). The spirits are believed to act as intermediaries between people and God. Failure to perform certain rituals is believed to invite the wrath of the ancestors who may unleash bad luck and illness on an individual. Bad luck may lead to a divorce, illness or loss of a job.

Illness is considered to be unnatural and is attributed to God's anger or the displeasure of the ancestral spirits. God is believed to punish those who break cultural taboos by withholding rain, and by causing illness or death. If a person follows tribal mores and norms, God and the ancestors would have no reason for displeasure, and the person would enjoy good health. Because illness is believed to occur as a result of a disturbance of the balance between people and spiritual or mystical forces, the aim of health seeking is to restore the equilibrium (Andrews and Boyle 1999:381; Buhrmann 1989:30). The Tswana still try to maintain this equilibrium through rituals called '*go phekola*' or '*go kgwa dikgaba*'. These rituals are practised to seek guidance, to appease offended ancestors so that the bad luck is cleansed and illness is healed.

Another explanation of illness is the influence caused by witchcraft. Witches are believed to cause illness by using medicine and charms against people about whom they harbour malicious feelings. The aim of treatment strategies is to combat the influence of witchcraft. This philosophy reflects the supernatural and sorcery explanatory models for health and illness (Andrews and Boyle 1999:246).

The biomedical explanatory model is science based, and disease is believed to be a result of specific identifiable factors that can be detected through diagnosis and manipulated through treatment. An individual who explains illness through this model is likely to seek assistance from the professional health care system as opposed to the traditional health care system. Factors that cause illness are considered to be "wear and tear (stress), external trauma (injury, accident), external invasion (pathogens), or internal damages (fluid and chemical imbalances or structural changes)" (Andrews and Boyle 1995:26; Giger and Davidhizar 1999:116).

Those who adopt the supernatural and sorcery explanatory models of health and illness believe that germs will not harm a person unless a catalyst is present in the form of *boloi* or displeasure of God or the ancestral spirits.

The holistic explanatory model suggests that there must be harmony within the body, as well as between people and the physical and social environment. The state of harmony would lead to health, and disharmony would lead to illness (Andrews & Boyle 1995:26-28). Lack of harmony in the social dimension may lead to strife, wars and injury, and pollution of the air may lead to illness. According to this model health as a goal may be achievable by maintaining a balance between all internal and external factors. Eating well, dressing appropriately, living in a clean environment, and maintaining good human relations are all considered significant contributors to health (Andrews and Boyle1999: 321-323; Butler 2001:3-10). Proponents of this model who are ill may want to address issues in their internal, social and physical environment in addition to seeking professional care.

For instance, in Botswana, traditionally cause of illness is attributed supernatural powers such as God's interventions or punishments by the ancestors. This may be as a result of people breaching cultural taboos. Illness is also attributed to witchcraft and demonic possession. Another explanation for illness is that it has natural causes such as natural substances, forces or conditions. This includes the presence of an imbalance or impurities in the body (Magesa 1997:172-173; Staugard 1985:68-73).

With this background it is clear that people of the Africa Gospel Church may have a unique view on the cause of illness.

It is imperative to consider such views when planning health care delivery. If service delivery is not congruent with people's explanatory model, they may be reluctant to utilise the services.

1.2.3.3 The Paradox

The Declaration of Alma-Ata states that health is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal… (Tarimo & Webster [sa]: 107). Rights are always accompanied by obligations. The individual and the government, through the health care system, must work together to ensure that people are healthy. It is commonly understood that government has an obligation to provide health care for its people. However problems may arise when the community and health professionals (including nurses) have different understandings of health, health promotion, and illness prevention and treatment, and when the professional health care system is not compatible with the understandings and expectations of health care consumers.

The problem arises when principles of paternalism and autonomy conflict. In the words of Kemm and Close (1995:33) "paternalism is taking decision on behalf of and in the best interest of others. Autonomy is allowing others to make their own decisions even when they harm themselves by doing so". When health policy states that immunisation is mandatory, it is being paternalistic, and when an individual refuses to immunise a child, he/she is being autonomous. Health professionals are entrusted with the mandate to ensure that services are accessible and to encourage all sectors of the community to participation in health care. However, people cannot be coerced into participation if they are not willing to be participants. This situation may lead to conflict.

If a small section of the community dissociates itself from using professional health care services this may endanger the rest of society. Communicable diseases in particular require participation from all in an attempt to eradicate or control them.

The researcher has learnt through experience in the community that the Africa Gospel Church does not allow use of professional health care services by its members. Amanze (1994:7) reports that its members prefer to pray for their sick at home and to do their own nursing according to their belief systems, and prescriptions and practices of the Church. Members of the Africa Gospel Church may therefore decide to utilise the traditional or folk care system as opposed to the professional system, or decide not to utilise any of these two health care systems.

It is the task of health professionals, including nurses, to render culture congruent care by combining aspects of both the professional and the traditional health care systems creatively. This research explored the religious beliefs of the Africa Gospel Church and members' health seeking behaviours to enhance health professionals' understanding of these issues. The purpose was to contribute towards a knowledge base that would support culture congruent care. Culture congruent care may contribute towards increased utilisation of the professional health care system by members of the Africa Gospel Church.

1.3   STATEMENT OF THE PROBLEM

There is lack of knowledge and understanding of the belief system and the health seeking behaviours of the Africa Gospel Church people among health professionals. This may result in nurses providing care that is culturally not acceptable to members of the Africa Gospel Church.

This could result in alienating members of this church from the professional health care system. Non-utilisation of professional health services as stated in paragraph 1.2.3.3 could impact negatively on the health status of the people of Botswana.

For instance the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) in Francistown are major health problems. Since 1992 Botswana has been conducting annual surveillance of H I V prevalence among antenatal patients. Between 1992 and 1997, Francistown had the highest sero-prevalence rate among fifteen sites included in the countrywide survey. In 1993 the sero-prevalence rate in Francistown was 34.2%, while Gaborone, the capital city, had a rate of 19.2%. This is despite its population being about 70 000 more than that of Francistown (Abt Associates 2000). Non-utilisation of professional services may hinder control and management of diseases such as HIV/AIDS.

Maternal and child health could also be negatively affected. A diabetic pregnant woman who does not attend antenatal care would not know about her condition, and both mother and child would be at risk of death. These are just a few examples of what could happen as a result of non-utilisation of professional health care services. It is therefore essential for nurses to learn about the beliefs and health seeking behaviours of this religious group and to promote provision of culturally congruent care. In light of these issues, the researcher anticipated that learning about the beliefs and health-seeking behaviours of members of the Africa Gospel Church through in-depth research, would enable her to generate information that would help nurses to provide culture congruent care.

The problem statement for this study was:

> ***How do religious beliefs of members of the Africa Gospel Church and their beliefs on health, illness and care guide their health seeking behaviour?***

1.4   AIM OF THE STUDY

The aim of this study was to contribute towards culture congruent care by broadening the knowledge base on the religious beliefs of members of the Africa Gospel Church and the beliefs concerning health, illness and care that influence the Church members' health seeking behaviour. A study of the literature has not shed sufficient light on these issues, as previous research in Botswana was done more than a decade ago.

1.4.1 Research purpose

The purpose of the study was to improve nurses' knowledge of the religious beliefs surrounding health, illness and care and the associated health-seeking behaviour within the Africa Gospel Church. This enhanced understanding and knowledge could lead to the provision of culturally congruent and sensitive care, based on the recommendations that were formulated by the researcher.

1.4.2 Research questions.

This research sought to answer the following questions:

- *What are the health-seeking behaviours of the members of the Africa Gospel Church?*

- *How are the health-seeking behaviours of the members of the Africa Gospel Church influenced by their religious beliefs, and beliefs on health, illness, and care?*

The research questions have been contextualised by also investigating the general teachings and prescriptions of the Africa Gospel Church, and the lifestyle of its members.

1.5   SIGNIFICANCE OF THE STUDY

The results of this study will benefit the health care system. A better understanding of the beliefs of the religious group will assist health professionals, and nurses in particular, in their participation with the planning and implementing culture congruent health care services. It is also expected to assist nurse educators and students of nursing in the teaching of and learning about culture in general, and religion in particular and their influence on health and health care. The study is also significant in that, to the researcher's knowledge, it is the first ethnonursing study to be done within the Africa Gospel Church of Botswana.

1.6   DEFINITIONS OF TERMS

The concepts defined in this section are considered crucial in aiding understanding of the parameters of this research.

1.6.1 Health

The Concise Oxford Dictionary (1995:626) defines health as "the state of being well in body and mind".

In this study, health is defined as "a state of well-being that is culturally defined, valued, and practised, and which reflect the ability of individuals (or groups) to perform their daily role activities in culturally expressed, beneficial and patterned lifeways" (Leininger 1991:48).

1.6.2 Illness

Andrews and Boyle (1995:22) define illness as a "state of perception, a subjective feeling in which a person may describe symptoms of disease or discomfort". In this study, it is defined as "the experiencing of the disease or injury or psychophysiologic disorder in its personal, interpersonal, and cultural dimensions" (Germain 1992:3).

1.6.3 Care

Care is defined as "protection", or "a thing to be done or seen to" (Concise Oxford Dictionary 1995:197). Leininger's (1995:105), definition was used in this study, namely "abstract and concrete phenomena related to assisting, or enabling experiences or behaviours toward or for others with evident or anticipated needs to ameliorate or improve a human condition or lifeway".

1.6.4 Health seeking behaviour

Behaviour is defined as the response of a person to a stimulus (Concise Oxford Dictionary 1995:116). Scrimshaw and Hurtado (1984) define health seeking behaviour as "what people do in order to maintain health and/or return to health, ranging from individual to collective behaviour". This definition covers the individual and communal dimensions of health seeking behaviour and was applied in this research.

1.6.5 Religion

The Collins English Dictionary and Thesaurus (1993:972) defines religion as "belief in, worship of a supernatural power or powers considered to be divine or to have control of human destiny". It is a system of beliefs that gives meaning to human existence through its explanation of people's origin and purpose in life, it is a source of security and comfort, it defines parameters for social control of its adherents, and it can be both unifying and divisive (Aldridge 2000:71).

1.6.6 Religious beliefs

The Concise Oxford Dictionary (1995:117) defines beliefs as " a person's religion; religious conviction; a firm opinion or an acceptance of a thing or fact". Andrews and Boyle (1999:87) define beliefs as "something held to be actual or true on the basis of a specific rationale or explanatory model". Prescriptive beliefs govern behaviour; they state what should be done, and restrictive beliefs state what should not be done.

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Religious beliefs are truths that are grounded in the belief in God or the supernatural. They define what a believer should or should not do in specific situations.

1.7   FOUNDATIONS OF THE STUDY

This study was based on meta-theoretical assumptions and a nursing theory.

1.7.1 Assumptions

This study is based on four assumptions:

- Cultural and religious orientation influence health care beliefs and practices.

- A person acts within the cultural boundaries of the group to which he/she belongs.

- Illness is undesirable and would prompt a person towards health-seeking activities.

- Health-seeking activities will be in accordance with an individual's religious beliefs.

1.7.2 Theoretical framework

This research is guided by Leininger's (1991:35-49; 1995:97) theory of Culture Care Diversity and Universality (refer to section 2.2). The purpose of the theory is to discover human care diversities (differences) and universals (similarities) in order to generate new knowledge to guide nursing care practices and its goal is to provide culturally congruent care.   Culturally congruent care is defined by Leininger (1995:75) as, "those cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are mostly tailor-made to fit with an individual's, group's or institution's cultural values beliefs and lifeways in order to provide meaningful, beneficial, satisfying care that leads to health and well being".

The theory enabled the researcher to view the cultural group under investigation holistically. The Sunrise Model (Leininger 1991:49), which visually portrays the concepts of the theory, was used as a point of reference to determine the focus of this research. It guided the researcher to select one cultural social structure dimension, namely religion, and investigate its influence on care expressions, patterns and practices with specific reference to health seeking behaviour.

It also guided the researcher in viewing these interrelated aspects within the broader context of the worldview and other cultural and social structure dimensions of the Africa Gospel Church.

Leininger's ethnonursing research method was applied (Leininger 1991:79). The method is defined as, "the study and analysis of the local people's viewpoints, beliefs, and practices of designated cultures" (Leininger 1985:38). This researcher regarded the method to be suitable because of its ability to tease out new knowledge on health-seeking behaviours and their influence on religious beliefs within the Africa Gospel Church.

1.8   RESEARCH DESIGN AND METHOD

A qualitative design using the ethnonursing research method was used in this study. Face to face interviews were done with seven key informants and five general informants who were selected through a non-probability network sampling method. Interviews were conducted in Ndebele. Data was recorded verbatim, and later transcribed and translated into English. Analysis was done by applying Leininger's four phases of data analysis (Leininger 1991:95).

1.9   ORGANISATION OF THE DISSERTATION

In chapter 1, an overview of the research problem, purpose and foundations was given.

Chapter 2 of this dissertation gives an overview of the theoretical foundation of the study and explores the interrelationships between religion, culture and health.

The research design and method are discussed in Chapter 3. The enablers used for data collection and data analysis are outlined. Trustworthiness and ethical considerations are also discussed.

Chapter 4 of the study presents the methods used to analyse the data as well as the results of the study.

Chapter 5 presents a discussion of the findings, recommendations and conclusions.

1.10   SUMMARY

In this chapter the researcher introduced the general background of the study through a description of the geographical setting and health care system of Botswana, and the ethno-history of the Africa Gospel Church. An African perspective on health and illness was outlined. The researcher proposed an ethno-nursing study to investigate how the religious beliefs of members of the Africa Gospel Church on health, illness and care influence their health seeking behaviour. The study is grounded in Leininger's Theory. The study will benefit health care delivery by strengthening the knowledge of health professionals and promote culture congruent care that could potentially increase utilisation of the professional health care system.